ATTENTION ALL LONG-TERM CARE HOSPITALS (LTCHs)

CMS SPECIAL OPEN DOOR FORUM

THURSDAY, SEPTEMBER 20, 2012

2:30 pm – 4:00 pm

CMS will hold a Special Open Door Forum this Thursday, September 20, 2012. Topics of discussion will include:

- Updates from the Division of National Systems
- Frequently Asked Questions (FAQ's) related to the LTCH Quality Reporting Program. FAQ's will include a review of questions asked by providers at the last SODF held on August 30, 2012, additional FAQ's submitted to the CMS LTCH Quality Reporting help desk mailbox.
- Question and Answer session for LTCH providers

Conference ID # 25078457

Participant Dial-In Number(s): *Operator Assisted Toll-Free Dial-In Number: (800) 603-1774

For automatic emails of Open Door Forum schedule and updates (E-Mailing list subscriptions) please visit our website at http://www.cms.gov/opendoorforums/ .

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/092012LTCHSODFAudioID25078457.mp3

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Charles Padgett
September 20, 2012
2:30 p.m. ET

Operator: Good afternoon. My name is Denise and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Long Term Care Hospital Quality Reporting Program Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Mr. Charles Padgett, you may begin your conference.

Charles Padgett: Thank you, Denise. Good afternoon and good morning to those on the West Coast. I'd like to welcome everybody to today's Long Term Care Hospital Special Open Door Forum.

Today, we're going to be reviewing frequently asked questions. Some that you will recognize because your were on last months call on August 30th and others that are newer and we'll be going over those. And at the end of the call, we will, of course, have a question and answer session. So any questions that have not been answered through this process, you'll be able to then ask and have answered hopefully. And if we can't answer them, of course, we'll have you submit them. But for the most part, we hope to be able to answer them for you.

Also, I have with me today Lori Grocholski from the Division of National Systems. Lori is going to provide the LTCH hospitals with a few updates

prior to my beginning the frequently asked question. So right now, I'll turn it over to Lori.

Lori Grocholski: Thank you, Charles. I just have a few announcements. First, providers who have submitted their CMSNet access request form should be contacted beginning on Monday. For those providers who have not completed their form, we encourage you to complete by September 30th. The QTSO help desk has received numerous requests regarding their provider facility I.D. We have posted the LTCH Medicare CCN to submission facility I.D. crosswalk on the qtso.com under the LTCH section. And this was the CCN and the associated facility I.D. Just as a reminder that each provider, CCN will be issued two user IDs.

Also, the CMS LASER which is the LTCH Assessment Submission and Trigger Reporting Software is now posted on the QIES Technical Support Office website which is www.qtso.com . LASER is also undergoing its posting on the CMS website.

CMS has made available the last two new recorded training sessions for LTCH on the QTSO website. The last two sessions to be posted are the LTCH Assessment Submission Process and CASPER Reports for LTCH. With the addition of the two last WebEx trainings, all of the LTCH CARE data submission and LASER WebEx trainings are now posted.

CMS wants to ensure that LTCH are aware of the following WebEx technical trainings related to the LTCH CARE data submission and LASER that are available for downloading on the QTSO website. Those are under data submission training, we have CMSNet and QIES user I.D. registration training, LTCH Assessment Submission Process, LTCH Assessment and Validation Report.

Also, under LASER training, we have the Login Process, Patient and Assessment Entry, Import and Export Process, Reports, and there is also the LASER Demonstration Version of the tool.

Lastly, the reporting can be accessed via the e-University page on QTSO. Please contact the QTSO Help Desk at 800-339-9313 or help@qtso.com if you have any questions regarding the training sessions.

Thank you and I'll hand this back over to Charles.

Charles Padgett: Fantastic. Thank you, Lori. And kind of on the same note, I just want to let our participants on the call know that the LASER software Lori was referring to is now available on the CMS Long Term Care Quality Reporting website. And additionally, we have posted the slide deck and the audio MP3 file from last month, August 30th, LTCH Special Open Door Forum. Those are both available by navigating to the Long Term Care Hospital Quality Reporting Program web page. And we'll give that web address at the end of this conference. It's very long so I just wanted – it's easier to do at the end.

So now, I'm going to go over several frequently asked questions. These are questions some of which you'll recognize from last month's open door forum as I said. Some of these get submitted to the CMS Quality Reporting Program Help Desk Mailbox. Some of these get submitted to the Technical Mailbox. So from all of those sources, we've compiled the most frequently asked questions. And the ones we feel are important and we're going to go over some of those now.

So, I'll begin. I also like – I just want to let you know this document is available on the Special Open Door Forum – the CMS Special Open Door Forum website. If you haven't gone there, that website is (www.cms.gov/outreach-n-education/outreach/opendoorforum/odfspecialodf.html). You can also find your way to that page by going to Google and Googling CMS Special Open Door Forum. That web page is one of the first or second that pop up when you do that search.

Matthew Brown: And, Charles, this is Matthew Brown on …

Charles Padgett: Yes.

Matthew Brown: … (inaudible). It's also located on the SNF and Long Term Care Open Door Forum page and the Rural Health Open Door Forum page.

Charles Padgett: OK, fantastic. Thank you, Matthew. I appreciate that.

OK, so I'm going to begin on page one of the FAQ document if you have it. If not, you can listen along. As I said, this document is available online. It also will be posted on the LTCH quality reporting website shortly. And next week we will also post the transcript and the audio files of today's Special Open Door Forum. So those all can be resources for you.

Alright. So, question number one that I'm going to go over was submitted. It states, I need clarification on the definition of LTCH. Are these long term acute care hospitals or long term care hospitals?

And Long Term Care Hospitals and Long Term Acute Care Hospitals are different names for the same type of hospital. Medicare uses the "Long Term Care Hospitals". These hospitals are certified as acute care hospitals that treat patients requiring extended hospital level care, typically following an 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 or CCN, in the range of 2000 to 2299, it is subject to the requirements of the LTCH quality reporting program. If your critical access hospital, or CAH, has long term care beds that either provides skilled nursing facility level or nursing facility level care, it is not required to comply with any of the requirements mandated for LTCHs under the LTCH QR program.

Next question, where can I find the definitions for the LTCH quality measures for October 1, 2012? For the most current definitions for the three LTCH quality measures, catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infections, or CLABSI, or the pressure ulcer measure, please refer to the LTCH quality reporting program manual available for download at the LTCH quality reporting website. Again, I will give that website out at the end of this session. We also invite you, you know, to visit

the website for updates to specifications for each of these measures that may result from the NQFs forum's review – or NQFs review, rather.

Next question, what document is the final word when it comes to the specifications?

For submission of data for the pressure ulcer measure using the LTCH CARE data set, LTCH must follow the LTCH CARE data submission specifications version 1.00.3. The submission specifications are posted on the CMS website and that's the LTCH Quality Reporting Program website. And once you get there, you want to navigate to the technical page which is accessible by going to the upper left hand corner of the main web page. And you'll see a heading that states Technical Page. You click on that and that will bring you to the technical page. I will give that address out at the end of this session as well.

For submission of the data for the urinary catheter-associated urinary tract infections, CAUTI measure, and the central line-associated blood stream infections, or CLABSI measure, we ask that you follow the Centers for Disease control – Centers for Disease Control and Prevention, or CDC definition guidelines, for submission of those two measures for the event data associated with them via the CDC's National Health Safety Network, or NHSN. And that information is also included in chapter five of the LTCH quality reporting program manual.

Next question, if a discharge is delayed, do we fill out the discharge assessment on the planned day of discharge or the actual day of discharge?

For discharge assessments, the assessment reference date otherwise known as the ARD is always the patient's actual discharge date. The LTCH has five days to complete the discharge assessment following that date of discharge. Chapter two of the LTCH quality reporting program has more information related to that. You can reference that in that chapter.

Moving on, if a patient is discharged to IPPS and expires within 72 hours of being discharged to the other hospital or facility and we do not receive notification of this, how do we fill out the expired outside CARE data set?

There should be communication between the LTCH and the provider to which the patient was discharged is what we're saying here. And, however, I will say, if the LTCH is unaware the patient expired after being transferred, the last assessment that was completed for that patient in the LTCH would be the last assessment required. If the LTCH learns of the death, they can submit the expired data set. If the patient is – if the patient is discharged to another facility, then the LTCH should have submitted either the planned or unplanned discharge data set as their last submitted data set.

Moving on, if a patient dies during the assessment period, do you fill out admission and expired assessment?

And the answer to that question is yes. We require both an admission and expired assessment in that situation. The ARD or the assessment reference date for discharge would be the date of death.

If a patient has an acute unplanned discharge and I have already completed my unplanned discharge assessment record and six days later the patient expires. What would my actual assessment reference date be?

If the – if the patient was away from the LTCH for more than 72 hours, you know longer track the patient. That patient is considered discharged from your LTCH. So we would expect that you would complete and – LTCH does not have to complete the expired assessment but we would expect that you would submit the planned or unplanned discharge depending upon whether the discharge to a short stay or acute care hospital was planned or unplanned.

But we would require that you submit a discharge assessment in that situation but because it's been longer than 72 hours, we do not expect that you continually track patients after 72 hours. We consider that patient is discharged from the LTCH. It's no longer considered an interrupted stay and you would then go ahead and submit a planned or unplanned discharge as appropriate.

Next question, will LTCHs be expected to copy the LTCH CARE data set and keep it as part of the medical record? And are LTCHs required to print each assessment record?

And CMS is stating, LTCHs should retain copies of the LTCH CARE data set assessment record as part of the patient's medical record in accordance with facility and State and Federal requirements pertaining to the retention of patient record. More information on this is also available in chapter two of the LTCH quality reporting program manual. Under the LTCH quality reporting program, there is no current requirement for LTCH regarding the printing of the assessment records.

Next question has to do with LTCH CARE data set. Are all demographic information items required? And specifically, are the following items required only on the admission assessment? And they're referring to items GG0160C which has to do with functional mobility, lying to sitting on the side of the bed; H0400 which has to do with bowel incontinence; I0900 which has to do with peripheral vascular disease or peripheral arterial disease; I2900 which has to do with diabetes; K0200A which has to do with height; and K0200B which has to do with weight.

And when a question like this is asked, what we're going – what we're always going to ask is that you please refer to the LTCH quality reporting program manual. It's, of course, available for download at the LTCH quality reporting program website.

Now Appendix E provides item-specific guidance on the requirements for the completion of the LTCH CARE Data Set. However, it's really extremely important that you know that Appendix E is provided to illustrate which items are required versus which can be voluntarily submitted and when each type of LTCH CARE Data Set assessment record should be submitted. Appendix E is not to be used as a replacement for the data submission specifications. For data submission, the LTCH CARE Data Set must follow the LTCH CARE Data submission specifications version 1.00.3 that are posted on the CMS website.

So Appendix E essentially is there to distinguish between required versus voluntary items. However, what we're trying to communicate with that appendix is that some items, even though they are voluntary, they do require

that you submit one of the available default responses in order to submit that record to the QIES Data System. If you do not use one of the default responses for some of those questions, the record will be rejected from the system. So we are just trying to help you understand which items actually do require a default response which, for example, could be 99 or Z if they're listed as one of the available responses under the question. Or it could also be a dash or a hyphen that's used to indicate this question is not being answered.

According to the specifications of the pressure ulcer measures, height, weight, diabetes mellitus, peripheral vascular disease and peripheral arterial disease, bowel incontinence, and functional mobility are all used as covariates or risk adjusters to calculate the percentage of patients with pressure ulcers that are new or worsening.

The data for these risk adjustment items are derived from the admission assessment. Therefore, the provider must submit these risk adjustments items on the admission assessment. These items are not used in the measure of calculation at discharge and are therefore not required at that time.

If providers do not want to provide an actual assessment-based response on these items at the time of discharge, they must enter a default code for some of the items. The default codes vary according to data item. Appendix E provides item specific information on which items are voluntary but we require a default code. Again, we refer you to the data submission specifications document that is the primary source for these codes and when they are to be used.

Moving on, we have a question that asked what does it mean when the fields are identified as voluntary but a default response is required for submission? So very similar, these voluntary fields require a default response such as a dash, 99 or Z for successful submission of the record. These responses – let CMS know that a provider did not accidentally skip an item on the LTCH CARE Data Set but chose not to answer it or couldn't answer it.

Alright. Based on the guidance and the LTCH QR program manual, there are some instances where it is expected that patient information will be obtained

subjectively through interviewing the patient's family or other caregivers. So this information also has to be documented in the medical record? And our answer is yes. Whatever is documented in the LTCH CARE Data Set must also be reflected in the patient's medical record.

Next question, do we report LTCH patients with all payer sources for CAUTI, CLABSI and pressure ulcers or just patients admitted with Medicare as the payer source?

For the pressure ulcer measure, the LTCH CARE Data Set applies to all patients receiving inpatient services in a facility that is 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, diagnoses, length of stay, or payment, or payer source. You can – and you can find more information about that in chapter two of the manual in section 2.1.

For the urinary catheter-associated urinary tract infections, or CAUTI measure, and the central line-associated bloodstream infections, or CLABSI measure, each LTCH must submit data for these measures on all patients from all patient locations – inpatient locations regardless of payer source. And for more information related to that, you can also refer to chapter five of the LTCH quality reporting program manual section 5.1.

Next question, do we report patients who are discharged after October 1st but who were admitted before October 1st. And the answer to that question is no. For the LTCH quality reporting program, LTCHs are only to report on patients who are admitted on or after 12:00 a.m. on October 1, 2012. So any patient that's admitted before that will automatically not become part of your data reporting. The admission for every patient you report on related to this program has to be after 12:00 a.m. on October 1, 2012.

Do I need to report quality measures from my pediatric patients? LTCH must report data for three quality measures, again, CAUTI, CLABSI, and pressure ulcers for all patients including pediatric patients receiving inpatient services

in a facility certified as a hospital and designated as an LTCH under the Medicare program.

Applicable assessments using the admission, unplanned discharge, planned discharge, and expired LTCH CARE Data Sets must be completed for all patients regardless, again, of payment payer source, age, or diagnoses including pediatric patients or patients with psychiatric diagnoses. For additional information regarding the LTCH CARE Data Set requirements, please refer to chapter two of the program manual which again is available for download on the LTCH quality reporting website.

Next question I'm going to go over asked about patients – a patient is – if a patient is admitted on October 11th, for example, and for some reasons such as a death or they leave AMA or because of medical instability, you know, something that is outside the scope of services that are provided at that LTCH, maybe they need surgical intervention. The patient does not stay in that LTCH beyond midnight on that same day that they were admitted.

This person is asking, does this patient require an assessment for admission and discharge even if they do not stay? And most of the assessments would be dashed they say. Meaning, they would use hyphens because they may not know all of the information because this patient was discharged.

And our answer to that is – and the requirement is that the data to be collected and submitted for all patients that are admitted to your LTCH on or after October 1, 2012 at 12:00 a.m. LTCH must submit an admission assessment and a discharge assessment even when a patient is admitted and discharged on the same day. Please use appropriate discharge assessment for the time of discharge, meaning planned versus unplanned.

We get this question quite frequently. And this is again, what is the definition for unplanned discharge for purposes of determining whether to submit an unplanned discharge assessment?

So, again, an unplanned discharge is one in which a transfer of the patient to be admitted to another hospital or facility that results in the patient's absence from the LTCH for longer than three days including the date of transfer, or a

transfer of the patient to an emergency department of another hospital in order to either stabilize their 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 three days, or the unexpected departure of the patient from the LTCH against medical advice, or the unexpected decision of the patient to go a home or to another setting, perhaps they want to complete treatment in an alternate setting.

So unplanned discharges do not include any 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 three days.

Moving ahead, what is the definition for planned discharge for purposes of determining whether to submit a planned discharge? So this is the opposite, of course – excuse me. A planned discharge is one in which the patient is non-emergently medically released from care at the LTCH for some reasons for – or for some reason that is arranged for in advance.

Alright. Next question, if a patient's planned discharge is Friday, but the discharge is delayed until Sunday, what should the ARD be? So they're asking what the assessment reference date would be on a patient that is – the LTCH had planned to discharge this patient on Friday. Their discharge was delayed. They weren't actually discharged until Sunday. Where do they set the ARD?

So the ARD on a discharge assessment will always be the patient's actual discharge date. It will never waiver from that. So the day that patient gets discharged from that facility, that will be the ARD. And the information pertaining to that discharge assessment will be from that day and then two previous days.

If a patient dies during the assessment period, should we fill out those admission and expired assessment? I covered the question like this - very similar earlier and the answer is yes. Both the admission and the expired assessment should be complete.

The question asking, how do we define a day? Is it from midnight until 11:59 p.m.? And the answer to that is yes. We consider a day beginning at midnight or 12:00 a.m. and lasting until 11:59 p.m.

If a patient goes to an ER at 11:59 p.m. on day one and then returns by 11:59 p.m. on day three, it is considered an interrupted stay. But if a patient returns after 11:59 p.m. on day three, what assessments would need to be completed?

So they're correct in stating if a patient goes to an ER is transferred out of the LTCH to the ER at 11:59 p.m. on any given day, that would be day one. And then they return by 11:59 p.m. on day three. It would be considered an interrupted stay in which case, no paper work, no discharge admission or expired assessments would be required.

Now, if that same patient returned after 11:59 p.m. on day three, we would require a discharge assessment because it's no longer considered an interrupted stay. So if an LTCH transferred a patient to the ER at 11:59, for example, on August 1st. Then August 1st would be considered day one, which is always the date of transfer.

Should the patient remain away from the LTCH past the third calendar day which would be August 1st plus two calendar days, that would be August 3rd at 11:59 p.m., then the LTCH would be responsible for completing assessment records. They would need to complete an unplanned discharge assessment record because the patient was away from the LTCH past the third calendar day, a discharge assessment is required. We require the unplanned discharge because the patient was transferred emergently.

We would also require that a new admission assessment record be completed and submitted because the patient was away from the LTCH, again, past the third day, a discharge assessment was completed and filed. Therefore, the patient who has reentered the LTCH would now have a new admission assessment record completed because it's as if the patient is entering the LTCH as a new patient. The patient's absence is no longer considered an interrupted stay.

Next question, training indicates we have three days to enter data on new admission. Does this include weekends and holidays or are they excluded? And the assessment reference date or ARD is the end point of the assessment period for the LTCH CARE Data Set assessment records. And it always includes weekends and holidays. If a patient was admitted on Friday, the ARD for admission assessment is Sunday. Friday plus two calendar days is Sunday.

For example, if a patient was admitted on Friday, October 19th, the ARD for the admission assessment is Sunday, October 21st. For more information on this subject, you can refer to chapter two of the CMS LTCH quality reporting program manual.

Moving on, if the patient is admitted – I'm sorry, I already asked that question. OK. Would a patient who requires assistance to maintain the passage of stool be considered continence?

So this has to do with section H of the LTCH CARE Data Set. Would a patient who requires assistance to maintain the passage of stool either through manual stimulation, rectal suppositories, or an enema, et cetera, would they be considered continent? And for the purposes of the LTCH CARE Data Set, this person would be considered continent. If the patient has had no incontinent episodes during the three-day assessment period, then H0400 should be coded zero, always continent. And this is on – you can find this information on the LTCH program manual on page H2.

OK. I have a question that asks, what if a patient is weighed on the date of admission and weighs 120 pounds, and is weighed again on day two and is 119 pounds. What should be reported in section K? So section K is height and weight. For an admission assessment, if the patient has been weighed multiple times during the assessment period, we would like you to use the first weight. So K0200 would be quoted as 120 pounds as the patient – that was the patient weighed the first time they were weighed during that day. And you can find more information on this in the LTCH manual on page K2.

Admission documentation of pressure ulcers must be done within the first three days? Discharge documentation is taken away – is taken from the last three days of the patient's stay? These are both questions that somebody is asking. So they're asking does CMS requiring that admission documentation of pressure ulcer be done within the first three days. And they're also asking if discharge documentation is taken from the last three days of the patient's stay.

So the assessment reference date, again, it provides the endpoint of the assessment period for any of the LTCH CARE Data Set assessment record. So for an admission assessment, the ARD is the date of admission plus two calendar days. The facility has three days to actually gather the data. And then once we get to the end of those three days, the facility will then have an additional five days to complete the LTCH CARE Data Set admission assessment.

As far as the discharge and expired assessments are concerned, the assessment reference date is the date of discharge or the date of death. So, each of this assessment looks back to the three-day span of the assessment reference date with the exception of the following items on the planned discharge assessment. A, 1955 which is discharge delay, this asks that providers look back 24 hours from the date of discharge. Item M0800 which is worsening in pressure ulcer status and this asks that providers look back to the prior assessment – admission assessment. And the following item on the unplanned discharge assessment, M0800 which again is worsening in pressure ulcer status which looks back to the prior assessment or the admission assessment.

Why had CMS adapted National Pressure Ulcer Advisory Panel, or NPUAP guidelines related to blisters and deep tissue injury? And our answer to that is CMS consulted subject matter experts for clinical validation of pressure ulcer coding. And at the time these were finalized, it was determined that there was – there was much that current science was unable to confirm regarding a deep tissue injury, or DTI. CMS opted for a holistic approach to pressure ulcer assessment that include a characteristic of the surrounding skin instead of just a pure focus on what the color of the fluid was that was visible inside an intact blister.

OK. What types of clinical personal can stage pressure ulcers and report the pressure ulcer items on the LTCH CARE Data Set? Patient assessments are to be done in compliance with facility, State, and Federal requirement. The State laws provide guidance on who may complete assessments on the patients.

Why are pressure – why are pressure ulcers that have been repaired with grafting procedures – and I'm on question 37 if you're following along on the FAQ document. Why are pressure ulcers that have been repaired with grafting procedures considered surgical wounds and not coded as pressure ulcers?

And the answer to that is 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 a wound. And after the surgical wound dehisced, it's no longer able to be staged or classified as a pressure ulcer. So for purposes of coding the LTCH CARE Data Set assessment, 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.

What do we do if a pressure ulcer worsens during the first three days of a patient's admission to the LTCH? How do we code the wound? The patient assessment reflected in the admission assessment data should coincide with the patient's admission assessment for the purpose of determining if a pressure ulcer was present on admission. A wound that is determined to be present on admission would specifically need to be on admission. Thus, if a present on admission wound worsens during the three days, the admission assessment record should the capture the wound stage at admission and the stage to which it worsens.

On the discharge record, the wound would be captured in a stage to which it worsened if it had not healed. You know, the wound, because it worsened would no longer be captured as present on admission on the discharge assessment.

OK. Moving on. I'm going to answer some questions or go over some questions related to section Z. If you're following along on the FAQ document, this is – I'm going to begin with question 52 which states, do I have to retain a section Z? CMS will not be receiving the signatures from the LTCH CARE Data Set section Z item 0400 and 0500. So when you transmit the LTCH CARE Data Set through LASER which essentially allows you to transfer that data set to us, these items, Z0400 and Z0500 in which you capture signatures from your staff are not transmitted to us.

We strongly suggest, however, that you retain what you submit to CMS including section Z according to policies administered by your facility or State and Federal regulations and requirements. So facility should comply with their requirements also pertaining to electronic signatures should they require them.

And does the LTCH CARE Data Set require the signature of a registered nurse? And the answer is no. CMS has removed the language surrounding this requirement or the requirement for registered nurse's signature for the submission of the LTCH CARE Data Set.

Moving along, I'm going to move on to question 56. How often and what are the due dates for submitting patient assessment? Admissions, planned discharge, unplanned discharged, and expired to come through QIES – through QIES ASAP. Do you require them weekly, monthly, quarterly? What is the timeframes for submission of an individual record or file?

And our answer to that is each assessment whether it's an admission or a discharge must be submitted within seven days of the date of completion. So all files generated by a facility between October 1, 2012 and December 31, 2012 must ultimately be submitted to CMS or the NHSN system no later than 11:59 p.m. on May 15, 2013. File submitted after this date and time will not be accepted.

So just to clarify here, the ARD ends on the third calendar day. Day one is the date of admission plus two calendar days equal the ARD. So that's the third day. When you get to the ARD, you then have five calendar days from that

date to then complete the assessment record whether it's admission, planned discharge, unplanned discharge, or expired. So day three plus five calendar days, you get to day eight. And then once you reached day eight, you then have seven additional days during which to submit your data set.

We ask, you know, that you submit them according to this rule. However, should you missed one or realized that you've missed the submission of a data set, you ultimately do have until May 15th of 2013 for any records that occurred between October 1st and December 31st of 2012. You have until 11:59 p.m. on May 15th to ultimately get those submitted or corrections submitted to us at CMS. And after that, we will not – the items will not be accepted.

Where can we find the timelines in terms of data collection periods and submission periods associated with this program? The timelines related to data collection periods and data submission periods can be found in the fiscal year 2012 IPPS LTCH PPS final rule as well as the LTCH QR program manual provided under the downloads section on the LTCH quality reporting web page.

And so if you navigate through the LTCH quality reporting web page, at the bottom of the page you'll see a section labeled 'Download'. You'll also see a section labeled 'Related Links'. And those two sections are where you'll find the manual and you'll also be able to find a link to the final rule to look at the submission date.

OK. Looking for guidance as to what to do when a facility realizes assessments were missed? And LTCHs need to ensure that they have some sort of mechanism in place to track whether or not all assessments have been submitted for each patient. If for example, an LTCH forgets that the admission assessment record and upon discharge, the LTCH submits a planned or unplanned record, the QIES ASAP system to which the LTCH submits its records will issue a warning stating that the LTCH has submitted an assessment out of sequence. This should alert the LTCH that it has forgotten to submit an assessment. The LTCH should submit the missing assessment as soon as the staff realizes the error has occurred. But ultimately,

LTCHs will have until the May 15, 2013 final deadline to submit any missing or corrected assessments.

OK, moving on. I'm going to move on to question 66 which asks for the CAUTI and CLABSI measures, will CMS be pulling data from NHSN? The answer to that essentially is yes. We don't actually pull the data but we work with the CDC to have that data transferred to us in a secure manner.

And I'm going to move back to question 63 which states, I have a question concerning the completion of the long term care hospital continuity assessment record and evaluation of CARE Data Set. The handout we received talked about completing the assessment on the third day of admission.

For example, for a patient admitted on a Friday, the guidelines indicate it needs to be completed by Monday. What happens if the assessment is not completed by then, the third day? Do we have three more days to complete? Any penalties apply if we don't complete the assessment in three days? Are these guidelines and not rules?

And our answer to that is there are no grace periods for the LTCH CARE Data Set assessment completions or submission timeframe, LTCHs are expected to follow the timeframes as expected regardless of the day of the week that a patient is admitted on – admitted to the LTCH. There is more information related to this and you can update yourself by looking – referring to chapter two in the LTCH quality reporting program manual.

On the assessment reference date, the third day is – day three of admission so the date of admission plus two more days, like I said, you then have – we'll have five days to actually complete the LTCH CARE Data Set assessment record. But all information must pertain to those first three days.

Furthermore, the skin assessment section or section M pertains to a patient's assessment completed on admission based on hospital policy generally within the short time of arrival. Completing or submitting the assessment in an untimely manner will result in a warning message as these dates are based on the admission date.

That's all I have in the way of frequently asked questions today. We are going to turn it over to see if providers have any questions. Before I do that, I will go over some of the websites that I've just mentioned again. The LTCH quality reporting program website, I'm going to give that address. That is www.cms.gov/medicare/quality-initiative-patient-assessment-instruments/ltch-quality-reporting/index.html .

And I'm going to give that one more time, I know it's long. It's www.cms.gov/medicare/quality-initiative-patient-assessment-instruments/ltch-quality-reporting/index.html .

Additionally, I'm going to go ahead and give the special open door forum web page which is www.cms.gov/outreach-and-education/outreach/opendoorforum/odfspecialodf.html .

And lastly here, I'm going to give the LTCH quality questions – or the LTCH quality reporting mailbox to which you can – I encourage you to e-mail any questions that aren't answered today or don't get answered in the next question and answer session which is ltchqualityquestionsltchqualityquestions@cms.hhs.gov .

And the web address for our technical mailbox is ltchtechissues – that's ltchtechissues@cms.hhs.gov .

Alright. So I guess we will turn it over to the operator for our question and answer session.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star one on your telephone keypad. If you would like to withdraw your question, press the pound key. Please limit your questions to one question and one follow up to allow other participants time for questions. If you require any further follow up, you may press star one again to rejoin the queue.

OK, your first question comes from the line of Kristen Smith from Vibra Healthcare. Your line is open.

Kristen Smith: Hi, thank you. I still need some clarification on planned versus unplanned discharge.

Charles Padgett: Yes.

Kristen Smith: From your definition, it states that a planned discharge can be a planned intervention procedure at a short term acute hospital if they don't stay greater than three days, is that correct?

Charles Padgett: Yes – no, if they stay greater than three days.

Kristen Smith: So if they stay greater than three days …

Charles Padgett: If they don't stay greater than three days, then it's considered an interrupted stay, correct?

Kristen Smith: Correct. And that's why I'm confused because in the definition it says for a planned discharge or planned intervention procedure unless they stay greater than three days.

Charles Padgett: OK, so …

Kristen Smith: Then it wouldn't be – then it wouldn't be a discharge.

Charles Padgett: Yes. So, thank you for pointing that out. And we'll take a look at that definition. And I'm sorry if that caused confusions. If a discharge from your – if somebody is discharged from your facility and it then last longer than three calendar days including that date of discharge, it's no longer considered an interrupted stay and that's when you would fill out a discharge assessment, correct?

Kristen Smith: Correct.

Charles Padgett: OK.

Kristen Smith: And I just want to clarify and make sure that you can have a planned discharge to a short term acute care hospital if it's a planned procedure, intervention, et cetera.

Charles Padgett: Yes, absolutely.

Kristen Smith: OK. Thank you.

Charles Padgett: Thank you for your question.

Operator: Your next question comes from the line of (Christina Wing) with Fundamental Administrative Services. Your line is open.

(Christina Wing): Hi. Thank you for this open door forum. I would like to clarify with the assessment reference date for an admission event. It says – I'm looking at question number 63. It says that the assessment reference date is day three of admission. Date of admission plus two more days. Does that mean the assessment reference date will have to be day three if admission is day one?

Charles Padgett: That's correct.

(Christina Wing): It has to be day three?

Charles Padgett: Yes.

(Christina Wing): It cannot be day one or day two?

Charles Padgett: No, the assessment reference date is always the date of admission plus two calendar days when we're talking about admission.

(Christina Wing): Yes.

Charles Padgett: But it will always be day three …

(Christina Wing): OK.

Charles Padgett: … for admission.

(Christina Wing): And so – but in case the – let's say the patient is admitted on day one and discharged on day two, would – that would be an exception which means the admission – ARD, assessment reference date will be a different date.

Charles Padgett: The date of discharge, yes.

(Christina Wing): That will be the date of discharge.

Charles Padgett: Yes.

(Christina Wing): So the ARD for admission will be day two in this case and the discharge date and the discharge ARD should be on day two in this case?

Charles Padgett: Exactly, exactly.

(Christina Wing): Oh, I see. If the patient is admitted on day one and discharged on day one, then all the admission date, discharge date, and – or both ARD date will be day one.

Charles Padgett: That's correct.

(Christina Wing): So these are – I guess, these two scenarios are exceptions.

Charles Padgett: Yes.

(Christina Wing): OK.

Charles Padgett: So I'm glad you brought that to light and perhaps we can add something that speaks to that so that everybody is clear about that.

(Christina Wing): Yes. So – yes, thank you.

Charles Padgett: OK.

(Christina Wing): Thank you so much.

Charles Padgett: Thank you for your question.

Operator: Your next question comes from the line of (Jerlinda Trek) with Jefferson Regional. Your line is open.

(Jerlinda Trek): I was calling now – I just want to ask can I reference to a patient if the patient had been on my floor for 21 days and then the patient passes, I just want to see if I had to do the death and facility record or do I have to do the discharge also?

Charles Padgett: If the patient dies in your facility, you would fill out an expired assessment on that patient.

(Jerlinda Trek): OK, thank you.

Charles Padgett: Yes.

Operator: Your next question comes from the line of (Jim Codling) with Spectrum Health. Your line is open.

(Jim Codling): Thank you for taking my question. The NPUAP mentions a group of pressure ulcers that they call mucosal pressure ulcers. And they define those as pressure ulcers but that they're not stageable. So I'm wondering how you recommend we report those if at all, those type of pressure ulcers.

Charles Padgett: Sure. So a mucosal pressure ulcer would not be one that is recorded on the LTCH CARE Data Set. It's not one that's staged in the same way that normal pressure ulcers are. The layers of skin are not the same. And though it would be something that of course you record in the medical record as you would doing any skin assessment on a patient but you would not record a mucosal ulcer on the LTCH CARE Data Set.

(Jim Codling): OK, thank you.

Charles Padgett: You're welcome.

Operator: Again, to ask a question, press star one on your telephone keypad. If you would like to withdraw question, press the pound key.

Your next question comes from the line Karen Finerty from RML Specialty Hospital. Your line is open.

Karen Finerty: Good afternoon. I have a question regarding an emergent discharge situation.

Charles Padgett: OK.

Karen Finerty: Let's say our patient is discharged whatever day – October 3rd at two in the morning. Now, for the discharge assessment, we obviously, just before the patient leave can't do a wound assessment. And actually that wound assessment maybe not – maybe wasn't done the day of – the previous day either. How far back can we look into, you know, when the wound care nurses evaluated to be able to give that information? Or does it – does everything that is not done on the day of discharge, does it have to be just dash?

Charles Padgett: I mean, we ask that you consider the assessment reference period so we ask that you consider that date of discharge plus the two previous days.

Karen Finerty: What is the previous days for the wound? So …

Charles Padgett: That's correct?

Karen Finerty: … if my wound care clinician saw the patient, let's say, on October 1st, we could take that information and use that for the unplanned discharge assessment.

Charles Padgett: Yes.

Karen Finerty: But if it was September 28 that she saw him, that would not be acceptable?

Charles Padgett: You know, I'm going to ask ultimately that you submit that question to our mailbox.

Karen Finerty: Sure.

Charles Padgett: And I'll provide a written answer. And I'll certainly post the written answer also so everybody has access to it.

Karen Finerty: Sure, I'd be happy to.

Charles Padgett: OK, thank you so much for your question. I really appreciate it.

Karen Finerty: Thank you.

Operator: Your next question comes from the line of (Stephanie Con) with Specialty Hospital. Your line is open.

(Stephanie Con): Thank you very much. I'm referring to question number nine.

Charles Padgett: OK.

(Stephanie Con): The retaining copies of the LTCH CARE Data Set as patient – as part of the patient's medical record but there's no current requirement for the printing of this. Now, if we do not – if we still have a paper medical record, then we need to essentially print them out and store them in the medical record. Is that correct?

Charles Padgett. Yes. I mean, if you – if you have a paper record, there would be no other way for you.

(Stephanie Con): No other option.

Charles Padgett: Yes.

(Stephanie Con): OK. That's – and – OK, thank you very much.

Charles Padgett: You're quite welcome.

Operator: Your next question comes from the line of (Donna Ismaha) with (Newland) Health Services. Your line is open.

(Donna Ismaha): I had a follow up question to the one who just asked. We also have a paper record but we will be using a software program where the information is stored. Will we still require – be required to print off the assessment and put it on the medical record since we'll be able to access it online? Or do – can we just use the online storage?

Charles Padgett: I believe the answer is you'll be able to store it electronically. However, I'm going to – I'm going to ask that you submit that question also. And I'll give you a formal written answer on that.

(Donna Ismaha): OK, thank you.

Charles Padgett: You're quite welcome.

Operator: Your next question comes from the line of (Mary Dalrymple) with (ALTRAX). Your line is open.

(Mary Dalrymple): Hi. Thanks for answering all the question in that FAQ. I have two questions about dates.

Charles Padgett: All right.

(Mary Dalrymple): And I apologize that the first one was answered in the earlier question. I missed it.

Charles Padgett: Oh, that's OK.

(Mary Dalrymple): If a patient is admitted on day one and they die on day two, is the assessment reference date for the admission assessment still admission plus two days?

Charles Padgett: Well, no, it would just – it would be day two because the patient is deceased.

(Mary Dalrymple): OK. Yes.

Charles Padgett: You just – well, you wouldn't have any information (from dates, I believe so.)

(Mary Dalrymple): Right, exactly. That's why I was confused. OK. And my second question is if, let's say, you have filled out a full assessment and you've entered a completion date and then sometime in that week between the completion date and the transmission date, you find an error and you correct the assessment before you transmit it. Should you change the completion date to the date that you entered that corrected item or leave it as is?

Charles Padgett: Oh, that's a good question. That's a really good question. I'm going to ask that you submit that to us and …

(Mary Dalrymple): OK.

Charles Padgett: That way we can provide you with a written answer. Yes, I'll ask that you submit …

(Mary Dalrymple): OK.

Charles Padgett: … to us.

(Mary Dalrymple): We'll do, thank you.

Charles Padgett: Thanks for the great question.

(Mary Dalrymple): Yes, sure.

Operator: Your next question comes from the line of (Sharon Bready) with CareOne. Your line is open.

Male: Hi, thank you for answering all the questions. Regarding the first three days and what has to be done in the first three days, in the LTCH assessment portion of LASER or sections A, B, GG, H, I, and so on, which of those need to be completed within (inaudible) days?

Charles Padgett: Well …

Ellen Berry: Hi, this is Ellen Berry. Can you repeat that question?

Male: Of course. For the – we've been using LASER and completing the LTCH assessment portion of the quality reporting, the different sections, section A, B, GG, et cetera, which sections need to be completed within that three-day timeframe – the initial three-day?

Ellen Berry: Well, all right, with any of the software that we found in the CMS specifications, when you have to have the data that you enter into your software tool has to apply to that (inaudible) which is the ARD which it

sounds like in your example, it would be day three. When you complete that information might be different. You might complete it on day four so your Z dates, which I don't have the tool in front of me, would be day four. So you might be collecting information but entering it into the tool on different days.

Male: OK. But within the three days, what is required of the LTCH – I mean, it's the entire admission portion of the LTCH assessment do within the three days?

Charles Padgett: You have – the three days are the – are the time during which you will be assessing the patient and you will use the data or the patient information from those three days in order to complete the LTCH CARE Data Set. The LTCH CARE Data Set, you have five days beyond the ARD to complete that data set. So no section of that LTCH CARE Data Set has –or must be completed within those three days. But you – you will have until day eight to complete all of those sections.

Male: You're just driving the ARD during those three days.

Charles Padgett: Yes, that's correct.

Male: OK. Great, thank you very much.

Charles Padgett: Did that help?

Male: Good, thank you.

Charles Padgett: OK, good.

Operator: Again, to ask a question, press star one on your telephone keypad. To withdraw your question, press the pound key.

Your next question comes from Susan Hostage with Gaylord Hospital. Your line is open.

Susan Hostage: Yes, good afternoon. This has been very helpful. I have a question in regard to the user IDs. We have applied as of a week or 10 days ago for the QIES user I.D. I have not received that. And then there is also another set of user

IDs which we can't access without the first step. Our understanding was by today, September 20th, this information was going to be available. So we just want to be able to move ahead on this. Could you give me an idea on the timeframe?

Female: Ellen?

Ellen Berry: Yes. Lori, did you make the announcement in the beginning of the call?

Lori Grocholski: I did. I did.

Susan Hostage: (Inaudible), guys.

Ellen Berry: OK, that's no problem. So, the information that we have to give to you today is that CMSNet if you have submitted your application, your access request form should by Monday start sending e-mails to those who have requested access. From there, if you review the registration WebEx and look at the steps that need to be taken, you will eventually then be provided with your QIES access I.D. and password.

Susan Hostage: Yes, thank you. And I apologize for missing …

Lori Grocholski: That's no problem.

Charles Padgett: Yes, no problem.

Operator: Your next question comes from the line of (Patricia Stemich) with (Battenberg) Hospital. Your line is open.

(Patricia Stemich): Good afternoon. I was hoping that there was a way that we could print the WebEx training related to some of the login, LASER processes, and submission. Since you have to listen and you can't fast forward to different parts of it, is there any way that those are downloadable to print?

Ellen Berry: This is Ellen Berry. At this point, we do not have the ability to print. But once the WebEx download completely to your computer, you should be able to "fast forward" through it. You move the bottom …

(Patricia Stemich): Yes, it would not – you have to listen to it for about 30 minutes before it'll allow you to manipulate the fast forward mechanism. And since we're doing these steps, it is – we tried to do print screens and it just came out black. So I just shared that in terms of useful tool, if there was a way that that is – in some way - in a printed format that was available that you could scan through the slides. It would be extremely helpful.

Ellen Berry: All right, we'll take that into consideration. But it may be that the web browser or your computer may not be downloading it quickly. Because I can …

(Patricia Stemich): OK.

Ellen Berry: … (Edit) from my work and my home and we had other people tested in it, did download quicker than the 30 minutes. So I'm sorry about that.

(Patricia Stemich): OK. We'll try it on a different computer as well. Thank you.

Ellen Berry: Yes.

Charles Padgett: Thanks for your question.

Operator: Your next question comes from the line of (Kevin Williams) with Acuity Healthcare. Your line is open.

(Kevin Williams): Hi, thanks for taking my call. This is a question just to clarify section K. Under the weight, it says, base weight are most recent measures. But if you go to the manual, under assessment for weight, it says, for an admission assessment, if the patient had been weighed multiple times during the assessment period, use the first weight. Which one should it be?

Charles Padgett: It should always be the first weight during the assessment period.

(Kevin Williams): OK. OK, thank you.

Charles Padgett: You're welcome.

Operator: Your next question comes from the line of (Stephanie Smith) with Health East. Your line is open.

(Stephanie Smith): I have a question regarding section H – or section H. If a patient has a rectal tube, how would you be coding that?

Female: For incontinence?

Charles Padgett: Are you asking as far as incontinence is concerned?

(Stephanie Smith): You know, if they've had a rectal tube for multiple days and – yes.

Ellen Berry: (Inaudible).

(Stephanie Smith): Yes.

Charles Padgett: Teri?

(Teri): Hi, yes. Could you expound a little bit more on your question?

(Stephanie Smith): If a patient has a rectal tube in placed for purposes of perhaps enhancing skin condition or preventing skin breakdown, is the patient considered continent or incontinent?

(Teri): You would have to base that on their continence without the rectal tube in.

(Stephanie Smith): OK.

(Teri): OK. Thank you.

(Stephanie Smith): That works, thank you.

(Teri): Yes.

Operator: Your next question comes from the line of Roberta Steinhauser with Madonna Rehabilitation. Your line is open.

Roberta Steinhauser: Hi. I have – my first question is, if we had a patient – you know, we're starting October 1st, so we had a patient that discharged to the hospital on

September 29th and they come back on the 1st. So technically, it's an interrupted stay by the rule. But since they're coming on October 1st, do we just start freshen up an admission or that's still an interrupted stay and they don't need a CARE Data Set?

Charles Padgett: It would be – it would still be considered an interrupted stay. And they were actually admitted to your institution before that so you would not include them.

Roberta Steinhauser: OK, thanks. And then I just want to clarify on the rectal tube question. Because I don't know that you can base it on their incontinence without the rectal tube because that's making a judgment. If they have a fecal management system and you're containing their stool, you know. I don't – you know, a lot of times just because they're having constant diarrhea.

So I don't know – I guess, I don't – so like the answer to the question was sufficient. It seems like it would be more similar to an ostomy, you know, where you're containing their stool rather than making the judgment that they'd be incontinent without the tube.

(Teri): I think you bring up a very good point and we've had discussion about this particular issue. And using it specifically as a fecal management tool for a fecal incontinence is not really indicated. It's …

Roberta Steinhauser: It's not really what?

(Teri): It's not – it's not the best clinical practice to use a fecal tube to manage …

Roberta Steinhauser: Well, like she said it's for skin protection as well.

(Teri): If it's for skin …

Roberta Steinhauser: It's not just (inaudible).

(Teri): If it's for skin, it's a whole different thing. It's being used – it's being used properly.

Roberta Steinhauser: Right.

(Teri): (Inaudible).

Roberta Steinhauser: But if it's still containing it.

(Teri): Right. But you would just a dash in that item. You wouldn't be able to answer that item …

Roberta Steinhauser: OK.

(Teri): … until whatever diarrhea if it was being caused by CDiff …

Roberta Steinhauser: Right.

(Teri): … or if it was being caused by a food allergy or something like that. You would put that as a dash for that particular …

Roberta Steinhauser: OK.

(Teri): … instance. But there's …

Roberta Steinhauser: OK, that's helpful.

(Teri): … (inaudible) rectal tube, yes.

Roberta Steinhauser: OK, thank you.

(Teri): You're welcome. Thank you.

Operator: Your next question comes from the line of (Ray Gilroy) with Special Care Hospital. Your line is open.

(Ray Gilroy): Thank you for taking my question. And I just looked ahead. Christmas falls on a Monday this year in 2012. And I'm thinking if we get admissions on Friday, we might not be able to make that three-day window.

Charles Padgett: I'm not sure what you mean.

Ellen Berry: Charles, I can help out with this. This is Ellen.

Charles Padgett: OK.

Ellen Berry: CMS does not exempt holidays when you're caring for a patient because you are open 24/7.

(Ray Gilroy): Oh, OK.

Charles Padgett: Yes.

Ellen Berry: Yes.

Charles Padgett: But I'm not sure what you mean by you wouldn't be able to make the three-day window.

(Ray Gilroy): No. To fill – if there was an admission on Friday.

Charles Padgett: Yes.

(Ray Gilroy): And you have, like, a three-day window to fill out the assessment.

Charles Padgett: The ARD is the assessment time during which you consider the patient's status in relation to the LTCH Care Data Set. So you'll have five days from that ARD which is the third day during which that complete …

(Ray Gilroy): Oh.

Charles Padgett: … the LTCH CARE Data Set.

(Ray Gilroy): Oh, well – OK.

Charles Padgett: OK?

(Ray Gilroy): OK, yes. That clarifies that.

Charles Padgett: OK.

(Ray Gilroy): Thank you.

Charles Padgett: You're welcome.

Operator: Your next question comes from the line of Karen Finerty with RML Specialty Hospital. Your line is open.

Karen Finerty: Hi again. I just wanted to clarify both with this previous question and the gentlemen earlier with regarding to what data elements are due in those three days. Those three days – this is my understanding and please correct me if I'm wrong. Those first three days, the date of admission plus the two calendar days following that getting to the assessment reference date, all of the data elements must reflect the patient's condition during that time period. The five days following the ARD is just paper work time, if you will, for us to get that data into the system. Is that correct? Or are you saying that we really have the eight days together and put the data in?

Charles Padgett: You're correct with the way you put it the first time.

Karen Finerty: OK.

Charles Padgett: The three days are the days during which you consider the patient's status, their health status. And then you're right, the five days that you have to complete that are essentially, as you put it, paper work days or the days during which you can record that data into the LTCH CARE Data Set.

Karen Finerty: Thank you for that clarification of CARE …

Charles Padgett: Sure.

Karen Finerty: … Data.

Operator: Your next question comes from the line of (Donna Ismaha) with (Newland) Health Service. Your line is open.

OK. And your next question comes from Roberta Steinhauser with Madonna Rehabilitation. Your line is open.

Roberta Steinhauser: I just have one question on the pressure ulcers staging. Because we, you know, just reviewing some data we have now. Like, we had a patient come in with a grafted wound. And what happened was the admitting nurse

documented those as pressure ulcers which, you know, we've clarified is a wound and not a pressure ulcer because it's a surgical wound.

So, you know, that would be changed so even though it was in the medical record as a pressure ulcer, we kind of have our wound ostomy nurse following up on all of those to become and reclassify and say, "No, that's not a pressure ulcer." I just want to be cleared if that's an OK process because I know at one point it sounded like if it's documented as a pressure ulcer, you know, it's difficult to change it. But we have had some of those …

Charles Padgett: Well, I mean, if you have – if you have another clinician, I mean, behind, you know, and documenting that, you know, the call that was made earlier was incorrect and is correcting that in the medical record, that's fine.

Roberta Steinhauser: OK. And is that OK too if she stages them differently? Like, a nurse would think it's a stage three and she looks at the picture from admission and talks to the nurse and said, "No, actually that's bone, that's a stage four." Is that OK for her to – because she's documenting an internal review and why she chose to stage it differently, you know.

Charles Padgett: I'm not sure what you mean by a picture.

Roberta Steinhauser: Well, like, we do wound pictures on admission. I don't know that we would – we're not going to base our assessments on that. I'm just saying if the admitting nurse puts stage three and the next day, the wound ostomy nurse comes and talks to that admitting nurse and looks at the picture and can see that it didn't worsen in that day. You know what I mean?

Charles Padgett: Yes.

Roberta Steinhauser: Like, it was – can I put it in as a stage four on admission because the admitting nurse may have incorrectly staged it (instead of) stage three and then document it as worsening, I guess?

Charles Padgett: Yes. You know, can you submit that question to our mailbox?

Roberta Steinhauser: I think I did. I'll just wait for …

Charles Padgett: OK.

Roberta Steinhauser: … a response.

Charles Padgett: OK.

Roberta Steinhauser: OK?

Charles Padgett: It's very good. Thank you, I appreciate that.

Roberta Steinhauser: Thanks.

Operator: And again, to ask a question, press star one on your telephone keypad.

Your next question comes from Linda O'Bryan with Kindred Healthcare. Your line is open.

Linda O'Bryan: Hi. Thank you for all the great responses. My question is related to getting these user IDs for the submission process for CMSNet. I understand that currently that will be restricted to two users per provider number. Are there future plans to expand that for facilities that have more than two facilities under one provider number?

Ellen Berry: Hi, this is Ellen Berry. We are looking into that but we don't have any definitive plans at this point as to when we might be able to accommodate that.

Linda O'Bryan: Thank you.

Ellen Berry: You're welcome.

Operator: Your next question comes from Rebecca Roman with Whittier Hospital. Your line is open.

Rebecca Roman: Hi. Thank you for all your great information today. My question pertains to section – on the admission assessment A 18, 20 – what was the primary diagnosis being treated at previous setting. If it is not clearly stated on the information that we received from the facility where the patient comes from,

how are we going to determine that? Or even so, this is not always a clear diagnosis that with a different ICD code form, are we responsible to have an ICD-9 manual and look this up?

Charles Padgett: Well, I mean, I can tell you that it's – I mean, you may not always have the answer to this question. And in the case that you don't have the answer to this question, you would – you would enter a dash indicating that you don't have the information or you can't answer the question. As far as the ICD-9 code, I'm going to ask that you submit that part of the question to our quality mailbox so we can get you an answer back on that.

Rebecca Roman: OK.

Charles Padgett: Before coming to look it up or, you know, having it provided for you from one provider to another and so forth.

Rebecca Roman: Right. So the same kind of situation would present when you're asking of the date of the oldest stage two. If somebody comes in to my facility with a stage two, how are we going to know if it's not identified in the records from the previous setting when that stage two was first identified? Or do they …

Charles Padgett: Yes. I understand. That can sometimes be very difficult question to answer. But all we ask is that you do your best in trying to determine that. And if you can answer it, again, it is one of the voluntary responses you can put a dash or one of the default – appropriate default responses there.

Rebecca Roman: Great, thank you.

Charles Padgett: You're welcome.

Operator: Your next question comes from the line of (James Mike) with Heartland Long Term. Your line is open.

(Amanda): Hi, this is actually (Amanda). I'm listening with James today. We had a question regarding the QIES and the LASER tool. In the LASER tool, we went in and assign our facility, went in to assign our users. And the user I.D.,

is that an I.D. that we make up as a facility and as an administrator? Or is that an I.D. that comes from the QIES website or e-mail?

Ellen Berry: No, your – this is Ellen Berry again. So you're going to have a couple of different IDs depending on who you are in your facility. So, you'll have the CMSNet user I.D. which will get you through CMSNet. You'll have two people who can do that. And then those people would also then have user IDs through QIES. For whatever software you use, the LASER software sets it up that whoever you're going to have data enter or view those assessments or your system administrator; those would be set up for your software. And they would be different than those two other user IDs I spoke about.

(Amanda): OK, great. And then kind of a follow up to that question, when we were on the QTSO website, we went and follow the WebEx. And we went in and filled out the CMSNet Verizon Access Request for LTCH users' forum and submitted that. But there is also a second forum that's on the QTSO website and it's titled LTCH Individual User Account Request.

Ellen Berry: Yes. You won't use …

(Amanda): That was not listed on the WebEx. And the QTSO Help Desk, they were unclear and they just advise me to fill it out to be "safe".

Ellen Berry: OK. We'll talk with them but, no. That actually is – you'll get your two user IDs for the QIES system. And if one of the users leaves your facility, goes on maternity leave, other changes duties and you have to have a second – a third person come in, you would have to delete one of those user IDs to have this third person obtain a user I.D. So that's when that form would be used.

(Amanda): OK, thanks for the clarity.

Ellen Berry: Yes.

Operator: Your next question comes from the line of (Lena De la Cruz) with Columbia's LTCH. Your line is open.

(Lena De la Cruz): Hi, good afternoon. And just a clarification, if we admit a patient and then we already submitted the admission ARD. And then a week after, we sent the patient out for a skin graft and within interrupted stay which is a third day before (inaudible), the patient comes back, is that pressure ulcer – can we change it to surgical wound?

Charles Padgett: Change it on what? On the admission?

(Lena De la Cruz): Like when the patient gets discharged, how could we modify that pressure ulcer went to surgical wound?

Charles Padgett: It would just not be recorded as a pressure ulcer on discharge. So it would – it would essentially disappear.

(Lena De la Cruz): It would disappear.

Charles Padgett: Yes. It would be as if the wound healed.

(Lena De la Cruz): OK. Thank you so much.

Operator: Your next question comes from the line of (Jim Codling) with Spectrum Health. Your line is open.

(Jim Codling): Thank you. I have a question about the National Provider Identifier that's mentioned in the program manual. Is that the same number that you mentioned at the start of today, the facility I.D. number? And if not, what is that National Provider Number?

Charles Padgett: Ellen?

Ellen Berry: Hi, this is Ellen Berry. No, they are not the same number. Your National Provider I.D. is actually what's used on your claims.

(Jim Codling): So is that the same as the tax I.D. number?

Ellen Berry: I have not looked at a UV40 in a while so I am not comfortable answering that question. But it's your – it's your National Provider – the NPI.

(Jim Codling): OK.

Ellen Berry: I guess, you'd have to look in the claims manual – claims manual is …

Charles Padgett: At the CMS website.

Ellen Berry: Yes. Go to the CMS website.

(Jim Codling): OK.

Ellen Berry: Or check your FI MAC. They'll be able to tell you where the NPI is on the claim.

(Jim Codling): OK, thank you.

Operator: Your next question comes from the line of (Donna Ismaha) with (Newland) Health Services. Your line is open.

(Donna Ismaha): I have a question about the signature page. We are having some of our nurses, for examples, admission nurses complete a worksheet and then turn it to someone who's actually going to go in online and complete the information. So would the signature base, the person that's actually entering the information or would it be, for example, nurse's name by the person that's entering the information?

Charles Padgett: It would be the person who collected the data on the patient.

(Donna Ismaha): OK.

Charles Padgett: The person that did an assessment on the patient was the one that collected that data.

(Donna Ismaha): So they're signing someone else's name that collected it, correct?

Charles Padgett: Well, I don't know what you mean by signing someone else's name. You mean, in the attestation page in section Z?

(Donna Ismaha): Yes, on the signature page where it says person completing and it has sections and dates. It's on the signature page.

Charles Padgett: Yes.

(Donna Ismaha): The person …

Charles Padgett: You know, I'm not …

(Donna Ismaha): … is actually …

Charles Padgett: I'm not …

(Donna Ismaha): Go ahead.

Charles Padgett: … condoning having somebody sign for somebody else but as far as who is responsible – ultimately responsible for signing that signature page is going to be up to your facility policy. And …

(Donna Ismaha): OK.

Charles Padgett: … who your facility has decided is qualified and allowed to do that.

(Donna Ismaha): So would there be a problem and if we put the person's name who did the assessment and then by the person's name that entered it? So that you'll actually have both names there which would indicate that one person did the assessment and the other one did the actual date of entry.

Ellen Berry: Hi, this is Ellen. Actually, you don't have the data entry person necessarily sign. So in the first portion of the form, if anybody who's provided data for that assessment would sign that area. And then the second area for signature would be the person who's just verifying that the information is complete.

(Donna Ismaha): I understand but what I'm saying is this is – not all of our – the whole staff is not going to be entering these things online because I'm just not going to have every single nurse …

Charles Padgett: So …

(Donna Ismaha): … kind of access …

Charles Padgett: … I understand. And I mean, you said, you were working it out with worksheets that your nursing staff would then turnover to the data entry person.

(Donna Ismaha): Yes.

Charles Padgett: You know, as we said, the signature portion does not get transmitted to us. If you have those nurses sign those worksheets, you know, attesting to the data that they're given that, you know, contributing to the LTCH CARE Data Set, I imagine that's one way it could be handled. But if you would – if you would e-mail your question to me so we could give you a written response, I'd appreciate that.

(Donna Ismaha): OK, thank you.

Charles Padgett: OK, thank you.

Operator: OK. There are no further questions queued up at this time. I turn the call back over to the presenters.

Charles Padgett: All right. Thank you so much for attending the LTCH Special Open Door Forum today. A lot of really fantastic questions. I like questions that we can't answer because they really make us think. And it shows us that you're engaged and thinking about this. And it really helps to kind of we have to get to the bottom with some of the issues that remained with this.

So I really appreciate everybody that attended and that contributed in the question and answer session. And I will – I encourage you to attend the next one in October which I believe is on October 14th. That date will be posted on the LTCH Quality Reporting Program web page.

Again, next week the transcript from this call and the MP3 file should also be available on the Special Open Door Forum website as well as the LTCH Quality Reporting website.

And everybody has been very patient in waiting for your user IDs. Lori made the announcement at the beginning and so keep an eye out for those. And, again, we all appreciate it. And have a great weekend and we'll see you soon.

Operator: Thank you for participating in today's (in) Long Term Care Hospital Quality Reporting Program Special Open Door Forum Conference Call. This call will be available for replay beginning Monday, September 24, 2012 at 9:00 a.m. Eastern Standard Time through midnight on September 26, 2012. The conference I.D. number for the replay is 25078457. The number to dial for the replay is 1-855-859-2056.

This concludes today's conference call. You may now disconnect.

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