LONG-TERM CARE HOSPITALS QUALITY REPORTING PROGRAM

FREQUENTLY ASKED QUESTIONS WITH ANSWERS

V 3.0

Current as of December 4, 2012

FAQs added in Version 1.0, presented at CMS-sponsored LTCH Special Open Door Forum on September 20, 2012

#	Question Category	Question	Answer
1.	Definition of LTCH for LTCHQR Program	I need clarification on the definition of LTCH. Are these long-term acute care hospitals or long-term care hospitals?	Long-term care hospitals (LTCHs) and long-term acute care hospitals are different names for the same type of hospital. Medicare uses the term long-term care hospitals. These hospitals are certified as acute care hospitals that treat patients requiring extended hospital-level care, typically following initial treatment at a general acute care hospital. If a hospital is classified as an LTCH for purposes of Medicare payments (as denoted by the last four digits of its six-digit CMS Certification Number [CCN] in the range of 2000–2299), it is subject to the requirements of the LTCH Quality Reporting (LTCHQR) Program. If your critical access hospital (CAH) has long-term care beds that either provide skilled nursing facility–level or nursing facility–level care, it is not required to comply with any requirements mandated for LTCHs under the LTCHQR Program.
2.	Definition of LTCH Quality Measures	Where can I find the definitions for the LTCH quality measures for October 1, 2012?	For most current definitions for the three LTCH quality measures—catheter-associated urinary tract infection (CAUTI; NQF#0138), central line-associated bloodstream infection (CLABSI; NQF#0139), and pressure ulcer (NQF#0678)—please refer to the LTCHQR Program Manual available for download at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html (Chapter 1). We also invite you to visit this Web site for updates to specifications for each of these measures that may result from the National Quality Forum's review.
3.	LTCH CARE Data Set Technical Specifications	Which 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, LTCHs must follow the LTCH CARE Data Submission Specifications version V1.00.3. The Submission Specifications are posted on the CMS Web site: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html. For submission of data for the Urinary Catheter–Associated Urinary Tract Infections (CAUTI measure) and Central Line–Associated Blood Stream Infections (CLABSI measure), please follow Centers for Disease Control and Prevention (CDC) definitions guidelines for submission of CAUTI and CLABSI event data via CDC's National Health Safety Network (NHSN) (Chapter 5).
4.	LTCH CARE Data Set—All	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 assessment, the assessment reference date (ARD) is always the patient's actual discharge date (Chapter 2). The LTCH has five days to complete the discharge assessment from the ARD (i.e., date of discharge on discharge assessment).

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#	Question Category	Question	Answer
5.	LTCH CARE Data Set—All	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 LTCH CARE Data Set?	There should be communication between the LTCH and the provider to which the patient was discharged. However, if the LTCH is unaware that a patient expired after being transferred, the last assessment that was completed for the patient in the LTCH would be the last assessment required. If the LTCH learns of that death, they can submit the Expired Data Set. If a patient is discharged to another facility, then the LTCH should have submitted either the Planned or the Unplanned Discharge Data Set.
6.	LTCH CARE Data Set—All	If patient dies during the assessment period, do you fill out admission and expired assessments?	Yes, both an admission and expired assessment would be completed. ARD for discharge would be the date of death.
7.	LTCH CARE Data Set—All	If a patient has an acute unplanned discharge and I have already completed my unplanned discharge assessment record, and 6 days later, the patient expires, what would my actual assessment reference date be?	If the patient was away from an LTCH for more than 72 hours, you no longer track the patient for the purpose of LTCHQR Program. You would submit the unplanned discharge assessment. For discharge assessment, the Assessment Reference Date will always be the patient's actual discharge date (Chapter 2).
8.	LTCH CARE Data Set—All	If a patient is discharged to a short-stay acute care hospital and then dies at the acute care hospital 6 days later, does the LTCH have to complete an expired assessment?	No. If the patient is away from the LTCH for more than 72 hours, the LTCH does not have to complete an expired assessment. You would just submit the unplanned or planned (depending on whether the discharge to the short-stay acute care was planned or unplanned) discharge assessment.
9.	LTCH CARE Data Set—All	Will LTCHs be expected to copy the LTCH CARE Data Set and keep it as part of the medical record? Are LTCHs required to print each assessment record?	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 records (Chapter 2). Under the LTCHQR Program, there is no current requirement for LTCHs regarding the printing of assessment records.

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#	Question Category	Question	Answer
10.	LTCH CARE Data Set—All	Are all demographic information items required? Are the following items required only on admission assessment: GG0160C. Functional Mobility: Lying to sitting on side of bed; H0400. Bowel incontinence; I0900. PVD / PAD; I2900. Diabetes; K0200A. Height; and K0200B. Weight?	Please refer to the LTCHQR Program Manual, available for download at http://www.cms.gov/Medicare/QualitysInitiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html. Appendix E provides item-specific guidance on requirements for the completion of the LTCH CARE Data Set. It is extremely important to note that Appendix E is provided to illustrate which items are required, which can be voluntarily submitted, and when each type of LTCH CARE Data Set assessment record should be submitted. The 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 V1.00.3 posted on the CMS Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html. According to the specifications of pressure ulcer measure (NQF#0678), height and weight, diabetes mellitus, peripheral vascular disease/peripheral arterial disease, bowel incontinence, and functional mobility are used as covariates (risk adjustment) to calculate the percentage of patients with pressure ulcers that are new or worsened. Data for these risk adjustment items are derived from the admission assessment. Therefore, the provider must submit these risk adjustment items on the admission assessment. These items are not used in the measure's 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 items. The default codes vary according to the data item. Appendixes E provide item-specific information on which items are voluntary but require a default code. We refer you to the Data Submission Specifications as the primary source for these codes and when they are to be used.
11.	LTCH CARE Data Set—All	What does it mean when the fields are identified as voluntary but a default response is required for submission?	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.

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#	Question Category	Question	Answer
12.	LTCH CARE Data Set—All	Based on the guidance in the LTCHQR Program Manual, there are some instances where it is expected that patient information will be obtained subjectively (i.e., through interviewing the patient's family or other caregivers). Does this information also have to be documented in the medical record?	Yes, whatever is documented in the LTCH CARE Data Set ought to be also reflected in the patient's medical record.
13.	LTCH CARE Data Set—Applicable Patients	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 certified as a hospital and designated as an LTCH under the Medicare program. Data collection using the LTCH CARE Data Set applies regardless of patient's age, diagnosis, length of stay, or payment/payer source (Chapter 2, Section 2.1). For the urinary catheter–associated urinary tract infections (CAUTI measure) and central line–associated blood stream infections (CLABSI measure), each LTCH must submit data for these measures on all patients from all inpatient locations, regardless of payer source (Chapter 5, Section 5.1).
14.	LTCH CARE Data Set—Applicable Patients	Do we report patients who are discharged after October 1, but who were admitted before October 1?	No, for the LTCHQR Program, LTCHs are to report on patients who were admitted on or after 12:00 a.m. on October 1, 2012.
15.	LTCH CARE Data Set—Applicable Patients	Do I need to report quality measures for my pediatric patients?	LTCHs must report data for three quality measures (CAUTI, CLABSI, 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 Set must be completed for all patients regardless of payment/payer source, age, or diagnosis (i.e., including pediatric patients or patients with psychiatric diagnoses). For additional information regarding the LTCH CARE Data Set requirements, please refer to Chapter 2 of the LTCHQR Program Manual, available for download at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip.

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#	Question Category	Question	Answer
16.	LTCH CARE Data Set—Applicable Patients	We have several LTCH hospitals with psychiatric units. Are psychiatric patients included in the mandatory data reporting for LTCHs beginning October 1, 2012?	LTCHs must report data for three quality measures (CAUTI, CLABSI, pressure ulcers) for all patients, including psychiatric 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 Set must be completed for all patients regardless of payment/payer source, age or diagnosis (i.e., including pediatric patients or patients with psychiatric diagnoses). For additional information regarding the LTCH CARE Data Set requirements, please refer to Chapter 2 of the LTCHQR Program Manual, available for download at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip.
17.	LTCH CARE Data Set—Section A	Patient admitted on 10/11/2012. For some reason, such as death, AMA, medical instability that is outside the scope of services provided (i.e., needing surgical intervention), the patient does not stay in the LTCH beyond midnight on 10/11/2012. Does this patient require an assessment for admission and discharge even if they do not stay (and most of the assessments would be "dashed")?	The requirement is that data be collected and submitted for all patients admitted to the LTCH on or after October 1, 2012, 12:00 a.m. The LTCH must submit an admission assessment and a discharge assessment even when a patient is admitted and discharged on the same day. Please use the appropriate discharge data set at the time of discharge.

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#	Question Category	Question	Answer
18.	LTCH CARE Data Set—Section A	What is the definition for unplanned discharge for purposes of determining whether to submit an unplanned discharge assessment?	An unplanned discharge is: • 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 3 days (including the date of transfer); or • A transfer of the patient to an emergency department of another hospital in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation, resulting in the patient's absence from the LTCH for longer than 3 days; or • The unexpected departure of a patient from the LTCH against medical advice; or • The unexpected decision of a patient to go home or to another setting (e.g., to complete treatment in an alternate setting). Unplanned discharges do not include planned transfers to acute-care inpatient hospitals for admission for planned interventions, treatments, or procedures, unless the patient does not return to the LTCH within 3 days.
19.	LTCH CARE Data Set—Section A	What is the definition for planned discharge for purposes of determining whether to submit a planned discharge assessment?	A planned discharge is one in which the patient is nonemergently, medically released from care at the LTCH for some reason arranged for in advance.
20.	LTCH CARE Data Set—Section A	Can CMS please clarify, for purposes of determining whether a LTCH must submit a discharge assessment, whether there is a 72-hour rule or a 3-calendar-day rule in the following instances: • When a patient leaves an LTCH to go to another facility and then returns to the LTCH? • When a patient dies within 72 hours or 3 days after leaving an LTCH for another facility?	The 3-day interrupted stay is in accordance with the payment policies that have been established. If the policy states that day 1 of 3 begins on the day of transfer, then that day plus 2 would dictate the definition of the 3 days. If a patient dies during an interrupted stay, then the LTCH should submit an Expired data set. If the patient dies afterward, the LTCH should have submitted a Discharge item set because the patient did not return within 3 days. Please note that "72 hours" has been replaced with "3 calendar days" throughout the current version of LTCHQR Program Manual V 1.1, available for download at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip."
21.	LTCH CARE Data Set—Section A	If patient's planned discharge is Friday, but the discharge is delayed until Sunday, what should the ARD be?	The ARD on discharge assessment will always be the patient's actual discharge date (Chapter 2).

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#	Question Category	Question	Answer
22.	LTCH CARE Data Set—Section A	What would happen in the following scenario: If we discharged the patient, say, to a short-term acute care hospital for a surgical intervention and the planned stay was 5 days, longer than the 3-calendar-day rule.	It would be considered a planned discharge. You sent a patient out for a surgical procedure and they were away for 5 days, as you had planned.
23.	LTCH CARE Data Set—Section A	How do we define a day? Is it from midnight until 11:59 p.m.?	Yes.
24.	LTCH CARE Data Set—Section A	If a patient goes to an ER at 11:59 p.m. on day 1 and then returns by 11:59 p.m. on day 3, it's considered an interrupted stay, but if a patient returns after 11:59 p.m. on day 3, what assessments would need to be completed?	If an LTCH transferred a patient to the ER at 11:59 p.m. on August 1, for example, then August 1 would be considered Day 1 (which is always the date of transfer). Should the patient remain away from the LTCH past the third calendar day (Aug 1 + 2 calendar days = August 3 at 11:59 p.m.), then the LTCH would be responsible for completing the following assessment records: • Uplanned discharge assessment record: Because the patient was away from the LTCH past the third calendar day, a discharge assessment is required. The discharge assessment is unplanned because the patient was transferred emergently. • New admission assessment record: Because the patient was away from the LTCH past the third calendar day, a discharge assessment was completed and filed. Therefore, the patient will now need to have a new assessment record completed because it is as if the patient is entering the LTCH as a new patient (the patient's absence is no longer considered an interrupted stay).
25.	LTCH CARE Data Set—Section A	Training indicates we have 3 days to enter data on new admissions. Does this include weekends and holidays, or are they excluded?	The ARD is the end point of the assessment period for the LTCH CARE Data Set Assessment records, and it includes weekends and holidays. If a patient was admitted on a Friday, the ARD for the admission assessment is Sunday. For example, if a patient was admitted on Friday, October 19, the ARD for the admission assessment is Sunday, October 21. More information about LTCH CARE Data Set assessment can be found in Chapter 2 of the CMS LTCHQR Program Manual, available at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip.

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#	Question Category	Question	Answer
26.	LTCH CARE Data Set—Section A	Should the ARD be set as no later than the admission date plus two calendar days?	For admission assessment, ARD will always be the date of admission plus two calendar days. Assessments performed on day 1 can be entered into the admission assessment. For discharge and expired assessments, ARD is the date of discharge or date the patient expired.
27.	LTCH CARE Data Set—Section A	If patient is admitted on Friday, then the ARD is on Sunday. Are we expected to complete and sign the LTCH CARE Data Set between Friday and Sunday?	If a patient is admitted on Friday, the ARD is Sunday at midnight. The assessment information related to the patient must reflect assessment data obtained during that time.
28.	LTCH CARE Data Set—Section A	If the patient is admitted to the LTCH on November 13, 2012, at 1:00 p.m., what would the ARD be?	The ARD would be November 15, 2012, at 11:59 p.m. (LTCHQR Program Manual, Chapter 3, Section A).
29.	LTCH CARE Data Set—Section H	Would a patient who requires assistance to maintain the passage of stool (e.g., through manual stimulation, rectal suppositories, enema, etc.) be considered continent?	For the purposes of the LTCH CARE Data Set, this patient would be considered continent. If the patient has had no incontinent episodes during the 3-day assessment period, then H0400 should be coded 0, always continent (LTCHQR Program Manual, page H-2).
30.	LTCH CARE Data Set—Section I	The guidelines for active diagnosis say that the diagnosis needs to be physician documented. How close to those specific words does the documentation need to be? For instance, could “weight loss,” “a new PEG,” etc., be considered documentation for malnutrition?	A specific diagnosis must exist in order to code any of the diagnoses listed in Section B and I of the LTCH CARE Data Set. The definition of active diagnosis is that the diagnosis has a direct relationship to the patient’s functional, cognitive, mood or behavior status, medical treatments, nurse monitoring, or risk of death. In the example given, CMS requires the exact word “malnutrition” in the patient’s medical record, not an interpreted diagnosis.
31.	LTCH CARE Data Set—Section K	What if the patient is weighed on the day of admission at 120 pounds and is weighed again on day 2 at 119 pounds? What should be recorded in Section K?	For an admission assessment, if the patient has been weighed multiple times during the assessment period, use the first weight. K0200B would be coded “120” (LTCHQR Program Manual, page K-2).

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#	Question Category	Question	Answer
32.	LTCH CARE Data Set—Section M	Admission documentation of pressure ulcer must be done within the first 3 days? Discharge documentation is taken from the last 3 days of a patient's stay?	The ARD provides the endpoint of the assessment period for any of the LTCH CARE Data Set assessments. For admission assessment, the ARD is the date of admission plus 2 calendar days. The facility has 3 days to actually gather the data and an additional 5 days to complete the LTCH CARE Data Admission Assessment. For the discharge and expired assessments, the ARD is the date of discharge or date of death (Chapter 2). Each of these assessments looks back to the 3-day span of the ARD with the exception of the following items on the Planned Discharge Assessment: A1955 Discharge Delay, which looks back 24 hours from the date of discharge, and M0800 Worsening in Pressure Ulcer Status, which looks back to the prior assessment (i.e., admission assessment); and the following item on the Unplanned Discharge Assessment: M0800 Worsening in Pressure Ulcer Status, which looks back to the prior assessment (i.e., admission assessment).
33.	LTCH CARE Data Set—Section M	Why has CMS adapted National Pressure Ulcer Advisory Panel (NPUAP) guidelines related to blisters and deep tissue injury?	CMS consulted subject matter experts for clinical validation of pressure ulcer coding. At the time these items were finalized, it was determined that there was much that current science was unable to confirm regarding Deep Tissue Injury (DTI). CMS opted for a holistic approach to pressure ulcer assessment that included characteristics of surrounding skin instead of a pure focus on what color fluid was visible inside an intact blister.
34.	LTCH CARE Data Set—Section M	In short-stay acute care hospitals, Present on Admission (POA) pressure ulcers are only allowed to be coded when physicians or those with legal authority to make medical diagnoses have documented a POA pressure ulcer. So why is documentation by a nurse allowed in LTCH for coding POA pressure ulcers?	POA coding for short-stay acute care hospitals focuses on billing codes specifically for purposes of Medicare payment under the Inpatient Prospective Payment System (IPPS). There are no CMS POA regulations related to Medicare payment for LTCHs at this time. While State Nurse Practice Acts differ among states as to who can stage pressure ulcers, the American Nurses Association has confirmed that it is within the scope of the nurse to stage pressure ulcers. Hence, for the LTCHQR Program purposes, POA pressure ulcers are allowed to be coded when nurses, physicians, or those with legal authority to make medical diagnoses have documented a POA pressure ulcer.
35.	LTCH CARE Data Set—Section M	What types of clinical personnel 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, and State and Federal requirements. State laws provide guidance on who may complete assessments of patients.

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#	Question Category	Question	Answer
36.	LTCH CARE Data Set—Section M	Why are pressure ulcers that have been repaired with grafting procedures considered surgical wounds and not coded as pressure ulcers?	Due to the surgical intervention, tissue has been moved from the patient to close the pressure ulcer. Grafting provides the tissue to assist in that closure. Therefore, this is a surgical closure of the wound, and after this surgical wound dehisced, it is no longer able to be staged or classified as a pressure ulcer. Therefore, for purposes of coding the LTCH CARE Data assessments, a pressure ulcer that has been repaired by a grafting procedure is considered a surgical wound and is not coded on the LTCH CARE Data assessment as a pressure ulcer.
37.	LTCH CARE Data Set—Section M	How are Kennedy Ulcers to be documented in the LTCH CARE Data Set?	Kennedy Ulcers are considered pressure ulcers; therefore, they should be coded as pressure ulcers in the LTCH CARE Data Set, Section M, at the appropriate stage.
38.	LTCH CARE Data Set—Section M	If a patient had an identified Stage 2 pressure ulcer on the admission assessment, and the pressure ulcer was Stage 3 on Day 2, as I understand it, it is coded as Stage 3, not POA. Is that correct?	No, the LTCH CARE Data Set requires that the skin condition be documented from the skin assessment obtained as close to the time of admission as possible, so in this case, the Stage 2 is what would be coded on the admission assessment as POA. If on the discharge assessment, this pressure ulcer is still a Stage 3, it would be coded as a Stage 3, worsened, and not POA.
39.	LTCH CARE Data Set—Section M	What do we do if a pressure ulcer worsens during the first 3 days of the patient's admission to the LTCH? How do we code the wound?	The patient assessment reflected in the admission assessment data set should coincide with the patient's admission assessment for the purposes of determining if a pressure ulcer was POA. A wound determined to be POA would specifically need to be "on admission." Thus, if a POA wound worsened during the 3 days, the admission assessment record should capture the wound's stage at admission based on the admission skin assessment. On the discharge record, the wound would be captured in the stage to which it worsened, if it had not healed. Still, the wound, because it worsened, would no longer be captured as POA.
40.	LTCH CARE Data Set—Section M	On Day 2 of the 3-day assessment period, a pressure ulcer was assessed as unstageable. On Day 5, the wound was debrided and staged as a Stage 3. On Day 24, the day of discharge, the wound was restaged as a Stage 4. How would this scenario be coded on the admission and discharge assessments?	On the admission assessment, it would be coded as unstageable and POA. On the discharge assessment, it would be coded as a Stage 4, worsened, not POA. This is because the first time it was able to be numerically staged after debridement, it was staged as a Stage 3, then it subsequently increased in numerical staging (worsened) to a Stage 4 prior to discharge.

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#	Question Category	Question	Answer
41.	LTCH CARE Data Set—Section M	If a patient is transferred out of the LTCH to another level of care and returns to the LTCH 4 days later with a new pressure ulcer, is that pressure ulcer coded as "present on admission"?	Yes, that pressure ulcer would be coded as present on admission on the new admission assessment.
42.	LTCH CARE Data Set—Section M	If a Stage 2 wound is present when the patient is admitted to the LTCH, but then worsens to a higher stage by the time of discharge, how would we code that higher stage pressure ulcer?	The higher stage pressure ulcer would not be considered present on admission when filling out the discharge assessment.
43.	LTCH CARE Data Set—Section M	If a patient is discharged on day 1 with a stage 2 pressure ulcer and returns on day 3 with a stage 3 pressure ulcer, how do we document this? Is there a way to document that the pressure ulcer worsened at another facility?	There is not a way to document this on the LTCH CARE Data Set. The pressure ulcer's worsening is considered the responsibility of the LTCH if it happened within the 3-calendar-days.
44.	LTCH CARE Data Set—Section M	If an unstageable pressure ulcer is debrided and is determined to be a Stage 4, is this considered worsened?	No. If an unstageable pressure ulcer becomes numerically stageable, it is considered present on admission at the stage at which it first appeared to be stageable. This is not considered worsened.
45.	LTCH CARE Data Set—Section M	If a pressure ulcer is assessed as a Stage 3 on admission, but by discharge has improved and now has the characteristics of a Stage 2, how would it be staged at discharge?	Do NOT reverse stage. A Stage 3 pressure ulcer remains a Stage 3 pressure ulcer until it is completely epithelialized (healed) or worsens to a deeper stage. The LTCH CARE Data Set would be coded as follows: LTCH would code the LTCH CARE Data Set admission assessment to indicate that a Stage 3 pressure ulcer was present on admission (M0300C1 = 1, M0300C2 = 1). At discharge, because the Stage 3 pressure ulcer has neither healed nor worsened to a deeper stage, the LTCH would code the LTCH CARE Data Set discharge assessment to indicate that a Stage 3 was present at discharge and present on admission (M0300C1 = 1, M0300C2 = 1).
46.	LTCH CARE Data Set—Section M	If a stage 2 pressure ulcer worsens during the stay, but it heals before discharge, how is that recorded on the LTCH CARE Data Set?	The stage of the pressure ulcer is recorded on admission and again at discharge. Any changes that occur between admission and discharge should be entered into the patient's medical record but are not recorded on the LTCH CARE Data Set

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#	Question Category	Question	Answer
47.	LTCH CARE Data Set—Section M	Can you give examples of worsening pressure ulcers?	• A Stage 2 on admission that becomes a Stage 3 by discharge • An unstageable on admission that is debrided to a Stage 3, then evolves to a Stage 4 • A Stage 3 on admission that becomes a Stage 4 by the third day and is still a Stage 4 at discharge • Intact skin on admission that becomes a Stage 2 by discharge • A Stage 1 on admission that becomes a Stage 2 by discharge
48.	LTCH CARE Data Set—Section M and Section M	If a patient is transferred out of the LTCH to another level of care and returns to the LTCH within 2 days with a new pressure ulcer, is that pressure ulcer coded as "not present on admission"?	If, by the time the patient is discharged from the LTCH, this pressure ulcer has not healed, then yes, it would be considered "not present on admission."
49.	LTCH CARE Data Set—Section Z	Our LTCH does not use electronic health records, so should the signature part of the LTCH CARE Data Sets be retained in the patient's medical record?	CMS encourages LTCHs to retain the signature part of the LTCH CARE Data Set assessment record for all patients.
50.	LTCH CARE Data Set—Section Z	Should the signature sections be filed and held at the hospital and, if so, how long should they be kept?	CMS will not be receiving the signatures from LTCH CARE Data Set, Section Z: items Z0400, and Z0500. We will receive the submission date. We strongly suggest that you retain what you submit to CMS, including Section Z, according to your facility and State and Federal regulations and requirements. Facilities should comply with their requirements pertaining to electronic signatures, should they require them.
51.	LTCH CARE Data Set—Section Z	Do I have to retain section Z?	CMS will not be receiving the signatures from LTCH CARE Data Set, Section Z: items Z0400, and Z0500. We will receive the submission date. We strongly suggest that you retain what you submit to CMS, including Section Z, according to your facility and State and Federal regulations and requirements. Facilities should comply with their requirements pertaining to electronic signatures, should they require them.
52.	LTCH CARE Data Set—Section Z	Does the LTCH CARE Data Set require the signature of a registered nurse?	No. CMS has removed the language surrounding and requirement for a registered nurse's signature for the submission of LTCH CARE Data Set's submission.

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#	Question Category	Question	Answer
53.	LTCH CARE Data Set—Section Z	The language accompanying the signatures section of the LTCH CARE Data Set forms states: I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. In the case when someone is copying clinical information that has been collected by someone else and simply doing the data entry, whose name gets entered into that place? The name of the person who collected the information? Or the person doing the data entry?	We interpret that you are asking whose signature should be provided in Z0400. The LTCH would follow its own policies regarding who is appropriate for the data collection for a specific section of the LTCH CARE DATA Set, and that person would then sign the signature line(s) provided in Section Z0400 to certify data collection. CMS requires that whoever is certified confirm that the information collected, or coordinated, is true and accurate; the dates provided are accurate, and that the person signing is authorized by the facility to submit the information. Further, please note that CMS will not be receiving the signatures from LTCH CARE Data Set, Section Z: items Z0400 and Z0500. We will receive the submission date. We strongly suggest that you retain what you submit to CMS, including Section Z, according to your facility and State and Federal regulations and requirements. Facilities should comply with their requirements pertaining to electronic signatures, should they require them.
54.	LTCH CARE Data Set—Section Z and General	Does the LTCH CARE Data Set require that the LTCH have an assessment coordinator on staff?	No. CMS has removed language pertaining to an assessment coordinator.
55.	LTCH CARE Data Set—Submission	How often and what are the due dates for submitting patient assessments (admissions, planned discharge, unplanned discharge, and expired) to CMS through QIES? ASAP? Weekly? Monthly? Quarterly? What are the time frames for submission of an individual record? Of a file?	Each assessment, whether admission or discharge, must be submitted within 7 days of the "date of completion." All files generated by a facility between October 1, 2012, and December 31, 2012, must be submitted to CMS or the NHSN system no later than 11:59 p.m. on May 15, 2013. Files submitted after this date and time will not be accepted.
56.	LTCH CARE Data Set—Submission	Where can we find the timelines (in terms of data collection periods and data submission periods) associated with this program?	The timelines related to the data collection periods and data submission periods can be found in the FY 2012 IPPS/LTCH PPS Final Rule, as well as in the LTCHQR Program Manual, provided under downloads on the LTCH Quality Reporting web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html.

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#	Question Category	Question	Answer
57.	LTCH CARE Data Set—Submission	What are the time frames for submission of an individual record? Of a file?	Each assessment, whether admission or discharge, must be submitted within 7 days of the "date of completion." All files generated by a facility between October 1, 2012, and December 31, 2012, must be submitted to CMS or the NHSN system no later than 11:59 p.m. on May 15, 2013. Files submitted after this date and time will not be accepted.
58.	LTCH CARE Data Set—Submission	Looking for guidance as to what to do when a facility realizes assessments were missed.	LTCHs need to ensure that they have a mechanism in place to track whether or not all assessments have been submitted for each patient. If, for example, an LTCH forgets to submit the admission assessment record, and upon discharge, the LTCH submits a planned or unplanned discharge 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. Ultimately, LTCHs will have until the May 15, 2013, final deadline to submit any missing or corrected assessments.
59.	LTCH CARE Data Set—Submission	Is there a time frame for resubmission (if there is an error)? Is there a time limit on when an LTCH can modify or inactivate the record?	All quality data, including original assessment records, corrected assessment records, and requests for deactivation of assessment records must be submitted to CMS by the final deadline of May 15, 2013, at 11:59 p.m. Any quality data that is not submitted by this final deadline will not be used in determining compliance for the LTCHQR Program.
60.	LTCH CARE Data Set—Submission	Will each admission and discharge assessment need to be submitted individually, or can a facility or their vendor submit the assessments in a file?	Because we are requiring facilities to submit each assessment within 7 days of the completion date, it will depend upon when a particular patient is discharged, and thus, when their discharge assessment is completed. If it falls within the same time frame as the required submission of the admission assessment, then yes, facilities may submit them together; if not, they must be transmitted separately.

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#	Question Category	Question	Answer
61.	LTCH CARE Data Set—Submission	Can you please help us understand a process question relating to the CARE set assessments? Consider the following scenario: • Patient is admitted and clinical quality information is captured in the patient's medical record on the day the patient is admitted. • Admission assessment xml is generated using information from the medical record. • Assessment coordinator attests that care set is complete, and submits xml file to CMS. Submission is accepted. • After submission, it is discovered that medical record information was entered incorrectly. Information is updated. At this point, the information stored within the medical record no longer agrees with the information submitted in the quality report. Would the hospital potentially be exposed by this? Would the hospital be responsible for updating the quality report submission (even though submission due date may have already passed, and therefore hospital would not be in compliance with submission deadline)?	In reviewing the scenario you provide, we want to take the opportunity to ensure that you are aware that an assessment coordinator is not required by CMS and that the name of the tool is "LTCH CARE Data Set" (and this is different than CARE). In the event that an LTCH CARE Data Set record in which an error was identified had been successfully submitted to CMS, the corresponding record must be modified with the corrections. Please refer to chapter 4 of the CMS LTCHQR Program Manual. Records will be accepted after the submission timeline. However, when the submission date is greater or equal to 7 days from the completion date, you will receive a warning message on the validation report. For quality reporting purposes, LTCHs have until May 15, 2013, to submit or modify data that was already submitted. Please again note that record modifications are appropriate for correcting errors. Please refer to both Chapter 3 (Section A) and Chapter 4 of the LTCH Quality Reporting Program Manual for additional information.

(continued)

#	Question Category	Question	Answer
62.	LTCH CARE DATA Set—Submission	I have a question concerning the completion of the Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation Care Data Set. The handout we received talks about completing the assessment on the 3rd day of admission. For example, for 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 3rd day? Do we have 3 more days to complete? Any penalties apply if don't complete the assessment in 3 days? Are these "guidelines" and NOT rules?	There are no grace periods for the LTCH Care Data Set assessment, completions, or submission timeframes. LTCHs are expected to follow the timeframes regardless of the day of the week a patient is admitted to an LTCH. For information related to LTCH CARE Data Set assessment, completion, and submission timing, please refer to Chapter 2. The Assessment Reference Date can be up to day 3 of admission (date of admission plus 2 days). You have 5 days to complete the data set, but all information must pertain to those first 3 days. Furthermore, the skin assessment section pertains to a patient's assessment completed upon admission (based on hospital policy; generally within a short time of arrival). Completing or submitting the assessment in an untimely manner will result in a warning message, because these dates are based upon the admission date.
63.	LTCH CARE Data Set—Submission	What is the cutoff date for sending in data from the October 1 to December 31, 2012, quarter?	You have until May 15, 2013, to submit corrections to data submitted for the October 1-December 31, 2012 reporting period. Anything submitted after that date will not be considered in determining compliance versus noncompliance for fiscal year 2014 payment update. For CLABSI and CAUTI reporting, CLABSI and CAUTI events ought to be reported to NHSN as close to the time of the event as possible. If that's not feasible, then there is a certain monthly timeframe that is provided in the NHSN guidance. If there are no infections to report, that data should be submitted monthly as well. If you need to correct any of that information, you have until May 15, 2013.
64.	LTCHQR Program Manual—Submission	In the LTCHQR Program Manual, there are timelines indicating that fourth-quarter calendar year data should be submitted by May 15, but then there are also references to the data being submitted "concurrently" (i.e., a certain number of days after the patient is discharged). Can you clarify these timelines?	We are asking that LTCH CARE data sets be submitted concurrently. For the October 1-December 31, 2012 quarter, CMS is allowing until 11:59 pm on May 15, 2013 to submit corrections to the record (pursuant to the policies outlined in Chapter 4 of the LTCHQR Program Manual).
65.	LTCHQR Program—Submission	For the CAUTI and CLABSI measures, will CMS be pulling the data from NHSN?	Yes.

FAQs added in Version 2.0, presented at CMS-sponsored LTCH Special Open Door Forum on October 18, 2012

#	Question Category	Question	Answer
66.	LTCH CARE Data Set—All	A patient is emergently discharged out of the LTCH at 2 AM on October 10th. The wound care clinician (WOCN) did not evaluate the patient immediately prior to discharge. How far back can we look to gather the wound data? If the WOCN 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?	The 3-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 always the ARD for discharge assessments. 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 3-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 an 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 3 days as outlined in the LTCHQR Program manual.
67.	LTCH CARE Data Set—All	Which sections need to be completed within that 3-day timeframe?	The 3 days are the time during which you will be assessing the patient. The LTCH will use the data or the patient information from those 3 days in order to complete the LTCH CARE Data Set. The LTCH has 5 days beyond the ARD to complete that LTCH CARE Data Set. No section of that LTCH CARE Data Set must be completed within those 3 days. But the LTCH will have until day 8 to complete all of those sections.
68.	LTCH CARE Data Set—All	According to the handout we received it talks about completing the Assessment on the 3rd day of admission…for example, 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 3rd day? Do we have 3 more days to complete? Any penalties apply if don't complete the assessment in 3 days?	There are no grace periods for the LTCH Care Data Set assessment, completions, or submission timeframes. LTCHs are expected to follow the timeframes, regardless of the day of the week a patient is admitted to an LTCH. For information related to LTCH CARE Data Set assessment, completion, and submission timing, please refer to Chapter 2. The Assessment Reference Date can be up to day 3 of admission (date of admission + up to 2 calendar days = ARD for admission assessment; ARD + 5 calendar days = date of completion (data set must be complete)). You have 5 days to complete the data set after the ARD, but all information must pertain to those first 3 days. Furthermore, the skin assessment section pertains to a patient's assessment completed upon admission (based on hospital policy; generally within a short period of time of arrival). Completing the assessment in an untimely manner, or submitting it in an untimely manner will result in a warning message, as these dates are based upon the admission date.

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#	Question Category	Question	Answer
69.	LTCH CARE Data Set—All	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 the printing of this. If we still have a paper medical record, then will we need to essentially print them out and store them in the medical record?	Yes. If you have a paper record you will need to print the LTCH CARE Data Set and store them in the medical record.
70.	LTCH CARE Data Set—All	We also have a paper record but we will be using a software program where the information is stored. Will we be required to print off the assessment and put it on the medical record since we'll be able to access it online? Or can we just use the online storage?	You will be able to store it electronically.
71.	LTCH CARE Data Set—ARD	I would like to clarify with the assessment reference date for an admission event. Is the ARD day three of admission—date of admission plus two more days. Does that mean 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?	The assessment reference date can be the date of admission plus up to 2 calendar days. In the scenario presented, the ARD can be the day of admission or day two. The discharge date and ARD for discharge assessment would be day two. So, in this example, admission date, ARD for admission assessment, discharge date and ARD for discharge assessment could all be day 2. This scenario is an exception.
72.	LTCH CARE Data Set—ARD	If a patient is admitted on day one and they die on day two, is ARD for the admission assessment still admission plus two days?	In this case, the ARD would be day two because the patient is deceased.

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#	Question Category	Question	Answer
73.	LTCH CARE Data Set—ARD	If information is documented in the medical record after the ARD but before the Completion Date (i.e., 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?	The LTCH CARE Data Set assessments should contain information/data that was applicable to the patient's health status during the 3-day assessment reference period. Any information or clinical data gleaned after the ARD, but before the completion date would not be included in the LTCH CARE Data assessment records.
74.	LTCH CARE Data Set—Discharge	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?	If the patient dies in your facility, you will fill out an expired assessment on that patient.
75.	LTC H CARE Data Set—Discharge	I am 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 3 days prior to Discharge? Also, if the patient has an unplanned discharge on Monday at 2am and there is no Mobility/Wound assessment over the previous weekend, do I leave the assessment blank or do I report the most recent info available?	The 3-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 always the ARD for discharge assessments. 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 3-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.
76.	LTCH CARE Data Set—Interrupted Stay	If we had a patient we had a patient that discharged to the hospital on September 29th and the patient returns on October 1st, would it be an interrupted stay or does the patient require a LTCH CARE Data Set?	This case would be considered an interrupted stay. Because they were admitted to the LTCH before October 1, they will not need to be included.

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#	Question Category	Question	Answer
77.	LTCH CARE Data Set—Interrupted Stay	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 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?	In the scenario you outline in your question, if a patient returns to the LTCH after more than 3 calendar days at another hospital/facility/location, 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 to the LTCH should be used as the Admission Date.
78.	LTCH CARE Data Set—Interrupted Stay	The requirements for quality reporting indicate that if a patient has an interrupted stay and does not return within 3 days, 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 indicated two types: 3 days or less and greater than 3 day interruption. The fixed day period for inpatient acute care hospitals is between 4 and 9 days. Can you clarify that if the patient is on interrupted stay and returns between 4 and 9 days we should discharge and readmit them? The Long Term Care Hospital PPS fact sheet indicates if they return in 9 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.	We are aware that patients with an interrupted stay of between 4 and 9 days that are treated in to inpatient acute care hospitals or patients with an interrupted stay of between 4 and 27 days; in an inpatient rehabilitation facility; or patients with an interrupted stay between 4 and 45 days at a SNF/ Swing Bed are not "technically" discharged from the LTCH for payment purposes under the LTCH PPS. 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, i.e., who have a with "Three-Day or Less Interruption of Stay." However, we require that LTCHs submit the LTCH CARE Data Set discharge assessment record for patients with "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 3 days, i.e., a "greater than Three-Day Interruption of Stay."

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#	Question Category	Question	Answer
79.	LTCH CARE Data Set—Planned/Unplanned	I need some clarification on planned versus unplanned discharge. 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. If the patient stays longer than three days then it is 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?	If a patient is discharged from your facility for longer than three calendar days, including that date of discharge, then it is no longer considered an interrupted stay. You would fill out a discharge assessment.
80.	LTCH CARE Data Set—Planned/Unplanned	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.	Yes, a LTCH can have a planned discharge to a short-term acute care hospital if it is for a planned procedure or intervention.
81.	LTCH CARE Data Set—Planned/Unplanned	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 hospital. The patient is subsequently discharged to the short term acute hospital and stays longer than 3 days for the planned intervention. Is this scenario a planned or an unplanned discharge?	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 3 days; it is 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/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 3 calendar days, but the patient's absence from the LTCH lengthens unexpectedly (due to de-compensation, sepsis, etc.) and ultimately lasts longer than 3 days, the LTCH would be required to submit an unplanned discharge. The LTCH must submit a discharge as the patient was gone longer than 3 days. The discharge is considered unplanned as the LTCH expected that the patient would return to the LTCH within 3 calendars but did not. If the patient had returned to the LTCH from the acute care hospital before the end of the 3 day period, the LTCH would not be required to file any of the four assessment records (admission, planned discharge, unplanned discharge, expired) because the patients absence would simply be considered an interrupted stay.

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#	Question Category	Question	Answer
82.	LTCH CARE Data Set—Planned/Unplanned	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?	Guidance on how to handle hospice patients is included in Chapter 2 (page 2-2) of the LTCHQR Program Manual (available in the "downloads" section of the LTCHQR Program Web site). 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 (even "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.
83.	LTCH CARE Data Set—Section A	My question pertains to Section A1820 on the Admission Assessment. 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? Additionally, 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?	You may not always have the answer to this question. This can sometimes be a very difficult question to answer. In the case that you don't have the answer to this question, you would enter a dash indicating that you don't have the information or you can't answer the question. We ask that you do your best in trying to determine the primary diagnosis being treated at the previous setting.
84.	LTCH CARE Data Set—Section A	Should a patient's Medicaid number (question A0700) be entered into the LTCH CARE Data Set if the patient has Medicaid as the secondary payer, or only when Medicaid is the primary payer?	If a patient has a Medicaid number, please enter it in A0700. If the patient's number is pending, please follow instructions as provided in Chapter 3, Section A.
85.	LTCH CARE Data Set—Section A	A1200 Do we need to ask pt specifically "were you ever married"? Someone might identify themselves as "Single" even if married prior so as to avoid the stigma of divorced status.	The question to which you are referring is asking for current marital status. Please record the patient's response.
86.	LTCH CARE Data Set—Section A	Is the National Provider Identifier the same number that you mentioned at the start of today, the facility ID number? And if not, what is that National Provider Number?	No, they are not the same number. Your National Provider ID is the number used on LTCH claims.

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#	Question Category	Question	Answer
87.	LTCH CARE 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 MD 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."
88.	LTCH CARE Data Set—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? 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.
89.	LTCH CARE Data Set—Section I	How far can we use clinical judgment to "connect the dots" between documented patient condition/care and the specific three diagnosis 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 s/p 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.
90.	LTCH CARE Data Set—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.

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#	Question Category	Question	Answer
91.	LTCH CARE Data Set—Section M	The NPUAP mentions mucosal pressure ulcers, which they define as pressure ulcers that are not stageable. How you recommend we report those types of ulcers, if at all?	For the purpose of the LTCHQR Program, mucosal ulcers should not be recorded on the LTCH CARE Data Set Assessment record. *Mucosal ulcers* are not considered skin ulcers. The tissue type of skin and mucosa are different and the treatment of skin ulcers and mucosal ulcers is also very different. NPUAP has a position statement on this: http://www.npuap.org/wp-content/uploads/2012/03/Mucosal_Pressure_Ulcer_Position_Statement_final.pdf Hence, mucosal ulcers are not coded in the LTCH CARE Data Set at this time for the LTCHQR Program
92.	LTCH CARE Data Set—Section M	If on admission a RN assesses a wound as a pressure ulcer, then on day two of the admission the wound care nurse assesses the wound and notes it is not a pressure ulcer –is the initial incorrect assessment of the wound reported on the CARE Tool as it was the first assessment of the wound?	The facility needs to have policies in place that address discrepancies in assessment and documentation. It is the responsibility of the facility to come to a consensus and code the LTCH CARE Data Set accurately.
93.	LTCH CARE Data Set—Section M	We admitted a patient and then we already submitted the admission ARD. A week after, we sent the patient out for a skin graft and within interrupted stay (which is a third day), the patient returns, can we change that pressure ulcer to surgical wound? If the patient is discharged, how could we modify that pressure ulcer went to surgical wound?	It would not be recorded as a pressure ulcer on discharge.
94.	LTCH CARE Data Set—Section M	Section M 0300 B #3—Date of oldest Stage 2 pressure ulcer—if this information is not found in the records from previous setting (because POA to LTCH) do we use the admission date for "first identified" or use "dashes" because unknown?	The question asking you to provide the "Date of the Oldest Stage 2 Pressure Ulcer" may sometimes be difficult to answer. An appropriate answer would be found in the records from the patient's previous setting. If a provider cannot locate this information, they should use a dash to indicate that the answer is unknown. An LTCH should not use the date of admission as the date this pressure ulcer was first identified if it was present upon the patient's arrival and admission to the LTCH.

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#	Question Category	Question	Answer
95.	LTCH CARE Data Set—Section M	The question pertains to a patient at the time of admission who has demonstrates deteriorating changes to a previously healed pressure ulcer that may have been a stage 3 or 4. That same previously healed wound is now open on admission. How is this pressure ulcer staged? The concern is that the current staging may not reflect the appropriate staging of the pressure ulcer previously.	On admission, the LTCH would stage the ulcer by visually inspecting it and staging it according to the ulcer's deepest visible anatomical level on admission. Once an ulcer has fully healed, the important thing to understand is that this area is always at higher risk of skin breakdown and the area requires continued monitoring and prevention strategies. If this response does not address your question, please resubmit the question with additional clarification so, we can provide you with further clarification/guidance.
96.	LTCH CARE Data Set—Section M	When completing the CARE Data Tool, the following inquiry was raised to which we could not find definitive guidance in the manual. How do you report when a patient acquires a pressure ulcer during the LTACH stay which resolves prior to discharge? Understanding that this would not be reported on the admission assessment, but would it be required to be reported somehow on the discharge assessment although already healed?	Because the pressure ulcer was not present on admission and is not present on discharge, it would not be captured on the LTCH CARE Data Set Admission or Discharge assessments.

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#	Question Category	Question	Answer
97.	LTCH CARE Data Set—Section M	We have started to do KCI Graft Jackets which is a procedure done at the bedside and does not involve a transfer out of the facility. Should the pressure ulcer being grafted be considered a healed pressure ulcer and the grafted ulcer be followed as surgical wound? Same sort of question—our Stage IV PU patients leaving the facility for flap surgery • Those out 1-2 days—should we "heal" the pressure ulcer and then follow as a surgical wound? • Those that return after 3 days—should we discharge with a Stage IV and re-admit with a surgical wound?	Once a graft is used to close a pressure ulcer, the pressure ulcer is no longer coded as a pressure ulcer, because it is a surgical wound. You would not consider a grafted pressure ulcer as a healed pressure ulcer, because the graft is actually being used to close the pressure ulcer which was not healing on its own. Response: No, once there is a graft that is used to close a pressure ulcer, it is no longer coded and tracked as a pressure ulcer on the LTCH CARE Data Set. The wound is now a surgical wound. As stated above, it is not considered a healed pressure ulcer. Also, please note that since the patient returned in less than 3 calendar days, you will not complete a discharge assessment (at the time patient leaves the facility for flap surgery). Response: Since the patient returned after 3 days, you will complete a discharge assessment and note Stage IV pressure ulcer on the discharge assessment. Since the patient is being re-admitted (i.e., at the time of return from another facility after flap surgery and since patient returned after 3 days) with a grafted area, it won't be coded on the LTCH CARE Data Set Admission assessment because it is a surgical wound (and not considered a pressure ulcer).

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#	Question Category	Question	Answer
98.	LTCH CARE Data Set—Section M	Is it permissible to have an RN take a picture, describe and do measurements of the wound (Pressure Ulcer) but not Stage in the ARD? Thinking of Friday and Saturday admissions. In these cases, wondering if the staging could be done by the Wound Care expert on Monday if the wound is identified and assessed by an RN over the weekend. Thank you for your time.	CMS expects that patient assessment data in the LTCH CARE Data Set Admission Assessment should be consistent with the initial clinical assessment. For example, the information submitted on the Admission Assessment for the LTCH CARE Data Set, Section M: Skin Conditions needs to be based on the skin assessment that is conducted in conjunction with the patient admission to the LTCH (see page M-5). Further, the patient's skin assessment, which will inform the LTCH CARE Data Set admission assessment record must be performed within the 3 calendar days (assessment reference period) that end on the ARD. Any information from patient assessment conducted after the ARD should not be captured on the LTCH CARE Data Set Admission Assessment (see page A-6). Therefore, in the scenario you describe, if a patient is admitted to the LTCH on Friday and the wound care expert does not stage the ulcer until Monday, the pressure ulcer assessment data cannot be captured on the LTCH CARE Data Set Admission assessment. All data items on the LTCH CARE Data Set not assessed by the ARD would be dashed. For example, items in Section M about pressure ulcer stage at admission would need to be dashed on the admission assessment. This is a serious consideration when creating facility policies such as those that require that only certain clinical personnel are authorized to stage pressure ulcers. Please note that CMS recognizes that skin assessment including pressure ulcer staging is accepted within the scope of practice for many healthcare professionals, such as Registered Nurses, Physical Therapists, and Physicians. CMS does not require that healthcare professionals completing skin assessments and staging pressure ulcers be wound care certified experts.

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#	Question Category	Question	Answer
99.	LTCH CARE Data Set—Section M	If a patient has a wound, a standard of practice is to complete the wound assessment weekly. If the patient is an unplanned discharge, can we use a wound assessment outside the ARD timeframe? For example: The patient's wound assessment is completed on 10/2, 10/9 and should be reassessed on 10/16 but is unexpectedly due to a significant change in condition discharge to acute care on 10/14. The last documented wound assessment would have been done on 10/9 outside the ARD. Patients are not weighed daily unless there is a fluid management or weight loss consideration. Can we used the last weight if the patient is again an unplanned discharge?	Chapter 2, pages 2-8 and 2-9 of the LTCH Quality Reporting Program Manual, available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html, provides guidance on completing the Unplanned Discharge assessment. It states, "For unplanned discharges, the LTCH should complete an Unplanned Discharge assessment to the best of its ability. The use of the dash, "-," is appropriate when the staff are unable to determine the response to an item. In some cases, the LTCH may be in the process of completing or may have already completed some items of the assessment, and should record those responses." If there is no pressure ulcer documentation available within the appropriate timeframe as established by the ARD of the assessment, the items in Section M would be coded with a dash. Please review page K-2 in the LTCH CARE Quality Reporting Manual. It states "For an Unplanned or Planned Discharge assessment, record the most recent weight (in pounds) measured since admission."
100.	LTCH CARE Data Set—Section Z	We are having some of our admission nurses complete a worksheet and then turn it to someone who will go in online and complete the information. So would the signature be from the person that is entering the information or would it be nurse?	The LTCH CARE Data Set will need to be signed by the person who assessed the patient and collected the data.
101.	LTCH CARE Data Set—Section Z	Would there be a problem if we put the person's name who assessed the patient and then by the person's name that entered the data to include both names?	The signature of the person who entered data is not necessary. In the first portion of the form requires the signature of the person who provided data for that assessment. The second area for signature would be the person who verifies that the information is complete. The signature portion is not transmitted to CMS. This could be handled by having those nurses sign those worksheets, to attest.
102.	LTCH CARE Data Set—Submission	If an error is found on an assessment after the Completion Date but before the Submission Date, then should the Completion Date be updated to whatever date the error was corrected?	The updated completion date would be used.

FAQs added in Version 3.0

#	Question Category	Question	Answer
103.	CDC NHSN – Interrupted Stay	Please clarify whether or not the CLABSI and CAUTI measures are affected by the 72 hour rule for patients leaving and possibly returning to the LTCH.	Thank you for your inquiry. Both the CAUTI and CLABSI protocols use a 48 hour transfer rule (in 2013, this will be an updated to a 2-day rule). See page 7-2 of the CAUTI protocol (available here: http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf) for NHSN transfer rule definition and examples. See page 4-2 of the CLABSI protocol (available here: http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf) for the NHSN transfer rule definition and examples.
104.	LTCH CARE Data Set - All	I'm having some instances where page three of the assessment is completely blank. Do we need to scan in that blank page and perhaps use a stamp that tells you this page printed blank? Is it necessary to scan that third page so that you can understand if that were ever reviewed retrospectively?	If all of the data for the LTCH CARE Data Set are included in the pages that you scan, that will be sufficient. We will not verify page numbers.
105.	LTCH CARE Data Set - All	If a patient has refused height and weight, what is the code do I enter into the data set? When we enter the dash or 99, I get immediately that it is an invalid answer.	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. The specifications are written to accept a dash (or hyphen) as a default response to this item. You may need to contact your software vendor.

#	Question Category	Question	Answer
106.	LTCH CARE Data Set - All	It is my understanding that some items are used as covariates (risk adjustment) to calculate the percentage of pressure ulcers that are new or worsened. Data for these risk adjustment items are derived from the admission assessment. Therefore, the provider must submit these risk adjustment items on the admission assessment. These items are not used in the measure's 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 items. The default codes vary according to the data item (found in Appendixes E). While I don't have to submit answers for these data items at discharge, many of these items generate a warning if you enter the default code "A dash submitted in this quality measure item may result in a payment reduction for your facility of two percentage points for the FY 2014 payment determination." If I am not required to submit data in these elements, I understand that I should enter some default code to let you know that I didn't just skip the question. But if the item is not required, then it should NOT generate a warning message.	CMS is aware of the "discrepancies" between the measure submission specifications and Appendix E of the LTCHQR Program Manual, which distinguishes between "voluntary" and "required" items on the LTCH CARE Data Set. The discrepancy occurs as the data submission specifications were written in advance of the CMS decision to distinguish between "required" and "voluntary" data items. Because of this, certain items listed as voluntary in Appendix E of the LTCHQR Program Manual issue a warning when the provider codes the item with a default response. Please know that CMS is aware of this problem and working toward a solution. In the meantime, please disregard any warning message issued by the software when entering a default response on these Planned and Unplanned discharge items. If the item is noted as voluntary in Appendix E of the LTCHQR Program manual, you can be assured that any warning issued by the software after entering a default response can be ignored with no negative consequences to the provider. We hope to present a solution to this discrepancy in the near future and will announce it on CMS' LTCH Quality Reporting Program website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting.

#	Question Category	Question	Answer
107.	LTCH CARE Data Set - All	We have recently had a facility present us with the following scenario. Please advise how the admission and discharge assessments for this patient should be handled. Patient admitted to LTCH on 10/4 and had to return to acute care on same day, 10/4. Patient readmitted to LTCH (from acute) on 10/5. Patient had to return to same acute facility on 10/7. Patient readmitted to LTCH on 10/10. One Admission Assessment for the 10/4 admission, and no discharge due yet? OR does the 10/7 discharge (day 4 after the 10/4 admission, from which the original admission assessment was triggered) require a discharge assessment? Then the 10/10 another admission assessment?	For information related to LTCH CARE Data Set assessment, completion, and submission timing, please refer to Chapter 2 of the LTCH Quality Reporting Program Manual, available for download here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip LTCHs are responsible for completing and submitting an LTCH CARE Data Set admission assessment record for every patient admitted to their facility regardless of payor source, diagnosis, etc. If a patient is transferred to another care facility for a period of less than 3 calendar days (including the date of transfer), it is considered a "less than 3-day interrupted stay" and the LTCH is not responsible for submitting any related assessments to CMS. If a patient is transferred to another care facility for a period of greater than 3 days (including the date of transfer) the LTCH is responsible for completing and submitting an LTCH CARE Data Set discharge assessment record (planned or unplanned, as appropriate) to CMS. If that same patient should return to the LTCH after the third calendar day (including the date of transfer), the LTCH is then responsible for completing and submitting an LTCH CARE Data Set admission assessment record to CMS, as this admission would be considered a new admission from a quality reporting standpoint. With regard to the patient example given in your inquiry: • Patient admitted to LTCH on 10/04: LTCH completes and submits an LTCH CARE Data Set admission assessment record to CMS • Patient transferred to acute care hospital on 10/4 (same day): no action required • Patient transferred back to LTCH from acute care hospital on 10/5: no action required • Patient transferred back to acute care hospital on 10/7: LTCH CARE Data Set discharge assessment completed and submitted to CMS (Patient's transfer lasts greater than 3 calendar days including date of transfer) • Patient transferred back to LTCH on 10/10: LTCH CARE Data Set admission assessment completed and submitted to CMS (patient's transfer lasted longer than 3 calendar days (including date of transfer).

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#	Question Category	Question	Answer
108.	LTCH CARE Data Set – All	Regarding LTCH CARE Data Set forms: does the facility have to keep the paper form in its entirety? Can the facility just maintain the signature page and confirmation of submission acceptance? Also, can the facility alter the paper form to fit its needs and flow of information?	It is CMS' recommendation that LTCHs maintain copies of what they submit to CMS. Maintaining copies of the LTCH CARE Data Sets your facility submits acts to protect the LTCH should a discrepancy occur. To that end, CMS recommends maintaining copies of submitted data sets in their entirety, whether electronically or on paper. CMS does not approve the altering of the data set forms as the data must be submitted to CMS in the particular order in which the questions are asked. Further, Office of Management and Budget (OMB) approved the LTCH CARE Data Set on April 24, 2012 in accordance with the Paperwork Reduction Act (OMB Control Number is 0938-1163) in the format and order they are included in the Appendix C, LTCHQR Program Manual V1.1 for the purpose of LTCHQR Program.
109.	LTCH CARE Data Set – All	A patient is admitted on a Friday 5:00pm. The primary RN completes the admission skin inspection and documents a pressure is present on admission on the sacrum. The RN describes the wound but is not able to measure or stage the pressure ulcer. On Monday morning, the Wound Certified Advanced Practice Registered Nurse stages and measures the pressure ulcer. Questions: 1. Do we code the pressure ulcer in section M based on the primary RN description and put dashes for the measurement? 2. Do we use the information from the WOC APRN that includes staging and measurements? 3. How would we stage the pressure ulcer at discharge? 4. Would the ulcers be considered worsened?	1. The facility needs to have policies in place that address discrepancies in assessment and documentation. It is the responsibility of the facility to come to a consensus and code the LTCH CARE Data Set accurately. The patient assessment reflected in the admission assessment data set should coincide with the patient's admission assessment for the purposes of determining if a pressure ulcer was POA. A wound determined to be POA would specifically need to be "on admission." 2. If it is the policy of an 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 period at admission (which is the day of admission+ up to 2 days i.e., by the assessment reference date) as outlined in the LTCHQR Program manual. 3, 4.If a POA wound worsened during the 3 days, the admission assessment record should capture the wound's stage at admission based on the skin assessment closest to admission. On the discharge record, the wound would be captured at the stage to which it worsened, if it has not healed. For more information on pressure ulcers, we encourage you to refer to Chapter 3, Section M of LTCHQR Program Manual V1.1 (which is available to download in the "Downloads" section of the LTCHQR Program website).

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#	Question Category	Question	Answer
110.	LTCH CARE Data Set – All	Is it requirement for an RN to collect this data/report it or can a LPN do this?	Appropriate staff members should complete the section(s) of the LTCH CARE Data Set they are qualified to complete, per facility, State and Federal policy and requirements.
111.	LTCH CARE Data Set – All	A patient was admitted October 1 and discharged on October 1. All admission and discharged data was exported. If the same patient comes back in December, do I modify the patient for December admission as "01" or do I create a new patient and just ignore the duplicated patient information warning and proceed?	In the example you provide, when the patient is admitted to the LTCH in December, it will be considered a "new" admission and hence, a new record should be created for this "new" admission. LASER will match patient records using various items in the LTCH CARE Data Set, including, but not limited to: Patient First Name, Patient Last Name, Social Security Number, Date of Birth, and Gender
112.	LTCH CARE Data Set - ARD	Can you key in an assessment before the ARD date. Does the ARD date have to be 3 days past the admission date?	Yes, the admission assessment can be entered before the ARD. Please note that the ARD is the date of admission plus two calendar days rather than 3 days past the admission date, as is stated in your question. Also, we ask that you note that the "completion date" cannot be set before the ARD or the record will be rejected. The completion date must be equal to or greater than the ARD, but not greater than the ARD + 5 calendar days. For information related to LTCH CARE Data Set assessment, completion, and submission timing, please refer to Chapter 2 of the LTCHQR Program Manual, available here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip

#	Question Category	Question	Answer
113.	LTCH CARE Data Set - ARD	I want to clarify the look back period for discharge assessments. Our facility's policy is to do wound assessments once every seven days. A patient was admitted on October 1, and the admission wound assessment was done same day. The patient was discharged to the hospital on November 6. Can I use the admission wound assessment for my discharge assessment or not or should I use dashes since I don't have a current wound assessment information. Should we modifying our policy to do wound assessment every 3 days to be in correct timing with our LTCH CARE Data Set Assessment schedule?	The assessment reference period for the LTCH CARE Data Set Planned and Unplanned Discharge Assessment records begins two days prior to the date of discharge, with the actual date of discharge being the end of the assessment period (exception is the M0800 item for which assessment reference period goes back to admission assessment). The date of discharge is always considered the ARD as it is the day on which the assessment reference period ends. In the example presented in your question, the LTCH assesses patient wounds every seven days. The discharge assessment must fall within the three-day assessment reference period for it to be is considered a valid assessment and for inclusion in the submitted LTCH CARE Data Set Planned and Unplanned Discharge Assessment records. So, if your patient is discharged from the LTCH on November 6, the ARD for the discharge assessment would be November 6. Information to complete the LTCH CARE Data Set Planned and Unplanned Discharge Assessment records would come from skin assessment conducted on November 4, 5 or 6 in order to be included on the discharge assessment. If there is no current wound assessment that falls within the assessment period, the information in patient record available to complete the discharge assessment would not be available. Therefore the dash would need to be used where appropriate. As to your question regarding modification of your facility's current policies for completing wound assessments: The 3-day assessment period used in the LTCH CARE Data Set is not intended to replace the timeframe required for clinical assessments as established by accepted standards of practice, facility policy, state and Federal regulations. Therefore, the facility can modify policies, but it is not a requirement that you do so specifically related to when your facility performs internal clinical assessments. For more information on pressure ulcers, we encourage you to refer to Chapter 3, Section M of LTCHQR Program Manual V1.1 (which is available to download in the "Downloads" section of the LTCHQR Program website).

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#	Question Category	Question	Answer
114.	LTCH CARE Data Set – ARD	My understanding is that the ARD for discharge must equal the Discharge date itself. However, our nurses often must do the assessment the day before discharge, as our patients leave early in the morning on the day of discharge. These assessments are being rejected because the assessment date is earlier than/less than the ARD/Discharge Date. I am not sure how to work around this. Can you suggest anything?	The assessment reference period for the LTCH CARE Data Set Planned and Unplanned Discharge Assessment Records begins two days prior to the date of discharge. The date of discharge is always considered the ARD for discharge assessment as it is the day on which the assessment reference period ends. With regard to the assessment record rejections you are experiencing, please enter the Date of Discharge as the ARD on the LTCH CARE Data Set Planned and Unplanned Discharge Assessment Records even though the actual assessment was done the day before discharge. The date of completion must be equal to or greater than the ARD.
115.	LTCH CARE Data Set – ARD	We received a warning message for an admission assessment where the patient was admitted on 10/30 and expired 10/31. The ARD for the admission date was 10/31. The assessment was completed Nov 6 which was the 8th calendar day of the admission. The Manual states that the completion date for the admission assessment is the 8th calendar day of the patient's admission. It also states the ARD + 5 calendar days. In this case, since the ARD was the 2nd day of the patient's admission, instead of the usual 3rd day, which rule applies for completion of the assessment, the 8th calendar day of the admission, or the ARD + 5 days?	The reason your assessment record was rejected is because your completion date was greater than 5 days after the ARD. The date of completion (which is the last day that the record can be completed) is defined as the ARD (item A0210A) + 5 calendar days. Because your facility set the ARD on 10/31, the deadline for completion would be 11/05 (10/31 + 5 calendar days = 11/05). You set your date of completion on 11/06 and thus a warning was generated.

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#	Question Category	Question	Answer
116.	LTCH CARE Data Set - Discharge	If the patient is a planned discharge, is the wound assessment required to be done on the day of discharge since the ARD is the same? If the assessment is done prior to the day of discharge, for example, patient is discharged on 10/12/2012 and the last recorded wound assessment was 10/10/2012, would the recorded wound assessment on the form be from 10/10/2012 or left with dashes indicating no assessment?	The assessment reference period for the LTCH CARE Data Set Planned and Unplanned Discharge Assessment Records begins two days prior to the date of discharge. The date of discharge is always considered the ARD for discharge assessment as it is the day on which the assessment reference period ends. In the example presented in your question, the wound assessment performed on 10/10/12 would be acceptable as it falls within the assessment reference period. The date of discharge (the ARD) is 10/12/12. The assessment reference period in this example would include 10/10/12, 10/11/12, and 10/12/12. Because the wound assessment falls within the 3-day assessment reference period it is considered a valid assessment and may be included in the submitted data set. However, item M0800 on discharge assessment is unique in that assessment reference period for M0800 goes back to ARD of admission assessment.
117.	LTCH CARE Data Set – Section A	We sometimes admit patients when their insurance is pending. We will enter this patient in our system as, for example, "Medicaid Pending". Sometimes by discharge they are no longer pending, and sometimes they are still pending even at discharge. How should we answer their payor information? For the example above, should we answer "Medicaid" or should we enter "No insurance", since they are still pending?	Chapter 3, Section A, page A-11 of the LTCHQR Program Manual, Version 1.1 (available in the "Downloads" section of the LTCHQR Program website) provides the following guidance on how to complete A0700 in the case that the patient's Medicaid Number is pending: Enter a "+" in the left-most box if the number is pending. If you are notified later that the patient does have a Medicaid number, just include it on the next assessment.
118.	LTCH CARE Data Set – Section A	There are LTCH facilities with multiple buildings or sites working under the same CCN often have different NPIs for each building -- meaning, a single CCN can encompass multiple NPIs. Which NPI would be appropriate to enter on A0100A on the LTCH CARE assessment: the NPI belonging to the "main facility" under the CCN (where that can be determined) or the NPI for the patient's location?	The National Provider Identifier (NPI) refers to the number used on your LTCH claims. LTCHs should use the NPI for the patient's location.

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#	Question Category	Question	Answer
119.	LTCH CARE Data Set – Section A	On the LTCH CARE Data Set Admission Form: A1200: How do we classify a Domesticated Partner—as "Single" or Not Assessed, No Information?	For the Marital Status item (A1200), choose the answer that best describes the current marital status of the patient. In the example presented, your patient is in a domestic partnership. For the purpose of LTCH CARE Data Set, if the person is not legally married according to the current Federal definition, then the item should be coded as "Never Married." The patient in the provided example may also identify him/herself as "widowed" or "divorced', in which case you should code the appropriate answer. We invite you to refer to Chapter 3, Section A in the current version of the LTCHQR Program Manual (Version 1.1) as a source of information to inform completion of the administrative items on the LTCH CARE Data Set, available for download here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip
120.	LTCH CARE Data Set – Section A	I have Medicare Advantage patients in our hospitals, so I need to know if I should enter their Medicare Advantage number in the "Medicare Number Section A0600B." Our patients Medicare Advantage number starts with an alphabet and then has 10 numbers behind them. It is giving me a fatal error (message -1005) on both of these accounts. If it is not to be included in this section, do we just leave the Medicare section blank?	Item A0600B can only be a Medicare (HIC) number or a Railroad Retirement Board number. If no Medicare number or RRB number is known or available, the item may be left blank. Edits (or error messages)-1004, -1005, or -1017 applies when the number entered does not meet the format criteria for a Medicare or Railroad Retirement Board Numbers.
121.	LTCH CARE Data Set – Section A	The Manual states: "For an Unplanned or Planned Discharge assessment, record the most recent weight (in pounds) measured since admission." Does this mean that for discharge, if the patient was not weighed during the ARD, that you can use the last recorded weight found in the patients' medical record?	You may use the last recorded weight found in the patient's medical record for unplanned or planned discharge assessment. For more information, we refer you to page K-2 in the LTCHQR Program Manual V1.1 (which is available to download in the "Downloads" section of the LTCHQR Program website)

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#	Question Category	Question	Answer
122.	LTCH CARE Data Set – Section A	I am getting an error (#3844) for fields A1800 and A1810 supposedly being inconsistent. If a patient is admitted to the LTCH from a short-stay acute care hospital, and that patient was also in another short-stay acute care facility within the last 2 months in addition to being in one at time of referral and admission to the LTCH, would not the Admission assessment indicate in both A1800 and A1810 the answer "Short-stay acute care hospital"?	The original intent of A1800 was to collect which facility/setting immediately preceded the LTCH stay. A1810 was intended to collect the information on other settings in the 2 months preceding the LTCH stay and hence there is a consistency warning for selecting the same item twice. Given that this is just a warning, the record will not be rejected.
123.	LTCH CARE Data Set – Section A	If a patient has commercial insurance (such as Anthem or United Healthcare), what would I select on the Data set? Would it be A1400 (I) Private Managed Care?	If the patient has Medicare and has commercial insurance, then you would select B, Medicare (managed care/Part C/Medicare Advantage) and H (Private insurance/Medigap), and/or I (Private Managed Care). However, if the patient is not a Medicare patient and has only commercial insurance, you would select H (Private insurance/Medigap), or I (Private Managed Care). Please note that coding instructions for A1400 allows a LTCH to check all that apply. Please note that this is general guidance; the coding of the LTCH CARE Data Set should take into account patient-specific information.
124.	LTCH CARE Data Set – Section H	Please clarify the methodology for bowel continence in the admission assessment. The assessment indicates to complete during the 3-day assessment period. We use the Braden Scale to determine this. We complete the Braden Scale each shift. Should we be using the first completed Braden Scale after admission, or are you looking for a determination over the 3 day time period?	The Braden Scale should not be used to answer the LTCH CARE Data Set question H0400, which is used to collect data related to bowel continence. The Braden Scale is a tool used by clinicians to predict the risk of pressure ulcer development and does not address bowel continence. LTCHs should be using staff observation related to bowel continence which is documented in the patient's medical record. LTCHs should be choosing the best response to question H0400 that describes the patients bowel habits over the 3 day assessment reference period which ends on the ARD (date of admission + 2 calendar days).

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#	Question Category	Question	Answer
125.	LTCH CARE Data Set – Section M	When discharging a patient that had no history of a pressure wound during their stay, how do we document this? There is an answer choice of "Not assessed/No information" but that is different than out case. We did assess outpatient and we do have information. I don't like documenting "Not assessed/No information" when this is not true. We need a choice of "No history of PU during stay" or something to indicate this.	For the example you provide, you will answer with a "0" in M0210 (see item below) on the LTCH CARE Data Set – for the discharge record for this patient. M0210. Unhealed Pressure Ulcer(s). Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 0. No 1. Yes
126.	LTCH CARE Data Set – Section M	In the event that a patient has more than 9 pressure ulcers at any single stage, I understand that "9" should be entered for the M0300 count of pressure ulcers. How should the facility choose which of the patient's 10+ pressure ulcers to count among the 9 so as to reassess at discharge and determine which have worsened for purposes of M0800?	Thank you for your inquiry. In the case that patient admitted to your facility has greater than 9 pressure ulcers at any one stage, you would enter 9. Any additional pressure ulcers will be captured on the discharge assessment. For example, if you had 12 stage 2 pressure ulcers at admission, you would enter 9 when asked how many Stage 2 pressure ulcers the patient has, and you would enter 9 stage 2 pressure ulcers as present on admission. If, during the patient's stay, one of the pressure ulcers remained at a stage 2, 7 of the pressure ulcers worsened to a stage 3, one healed, one was covered with a surgical flap, and 2 worsened to a stage 4, the following would be recorded on LTCH CARE Data Set discharge assessment: • 2 of the pressure ulcers would not be recorded since one healed, and one became a surgical wound. • 1 would be recorded as a stage 2 pressure ulcer – present on admission • 7 would be recorded at a stage 3, not present on admission. • 2 would be recorded at a stage 4, not present on admission • 9 pressure ulcers would be recorded as worsened at their respective stages. As you can see from the above example, all 12 stage 2 pressure ulcers that were present on admission are eventually accounted for on the discharge assessment.

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#	Question Category	Question	Answer
127.	LTCH CARE Data Set – Section M	Would it be possible to add the Code 88, Not attempted due to medical condition or safety concern to Section M for the wound assessments? Virtually all of the unplanned discharge patients (many of them requiring vasopressor drips or perhaps freshly intubated) are too unstable to be turned and have multiple dressing (very rarely does a patient only have one) removed in order to assess their wounds.	In the example you provide, the information needed to complete the discharge assessment is not able to be assessed. Therefore, you would code a dash on the LTCH CARE Data Set. However, if the facility does have an available wound assessment that was conducted during the assessment reference period (i.e., two days before or on the day of discharge), that information could be used to code the LTCH CARE Data Set.
128.	LTCH CARE Data Set – Section M	The patient's initial wound assessment on admission was Stage III pressure ulcer wound. The patient's wound improved and was reassessed at discharge as a Stage II. It is noted in the Manual not to reverse stage. However, how do you address improvement at discharge on this wound assessment? What should be inputted?	Reverse staging of pressure ulcers is not clinically accurate and hence, not allowed on the LTCH CARE Data Set. The LTCH cannot at any point "reverse" code a Stage 3 ulcer to a Stage 2 ulcer. The items on the LTCH CARE Data Set do not allow documentation that a pressure ulcer is healing. The only time the ulcer would not be coded anymore on the LTCH CARE Data Set is if it is fully healed. For example, if the Stage 3 ulcer was present on admission and fully healed by discharge, it would be coded on the Admission Assessment as Stage 3 pressure ulcer, present on admission and it would not be captured on the Discharge Assessment. In the example you provide, on both the Admission and Discharge Assessments, M0300C1 and M0300C2 should be coded as 1. At admission: M0210: 1 M0300B1: 0 M0300B2: 0 M0300C1: 1 M0300C2: 1 At discharge: M0210: 1 M0300B1: 1 M0300B2:1 M0300C1: 1 M0300C2: 1

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#	Question Category	Question	Answer
129.	LTCH CARE Data Set – Section M	If we have a wound present on admission, do we still coding it at discharge at the same stage it was at admission even if the wound improved during the stay? Example: Unstageable Slough and/or Eschar at admission. When patient discharged the skin was now intact. We would still code this as Unstageable slough and/or eschar at discharge, noting a (1) for Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar, and a (1) under Number of these unstageable pressure ulcers that were present on admission.	Thank you for your inquiry. Reverse staging of pressure ulcers is not clinically accurate and hence, not allowed on the LTCH CARE Data Set. The items on the LTCH CARE Data Set do not allow documentation that a pressure ulcer is healing. The only time the ulcer would not be coded anymore on the LTCH CARE Data Set is if it is fully healed. For example, if the unstageable ulcer was present on admission and fully healed by discharge, it would be coded on the Admission Assessment as an unstageable pressure ulcer, present on admission and the pressure ulcer would not be captured on the Discharge Assessment because it was healed at the time of discharge. In the example you provide, on the Admission Assessment, M0300F1 and M0300F2 should be coded as 1. On the Discharge Assessment no pressure ulcer would be reported because the pressure ulcer healed. Therefore, M0210 would be coded as 0 on the Discharge Assessment, and the assessor would skip to item Z0400, Signature of Persons Completing the Assessment. At admission: M0210: 1 M0300F1: 1 M0300F2: 1 At discharge: M0210: 0
130.	LTCH CARE Data Set – Section M	Question regarding M0300-B3, Date of oldest Stage 2 pressure sore: our patients are often admitted with sores. As such, we don't have any information on when they might have been first observed. Is it acceptable to always leave this blank, or should we be asking the patient if he/she can provide an approximate date and use that information?	The use of the dash, "-," is appropriate when the staff are unable to determine the response to an item. In some cases, the LTCH may be in the process of completing or may have already completed some items of the assessment, and should record those responses. If there is no pressure ulcer documentation available within the appropriate timeframe as established by the ARD of the assessment, the items in Section M would be coded with a dash.

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#	Question Category	Question	Answer
131.	LTCH CARE Data Set – Section Z	When transmitting a corrected assessment, should the person add a signature to the signature page for whatever correction had been made? Should the completion date be changed again to reflect the date of corrected assessment? Or should the completion date be left as the original completion date?	The first portion of the form requires the signature of the person who provided data for that assessment. If it is the case that the staff member providing the corrected data has not yet signed the attestation section (Z0400), then they should sign and date the section with regard to the corrected information they provided. The second portion of the form (Z0500) requires the signature of the person who verifies that the information is complete. The updated completion date will need to be used.
132.	LTCH CARE Data Set – Section Z	I would like some clarification to what I need to "keep" on paper file or "scan" into my EMR in regards to section Z. My Hospital has an electronic EMR in which I am able to electronically pull all my information for my submittals of the Data Sets. Do I physically still need the nurse to sign section Z? Or is the nurse's electronic signature sufficient? If so, do I even need to keep section Z? Do I need to keep an electronic copy of my Provider Final Validation Report to show any surveyors if asked? Currently that is all am under the impression I need to keep.	If a provider has an Electronic Health Care Record (EHR), then they need to follow their facility's policies related to electronic signatures. Any LTCH staff member that completes any portion of the LTCH CARE Data Set must sign the attestation page in Section Z of the LTCH CARE Data Set. Whether this signature is on hard copy or electronic is to be determined by the LTCH facility per their facility's existing policies. Please note that CMS does not receive the signatures provided in Section Z of the LTCH CARE Data Set, however, CMS suggests that LTCHs retain this information document as part of the patient's medical record.

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#	Question Category	Question	Answer
133.	LTCH CARE Data Set – Section Z	We are using the discharge date as the ARD. We are having difficulty because the nurses must collect their data the day before discharge. When they do so, our documentation system is electronically assigning this date into field Z0500B. Our forms are then rejecting because Z0500B<ARD/discharge date. Is it appropriate to "default" the discharge date into Z0500B and allow the nurses to do their assessments the day before?	CMS suggests contacting your vendor to fix the auto-population of the completion date. The completion date must be greater than or equal to the ARD in order to submit the discharge assessment record. Please keep in mind that the completion date must never go beyond the ARD + 5 calendar days.
134.	LTCH CARE Data Set - Submission	What are the ramifications for submitting dashes? Are there (or are there any plans for the future) to apply penalties or disincentives for submitting dashes?	For items where dashes are a valid value (please refer to the LTCH CARE Data Submission Specifications, v1.00.3, available in the Downloads section of the LTCH Technical Information website and Appendix E of the LTCHQR Program Manual available here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip), dashes may be used when the information is not assessed or when there is no information to provide. Dashes should only be used in rare circumstances.

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#	Question Category	Question	Answer
135.	LTCH CARE Data Set - Submission	I had a hospital that submitted a file the first time on 10/12/12. All 10 assessments included in this file were accepted per the CASPER LTCH Provider Final Validation Report. Unfortunately the DQM had a difficult time obtaining the CASPER Report for this submission and inadvertently re-submitted these same assessments several times. The subsequent CASPER reports marked the files as rejected. Per the QRP, rejected files are to be corrected and re-submitted. However, in this instance, since it was just a duplicate submission and all assessments were accepted in the original submission, is there anything further we need to do?	Duplicate submissions do not need to be fixed or re-submitted. The duplicate message indicates the records were previously accepted and subsequent submissions are duplicates and are not needed or accepted.

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#	Question Category	Question	Answer
136.	LTCH CARE Data Set - Submission	I have a question regarding the LTCH CARE data set and the attestation page or Section Z. We have an electronic patient record. Additionally, we have a Word document used for Section Z, which we call our Attestation Page. We also 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. We have a vendor and we complete the CARE data set in our vendor software. The data is saved in a zip file that includes several XML files. We upload that saved copy from our shared network drive to CMS.	CMS suggests that LTCHs keep copies of the LTCH CARE Data Set assessment records that they submit to CMS, whether electronically or in a paper format. Your vendor's software should offer this capability. To address how electronic records are saved within your vendor's software, as well as how the vendor software communicates with your facilities electronic health records (EHRs), we suggest contacting your vendor representative.

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#	Question Category	Question	Answer
137.	LTCH CARE Data Set - Submission	What is the impact of some of our first batch assessments being transmitted to CMS late if all of our other batches are transmitted timely?	While CMS has provided a timetable related to the submission of the LTCH CARE Data Set assessment records and appreciates LTCHs submitting quality data according to this timetable, please note that LTCHs have until May 15, 2013 to submit all quality data for October 1-December 31, 2012 quarter. For this first quarter data submission under the LTCH Quality Reporting Program, CMS has provided this additional 4.5 months for data submission to allow LTCHs to submit corrections or inactivation requests as appropriate, as well as to allow LTCHs to verify that they have been comprehensive in their submission of quality data which will be used by CMS for FY2014 payment update determination. As long as an LTCH has submitted all quality data (LTCH CARE Data Set assessment records and data for CLABSI and CAUTI measures) for October 1-December 31, 2012 quarter by May 15, 2013 at 11:59 p.m., these data will be considered "submitted on time" for the purpose of FY2014 payment update determination. Any quality data submitted after May 15, 2013 at 11:59 p.m. for the quarter October 1-December 31, 2012 quarter will not be considered when CMS determines whether an LTCH has complied with the requirements for the LTCHQR Program. More information on this subject for the LTCH CARE Data Set can be found in the LTCH Quality Reporting Manual, Chapter 4 available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip. More information on this subject for the CDC's NHSN can be found in the LTCH Quality Reporting Manual, Chapter 5 available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip as well as at CDC's NHSN website www.cdc.gov/nhsn/LTACH/ltc-welcome.html.
138.	LTCH CARE Data Set - Submission	We have an electronic record. We were going to print the assessment because, as I understand it, there are signature lines on those assessments, and then we will scan those into our EMR once those have been signed. Is this process appropriate?	If your LTCH uses an EHR, but does not have the ability or the policies in place to capture electronic signatures, it is acceptable to print section Z, have staff members involved in the data collection for assessment record physically sign the document, and then scan it back into your medical record.

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#	Question Category	Question	Answer
139.	LTCH CARE Data Set – Submission	I submitted an assessment with incorrect ARD date. I inactivated it and submitted and it was accepted. Now to correct the ARD date, should I create a new assessment record for this patient or add a patient? I went through all the LTCH CARE Data Set Manual and submission manual, it discusses the process of modification and inactivation but does not indicate if we need to create a new assessment record when an assessment is inactivated.	If the inactivation was submitted and accepted the next step is to create a new assessment which will replace the one that was inactivated. There is no need to create a new patient record. More information on inactivation requests can be found in the LTCH Quality Reporting Manual, Chapter 4 available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip
140.	LTCH CARE Data Set - Submission	We have had a number of submissions across several facilities for which 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. Is that because it is calculated off of the completion date? Is that a requirement or is that an error in the system?	The requirement is that the completion date must fall on or within 5 days after the assessment reference date (ARD). You will not be able to submit an assessment record in which the completion date falls before the ARD. The completion date is the last day that you may complete an LTCH CARE Data Set assessment record and = ARD + 5 calendar days; the submission date (last day on which you can submit the assessment record) = completion date + 7 calendar days. Please note that in both instances, the definitions refer to the latest possible date for completion or submission; assessments may be completed before or on that date, but not after.
141.	LTCH CARE Data Set - Submission	We understand that LTCHs have until May 15, 2013 to submit corrected data. I think some people were looking at resubmitting this with a different completion date. Can you just clarify?	CMS is giving LTCHs the extra 4-1/2 months after the end of the quarter during which to submit or correct data. LTCHs will have until May 15, 2013 to submit data collected between October 1, 2012 and December 31, 2012. We are asking that LTCHs follow the guidelines outlined in the LTCHQR Program Manual related to ARD, submission, and completion dates. If your LTCH has a correction to a record or you have a record that you realize has not been submitted yet for some reason, you will have until May 15th of 2013 at 11:59 p.m. to get that record submitted to CMS.

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#	Question Category	Question	Answer
142.	LTCH CARE Data Set - Submission	We are having difficulties with our vendor and will end up having a lot of late files uploaded to QIES. Will this be a major problem for us if we can eventually get all the files uploaded without fatal errors. There are two reporting calendars so it is confusing as to which one CMS will use to determine our market basket reimbursement for 2014.	LTCHs have until 11:59pm on May 15, 2013 to submit all quality reporting data and corrections to CMS. All data submitted before this deadline will not be considered late. Although you may receive a warning message for data sets submitted to CMS after the formal "submission date" (date of completion + 7 calendar days), any data submitted before the above May 15, 2013 deadline will be accepted and considered compliant with respect to submission deadlines. Any data submitted by LTCHs after 11:59 pm on May 15, 2013 will not be considered by CMS when determining compliance.
143.	LTCH CARE Data Set - Submission	Three of our hospitals have been using the incorrect fac ID number. We were using the ones on the original crosswalk list instead of the one that was sent along with the QIES user information, therefore our submissions have been rejected by CMS. We are currently correcting the problem and have to resubmit the files but some of them will be late since they were not originally accepted. Will we be penalized while we are learning the system and working out the kinks?	While CMS has provided a timetable related to the submission of the LTCH CARE Data Set assessment records and appreciates LTCHs submitting quality data according to this timetable, please note that LTCHs have until May 15, 2013 to submit all quality data for October 1-December 31, 2012 quarter. For this first quarter data submission under the LTCH Quality Reporting Program, CMS has provided this additional 4-1/2 months for data submission to allow LTCHs to submit corrections or inactivation requests as appropriate, as well as to allow LTCHs to verify that they have been comprehensive in their submission of quality data which will be used by CMS for FY2014 payment update determination. As long as an LTCH has submitted all quality data (LTCH CARE Data Set assessment records and data for CLABSI and CAUTI measures) for October 1-December 31, 2012 quarter by May 15, 2013 at 11:59 p.m., these data will be considered "submitted on time" for the purpose of FY2014 payment update determination. Any quality data submitted after May 15, 2013 at 11:59 p.m. for the quarter October 1-December 31, 2012 quarter will not be considered when CMS determines whether an LTCH has complied with the requirements for the LTCHQR Program. More information on this subject for the LTCH CARE Data Set can be found in the LTCH Quality Reporting Manual, Chapter 4 available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip. More information on this subject for the CDC's NHSN can be found in the LTCH Quality Reporting Manual, Chapter 5 available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCHQRPManual1-1.zip as well as at CDC's NHSN website www.cdc.gov/nhsn/LTACH/ltc-welcome.html.

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#	Question Category	Question	Answer
144.	LTCH CARE Data Set - Submission	What do we do if we miss doing an admission assessment, but are able to do a discharge assessment for the patient?	In your question, you state that your LTCH "missed" doing an admission assessment. If by "missed" you mean that the admission assessment was never completed, then your LTCH should complete this document and submit it to CMS as soon as you realize the mistake. If you submit the discharge assessment before submitting the admission assessment, the QIES ASAP system will issue a warning – 909 Inconsistent Record Sequence. As long as you submit the missing admission assessment record to CMS by 11:59pm on May 15, 2012, CMS will accept the submission, although you may receive a warning stating the submission is late as the date of completion will not sync up with the date of admission. If, in completing the missing assessment, you realize that there is missing data (i.e. – there is no wound assessment during the three day assessment reference period) you will have to use a default response such as a dash to answer these items. If the LTCH overlooks the submission of the discharge assessment record for a patient, the LTCH should complete and submit the discharge assessment record as soon the mistake is realized. Again, as stated above, should the LTCH find that there is insufficient documentation (i.e. - a wound assessment), during the three day assessment reference period (which is the date of discharge + the previous two calendar days), the LTCH will have to enter dashes for those items in which there is no corresponding documentation in the medical record. With regard to your question asking whether this discharge data set should be considered unplanned in this instance, we ask that you reference the definitions outlined below (and in the LTCHQR Manual) related to planned and unplanned discharges. The LTCH should not consider this discharge unplanned solely because you have overlooked the submission of the discharge data set.

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#	Question Category	Question	Answer
145.	LTCH CARE Data Set - Submission	What happens if an admission assessment is done, but the discharge is overlooked? Do we consider it an unplanned discharge (even if it was not unplanned from the patient's perspective) or do we just not submit anything?	LTCHs are required to submit an admission and a discharge (or expired) assessment for all patients admitted to the LTCH starting at 12:00 am on October 1, 2012. Please refer to LTCHQR Program Manual available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting for definitions of planned and unplanned discharge for the purpose of CMS LTCH Quality Reporting Program. An unplanned discharge is: • 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 3 days (including the date of transfer); or • A transfer of the patient to an emergency department of another hospital in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation, resulting in the patient's absence from the LTCH for longer than 3 days; or • The unexpected departure of a patient from the LTCH against medical advice; or • The unexpected decision of a patient to go home or to another setting (e.g., to complete treatment in an alternate setting). Unplanned discharges do not include planned transfers to acute-care inpatient hospitals for admission for planned interventions, treatments, or procedures, unless the patient does not return to the LTCH within 3 days. A planned discharge is one in which the patient is nonemergently, medically released from care at the LTCH for some reason arranged for in advance.

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#	Question Category	Question	Answer
146.	LTCH CARE Data Set - Submission	Currently as per best practices, if a patient has a pressure wound a weekly assessment is completed. If a patient is an unplanned discharge on 10/21 and the last wound assessment was completed on 10/17, should that assessment be utilized for CMS form completion? If not, what should be entered on the CMS form?	The Assessment Reference Date (ARD) provides the endpoint of the assessment period for any of the LTCH CARE Data Set assessments. For admission assessment, the ARD is the date of admission plus up to 2 calendar days. The LTCH has up to 3 days to actually gather the data and an additional 5 days to complete the LTCH CARE Data Admission Assessment. For the discharge and expired assessments, the ARD is the date of discharge or date of death (Chapter 2 of the LTCHQR Program Manual). Each of the discharge/expired assessments looks back to the 3-day span of the ARD with the exception of the following items on the Planned Discharge Assessment: A1955 Discharge Delay, which looks back 24 hours from the date of discharge, and M0800 Worsening in Pressure Ulcer Status, which looks back to the prior assessment (i.e., admission assessment); and the following item on the Unplanned Discharge Assessment: M0800 Worsening in Pressure Ulcer Status, which looks back to the prior assessment (i.e., admission assessment). The discharge assessment must fall within the three-day assessment reference period for it to be is considered a valid assessment and for inclusion in the submitted LTCH CARE Data Set Planned and Unplanned Discharge Assessment records. So, if your patient is discharged from the LTCH on 10/21, the ARD for the discharge assessment would be 10/21. And, information to complete the LTCH CARE Data Set Planned and Unplanned Discharge Assessment records would come from skin assessment conducted on 10/19, 10/20 or 10/21 in order to be included on the discharge assessment, except for information for M0800 which looks back to admission assessment. If there is no current wound assessment that falls within the assessment period, the information in patient record available to complete the discharge assessment would not be available. Therefore the dash would need to be used where appropriate.
147.	LTCH CARE Data Set – Submission	The quality reporting program also refers to a completion date of the admission date + 7 days, which can be confusing, as the assessment can fall within this timeline. As a point of clarification, the completion date should always be the ARD + 5, correct?	The completion date will be the ARD + 5 calendar days.