LONG-TERM CARE HOSPITAL (LTCH) QUALITY REPORTING PROGRAM (QRP) PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM WEBINAR TRAINING ON AUGUST 22, 2017

Current as of September 2017

#	Question Category	Question	Response
1	Section A	Just to clarify, do all outside appointments count as program interruptions? Even if the patient returns the same day?	Yes, outside appointments count as program interruptions. Per the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) definition, a program interruption refers to an interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per agreement for medical services (e.g., when the patient requires a higher level of care and is transferred to an acute care hospital). Such an interruption must not exceed 3 calendar days, whereby day 1 begins on the day of transfer, regardless of hour of transfer. For such an interruption, the LTCH should not complete and submit an LTCH CARE Data Set Discharge record (planned or unplanned).
2	Section A – Coding Reminders	What is the difference between a "program interruption" and an "interrupted stay" for data purposes? My understanding is that the former is an event of less than 3 days, and the latter is an event lasting less than 9 days. However, it appears that they are counted together for data collection purposes. What is the rationale behind this?	There is no difference between the terms "program interruption" and "interrupted stay" for the purposes of the LTCH QRP. To clarify, the LTCH QRP definition is distinct from the interrupted stay payment policy. Per the LTCH QRP, a program interruption refers to an interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per agreement for medical services (e.g., when the patient requires a higher level of care and is transferred to an acute-care hospital). Such an interruption must not exceed 3 calendar days, whereby day 1 begins on the day of transfer, regardless of hour of transfer. For such an interruption, the LTCH should not complete and submit an LTCH CARE Data Set Discharge record (planned or unplanned).
3	Section A – Timeframes	Are physician office visits considered program interruptions? Also, if a patient has a procedure (X-ray, CT scan, etc.) in the host hospital, is that considered a program interruption?	Yes, both scenarios (i.e., physician office visits outside of the LTCH and procedures completed at the host hospital) are considered program interruptions per the LTCH QRP definition of program interruption.

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4	Section B	Regarding item BB0800 Understanding Verbal and Non-Verbal Content, how should we code this item if a patient who is intubated understands and communicates with nods and is completely alert and aware?	If the patient uses an alternative means of communication such as an electronic device (smart phone, tablet, laptop, etc.), writing, pointing, nodding, or using cue cards, assess the patient's status for item BB0800: Understanding Verbal and Non-Verbal Content while using the alternative means of communication. Additionally, and if appropriate, ensure that the patient has access to his/her hearing aid or hearing appliance and glasses or other visual appliances. Use clinical judgment to determine the code that best describes the patient's level of ability to understand complex messages and/or basic verbal and nonverbal content during the 3-day assessment period.
5	Section B	Regarding item BB0700 Expression of Ideas and Wants: If the patient is intubated and is alert and communicates using gestures and written notes, which code should we use? Should the code convey that they are able to express with no difficulty, or with some difficulty since it is not their normal method of communication?	If the patient uses one or more alternative means of communication such as an electronic device (smart phone, tablet, laptop, etc.), writing, pointing, nodding, or using cue cards, assess the patient's status for item BB0700: Expression of Ideas and Wants with the alternative means of communication. Additionally, if appropriate, ensure that the patient has access to his/her hearing aid or hearing appliance and glasses or other visual appliances. Use clinical judgment to determine the code that best describes the patient's level of difficulty to express complex messages, needs, and ideas—either verbally or nonverbally—during the 3-day assessment period.
6	Section GG	If a patient receives tube feedings on admission to LTCH, but did not receive them prior to acute care, are they considered dependent for feeding or n/a?	If the patient does not eat/drink by mouth at the time of the admission and was eating and drinking by mouth prior to the recent-onset medical condition, then the activity is coded as 88, Not attempted due to medical condition.

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7	Section GG – Coding Reminders	How do you code a goal for a patient who was not in the facility for 3 days? Admitted on Friday evening and discharged or leaves AMA on Saturday.	If the patient's stay is less than 3 days, code at least one goal to the best of your ability based on the predicted plan of care for the patient. For the Self-Care and Mobility Discharge Goal items, a minimum of one self-care or mobility goal must be coded per patient stay on the LTCH CARE Data Set as part of the LTCH QRP. For the Discharge Goal Section of GG0130 and GG0170, there is an instance where the use of a dash is allowable that does not affect the annual payment update (APU). If at least one self-care or one mobility item has a discharge goal, then using a dash (-) for the remaining discharge goals is allowed and will not affect APU determination.

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8	Section M	How do we code device-related pressure ulcers/injuries?	If a skin ulcer arises from a combination of factors that are primarily caused by pressure, then the skin ulcer should be included in this section as a pressure ulcer. Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers. All types of pressure ulcers/injuries should be included when completing your assessment. This would include pressure ulcers/injuries caused by medical devices. Each pressure ulcer/injury, including those caused by medical devices, should be assessed and staged and coded using the appropriate code. National Pressure Ulcer Advisory Panel (NPUAP) guidance provides further support for coding medical device-related pressure ulcers/injuries: “Medical Device-Related Pressure Injury: This describes an etiology. Medical device-related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.” It should be noted that mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity) should not be coded on the LTCH CARE Data Set.

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9	Section M	If the patient's wound worsened while outside of the facility in less than 3 days, why would the LTCH have to show a worsening ulcer as it worsened while outside the facility?	If the patient was transferred to another hospital or facility and the patient returned to the LTCH in less than 3 calendar days, the patient's return to the LTCH is not considered a new admission. It is considered a program interruption. Therefore, any new pressure ulcer formation, increase in numerical staging that occurred during the program interruption, should not be coded as "present on admission." If the pressure ulcer that is assessed on discharge was "present on admission" and subsequently increased in numerical stage during the patient's stay, the pressure ulcer is coded at that higher stage on discharge. That higher stage should neither be considered nor coded as "present on admission" in items M0300B2-G2 on the Discharge assessment.
10	Section O	If the patient received the flu vaccine during vaccination season at this facility during a prior admission, would we still code this as yes, patient received vaccine at our facility?	Yes, the coding should indicate that the patient received the influenza vaccine in the facility, even though it was administered during an earlier stay. When a patient has a stay in a facility during the influenza vaccination season, the patient should be assessed and the influenza vaccination status of the patient will be carried forward until the new influenza season begins. Since the patient was in the facility during the influenza vaccination season and the patient received the influenza vaccine during the current influenza season, this value will be used for this patient until the influenza season ends on July 31. The influenza vaccine items would be coded as the following: • O0250A = [1]. • O0250B = [MMDDYYYY]. • O0250C = [skipped]. O0250A = [1] states that the patient received the influenza vaccine in this facility for this year's influenza vaccination season, and O0250B = [MMDDYYYY] should display the date the vaccine was administered to the patient. O0250C (Influenza vaccine not received, state reason) would be skipped, as the patient received the influenza vaccination in this facility during a prior stay during the influenza vaccination season.

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11	Section O	If a patient is admitted on June 1, 2017, and discharged on June 12, 2017, how would you code the flu section (no vaccine given)?	The influenza vaccine items would be coded as the following: • O0250A = [0]; skip to O0250C. • O0250B = [skipped]. • O0250C = [1] Patient not in this facility during this year's influenza vaccination season. The coding above states that the patient did not receive the influenza vaccine in this facility because the patient was not in the facility during the current influenza vaccination season.
12	Section O	If we give a patient a flu vaccination on October 10 and they are then discharged and come back for a separate admission on January 19, for the January admission assessment, would we say that the patient received the flu vaccination at our facility and list the date administered as October 10?	Yes, once the patient is assessed and/or the influenza vaccination is administered, the influenza vaccination status for that patient should be recorded on the patient's assessment. Once the patient's influenza vaccination status is known for the current influenza season, this value is carried forward until the new influenza season, which begins on July 1. Additionally, the date in O0250B should reflect when the patient received the vaccination. Since the vaccine was administered on October 10, this is the date that should be entered for O0250B.
13	Coding Reminders	How do we complete an admission data care set if a patient was admitted for only a few hours then discharged to the emergency room?	LTCHs are required to submit admission and discharge assessments on all patients admitted to their hospital, regardless of length of stay. In the example that you provide, your LTCH should complete an admission and a discharge assessment (planned or unplanned, as appropriate). The Centers for Medicare & Medicaid Services (CMS) is aware that there are circumstances in which LTCHs may not be able to complete every item on the LTCH CARE Data Set assessment. In these cases, you should refer to the LTCH QRP Manual and code the dataset accordingly. For example, if you are unable to answer a particular data item on the LTCH CARE Data Set due to the inability to assess, you would code the item with the default response of a dash (-). CMS expects such default codes to be used infrequently. The -3900 edit (warning) is in place as a reminder to staff completing the assessment—that the item is required and may result in a 2% reduction to the LTCH's applicable FY APU. We specifically chose to use the word "may," as we realize that situations will occur that impede the staff members' ability to code the dataset with an actual response.

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			Code the LTCH CARE Data Set to the best of your abilities and use the following guidance when coding the Admission and Discharge assessments. Again, the use of a dash may result in a 2% reduction in the APU. <u>Admission Assessment:</u> Section B – Hearing, Speech, and Vision. B0100 – Code to the best of your ability. If you do not have any information, enter a dash. BB0700 and BB0800 – Expression and Understanding: Code to the best of your ability. If you do not have any information, enter a dash. Section C – Cognitive Patterns. Code Section C items to the best of your ability. If you do not have any information, enter a dash. Section GG – Functional Abilities and Goals. GG0100 – Prior functioning: Code if information is known; otherwise, enter Code 8, Unknown. GG0110 – Prior device use (use check boxes): If you do not have information about prior device use, check Z, None of the above. Admission Self-Care and Mobility Performance – GG0130 and GG0170 items: Code to the best of your ability. If you are unable to assess the patient due to medical issues, enter Code 88, Not assessed due to medical condition or safety issues. Self-Care and Mobility Discharge Goals: A minimum of one self-care or mobility goal must be coded per patient stay on the LTCH CARE Data Set. Code at least one goal to the best of your ability based on the predicted plan of care for the patient. Section H – Bladder and Bowel. Code to the best of your ability. If there is no information available, enter a dash.

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			Section I – Active Diagnoses. Check all that apply. Section K – Swallowing/Nutritional Status. Code to the best of your ability. If there is no information available, enter a dash. Section M – Skin Conditions. Code to the best of your ability. If there is no information available, enter a dash. Section O – Special Treatments, Procedures, and Programs. Code to the best of your ability. If there is no information available, enter a dash. For O0250 Influenza Vaccine, code based on chart review. <u>Discharge Assessment (planned or unplanned, as appropriate):</u> Section B – Hearing, Speech, and Vision: items not on the Unplanned Discharge assessment B0100 – Code to the best of your ability. If you do not have any information, enter a dash. BB0700 and BB0800 – Expression and Understanding: Code to the best of your ability. If you do not have any information, enter a dash. Section C – Cognitive Patterns: Items not on the Unplanned Discharge assessment. Code Section C items to the best of your ability. If you do not have any information, enter a dash. Section GG – Functional Abilities and Goals. Discharge Self-Care and Mobility Performance – GG0130 and GG0170 items: For a patient who has an unplanned discharge, the LTCH should complete an LTCH CARE Data Set Unplanned Discharge assessment

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			to the best of its ability. There are no Section GG (Functional Abilities and Goals) items on the Unplanned Discharge assessment. For a patient who passed away, complete the Expired assessment. There are no Section GG (Functional Abilities and Goals) items on the Expired assessment. In the event the discharge was considered planned, code the items to the best of your abilities, including use of Code 88, Not assessed due to medical condition or safety issues. Section H – Items not on the Unplanned Discharge assessment. Bowel and Bladder: Code to the best of your ability. If there is no information available, enter a dash. Section J – Health Conditions: Code based on chart review. Section M – Skin Conditions. Code to the best of your ability. If there is no information available, enter a dash. Section O – Special Treatments, Procedures, and Programs. Code based on chart review. As mentioned, failure to submit the required quality data may result in a 2-percentage-point reduction in the LTCH's APU. LTCHs must meet or exceed two separate data completeness thresholds: one threshold set at 80% for completion of quality measures data collected using the LTCH CARE Data Set submitted through the Quality Improvement and Evaluation System's Assessment Submission and Processing System and a second threshold set at 100% for quality measures data collected and submitted using the Centers for Disease Control and Prevention's National Healthcare Safety Network.

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14	Other	Is the LTCH QRP required for all Idaho facilities? I am a new Quality Manager and our previous person did not participate in this. I am wondering why?	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 QRP. The CMS LTCH QRP requires that LTCHs submit quality measure data to CMS. Failure to submit the required quality data will result in a 2-percentage-point reduction in the LTCH's APU. For more information regarding the requirements of the LTCH QRP, we refer you to the CMS LTCH QRP website at http://cms.hhs.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html. A list of the current quality measures is available on the following web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-MeasuresInformation.html. The data submission deadlines are provided on the following web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Data-SubmissionDeadlines.html.