LONG-TERM CARE HOSPITALS QUALITY REPORTING PROGRAM

FREQUENTLY ASKED QUESTIONS WITH ANSWERS

V 1.0

Current as of September 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.
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.

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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. You would just submit the unplanned discharge assessment. For discharge assessment, the ARD 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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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.
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.

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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.
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.

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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.
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.

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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).
22.	LTCH CARE Data Set—Section A	If patient dies during the assessment period, should you fill out both admission and expired assessments?	Yes, both admission and expired assessments should be completed. The ARD for the expired assessment would be the date of death.
23.	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.
24.	LTCH CARE Data Set—Section A	How do we define a day? Is it from midnight until 11:59 p.m.?	Yes.

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25.	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).
26.	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.
27.	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.
28.	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.
29.	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).
30.	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).

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31.	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.
32.	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).
33.	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 three 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).
34.	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.
35.	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.

#	Question Category	Question	Answer
36.	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.
37.	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.
38.	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.
39.	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.
40.	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 and the stage to which it worsened. On the discharge record, the wound would be captured in the stage to which it worsened, if it had not healed. Still, the wound, because it worsened, would no longer be captured as POA.
41.	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.

#	Question Category	Question	Answer
42.	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.
43.	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.
44.	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.
45.	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.
46.	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).
47.	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
48.	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

#	Question Category	Question	Answer
49.	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."
50.	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.
51.	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.
52.	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.
53.	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.

#	Question Category	Question	Answer
54.	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.
55.	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.
56.	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.
57.	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.

#	Question Category	Question	Answer
58.	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.
59.	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.
60.	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.
61.	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.

#	Question Category	Question	Answer
62.	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.

#	Question Category	Question	Answer
63.	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 expected, 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 is day 3 of admission (date of admission plus two more 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, as these dates are based upon the admission date.
64.	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. Anything submitted after that date will not be considered in determining compliance versus non-compliance 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, then that data should be submitted monthly as well. If you need to correct any of that information, you have until May 15, 2013.
65.	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. We are giving from the end of the quarter until May 15 to submit corrections to the record (pursuant with the policies outlined in Chapter 4 of the LTCHQR Program Manual).
66.	LTCHQR Program—Submission	For the CAUTI and CLABSI measures, will CMS be pulling the data from NHSN?	Yes.