Attention!
All Long-Term Care Hospital Providers (LTCHs)

CMS Special Open Door Forum for LTCHs
Thursday, October 18, 2012
2:30 p.m. – 4:00 p.m.

Topics for this LTCH Special Open Door Forum Include:

- Announcements
- Review of most recent Frequently Asked Questions
- Question and Answer period for LTCH providers

Call-in Information:

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Centers for Medicare & Medicaid Services

Moderator: Charles Padgett
October 18, 2012
2:30 p.m. ET

Operator: Good afternoon. My name is (Beth) 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.

Charles Padgett of Centers for Medicare and Medicaid Services, you may begin your conference.

Charles Padgett: (Beth). Good afternoon. This is Charles Padgett. I'm the CMS lead for the LTCH quality reporting program. I'd like to welcome everybody to the special open door forum and thank you for attending.

We have a good deal to cover today including announcements from the Division of National Systems, a review of the program requirements and useful resources available to LTCH, review of the most recently frequently asked questions, and we hope to have a good amount of time for those participating in today's call to ask questions.

So we're going to get started.

The materials for today's call are posted on the LTCH quality reporting program website as well as the CMS special open door forum website. I'm going to begin with the PowerPoint that's titled CMS special open door forum with today's date, Thursday, October 18, 2012.

Essentially this PowerPoint is two things. It's an overview of program requirements, just as reminders, and also it's a listing of the various resources that are available to you – the websites where information pertaining to this program is available and what information specifically is available on each of the websites.

So I'm going to go ahead and go over this.

I'm going to start on page 2. The top of page 2 is titled overview. It simply says highlights. We're going to go over program overview, information about the LTCH CARE Data Set and available resources and whom to contact for help.

Again, our program is based or mandated by the Affordable Care Act Section 3004. There are three quality measures for reporting by LTCHs which – for which quality data reporting commenced on October 1, 2012. Those measures are CAUTI, CLABSI, and pressure ulcer.

Two quality measures for reporting by LTCHs that we're just finalizing our rule beginning on January 1, 2014. And those measures are percent of patients or residents who were assessed and appropriately given the seasonal influenza vaccine – the short stay measure – and the influenza vaccination cover among healthcare personnel.

The Affordable Care Act Section 3004 directs establishment of quality reporting program for LTCHs, it requires providers to submit data on selected quality measures for fiscal year 2014 payment determination and subsequent fiscal year payment determination, and mandates a 2 percent reduction in the annual payment update for noncompliance with program requirements.

CMS finalized the three quality measures for data collection beginning October 1, 2012, for fiscal year 2014 annual payment update determination.

Again, those measures National Healthcare Safety Network catheter-associated urinary tract infection, or CAUTI, which is NQF I.D. 0138; the National Health Safety Network central-line associated bloodstream infection, or CLABSI, outcome measure, NQF 0139; and percentage of patients or residents with pressure ulcers that are new or have worsened, short stay measure, NQF 0678.

As I said and as I'm sure you all know data collection began on October 1 of this year, 2012. Data collection by the Centers for Disease Control and Prevention or the CDC via the National Health Safety Network which is at www.cdc.gov/NHSN/

LTCHs must register with NHSN. And I just want to put this out there as a reminder. I was in communication with the CDC just before the beginning of the program and there were still about 80 LTCHs that had yet to register with them.

So I really want to stress it's very important that you register with them, that you take the training, the online training that's needed in order to submit data through the NHSN network specifically with regard to these two health acquired or health care acquired infection measures. So you must register with them and you must submit the required data for the CAUTI and CLABSI measures.

You can find more information with important CDC links and contact information in chapter 5 of the LTCH quality reporting program manual. And that's available for download at the LTCH quality reporting program website. You can find that – I'm not going to give the web address right now. I'll give that at the end, it's very long. But you can easily find that by Googling LTCH quality reporting. It's usually one of the first three or four results that pop up.

The pressure ulcer measure is collected using the LTCH continuity assessment record and evaluation data set otherwise known as the LTCH CARE Data Set version 1.01.

And items on the LTCH CARE Data Set allow us to collect and calculate the pressure ulcer measure.

LTCHs can find the current version of the LTCH CARE Data Set in appendix C of the LTCH quality reporting program manual. Again, that manual is available at the LTCH – at the CMS LTCH quality reporting website.

And data submission of the LTCH CARE Data Set is via the quality improvement evaluation system assessment submission and processing system which is often known as the QIES ASAP system.

Available resources. We have the CMS LTCH quality reporting website, the CMS LTCH quality reporting technical information website, the LTCH quality reporting program manual, the CMS LTCH quality questions mailbox which is the LTCH mail or the help desk mailbox, essentially we have the CMS LTCH tech issues mailbox which is also a help desk mail box for technical issues, we have the QIES technical support office website otherwise known as the QTSO or Q-T-S-O website, we have the QTSO help desk, and

then as far as the CDC goes we have the CDC's NHSN website and the CDC's NHSN help desk.

I'm going to review some of these right now.

The LTCH website with information on quality reporting program – I'm going to give the address to that. That is www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html.

And this website provides a few things. It provides a vast background, various resources LTCHs can link to on that website. We post our updates on that website. You'll find updates related to changes in the manual, changes in – or references to special open door forums and call in information and that sort of thing. There are a number of downloads that are available on that website and also there are a number of useful links that you can just click on and we'll link you immediately to, you know, particular other resources.

We also have the technical information website page. And that is available by directly going to that page through a web address. Or you can also link to that page from navigating to the CMS LTCH quality reporting main web page in the upper left hand corner, the link to the technical page.

So the technical information website is www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCHTechnicalInformation – altogether –html.

And this website or web page has LTCH CARE data submission specifications, LTCH Assessment Submission Entry and Reporting, or LASER, updates. That's the free software that's available from CMS that allows you to submit the LTCH CARE Data Set.

Additionally, as I said, there – the LTCH quality reporting program manual is available on our main CMS LTCH quality reporting website.

The manual – and the manual should be your primary source for completing the LTCH CARE Data Set. All of the information you need in order to

complete that is in there. If you have questions about that, of course, you can e-mail us and we're happy to answer them.

And chapter 3 specifically of the quality reporting manual contains detailed instructions for each included section of the LTCH CARE Data Set. You know, so there's detailed instructions for, you know, section A or section M which is really the skin. You can look specifically in those sections for that information.

Again, I said it's available for download at the main LTCH quality reporting website.

And also the information or the – I'm sorry, the manual contains information for each of the LTCH CARE Data Set items. So for each question you're going to find information related to the intent of that question or the rationale behind us asking that question, the item display or a screenshot of that item, assessment and coding tips related to that item, coding instructions, and also we try and provide several examples related to each of the items that demonstrate how you would code that item in different – given different situations that might occur in your LTCH.

We also have the CMS LTCH quality questions mailbox. This is our help desk mailbox. It is – to reach it you can e-mail us at LTCHQualityQuestions@cms.hhs.gov. Again, that's LTCHQualityQuestions@cms.hhs.gov.

We certainly encourage you to submit quality questions. You're doing that I can tell you that. We've received a good stream of them since the program began. This is good in two ways. Hopefully you're getting answers back that are helping you, but these questions also help inform, you know, the program they inform us of, you know, possible problems that are occurring or problems that you're having, areas that we may need to talk about during these open door forums that, you know, you – people are misunderstanding or that, you know, we just need to provide a bit more clarity on that sort of thing. So I certainly encourage you to keep submitting questions to that mailbox.

Also, you can e-mail us with your e-mail address and your organization and your name to that mailbox and let us know if you'd like to be added to our list of notices.

As I said we have the LTCH tech issues mailbox and this is the help desk for technical information or the technical aspects of the program. You could reach that e-mail box at LTCHTechIssues – that's LTCHTech – T-E-C-H – Issues@cms.hhs.gov.

LTCH software developers, vendors, and providers are all encouraged to submit technical questions regarding submission requirements, measure specifications – those sorts of things – to this e-mail box.

In addition to this we have the QIES Technical Support Office website with information on data submission. This is the system through which you'll be submitting the LTCH CARE Data Set. And you can reach this support office at www.qtso.com/ltch.html.

And, again, this website will have background information related to the program and the technical aspects of the program. Updates are additionally posted on this website. You can have access to the recorded training sessions that we've posted by accessing this website and do have access to the LASER downloads and documentation, and also the LASER webex training videos are located on the QTSO website.

So, again, that address is www.qtso.com/ltch.html.

They also have a help desk, the QTSO help desk. If you have questions about the QTSO website or information on that website, you can e-mail them at help@ Q-T-S-O.com. Again, that's help -H-E-L-P- @ Q-T-S-O.com.

LTCH software developers, vendors and providers, again, are encouraged to submit questions related to QIES User I.D.s, the LASER software. Also, any questions having to do with CMSNet and your access you can e-mail to that help desk.

In addition to that because we have your report, two of the measures through the CDC, the CDC has website with information on CAUTI and CLABSI measures. And you can reach their National Health Safety Network by going to www.cdc.gov/nhsn/LTACH. Now the CDC refers to LTCH, long term care hospitals as long term acute hospitals or acute care hospitals. That's the difference you'll notice. Most of you, I'm sure, have noticed this if you've gone to our website versus their website, but again that is www.cdc.gov/nhsn/L-T-A-C-H- /ltc-welcome.html.

And you'd go to this site in order to read about the backgrounds of these measures and as they relate to our quality reporting program. Enrollment information is available there. And there's also operational guidance available there.

There's also a help desk for the CDC. Any questions regarding the CAUTI and CLABSI measures and how you would submit them how you gain access to their website and their submission process you would e-mail at the CDC at nhsn@cdc.gov. Again, that's nhsn@cdc.gov.

And LTCH providers are encouraged to submit your questions related, as I've said, to the CLABSI and CAUTI measures to that help desk.

And finally we just want to say we appreciate your continuing input. It helps us in our development and implementation of the help desk quality reporting program. It informs, you know, the agenda during these open forum meeting and informs the type of frequently asked questions that we decide to cover during these meetings.

So it's very helpful not only to you but to us. So we certainly appreciate all of your input.

OK. I'm going to move on now to the frequently asked questions. Again, this – both of these materials – the slide deck I just reviewed and the frequently asked questions, this is version 2.0.

So every time we have new frequently asked questions we're just going to be adding them to the same document. I didn't want to have, you know, 10 sets

of frequently asked questions out there. It gets very confusing. So any time we have another open door forum with new frequently asked questions they will just be added into the existing document. Of course they will be separated by date and you can – they'll be easy kind of to navigate your way to the questions that you haven't reviewed yet or you're not as familiar with.

So, I'm going to begin on page 17 of the frequently asked questions document. You'll see that the title page for – with today's date on it.

And it begins, actually, with question 67.

So what I'm going to do, once again as I did last time, I'll read the question, I'll read the answer, and I'll move through this.

At the end of this we're going to have a brief announcement – as I've said the Division of National Systems – and then we will open the lines for questions and answers. Yes, questions related to these questions that I've covered specifically. Or if you have new questions we will do our best to answer those as well.

So as I said I'm going to begin on question 67. This question – the question I was asked is, a patient is emergently discharged out of the LTCH at 2:00 a.m. on October 10th. The wound care clinician did not evaluate the patient immediately prior to discharge. How far back can we look to gather the wound data? If the wound care nurse evaluated the patient on October 8th, can I use her documentation on the patient's wounds to complete the unplanned discharge assessment? What if the last time she evaluated the patient was October 3rd? Can I use that data? If not, and I have to enter dashes, what are the ramifications? Are there, or are there any plans for the future, to apply penalties or disincentives for submitting dashes?

And our response to this was, the three-day assessment reference period related to the LTCH CARE Data Set discharge assessment record begins two days prior to the date of discharge. And there's a typo error in the next sentence that I want to correct. So the second sentence in this paragraph states, the date of discharge is day 2 and therefore considered the ARD. And

it should actually read the date of discharge is day 3 and therefore considered the ARD.

If it is the policy of an LTCH that only a wound and ostomy certified Nurse can assess a pressure ulcer, and there is no assessment recorded in the medical chart during the three-day assessment reference period, the LTCH would have no choice but to use a dash to respond to the questions in section M of the LTCH CARE Data Set discharge record. The LTCH cannot consider any data recorded in the medical chart prior to the three-day assessment reference period.

If it is the policy of the LTCH that only a wound and ostomy certified nurse has the authority to assess a pressure ulcer, then it is the responsibility of that LTCH to make certain that wound assessments are done in concert with the required assessment reference periods of three days as outlined in the LTCHQR program manual.

So, as this person is asking the patient is discharged at 2:00 a.m. on October 10, she first asked if she can use the wound evaluation that existed on October 8 that was two days prior to the 10th, it's within the three-day assessment reference period and, yes, she would be able to use that. However, she would not be able to use the October 3 assessment that she asked about in the second part of the question.

Moving on and next question, which sections need to be completed within that three-day timeframe?

And our response to that is, the three days are the time during which you will be assessing the patient. The LTCH will use the data or the patient information from those three days in order to complete the LTCH CARE Data Set. The LTCH has five days beyond the ARD to complete the LTCH CARE Data Set.

So no section of that LTCH CARE Data Set must be completed within those first three days. But the LTCH will have until day eight to complete all of those sections.

So the assessment reference date falls on day three which is admission plus two calendar days. You are not required to complete anything during those three days.

At the end – once you reach the ARD day three you will have five days from that data during which to complete the LTCH CARE Data Set.

So it's those five days that matter. And you have eight days in total. For instance you may have a skin assessment on day one. If you're, you know, assessing an acute patient you could record that information then. But you have until day eight to complete the entire LTCH CARE Data Set.

Moving on.

According to the handout we received it talks about completing the assessment on the third day of admission. For example, a patient admitted on a Friday, 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 if we don't complete the assessment in three days?

Again, there are no grace periods for the LTCH CARE Data Set assessment, completions, or submission timeframes. And LTCHs are expected to follow the timeframes regardless of the day of the week the patient is admitted to an LTCH.

And for information related to the LTCH CARE Data Set assessment, completion, and submission timing, we're going to ask that you refer to chapter 2 of the LTCH quality reporting manual.

But the assessment reference date, again, is day three of admission. So that's the date of admission plus two calendar days. That equals the assessment reference date. And the assessment reference date plus five calendar days equals the date of completion. That's the day the data set must be complete.

So you have five days during which to complete the data set, but all information must pertain to those first three days.

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

OK. Moving on. I'm on question 70 if you just joined in.

Question 70 reads, we are retaining copies of the LTCH CARE Data Set as part of the patient's medical record, but there's no current requirement for printing of this. We still have a paper medical record, then we will need to essentially print them out and store them in the medical record.

So they're asking if they need to print this out to store it in the medical record. And our response to this was, yes, if you have a paper record and – at your LTCH, you will need to print out the LTCH CARE Data Set in order to store them in your medical record.

Question 71. We also have a paper record but we will be using a software program where the information is stored. We will be required to print off the assessment or will we be required to print off the assessment and put it in the medical record since we will be able to access it online? Or can we just use the online storage?

And the answer to is, you will be able to store it electronically.

So the question above that I answered that said you must print that if you have a paper record, if you have means for storing this data electronically, you know, you have to submit it electronically. So if you have the means for storing it electronically, by all means, you can store it electronically.

Question 72. I would like to clarify with the assessment reference date for an admission event. FAQ number 63 states that the ARD is day three of admission – the date of admission plus two more days. Does that mean that

the ARD will have to be day three if admission is day one? For example, if the patient is admitted on day one and discharged on day two, would that be an exception?

OK. The assessment reference date is always the date of admission plus two calendar days. In this – in the example presented, the admission date and discharge date, both dates will be day one.

So I want to make a correction here also. Because in the example it states the patient is admitted on day one and discharged on day two. So they would not both be day one. So they're asking if the ARD changes if they can submit that.

So, for the example that's presented, the ARD would still be day three. That doesn't mean that they cannot complete the LTCH CARE Data Set before that, but the ARD would be still set at day three.

All right. Moving along. Question 73. If a patient is admitted on day one and they die on day two, is the ARD for the admission assessment still admission plus two days?

And the – our answer to that is, in this case the ARD would be day two because the patient is deceased.

Next page. Question 74. If information is documented in the medical record after the ARD but before the completion date – for example, the patient's education or lifetime occupation status which is documented on the case management evaluation at our hospitals – should it be included in the assessment, or because it was not documented during the ARD period, is it not included in the assessment?

And our response to that is the LTCH CARE Data Set assessments should contain information or data that was applicable to the patient's health status during the three day assessment reference period. Any information or clinical data that was gleaned after the ARD, but before the completion date would not be included in the LTCH CARE data assessment records.

All right. Question 75. If the patient has been on my floor for 21 days and then the patient passes, do I fill out an expired assessment or do I need to fill out a discharge assessment, as well?

And the answer is that, if the patient dies in your facility, you're simply required to fill out an expired assessment on that patient.

Moving on.

I'm trying to figure out if the information that I need to report for discharge has to be within the Assessment period? Does the three day assessment period for discharge apply to the previous three days prior to discharge? Also, if the patient has an unplanned discharge on Monday at 2:00 a.m. and there is no mobility/wound nurse – wound assessment over the previous weekend, do I leave the assessment blank or do I report the most recent information available?

Our response to that is that the three day assessment reference period related to the LTCH CARE Data Set discharge assessment record begins two days prior to the date of discharge. The date of discharge is day three and is therefore considered the assessment reference date.

If it is the policy of an LTCH that only a wound and ostomy certified nurse can assess a pressure ulcer, and there is no assessment record in the medical chart during the three day assessment reference period, the LTCH would have no choice but to use a dash to respond to the questions in section M of the LTCH CARE Data Set discharge record. The LTCH cannot consider any data that was recorded in the medical chart prior to the three day assessment reference period.

So the date of discharge and the previous two days you cannot consider any information or data that's been recorded in the medical chart prior to that.

Moving on.

We have a question that I believe refers to interrupted stay.

If we had – the question reads, if we had a patient – we had a patient that's discharged to the hospital on September 29 and the patient returns on October 1, would it be an interrupted stay or does the patient require an LTCH CARE Data Set?

And our response to that is, it would be considered an interrupted stay. And the reason for that, if they were admitted to the LTCH before October 1 they do not need to be included in a submission. The patient does not be – need to be included in your submissions to CMS.

And it also asks if it's an interrupted stay. That would fall in the – if the patient returns on October 1 that would fall on day three so it's inside the three day window for interrupted stay. It would be considered an interrupted stay.

But there's no need to submit any data on that patient because they were initially admitted before October 1.

Moving on to question 78. When a patient leaves the facility and goes to an acute care facility and is gone for 4 days, the facility must complete a discharge assessment and an admission assessment upon the return from the acute care hospital. Does the facility use the original admission date or do they use the day the patient transferred back as the admission date for the second admission assessment they must complete?

Our response to this is, in the scenario you outline in your question, if a patient returns to the LTCH after more than three calendar days at another hospital or facility, a new admission assessment should be completed. For the purposes of the LTCH quality reporting program, this admission would be considered a new admission and the date for this admission would – to the LTCH should be used as the admission date not the date of their original admission.

Moving on.

The question asks, the requirements for quality reporting indicate that if a patient is out on leave of absence and does not return within three days to the LTCH we are to discharge them. If they later return a new admission

assessment should be completed. The long term care hospital prospective payment system interrupted stay rules indicate two types of leave of absence – three days or less and greater than three day interruption.

The fixed day period for inpatient acute care hospitals is between four and nine days. Can you clarify that if the patient is on interrupted stay and returns between four and nine days we should discharge and readmit them? The long term care hospital PPS fact sheet indicates if they return in nine days or less it is still one payment off of the initial admission. But if we discharge them and then readmit them it would seem we are using the adjusted admission date.

This may be a little – it's difficult to listen to. I know it's a long question. Hopefully you are reading it while I'm reviewing it.

And I want to make a point that Medicare's rules related to payment and related to interrupted stays regarding payment are different than Medicare's rules for the quality reporting program. They're both based on the idea of the interrupted stay.

And I'll review our answer here in which we state we are aware that patients with an interrupted stay of between four and nine days treated in an acute care hospitals; or patients with an interrupted stay of between four and 27 days which are in an inpatient rehabilitation facility; or patients with an interrupted stay between four and 45 days at a SNF or swing bed facility re not technically discharged from the LTCH for payment purposes under the LTCH PPS.

However, for the purposes of the LTCH quality reporting program, LTCHs should not submit discharge assessment records for patients who return to the LTCH following treatment or care at one of the above sites for three days or fewer. For example, those who have a three-day or less interruption of stay. However, we require that LTCHs submit the LTCH CARE Data Set discharge assessment record for patients with a greater than three-day interruption of stay.

We also require that LTCHs submit a new LTCH CARE Data Set admission assessment record for patients that return to the LTCH after treatment or care

away from the LTCH for greater than three days. For example, a greater than three-day interruption of stay.

So, quite simply, if the patient is admitted or transferred to another facility from the LTCH and that stay lasts less than three days – that is they return to the LTCH before the end of three calendar days including the date of transfer – the LTCH does not need to do anything. They do not need to submit anything to CMS that is considered an interrupted stay for the three day or less interruption of stay.

And quite simply, if the stay – when a patient is transferred from the LTCH to any facility – any medical facility outside the LTCH – for treatment and that stay lasts beyond three calendar days which includes the four to nine range that they're asking about, the LTCH must submit a discharge assessment and then if the patient happens to return to the LTCH, they then need to submit a new admission assessment.

Moving on. I'm on page 22 now.

This is question 80. I need some clarification on planned versus unplanned discharge. From your definition, it states a planned discharge can be a planned intervention procedure at a short term acute hospital if they don't stay greater than three days. If the patient stays longer than three days then it's considered an interrupted stay. In the definition it says for a planned discharge or planned intervention procedure unless they stay greater than three days. Wouldn't it then be a discharge?

This was a little bit of a confusing question so we tried to answer it as best as we could. If a patient is discharged from your facility for longer than three calendar days, including that date of discharge – or date of transfer – then it is no longer considered an interrupted stay. You would fill out a discharge assessment.

Moving on to question 81. The question states, I want to confirm that you can have a planned discharge to a short term acute care hospital if it is a planned procedure or intervention.

Let me read that again. I want to confirm that you can have a planned discharge to a short term acute care hospital if it is a planned procedure or intervention.

And our response to that is, yes, an LTCH can have a planned discharge to a short-term acute care hospital if it is a planned procedure or intervention.

However, please – I hope that you understand that it does not actually become a discharge as far as the LTCH quality reporting program is concerned until the patient is transferred to the acute care hospital passes the three day calendar mark including the date of discharge. So it will never be considered a discharge until that day goes beyond the three day mark.

OK. Moving on.

82. An LTCH patient admitted has a plan of care developed by the LTCH physician and treatment team that includes the need for surgical or other intervention at the short term acute care hospital. The patient is subsequently discharged to the short term acute hospital and stays longer than three days for the planned intervention. Is this scenario a planned or an unplanned discharge?

And we state, in the example presented, the discharge would be classified as planned and thus the LTCH would need to complete a planned discharge assessment for this patient. In this scenario, the patient was transferred to an acute care hospital for an intervention that was planned for in advance. The patient is absent from the LTCH for longer than three days; it's because of this that the LTCH is required to file a discharge assessment record, and it is considered planned because, as we state above, the intervention or treatment the patient is receiving at the acute care hospital was planned for in advance.

If the LTCH transferred a patient to an acute care facility with the expectation that the patient would return to the LTCH within three calendar days, but the patient's absence from the LTCH lengthens unexpectedly due to de-compensation or sepsis or some reason along those lines and it ultimately lasts longer than three days, the LTCH would be required to submit an unplanned

discharge. The LTCH must submit a discharge as the patient was gone longer than three days.

The discharge is considered unplanned as the LTCH has – had returned – I'm sorry. The LTCH had expected that the patient would return to the LTCH within three calendars but did not. If the patient had returned to the LTCH from the acute care hospital before the end of the three day period, the LTCH would not be required to fill out any of the four assessment records because the patient's absence would simply be considered an interrupted stay.

OK. I'm on page 23 now. At the top of the page on question 83 which reads, if we have a patient in-house that converts to hospice and is discharged as a Medicare patient and admitted as a hospice patient under the supervision of an outside hospice contractor do we need to assess this patient on admission and expiration as a hospice patient?

And our response to that is, Guidance on how to handle hospice patients is included in chapter 2, specifically page 2-2, of the LTCH quality reporting program manual and it states hospice patients: if an LTCH patient "goes on hospice," the patient is discharged from the LTCH and the hospice benefit program pays for the care provided. They even pay for respite care provided by the LTCH. The LTCH is required to complete the planned discharge assessment for LTCH patients who are discharged from the LTCH. When a patient within the LTCH starts receiving benefits through the hospice benefit program, the LTCH hospital must comply with the Medicare participation requirements for the hospice benefit program.

OK, we're going to move on to a question that – on a – the data sets specifically question – section A. Their question pertains to section A item 1820 on the admission assessment. They asked, if it is not clearly stated on the information that they received from the facility where the patient comes from, how are we going to determine this? Additionally, this is not always clear – a clear diagnosis that with a different ICD code form, are we responsible to have an ICD-9 manual to look this up.

And we answered that you may not always have the answer to this question. We're talking about A1820. It can sometimes be a very difficult question to answer. And in the case that you don't have the answer to this question, you would enter a dash indicating that you do not have the information or that you cannot answer the question. We ask that you do your best in trying to determine the primary diagnosis being treated at the previous setting.

So A1820 is asking about primary diagnosis. That information does not always come with the transportation. We hope it does and we hope that you'll work with, you know, providers from which cancer patients are entering your facility, but should it not you can certainly enter a dash there, that is an acceptable response.

Next question. Should a patient's Medicaid number – which is question A0700 on the LTCH CARE Data Set – should it be entered into the LTCH CARE Data Set if the patient has Medicaid as the secondary payer, or should it only be entered when Medicaid is the primary payer?

And if a patient has a Medicaid number we ask that you enter it into A0700. If the patient's number is pending, please follow instructions as provided in chapter 3, section A.

So if they actually have a pending Medicaid number there's a certain code that you'll enter. That's outlined in chapter 3, section A. So, whether or not they're the first or second payer, we're asking that you enter the Medicaid number.

Moving on.

We're in question 86. This provider asked, question A1200. Do we need to ask a patient specifically were you ever married when they state – that someone might identify themselves as single even if they're married – if they were married prior so as to avoid the stigma of divorced status?

And our response to this was, the question to which you are referring is asking for current marital status. And we ask that you please ask the question in that manner, what is your current marital status and record the patient's response.

And question 87, at the bottom of page 23, asks, is the national provider identifier 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?

And we stated, no, they are not the same number. Your national provider I.D. is the number used on LTCH claims.

So your national provider I.D. is the number that you use when filling out your LTCH claims that identifies your LTCH.

OK. So now I'm going to introduce Lori Grocholski. She is with LTCH CMS. She works for the Division of National Systems and she's going to be covering the last few questions here on the frequently asked questions document. So she's going to begin with question 88.

Lori Grocholski: Thanks, Charles.

This has to do with data set section B, does the physician documentation need to specifically state the words comatose or persistent vegetative state, or do words like unresponsive and severe encephalopathy used in M.D. progress notes support a yes response to B0100?

A specific diagnosis must exist in order to code any diagnoses listed in section B for comatose and persistent vegetative state. A confirmed diagnosis of comatose or persistent vegetative state in the medical record is necessary in order to include this data in the LTCH CARE Data Set assessment. Other terms, such as unresponsive and severe encephalopathy should not be used to infer a diagnosis of comatose.

Question 89 has to do with section H. 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? And would patients with fecal management systems in place, such as flexiseal, be coded as 9?

The bowel continence item H0400 on the LTCH CARE Data Set is strictly limited to the bowel continence of a patient without the use of a fecal management system, rectal tube, or ostomy. Since rectal tubes and fecal management systems are meant to be temporary solutions for fecal incontinence, and are not considered a standard of care for the treatment of fecal incontinence, they are not to be considered when coding this item. A dash would be the appropriate code when these devices are in use unless there is a way to assess the patient's continence without these devices in place.

Also, do not confuse the use of rectal tube and fecal management system with ostomy and their associated pouching/drainage systems. Ostomies require a surgically created opening to drain waste. If the patient has an ostomy, the appropriate code on H0400 would be code 9.

Number 90, section I. How far can we use clinical judgment to connect the dots between documented patient condition and care and the specific three diagnoses in section I?

A specific diagnosis must exist in order to code any of the diagnoses listed in section I. A diagnosis should not be inferred by association with other conditions such as the example of PVD for patient who is status post CABG for CAD. Not all patients who undergo CABG for CAD also have PVD. They are two different diagnoses and affect two different areas of the body – CAD refers to arteries in the heart, and PVD, vasculature in the lower extremities, neck or kidneys.

The example cited in the LTCH quality reporting program manual states that the physician has documented a diagnosis of diabetes mellitus. Blood glucose monitoring should not be used to infer the diagnoses of diabetes.

Number 91, section K. In Section K, it says base weight is most recent measure. In the manual it states that, 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?

The first weight during the assessment period should be used.

Charles Padgett: All right. Thank you, Lori.

We're going to end with that frequently asked question. We need to move on so that we can have the announcements from Division of National Systems and so that we can give you some time to ask questions to the providers and folks that are participating in today's call.

So, again, I'm going to turn it over to Lori Grocholski. She's from the Division of National Systems and she has a few announcements to make.

Lori Grocholski: Thanks, again, Charles.

Charles Padgett: Yes.

Lori Grocholski: OK. And the first topic is technical issues that are now resolved.

There was an error identified in the ASAP system and because of the error admission assessments are being incorrectly rejected with the error 903. The item identified in the error message information on the final validation report was A0270 discharge date.

This has now been fixed and the providers affected by this were contacted via phone or e-mail. So this issue has now been resolved.

Additional issues to the help desk. We've had several calls to the QTSO help desk regarding user I.D. activation expiration. This occurs if the user does not activate their QIES LTCH user I.D. in the time allotted in the activation e-mail which is 10 days.

If the user attempts to activate their user I.D. after the allotted time, they will receive the supplied user activation information is not valid message online. When this happens, the user must contact the QTSO help desk to re-register.

To avoid this, we encourage users to activate their QIES LTCH user I.D. once they receive the e-mail which is usually within a few minutes.

We are also experiencing users who are locked out after three failed activation attempts. If the user attempts to activate their user I.D. three times without

success, they will receive the supplied user activation information is not valid message online. The user must contact the help desk to unlock the account.

Please ensure that users are entering their new LTCH user I.D. in the user I.D. field on the activation page and cutting and pasting the activation key value from the e-mail into the activation key field. It is possible users have included extra spaces at the beginning or end of the value when copying which makes it invalid.

Again, in both of these instances above, the user must contact the QTSO help desk for assistance. And the QTSO help desk number is 1-877-201-4721. Again, that is 1-877-201-4721.

Last, I wanted to review some of the error messages, a few of them that we've been receiving. These are the most common error messages LTCH are receiving on their final validation reports. I will review a few of them along with the usual causes and ways to avoid them on your validation report.

The first one is fatal error 907, duplicate assessments. Usually caused by – the submitted record is a duplicate of a previously submitted record for this patient which means the record was already successfully submitted and accepted into our ASAP system. A tip for you, folks, duplicate records are two assessment records from the same facility for the same patient with the same reason for assessment and the same ARD. Most often this occurred after the first and did not know or realize the file was already submitted.

The next is fatal error 903, required item missing or invalid. The date on the LTCH CARE data specifications in effect on the target date of this record, this item is required.

Based upon the LTCH CARE data specs in effect for this record, this item is required and was not submitted in this record file. In the LTCH CARE data specs, each item is identified as active or required on specific assessment records. An example of this is B0100 comatose is an active item or required on admission, planned and unplanned discharges that's not record.

This item is not active or required on the expired assessment record therefore it should not be included in the assessment record file submitted to the ASAP systems as indicated in the specifications.

If you are unable to make the correction to the assessment record in your software, please contact your software vendor.

The third fatal error I'm going to discuss is 1021, invalid FAC ID. The facility I.D. submitted in this file does not identify a valid provider in the QIES ASAP system.

The facility I.D. is the submitted record is not – in the submitted record is not associated with a valid provider in the QIES ASAP system. This verify your facility I.D. receipt on your QIES user I.D. registration confirmation page. If you did not print this page you can go to www.qtso.com. Again that's www.qtso – Q-T-S-O – .com and select the LTCH link on the left side navigation bar.

This link takes you to the LTCH information page where you will find a Medicare CCN to submission FAC I.D. Crosswalk. Use this crosswalk to locate your facility I.D.

This crosswalk was just updated 10/17 which is yesterday. This replaces the versions that were previously posted on September 20 and September 27. The facility I.D. in this document matches the facility I.D. returned on the QIES user I.D. registration confirmation page. This new facility I.D. should be entered into your software for LTCH CARE assessment submissions.

Please make appropriate corrections to the software and resubmit the assessment records that were rejected due to this error.

Information on all of the error messages that may appear on the final validation report may be found on the LTCH User Submission Guide located on qtso.com website on the LTCH information page.

Thank you very much, and I'll turn it back over to Charles.

Charles Padgett: All right. Thank you, Lori.

And it's about 3:30 so we're going to move on to our question-and-answer session, and I'll turn it over to (Beth), on you.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, press star then 1 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-1 again to rejoin the queue.

Your first question comes from the line of (Christine Albert), Kindred Hospital. Your line is open.

(Christine Albert): Thank you, ma'am. I have a question regarding the registration activation email that we get back that shows the link to activate your LTCH login I.D. and password. A lot of us have gotten – it goes into hour class mode and then ends up kicking us out, so we retry, it does the same thing and then we retry, and it does the same thing.

It took me, I think, two days and several attempts just relentless during that day. And I am wondering if something is going on with that link or if other people have had that problem, I just want it noted that if people are late getting their entries in probably because they don't have the registration activation yet. I just wanted to make you guys aware that that's a problem and that I dealt with for two people at my site.

Ellen Berry: Thank you. This is Ellen Berry. Was that sort of CMS net or to the QIES link?

(Christine Albert): So, the QIES link with access to the QIES in CASPER, that LTCH password or I.D. that it uses…

Ellen Berry: Yes. And was this a week or two weeks ago?

(Christine Albert): Yes, like – well, I just thought one day before yesterday and mine was last week.

Ellen Berry: We know we had connectivity issues last week and the week before. I was not aware that we had connectivity issues this week, so we will definitely look into that. And so if you do have issues, please contact the QTSO Help Desk.

(Christine Albert): Thank you, ma'am.

Ellen Berry: That's happening. Thank you.

Charles Padgett: And I also just want to say that – and just remind all the LTCHs that you have until May 15 of 2013 to get any of your data submitted. So, you know, if you're having a delay in the beginning because you're having trouble with user I.D. and password and so forth, you do have until May 15, 2013 to submit this data or to submit corrected data, so I don't want you to be worried about that.

All right.

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

(Donna Ismaha): I had a question about an entry that we tried several times yesterday, and we submitted it within the seven days of admission and it says that it was a late entry that it was required to be submitted within five days of the ARD which it was, so that was rejected. And I'm not sure what we need to do about that.

We had actually several of those admissions, for example, that were admitted on the third and they – the admission on – the admission entry date should have been the 10th. And when we entered that and tried to submit it, it said it was too late.

Charles Padgett: So they were…

(Donna Ismaha): And it was within – it was within the seven days.

Ellen Berry: Are you speaking about software or actual submission to the QIES ASAP system?

(Donna Ismaha): Submission to – submission to the QIES.

Ellen Berry: Because we don't reject based on timeliness.

(Donna Ismaha): OK.

Ellen Berry: There had to be another reason why the record was rejected. If you look at your validation report, it should have the error messages. So if you do have a specific question, please contact the QTSO Help Desk and let them know you have that validation report in front of you. Well, this was – yes.

Was the whole…

(Donna Ismaha): You want to…

Ellen Berry: …submission rejected, that's the whole submission file or just certain files within that?

(Donna Ismaha): One of the admission – the admission. We'll have to check it back, but then I'll follow up with that as well.

Ellen Berry: Thank you.

(Donna Ismaha): And I have further questions, but I'll wait until everyone else because three to four (inaudible).

Charles Padgett: Thank you.

Operator: Your next question comes from the line of (Jen Barker), Promise Hospital. Your line is open.

(Jen Barker): Good afternoon. I have a question about the final validation report. We can't seem to find where we go to get that report. Is there a page that you can refer me to?

Female 1: After we log in the CASPER.

(Jen Barker): After you've logged into CASPER the final validation report. We can't – we can't find it.

Ellen Berry: Yes. Hey, (Kathy), can you respond to that?

(Jean Eby): OK. I don't have the screen so I'll do it from memory as well as I can. After you signed in there should be some tabs on the top, and one of them says folders.

(Jen Barker): Yes.

(Jean Eby): And you press it on the folders. And the left side should have something that says your state code, your FAC_ID and V.R. at the end. You click on that, link on the left. And on the right, it will show a one line for each of your validation report.

Now, your validation reports have funny titles, but they have the date it was submitted and the submission I.D. which you get when you do the initial submission so you could pick them off by that. The LTCH submission manual explains to you in detail how to read the title so you know which one you get, so when you decide which one you want, you click on it, and then it should just open up in a PDF and you'll be able to do all your PDF functions on it – oh, they're text. I'm sorry, they're text. They're not PDF.

(Jen Barker): Oh, OK.

(Jean Eby): But they still – you still can read it and it's, you know, it's like opening up a text file. It's a little more restrictive than PDF.

Ellen Berry: Thanks, (Jean).

(Jean Eby): And if you have trouble you should call the help desk and they can walk you through it. But if you just do the folders and go through there, it's pretty easy. And if you get the wrong one, you just click on a different one – you know, throw that one and click on – go back and click on a different one until you find the one you want.

Operator: Your next question comes from the line of Robin Workman, Lake Taylor Transitional. Your line is open.

Robin Workman: Hi. I'm still asking about question number 72, the scenario you have there when the person is admitted on day one and then discharged on day two. You said the assessment date for both of those will be day three.

Charles Padgett: Yes, I'm glad you brought this up.

Robin Workman: Yes.

Charles Padgett: We realize that while we were giving this answer it was incorrect.

Robin Workman: OK.

Charles Padgett: OK. So just to clarify, I'm going to read to the question real quickly that says they like to clarify with the assessment reference date for an admission event. There's a question that states the ARD is day three of admission, which means the date of admission plus two more days. Then they're asking, does that mean that the ARD will have to be day three if admission is day one.

For example, if the patient is admitted on day one and discharged on day two, would that be an exception?

Ellen Berry: Yes, that would be an exception. And what you would do is you would have day two for your admission and then day two also for your discharge which…

Robin Workman: All right.

Ellen Berry: …you know, we don't have enough information to tell you if it would be unplanned or planned.

Robin Workman: OK. That's what I thought. All right. Thank you.]

Charles Padgett: You're welcome. Thank you.

Operator: Your next question comes from the line of Heather Bierbrodt, Methodist Extended Care. Your line is open.

Heather Bierbrodt: Yes, hi. I wasqw wanting to ask about the assessment. When you're talking about storing them electronically, we have an electronic record. But

what the process that we were going to use is to print the assessment because, as I understand it, there are signature lines on those assessments, and then we are going to scan those into our EMR once those have been signed.

Charles Padgett: That's fine.

Heather Bierbrodt: OK.

Charles Padgett: That's it for (inaudible).

Heather Bierbrodt: I did have one other part to that. Since the assessment is three pages long and I'm having somewhere page three is completely blank, we were wondering do we need to go ahead and scan in that blank page and perhaps use a stamp that tells you this page, you know, printed blank, you know, something to that effect? Is it necessary to scan that third one so that you can understand if that were ever reviewed retrospectively?

Charles Padgett: Yes, I think – I think as long as all of the – all of the data that's included in the LTCH CARE Data Set is included in the pages that you scan, that's all you need.

Heather Bierbrodt: OK, OK. Thank you.

Charles Padgett: We're not going to be verifying against page numbers so much as it would be verified against having every data point that we required. So…

Heather Bierbrodt: OK.

Charles Padgett: …yes, I would say don't worry about the blank page.

Heather Bierbrodt: OK, great. Thank you.

Charles Padgett: You're welcome. Thank you.

Operator: Your next question comes from the line of (Jhosa Paglayan), Holy Family Medical. Your line is open.

If your line is on mute, please unmute.

(Jhosa Paglayan): I would like to thank CMS because we're doing very well with LTCH. And it's very user-friendly.

And the only problem is I submitted two days ago and I discovered the day after that the ARD date was incorrect. The assessment was accepted, and there's no error messages at all. Do I still have to do a correction on this assessment?

Ellen Berry: So you…

Charles Padgett: Go, Ellen, now.

Ellen Berry: No, you go.

(Kathy): To say we can't change the ARD because that's how we find the records. You need to do an inactivation and a new assessment.

(Jhosa Paglayan): OK. So I will – I activated and submitted, and it was accepted. Do I need to make or create a new assessment or add a patient, or add a new assessment, or add a patient?

(Kathy): You need to do an activation of the record that was submitted.

(Jhosa Paglayan): Right. I did that.

(Kathy): OK.

(Jhosa Paglayan): It's been accepted in the QIES ASAP.

(Kathy): (Pat), are you on the phone? Would you like to talk about making a new one then?

(Pat): I'm sorry. What was the question now?

(Jhosa Paglayan): The question was the ARD date – it has been submitted, the ARD date was incorrect. It was accepted by the QIES ASAP. And then I did an activation. It was accepted again. So do I create a new assessment now or do I add a patient or add a new assessment?

(John): This is (John). Your patients would still be there.

(Jhosa Paglayan): Yes.

(John): You should see in your list of assessments to that page, you should see the original assessment you did and then the inactivation. And now you should be able to add another assessments and go ahead and do like you did the first time except, you know, changing the date to which you want it to be. And then go ahead…

(Jhosa Paglayan): Right, it won't let me though. If I put an add assessment, it won't let me. It says that the ARD date and admission date is out of sequence.

(John): Oh, OK, so that's what's stopping you from doing this right now then?

(Jhosa Paglayan): Right, right.

Female 2: (Marlene), are you on the phone? Do you have any thoughts on that if you are?

Ellen Berry: Well, why don't we have – call the QTSO Help Desk?

(John): Yes.

(Jhosa Paglayan): They've been – I've been with them the whole morning and the same – I have the same problem.

Ellen Berry: OK. Submit an email to the ltchtechissues mailbox, and we'll follow up with you, so ltchtech, T-E-C-H, issues, I-S-S-U-E-S, @cms.hhs.gov.

(Jhosa Paglayan): Thank you.

Ellen Berry: Thank you.

(Kathy): And what was your name again please?

(Jhosa Paglayan): Jhosa, J-H-O-S-A.

(Kathy): OK.

Charles Padgett: Thank you.

(Kathy): OK.

(Jhosa Paglayan): Thank you.

(Kathy): Thank you.

Charles Padgett: Yes, thanks.

Operator: Your next question comes from the line of (Linda Jones), Kindred Hospital. Your line is open.

(Linda Jones): Good morning. I have a high-level question from one of the warnings we received on our validation report. It's (Warning-915), and basically it's about patient information updated, submitted values, listed do not match values in the Q ASAP system.

Basically, it's saying that there's some data elements already in the system and they're not matching precisely with the ones that we're submitting, and to give examples of data virtual security number, gender, race, ethnicity. So as we're just starting, is it possible that the patient could have information – your database from SNIP or somewhere else?

Ellen Berry: Yes, actually that's what it's hitting up against. It would be…

(Linda Jones): OK.

Ellen Berry: …either SNIP or core home health.

(Linda Jones): All right.

Ellen Berry: So…

(Linda Jones): So it's quite possible that they could have had to change in the number, incorrect or whatever. And as I said your action and just to make sure what we submitted is correct and just move forward.

Ellen Berry: Yes, correct.

(Linda Jones): Very good. Thank you so much.

Ellen Berry: You're welcome.

Charles Padgett: Thank you.

Operator: Your next question comes from the line of (Chris Schaeffer), (Vendis). Your line is open.

(Chris Schaeffer): Hi. I have a question about an error that we're getting after submission on some of our XML files. A message is saying that the XML file is not well structured. Well, when we run those same XML files through the root, they're coming out fine.

(Jean): This is (Jean), and I got a help desk ticket. Did you call the help desk?

(Chris Schaeffer): Yes, I did.

(Jean): Or the LTCH, OK. I need your submission I.D. so I told them to write it back so you have to or you just read it to me.

Do you have any subdirectories in your – this file because they will come up as unstructured XML files if you're sending in subdirectories?

(Chris Schaeffer): We did that – we had that problem on the first submission. The second one, I thought that we – that we had taken those out, but I can double-check that.

(Jean): OK.

(Chris Schaeffer): (Inaudible) throw an error.

(Jean): Yes, that will throw that error. I mean, we'll process all the rest of them, but every time we hit a subdirectory we say, "Hey, we can't do anything with this file because we're not supposed to get any of those."

So, if you end up finding out that's what you did, please call the help desk to shut their (social) ticket. Otherwise, you know, call the help desk. You can give me your number so they can tell me.

(Chris Schaeffer): OK. But is that the only thing that you're aware of in terms of…

(Jean): Yes, basically, but those (who get booted) always go through there, so it's almost, you know, it'd be 99 and 44 of 100 ivory soap that you've got subdirectories in there.

(Chris Schaeffer): OK. Thank you.

Operator: Your next question comes from the line of (Shelene South), Windy Hill Hospital. Your line is open.

(Shelene South): Hi. My question goes back to the ARD, and it's similar to question 72 you discussed earlier.

Charles Padgett: Yes.

(Shelene South): We are completing our assessments or some of them fairly quickly, meaning, for example, a patient was admitted on October 1st. We have completed our assessment and we're ready to submit to the CMS on October 2nd.

Charles Padgett: OK.

(Shelene South): When we're entering our data in the (inaudible) 1:18:08.7, if I put an ARD date as October 3rd because that, according to the manual would be the ARD date. It kicks back as an error because you can't put a date and that's later than the current date. So, it's making us put October 2nd or earlier. Are we going to be penalized because of them?

Ellen Berry: Well, this is what you have to do. So the rule for timeliness is that day one, the admission is day one, the ARD is supposed to be day three, so on your example it would be October 3rd not October 2nd for your ARD.

(Shelene South): Why?

Ellen Berry: And that's – but you have said that you completed on October 2nd. Well, you can't complete an assessment before the ARD.

(Shelene South): Well, technically all our data is complete. We have done a complete admission assessment on our patient. And we've pulled it electronically which is easy for us to do, so I know we haven't reached the third but…

Ellen Berry: Right. The third – that third day is the last day that you should be collecting or assessing the patient, so you really need to wait until after the third day or the third day to complete the assessment. Something could happen from day two to day three so…

(Shelene South): If you get a discharge, but we'd have to just do it a discharge assessment at that point. But if we're going off of our first instances like our weight, we have multiple weights, but we're going to by our first weight. I think that's what it says in your frequently asked questions. If we're going to go off the true admission period, then we're choosing our first instances where we document it.

Yes, things can change, but there's very little critical data really that we're having the document on right now. If you think about it, we got height, weight, bowel control and when it's functional mobility. If you think of clinically, those aren't changing that much within that three-day period.

Ellen Berry: But you don't know that and you won't know that until day three that's happened. You cannot complete an assessment before the ARD. It's just – it's not allowed. That is a policy.

(Shelene South): OK. Can you put that in writing somewhere? Because from your help desk, I got an OK to go ahead.

Ellen Berry: From which help desk?

(Shelene South): I sent to the LTCH Quality email address where we can send questions.

Ellen Berry: OK. We'll address it. But I believe the timing rules are in chapter two.

Charles Padgett: And also can I – can I just ask that you submit another email and just alert us to the fact that you are on the call today. We'll remember this interaction and we can respond to you specifically.

(Shelene South): OK. Thank you.

Charles Padgett: Thank you. I appreciate your time.

Operator: Your next question comes from the line of (Catherine Nickerie), Kindred (Native) Hospital. Your line is operation.

(Catherine Nickerie): Yes, hi. I have a question regarding height and weight. If a patient has refused height and weight, what is the code that I can use to enter into the data set? I know the manual stated that we can use the dash or 99. But when I enter those codes, the information is not being transmitted. I get immediately that it is an invalid answer.

Charles Padgett: OK. I can answer your question. The only – the only response you could use if you do not have the information as far as height and weight are concerned is a dash or a hyphen. And the reason for that – when we say you can use Z or 99, you can only use those in questions where they're presented as one of the responses that you can choose.

So, for instance, height and weight does not give five possible choices, one of which is Z or one of which is 99. If it did, you could chose Z or 99, but since it doesn't, the only way you can indicate that you do not have the information to answer this question is by entering a dash.

(Catherine Nickerie): OK. I did enter the dash, and the system did not receive it.

Ellen Berry: Which system are you speaking of, your software?

(Catherine Nickerie): LTCH software.

Ellen Berry: You need to contact your software vendor then.

(Catherine Nickerie): OK. Thank you.

Ellen Berry: Thank you.

Operator: Your next question comes from the line of Linda O'Bryan, Kindred Healthcare. Your line is open.

Linda O'Bryan: Thank you. My question is related to two previous statements really. It's talking about the – one that were rejected due to timeliness. And I understand that it's not rejected for that. But if you get that clear message, we've had a number of submissions across several facilities that the submission time was within the timeframe of the ARD plus five days and then within the seven additional days of submission time, but it would still list it as late submission. So I'm assuming that that is because it's calculated off of the completion date. Is that – is that a requirement or is that an error in the system?

Ellen Berry: Hi, this is Ellen.

Linda O'Bryan: So if you complete it early in that completion timeframe, does that – when the seven days for submission clock starts to tick no matter what?

Ellen Berry: This is Ellen Berry. I don't have the warning messages in front of me. If you would submit an email or contact the QTSO Help Desk and provide an assessment validation report…

Charles Padgett: Yes. Ellen?

Ellen Berry: …And (inaudible) some I.D. and we can look into it. OK, (Jean).

Linda O'Bryan: OK. We can do that.

(Jean): (Kathy), did look it up? The requirement is that the completion date cannot be more than – the reference date plus five. So in order to get the completion dates, we have to be within the ARD plus five. The submission date must be the completion date plus seven or less.

Linda O'Bryan: So it can…

(Jean): So they're not both off the ARD. One is off the ARD, and one is off the completion date. And this is – then the LTCH reporting manual on chapter two on page five.

Linda O'Bryan: OK. Thank you. And so then just to take off on the other statement that was made about, we have until may 15th to submit. Again, that's to submit corrected data. So, you know, I think some people were looking at resubmitting this with a different completion date that, well, can you just clarify what was (inaudible) about we have, you know…

Charles Padgett: Sure. Ultimately…

Linda O'Bryan: OK.

Charles Padgett: …because we're giving you the extra 4-1/2 months on the end of the quarter, you have until May 15th to get any of the data submitted. Now, we are asking that you follow the guidelines we put in place as far as date of completion, date of submission you submit within seven days of completion. But if you have a correction to a record or you have a record that you realize has not been submitted yet for some reason, you had until may 15th of 2013 at 11:59 p.m. to get that record in.

Linda O'Bryan: OK.

Charles Padgett: OK?

Linda O'Bryan: Is there a compliance penalty for – after May 15th forward, even though it was accepted being late?

Charles Padgett: Well, we…

Linda O'Bryan: Or in those particular…

Charles Padgett: Any record that's submitted after 11:59 p.m. on May 15th will not be considered when determining compliance versus…

Linda O'Bryan: As I understand, I'm sorry. I'm not being very clear. But the instances where we obviously misread the way that submission date was calculated as to being

late or not, will those – do those late records even though accepted, do they can't in compliance as far as whether or not…

Charles Padgett: You have – you have until May 15th to submit them.

Linda O'Bryan: Yes – no, I get that part. I'm sorry.

Ellen Berry: This is Ellen. So, the CMS is not trying to be difficult. So we understand that this is a learning period and so what Charles is saying is that you have until May 15th which is a pretty good buffer window. We would prefer that you submit timely, so if in your example this time around, you were a day or two late with some assessments being submitted, is that going to be held against you? No, because you have those assessments within the system before May 15th.

Linda O'Bryan: OK. Thank you.

Ellen Berry: You're welcome.

Charles Padgett: Thank you, Ellen.

All right. I think, (Beth), I think it's 4 p.m. or after. Can you – can you let me know how many are in the queue?

Operator: We still have five participants on the line with questions.

Charles Padgett: OK. We can – we can continue.

Operator: OK. Your next question comes from the line of (Karen Finnerty), RML Specialty Hospital. Your line is open.

(Karen Finnerty): Thank you.

I thought I have this – the difference between a planned discharge and unplanned discharge done pretty well until you got the frequently asked question number 82. And now I'm going to need some part of the clarification, I think.

Charles Padgett: OK.

(Karen Finnerty): Question 82 talked about – it was – the patient was discharged for a surgical or other intervention to a short-term acute care hospital. It was planned. And they thought that the patient – the patient subsequently was discharged or returned to the acute care hospital and stays longer than three days for the planned intervention.

Charles Padgett: All right.

(Karen Finnerty): I was fine with the answer until we got to the if part because then it's – the first response is that it will be classified as a planned discharge which is what I interpreted as well.

Charles Padgett: Of course.

(Karen Finnerty): But then when the patient stayed longer than the LTCH had expected, which is longer than the three days, then the discharge is considered unplanned.

Charles Padgett: So…

(Karen Finnerty): So it takes five days, if not…

Charles Padgett: OK.

(Karen Finnerty): …that the intervention is planned.

Charles Padgett: Well, it's both. So, first of all, you'll never have a discharge until it's beyond three days, correct, until…

(Karen Finnerty): Right.

Charles Padgett: …the transfer of care especially on three days.

So if the LTCH planned for a patient to be transferred to another level of care – another setting of care…

(Karen Finnerty): Sure.

Charles Padgett: …and that transfer last beyond four days, there is our discharge, OK.

(Karen Finnerty): Got you.

Charles Padgett: If they had planned for that to be, that this would not just be an interrupted stay of less than three days then that's still considered a planned discharge.

However, if they sent a patient out for a procedure that they only expected this patient to be gone, say, two days, and that patient ends up for whatever reason being transferred – their transfer is extended beyond the three-day interrupted stay period. That is now considered unplanned. You didn't plan for that patient to be gone that long. You didn't plan to have to fill out a discharge on that patient.

(Karen Finnerty): Right. So – but, I guess, the – maybe the timing here. The three days requires the discharge whether it was planned or unplanned, that's the marker of the discharge.

The fact that it's a planned discharge, say you expect them back in five days, it's still a planned discharge.

Charles Padgett: Yes, yes.

(Karen Finnerty): But if they don't come back until day six, it was still a planned discharge and an unplanned discharge.

Charles Padgett: Yes, absolutely. So the only difference, if you plan – if you expect it that they would return inside of the three-day mark and they didn't. That's the only time it goes from planned to unplanned. If you plan for that to be gone…

(Karen Finnerty): But if he doesn't stay – if he doesn't stay the three days it's not a discharge.

Female: Right.

(Karen Finnerty): So why…

Charles Padgett: Exactly.

(Karen Finnerty): So in the first part of the question, it says it's a planned discharge but then it says it's an unplanned discharge in the second part of the answer.

Charles Padgett: I understand if they were not – if you plan for them to be gone less than three days, it wouldn't have been a discharge.

(Karen Finnerty): Right.

Charles Padgett: But the fact is they have stayed longer than three days and it became a discharge. And you did not plan on discharging that patient.

I'll tell you what, if you – if you want to just drop us an email to the LTCH Quality Questions mailbox, I'll be – I'll be happy to…

(Karen Finnerty): OK.

Charles Padgett: …communicate with you…

(Karen Finnerty): That would be great.

Charles Padgett: …on this, and help you with that. Absolutely.

(Karen Finnerty): Thank you.

Charles Padgett: No problem.

(Karen Finnerty): Yes.

Operator: Your next question comes from the line of Dorothy Porter from Asheville Specialty. Your line is open.

Dorothy Porter: Thank you. Thank you for this opportunity to get clarification. I had only one question, but with a previous caller now I have two. So my original question goes to the CARE data set and the attestation page or Section Z. Being a part of the patient's medical record, what we have is an electronic patient record. And then we have a Word document that we are doing for Section Z, what we call our Attestation Page. And then we have our electronic XML zip file.

I am struggling with how I would make a CARE data set and my attestation page or Section Z a part of my electronic health record on my patient if I don't print it out. I don't know how I would bring those three electronic mediums together.

Ellen Berry: This is Ellen Berry, and I'll – I need to clarify. You said the XML zip file, I'm not sure what that is. Is that the assessment within your software package?

Dorothy Porter: Right. I can clarify then. Yes, we have a vendor and we complete the CARE data set in our vendor software. And then we save it in a zip file that may include several XML files. And that – from that saved copy which is saved on our shared network drive, that's what we upload to CMS.

Ellen Berry: Right.

Dorothy Porter: So that is our CARE data set, and it is in the form of an XML file.

Ellen Berry: Yes, but you should also have a copy of that within your vendor software not just what you – once you submit it to us, it's not gone from your computer. It should still be somewhere on your…

Dorothy Porter: It is – it's in – we can at any time…

Ellen Berry: OK.

Dorothy Porter: …going our vendor software and…

Ellen Berry: Right.

Dorothy Porter: …look at it, it's where you're correct.

How does my vendor software communicate with my patient's medical record that is within our electronic health system here at the hospital.

Charles Padgett: Yes, that's a – that's a problem you need to work with your vendor to solve.

Dorothy Porter: OK. We'll talk about that. How about the part that doesn't include the vendor which is we have created the Section Z attestation page in Word document.

We have all of our contributors to the CARE data set go into that Word document, put their name and the date that they did that CARE data assessment. And then I am the assessment coordinator, so I go in and put my name and my date and we save it, and it is a Word document.

The only way I know to get that into the patient medical record is to print it and to scan it in, or are we able just to keep these Word documents such that we could produce it if CMS ever wants to know about the CARE data set and the attestation page in our patient medical record.

Charles Padgett: Yes, I guess, we're confused why you have this Word document – why you have the extra Word document when it's included in the – it should be included an attestation page as part of the software.

Dorothy Porter: The software has included the assessment coordinator's name, but there is no place for each of the individual such as our room nurse, our physical therapists, and the person that put in the demographic information from Section A.

Charles Padgett: Yes.

Dorothy Porter: Now those are – I guess, they could be identified in our vendors software on the back end via – because all of us are accessing the software through the RSA token which is tied to our user IDs.

Charles Padgett: Yes, I mean, I believe it's a problem you need to work out with your vendor. I mean, if you're using a vendor software, it needs to mirror the capability of the LASER software. I mean, if…

Dorothy Porter: Right. OK. And I'll look at my recall because we came very close to using LASER, but I don't remember this being available in LASER either in terms of…

Charles Padgett: Yes.

Dorothy Porter: …a place where everyone's name showed up.

Charles Padgett: OK. I mean, can I ask that you…

Ellen Berry: Well, you should be able to print off that last page. And if you don't have capabilities for electronic signature, then you would have to sign the hard copy and then you would scan it.

Dorothy Porter: Give me the – OK.

Ellen Berry: So you would not – you should not need a Word document. Let's just put it that way. You should be able to do it from whatever software you're using.

Dorothy Porter: OK. We will explore that more.

And my second question just very briefly.

Male: Excuse me. Can we – can we maybe get the caller's information and maybe talk to her offline. We are way over call time.

Charles Padgett: Absolutely.

Male: We need to wrap this one – this one up, I'm sorry.

Ma'am, can we get your name and number.

Dorothy Porter: I'd be glad for you to – Dorothy Porter, P-O-R-T-E-R, area code 828-7782010.

Charles Padgett: All right. Thank you, Ms. Porter. I appreciate it.

Dorothy Porter: Thank you.

Male: Thank you.

Charles, do you have any closing remarks?

Charles Padgett: I just – I just want to thank everybody for attending today. And again, I appreciate everybody's input and we hope to get from you on our mailboxes, our help desk mail boxes. And we'll be posting this on our website the transcript as we always do.

Thank you very much.

Male: Thank you.

And (Beth), if you have the Encore instructions.

Operator: Certainly. And thank you for participating in today's Long-Term Care Hospital Quality Reporting Program Special Open Door Forum Conference Call. This call will be available for replay beginning at 9 a.m. Eastern Standard Time, Monday, October 22, 2012, terminate on October 24, 2012. The conference I.D. number for this replay is 25080375. The number to dial for this replay is 855-8592056.

And this concludes today's conference call. You may now disconnect.

END