LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM
PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON MAY 8 AND 9, 2018

Current as of July 2018

Acronym List

Acronym	Definition
APRN	Advanced Practice Registered Nurse
APU	Annual Payment Update
BMI	Body Mass Index
CAM	Confusion Assessment Method
CASPER	Certification and Survey Provider Enhanced Reports
CMS	Centers for Medicare & Medicaid Services
CPAP	Continuous Positive Airway Pressure
DRR	Drug Regimen Review
FY	Fiscal Year
HCC	Hierarchical Condition Category
ICD	International Classification of Diseases
IMPACT	Improving Medicare Post-Acute Care Transformation Act
INR	International Normalized Ratio
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility Patient Assessment Instrument
IV	Intravenous
LTCH	Long-Term Care Hospital
LTCH CARE	Long-Term Care Hospital Continuity Assessment Record and Evaluation
NPUAP	National Pressure Ulcer Advisory Panel
NQF	National Quality Forum
PAC	Post-Acute Care
PPS	Prospective Payment System
QIES	Quality Improvement and Evaluation System
QRP	Quality Reporting Program
QTSO	QIES Technical Support Office
RN	Registered Nurse
SBT	Spontaneous Breathing Trial
SNF	Skilled Nursing Facility
URL	Uniform Resource Locator
VUT	Validation Utility Tool

#	Question Category	Question	Proposed Response
1	Overview of LTCH QRP and LTCH CARE Data Set Changes	Are corrections for calendar year 2017 being accepted with this upcoming quarterly deadline of May 15? I seem to have heard that on a recent call but cannot locate confirmation on the site.	You may be referring to the data submission deadlines for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) (announcement available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Spotlights-and-Announcements.html). However, for the Long-Term Care Hospital (LTCH) QRP, the May 15, 2018, submission deadline includes the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set and Centers for Disease Control and Prevention's National Healthcare Safety Network data collected Q4 (October–December) of calendar year 2017. Please refer to the Spotlight Announcement on the LTCH QRP website for more information regarding the May 15, 2018 data submission deadline: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Spotlight-Announcements.html.

#	Question Category	Question	Proposed Response
2	LTCH QRP Resources	Slide 46 of the LTCH QRP Resources presentation lists the LTCH QRP data completion thresholds. Is there another CASPER Report or another resource that I can look up our hospital's current compliance with meeting these two completeness thresholds?	The best method to verify your current LTCH CARE Data Set submission is by running final validation reports. Detailed guidance on how to run and interpret these reports can be found in the LTCH Submission User's Guide, available at https://www.qtso.com/ltchtrain.html. Select "Section 4 Reports" from the first drop-down box and then select the "Select" option to access the instructions. Additional information can be found in the CASPER Reporting User's Manual located on the same page. Please refer to the LTCH QRP Quick Reference Guide for more information: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-QRP-Quick-Reference-Guide-October-2017.pdf. In addition, the LTCH Provider Threshold Report is a user-requested, on-demand report that enables users to obtain the status of their data submission completeness related to the compliance threshold required for the LTCH QRP. This report is available in the LTCH Provider report category in the CASPER Reporting application. Please refer to Section 3 – LTCH Provider Reports in the CASPER Reporting User's Guide for additional information about this report. The CASPER Reporting User's Guide is available on the "Welcome to the CMS QIES Systems for Providers" web page and the LTCH User Guides and Training page on the Quality Improvement and Evaluation System (QIES) Technical Support Office (QTSO) website (https://qtso.cms.gov/ltchtrain.html).
3	Public Reporting and Overview of QRP Reports	When will the Validation Utility Tool (VUT) for the LTCH CARE Data Set Version 4.00 be released?	The LTCH VUT, v1.3.0, is posted on the QTSO Vendor page (as of May 21, 2018) in preparation for the July 1, 2018, effective date of the LTCH CARE Data Set Version 4.00.
4	Public Reporting and Overview of QRP Reports	Are readmission rates included in the CASPER reports?	Yes, information on claims-based measures, such as the readmission measures, are available in the Facility-Level Quality Measure reports and the Provider Preview reports.

#	Question Category	Question	Proposed Response
5	Section A: Administrative Information	To clarify: Program interruptions refer to patients that are discharged from the LTCH to receive services not provided at the LTCH and return within 3 calendar days. Previous clarifications stated discharges against medical advice, to home, or to a setting intended to be the final destination can be treated as a separate stay regardless if they were within 3 calendar days or greater than 3 calendar days.	Per the LTCH QRP definition, a program interruption refers to an interruption in a patient's care provided by an LTCH because of the transfer of that patient to another hospital/facility per agreement for medical services. The interruption must not exceed 3 calendar days; day one begins on the day of transfer, regardless of the hour of transfer. If the intent was for the patient to be discharged home, but due to unforeseen circumstances, the patient returned to the same LTCH within 3 calendar days, it is considered a separate stay. In this scenario, a discharge assessment should be completed for the date the patient was discharged from the LTCH and a new admission assessment should be completed for the date the patient is readmitted to the LTCH. If the patient returns to the same LTCH after 3 calendar days, it is considered a discharge, not a program interruption.
6	Section A: Administrative Information	How does the Centers for Medicare & Medicaid Services (CMS) recommend we code item A0800, Gender, for transgender patients?	Currently, CMS does not offer standard guidance on coding transgender patients. If this changes, providers will receive an announcement through the CMS website. Providers should refer to their facility policy for coding gender.
7	Section GG: Functional Abilities & Goals	We have a 600+ lb patient who needs 2 people to assist him (for staff safety) to get out of bed. He is independent once up and performing his activities (i.e., oral care). How would we code this situation? Do we code based on the need of two helpers?	Code the activity based on the amount of assistance the patient requires to complete only the tasks included in the definition. In the scenario provided, the patient's need for two helpers to get out of bed would be considered when coding GG0170D, Sit to stand, and this data element would be coded 01, Dependent. For oral hygiene and toileting hygiene, getting out of bed and walking to the bathroom are not considered when coding those activities. Another example is GG0170I, Walk 10 feet, which according to the definition is assessed "once standing" and does not consider the patient's ability to get from a sitting position to a standing position, only the patient's ability to walk 10 feet once standing.

#	Question Category	Question	Proposed Response
8	Section GG: Functional Abilities & Goals	Please give an example of when and why you would code 07 (patient refused) as a discharge goal for a self-care or mobility item.	We expect use of code 07, Patient refused, as a discharge goal for LTCH patients to be rare. Please note that a minimum of one discharge goal is required for either self-care (GG0130) or mobility (GG0170) items.
9	Section GG: Functional Abilities & Goals	Admission functional coding should reflect both usual performance and the patient's status prior to therapy. Should the LTCH avoid providing therapy during the 3-day admission assessment reference period?	No, the admission assessment should be conducted as soon as feasible to capture the patient's true status at the time of admission. Clinicians assess a patient's status prior to developing and implementing the patient's care plan. The assessment should occur prior to the patient benefitting from therapeutic intervention to capture the patient's true baseline status. The provider has up to 3 days to complete the admission assessments for Section GG items. Certain activities, such as Walk 50 feet with two turns, and Walk 150 feet, may only be assessed once during the 3-day assessment period. If this is the case, code the admission assessment Section GG items based on the single assessment of an activity, unless the clinician believes the patient has benefitted from therapy by day 3. Other activities, such as eating, will generally occur more than once during a 3-day assessment period. If the clinicians can determine the patient's baseline status during day 1 or day 2, and the patient has benefitted from therapy on day 3, the baseline assessment would consider assessments conducted on days 1 and 2 only. We provide more information about this topic in the LTCH QRP Manual posted on the CMS website.
10	Section GG: Functional Abilities & Goals	Regarding Section GG prior functioning, when querying the patient's family for usual performance, is it the expectation of CMS that this conversation be documented in the electronic medical record or is documentation on the LTCH CARE Data Set sufficient?	For prior functioning, the patient's status should be documented in the electronic medical record. The information in the medical record should be consistent with the information coded in Section GG of the LTCH CARE Data Set.

#	Question Category	Question	Proposed Response
11	Section GG: Functional Abilities & Goals	According to the decision trees, if two helpers are needed, the patient would be considered dependent. However, staff are encouraged to help each other to decrease stress and injury. Can you address this issue?	When conducting a clinical assessment of the patient's functional performance, allow the patient to be as independent as possible, while making sure the patient and staff are safe.
12	Section GG: Functional Abilities & Goals	Usual performance has proven to be highly variable, leading to most frequently reported code in documentation. Is this correct?	For Section GG self-care and mobility items, the admission and discharge assessments should be based on clinical assessments conducted by qualified clinicians as close to the time of admission and discharge as feasible to capture the patient's true status at the time of admission and at the time of discharge. For the admission assessment period, coding should reflect the patient's status prior to any benefit from therapy intervention or services to capture the patient's true admission baseline status. During the 3-day assessment period, some activities (e.g., eating, oral hygiene, toileting hygiene) may occur more than once and a patient's ability to perform each activity may vary prior to the patient benefitting from therapy. If this is the case, the admission and discharge assessments should capture the patient's usual ability to perform each activity. Certain mobility activities, such as GG0170K – Walk 150 feet, may only occur once during the 3-day assessment period. If this is the case, code the admission assessment Section GG items based on the single occurrence of an activity, unless the clinician believes the patient has benefitted from therapy.
13	Section GG: Functional Abilities & Goals	If the patient needs verbal cueing AND contact guard assistance (but not lifting, etc.) is code 04 appropriate?	Yes, code 04, Supervision or touching assistance, includes any or all combinations of the following type of assistance: verbal cues and/or touching/steadying and/or contact guard assistance.
14	Section GG: Functional Abilities & Goals	What is the Section GG data used for at CMS?	These data are used to calculate the function quality measures, which have been adopted in the LTCH QRP. CMS provides confidential feedback reports to providers with quality measure scores, and the quality measure score data are later displayed to the public on the "LTCH Compare" website.

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15	Section GG: Functional Abilities & Goals	Why are there two questions asking for the type of wheelchair used for wheelchair mobility?	The purpose of asking the type of wheelchair used for the two distances of wheelchair mobility is that some patients may use a manual wheelchair for short distances and a motorized wheelchair for longer wheelchair distances.
16	Section GG: Functional Abilities & Goals	Please provide examples of appropriate uses of 07, 09, 10, or 88 for discharge goals.	We expect use of code 07, Patient refused, for a discharge goal for LTCH patients to be rare. Please note that a minimum of one discharge goal is required for either self-care (GG0130) or mobility (GG0170) items. Use of code 09, Not applicable, as a discharge goal may be used if the patient did not perform the activity prior to the current illness, exacerbation, or injury and is not expected to perform the activity during or after the LTCH stay. For example, if a patient uses a wheelchair to self-mobilize, and the patient did not ambulate immediately prior to the current illness, injury, or exacerbation, and is not expected to walk during the stay, the patient's discharge goal for walking may be coded 09, Not applicable. Code 10, Not attempted due to environmental limitations, is only expected to be coded on rare occasions. Use of code 88, Not assessed due to medical condition or safety issues, may be used as a discharge goal if the medical condition or safety issues are not anticipated to change during the patient stay and the patient is not expected to perform the activity by discharge.
17	Section GG: Functional Abilities & Goals	Scenario 11 of the Section GG presentation provides status at admission, throughout the stay, and at discharge. Should the discharge code reflect the patient's status on the discharge assessment? Or the usual status documented in the record throughout the stay?	The discharge assessment data should reflect the patient's status at the time of discharge. The discharge assessment data must be collected during the last 3 days of the patient's stay. If the clinician determines that the patient's status at the time of discharge varies, then the clinician should code the patient's usual status.

#	Question Category	Question	Proposed Response
18	Section GG: Functional Abilities & Goals	Please explain the difference between the functional status measures and the "application of" the functional status measures (reported as separate line items).	There are two process function quality measures in the LTCH QRP: • The measure, Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF#2631), is a cross-setting quality measure that was adopted in the post-acute care (PAC) QRPs as an Improving Medicare Post-Acute Care Transformation (IMPACT) Act quality measure. • The "original" process measure, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF#2631), includes additional items that are on the LTCH CARE Data Set, including the communication items (BB0700 and BB0800), the Confusion Assessment Method (CAM) items (C1610A-E), the self-care item, Wash upper body (GG0130D), the mobility items, Roll left and right (GG0170A), Walk 10 feet (GG0170I), and the Bladder Continence item (H0350). You can find this information detailed in the LTCH Quality Measure User's Manual in Table 7-4 and Table 7-5, available for download at the following web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html.
19	Section GG: Functional Abilities & Goals	Why is it so important to be so exact when coding Section GG? For instance, why does it matter that a person needs some physical assistance (less than 50 percent versus greater than 50 percent).	The 6-level rating scale helps differentiate different types and levels of assistance needed by patients. As a result, patients who achieve higher scores at discharge are more likely to be discharged to the community.
20	Section GG: Functional Abilities & Goals	What are the patient characteristics/variables/data points that determine the level of risk adjustment?	The procedures used to calculate the quality measure, Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility among Patients Requiring Ventilator Support (NQF #2632), including the risk adjustors, are included in the LTCH Quality Measure User's Manual. The manual is available for download at the following website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html. Submission of accurate data enables appropriate risk adjustment so that the complexity of individual patients is accounted for when the facility risk-adjusted change in mobility score is calculated.

#	Question Category	Question	Proposed Response
21	Section I: Active Diagnoses	How does CMS define severe cancer?	Severe cancer refers to a group of cancer diagnoses (ICD-10 codes) categorized into hierarchical condition categories (HCCs). Examples of diagnoses that are included in HCC 9- Lung and Other Severe Cancers include, but are not limited to: malignant neoplasm of esophagus; malignant neoplasm of stomach; malignant neoplasm of unspecified main bronchus; malignant neoplasm of right main bronchus; malignant neoplasm of pancreatic duct; chronic myeloid leukemia BCR/ABL-positive, not having achieved remission; chronic myeloid leukemia, BCR/ABL-positive, in remission; and multiple myeloma not having achieved remission. The list of diagnoses for the 2018 HCCs, including HCC-9 – Severe cancer, can be found on the following CMS website: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2018.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending. On this website, you will find an Excel spreadsheet “2018 ICD-10 mappings,” and the column labeled “CMS-HCC Model Category V22” provides the relevant HCC number. Severe cancer is HCC group 9. A comprehensive list of mapped Section I comorbidities and coexisting conditions will be available later this year.
22	Section I: Active Diagnoses	How does CMS define left systolic ventricular dysfunction?	For the purposes of the LTCH CARE Data Set, left systolic ventricular dysfunction is defined as an ejection fraction of less than or equal to 30 percent. This comorbidity/coexisting condition will be used as a risk adjustor to calculate the Ventilator Liberation Rate outcome quality measure.
23	Section I: Active Diagnoses	How does CMS define severe for all of the comorbidities and coexisting conditions with that description in Section I of the LTCH CARE Data Set?	These conditions refer to a group of medical diagnoses categorized into HCCs. Using I5470, Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain as an example, the following diagnoses are some of the diagnoses included in this HCC-80 group: coma, brain compression/ anoxic damage: anoxic brain damage, not elsewhere classified; compression of brain; cerebral edema; coma; and persistent vegetative state. A comprehensive list of mapped Section I comorbidities and coexisting conditions will be available later this year.

#	Question Category	Question	Proposed Response
24	Section I: Active Diagnoses	Please clarify documentation necessary to support I5602. At Risk for Malnutrition. "At risk for" is not an accepted medical diagnosis, so physicians are hesitant to use this terminology. Is documentation from a dietician adequate to check this specific data element?	A documented assessment in the patient's medical record by a dietician would be sufficient to check I5602, At risk for malnutrition, on the LTCH CARE Data Set. For the purposes of the LTCH CARE Data Set, LTCHs should consider only active diagnoses confirmed and documented by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under State licensure laws). A diagnosis should not be inferred by association with other conditions (e.g., "weight loss" should not be inferred to mean "malnutrition").
25	Section I: Active Diagnoses	For item I2600, Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis, what are some examples of opportunistic infections?	Opportunistic infections are secondary infections caused by a bacteria or virus that occur more frequently and are more severe in individuals with weakened immune systems. Opportunistic infections, included in item I2600. Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis are a group of diagnoses categorized into HCCs. Examples of diagnoses that are included in HCC 6 – Opportunistic Infections include, but are not limited to: cytomegaloviral pneumonitis; cytomegaloviral hepatitis; invasive pulmonary; aspergillosis; and other pulmonary aspergillosis. A comprehensive list of mapped Section I comorbidities and coexisting conditions will be available later this year.
26	Section M: Skin Conditions	Are admission items M0300A-G used for data completeness and annual payment updates (APUs), or just the discharge Section M items?	Admission items M0300A-G are not used in determining the APU minimum submission threshold. The discharge items, M0300B1-G2, are used in determining the APU minimum submission threshold.

#	Question Category	Question	Proposed Response
27	Section M: Skin Conditions	Previous versions of the IRF-PAI and LTCH CARE Data Set include instructions for coding items in M0800, worsening in pressure ulcer status since admission, that indicate if a previous Stage 3 or Stage 4 pressure ulcer is unstageable due to slough or eschar at discharge, it would not be coded as worsened. The instructions for "the present on admission" items M0300x2, do not include the same guidance.	Effective with the implementation of the IRF-PAI V 2.0 and the LTCH CARE Data Set V 4.00, coding instructions for Stage 3 and Stage 4 pressure ulcers that become unstageable due to slough/eschar by discharge have been updated. Beginning July 1, 2018, for LTCHs and October 1, 2018, for IRFs, if a Stage 3 or Stage 4 pressure ulcer observed on admission is unstageable due to slough or eschar on discharge, the unstageable pressure ulcer would be coded on the discharge assessment (M0300F1 = 1) and it would not be considered as present on admission on the discharge assessment (M0300F2 = 0). Also, please note for the new skin integrity pressure ulcer quality measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, and with the implementation of the IRF-PAI V 2.0 and the LTCH CARE Data Set V 4.00, the M0800 data elements have been removed from the item sets. The discharge M0300 data elements, which capture the number of identified pressure ulcers/injuries at each stage on discharge (M0300X1) and whether that pressure ulcer/injury was present upon admission (M0300X2), are used to calculate the quality measure. For example, a pressure ulcer/injury reported at discharge and coded as not present upon admission on the discharge assessment would be considered a new or worsened pressure ulcer/injury. A pressure ulcer/injury reported at discharge and coded as present upon admission on the discharge assessment would not be considered new or worsened.
28	Section M: Skin Conditions	Please provide recommendations regarding the coding of wounds identified as mixed etiology; for example, moisture-associated skin damage and pressure.	If an ulcer/injury arises from a combination of factors, and pressure is considered the primary cause, then the ulcer/injury would be coded in Section M as a pressure ulcer/injury. Per the requirements of Section M of the LTCH CARE Data Set and the IRF-PAI, pressure should be the primary cause of the wound. Other types of skin injuries or alterations are not coded on Section M of the LTCH CARE Data Set or IRF-PAI.

#	Question Category	Question	Proposed Response
29	Section M: Skin Conditions	Please describe how to code a pressure ulcer when a patient admitted to an LTCH with a fragilely healed pressure ulcer that reopens during the LTCH stay. Would this be considered a progression or worsening of a pressure ulcer or a new facility-acquired pressure ulcer?	If a patient is admitted to an IRF/LTCH with a healed pressure/injury ulcer, and a pressure ulcer/injury occurs in the same anatomical area, and remains at discharge, it would be coded as observed at discharge and would not be coded as present on admission on the discharge assessment. Therefore, this pressure ulcer/injury would be considered new or facility-acquired.
30	Section M: Skin Conditions	Please confirm that a patient admitted with a healing Stage 4 pressure ulcer that is observed to be a Stage 2 on admission, should be coded as a Stage 4 on the admission assessment. Also, please confirm if the same pressure ulcer becomes a Stage 3 while in our facility, the wound has worsened, but is not coded as such since the wound started out as a Stage 4 pressure ulcer.	Correct, the pressure ulcer is a Stage 4 until it is healed. A healing Stage 4 pressure ulcer is coded as Stage 4 on the admission and discharge assessments until it has healed. Do not reverse or backstage. Pressure ulcers do not heal in a reverse sequence. That is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize.
31	Section M: Skin Conditions	If pressure ulcer/injury staging documentation from a previous stay is only found in a nursing note, but not a physician's note, is that considered sufficient?	Yes, the nursing notes are part of the medical record and, therefore, are considered sufficient for coding Section M. Documentation in the medical record from the previous facility, as well as a clinical assessment upon admission, is necessary to identify the history and stage of the pressure ulcer/injury.
32	Section M: Skin Conditions	Please clarify CMS' policy on coding stageable pressure ulcers/injuries that become unstageable pressure ulcers due to slough or eschar. It appears now that pressure ulcers/injuries that were assessed on admission are now considered to be unit-acquired.	If a numerically staged pressure ulcer/injury observed on admission worsens to an unstageable pressure ulcer due to slough or eschar, it is considered not present on admission. For example, if a numerically staged pressure ulcer observed on admission is unstageable due to slough or eschar on discharge, the unstageable pressure ulcer would be coded on the Discharge assessment (M0300F1=1) and would not be coded as present on admission (M0300F2=0). This guidance is effective as of the following item set implementation dates: July 1, 2018, for the LTCH CARE Data Set Version 4.00 and October 1, 2018, for the IRF-PAI Version 2.0.

#	Question Category	Question	Proposed Response
33	Section M: Skin Conditions	If a patient develops a Stage 2 pressure ulcer during an IRF or LTCH stay, but it heals prior to discharge, how would that be coded in Section M of the IRF-PAI and LTCH CARE Data Set?	The pressure ulcer items in Section M of the IRF-PAI and LTCH CARE Data Set collect data at two points in time: admission and discharge. This pressure ulcer would not be coded on either the admission or discharge assessments, because it was not observed upon admission and it was not observed at discharge (it healed prior to discharge). Only pressure ulcers/injuries observed at admission and discharge are coded on the IRF-PAI or LTCH CARE Data Set.
34	Section M: Skin Conditions	Would a wound vacuum-assisted closure device be considered an example of a nonremovable dressing if it is ordered to only be changed every 3 days and is changed prior to admission?	Yes, a wound vacuum-assisted closure device used for negative-pressure wound therapy would be considered a nonremovable dressing when there is a physician order that the dressing is not to be removed during the 3-day assessment period.
35	Section M: Skin Conditions	If a pressure ulcer is unstageable on admission for one reason (e.g., nonremovable device) and unstageable on discharge for another reason (e.g., slough/ eschar), would this be considered a new or worsened pressure ulcer?	For the new skin integrity pressure ulcer quality measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury and with the implementation of the IRF-PAI V 2.0 and the LTCH CARE Data Set V 4.00, the M0800 data elements have been removed from the item sets. The discharge M0300 data elements, which capture the number of identified pressure ulcers/injuries at each stage on discharge (M0300X1) and whether that pressure ulcer/injury was present upon admission (M0300X2), are used to calculate the quality measure. For example, a pressure ulcer/injury reported at discharge and coded as not present upon admission on the discharge assessment would be considered a new or worsened pressure ulcer/injury. A pressure ulcer/injury reported at discharge and coded as present upon admission on the discharge assessment would not be considered new or worsened. If a patient is admitted with an unstageable pressure ulcer due to a nonremovable device and that pressure ulcer is observed as an unstageable pressure ulcer due to slough/eschar when the device is removed, and it remains unstageable due to slough/eschar when the patient is discharged (M0300F1=1), it is considered present on admission on the discharge assessment (M0300F1=1).

#	Question Category	Question	Proposed Response
36	Section M: Skin Conditions	Please provide guidance for the following scenario. A patient is admitted to the PAC setting with documentation in the medical record of a sacral pressure ulcer/injury. This ulcer/injury is covered with a nonremovable dressing; therefore, this pressure ulcer/injury is unstageable. On Day 5 of the stay, the dressing is removed by the physician and the wound is assessed as a Stage 3 pressure ulcer/injury and remains at Stage 3 until discharge. Would M0300C2 be coded as "1" on the discharge assessment?	In the scenario described, if the pressure ulcer remained at a Stage 3 through the patient's stay, then that Stage 3 pressure ulcer/injury would be coded as present on admission on the discharge assessment (M0300C2 =1). If a patient is admitted with an unstageable pressure ulcer/injury that is subsequently numerically staged, then the first numerical stage is the stage at which the pressure ulcer/injury is considered to have been present on admission when coding the discharge present on admission data elements.
37	Section M: Skin Conditions	If a previous stay's documentation does not indicate a pressure ulcer/injury, but a head-to-toe skin assessment identifies a pressure ulcer/injury within 24 hours of admission, is that pressure ulcer/injury considered present on admission?	Yes, if a patient is assessed upon admission, which is defined as close to admission as possible, and a pressure ulcer/injury is observed, that pressure ulcer/injury would be coded on the admission assessment. If the pressure ulcer/injury does not worsen or heal by discharge, the pressure ulcer/injury would be considered present upon admission on the discharge assessment.
38	Section M: Skin Conditions	If a large pressure ulcer/injury that is assessed at admission begins to heal and appears as two separate wounds on discharge, how is this recorded on the discharge assessment?	If a large pressure ulcer/injury assessed at admission begins to heal and appears as two separate wounds at the time of discharge, the pressure ulcer would be considered a single, healing pressure ulcer at the time of discharge. If the pressure ulcer did not increase in numerical stage, then the pressure ulcer would be coded as present on admission (M0300X2=1) on the discharge assessment. If the pressure ulcer increased in numerical stage or became unstageable due to slough or eschar, then the pressure ulcer would not be coded as present on admission on the discharge assessment (M0300X2=0).

#	Question Category	Question	Proposed Response
39	Section M: Skin Conditions	What is the impact of the accuracy of coding risk assessment items for pressure ulcer coding?	The purpose of risk adjustment is to account for differences in patient complexities so quality measure scores can be fairly compared. For the purposes of quality measure calculation, not coding the risk adjustment items may negatively impact the facility's quality measure score that is publicly reported. The Quality Measure Reports also report risk-adjusted quality measure scores and are intended to help guide the facility's quality improvement initiatives. Data entered on the item set and submitted to CMS should be comprehensive and accurately represent the patient's status at the time of the assessment, as required as a part of the attestation in Section Z: Assessment Administration.

#	Question Category	Question	Proposed Response
40	Section M: Skin Conditions	Please provide guidance for coding the pressure ulcer/injury items for the following scenarios. Scenario 1: A patient is admitted to a PAC facility with a pressure ulcer that is unstageable due to slough/eschar. The pressure ulcer is assessed at Stage 3 on day 5 and remains a Stage 3 until discharge. Would this pressure ulcer be assessed as a Stage 3 pressure ulcer at discharge that was present on admission, or would this pressure ulcer be considered a new or worsened pressure ulcer? Scenario 2: A patient is admitted to a PAC facility with a pressure ulcer that is unstageable due to slough/eschar. The pressure ulcer is assessed at Stage 3 on day 5 and increases in numerical stage to a Stage 4 pressure ulcer at discharge. Would this Stage 4 pressure ulcer at discharge be considered present on admission or a worsened pressure ulcer at discharge?	If on admission, a pressure ulcer/injury was unstageable, but becomes numerically stageable later in the patient's stay, and remains at that stage until discharge, it would be considered and coded as present on admission on the discharge assessment at the stage at which it first becomes numerically stageable. However, if that same pressure ulcer/injury that becomes numerically stageable subsequently increases in numerical stage by discharge, it would be coded at that higher stage on the discharge assessment (M0300x1 = 1) and would not be considered nor coded as present on admission on the Discharge assessment (M0300x2 = 0).

#	Question Category	Question	Proposed Response
41	Section M: Skin Conditions	If a pressure ulcer/injury appears during a program interruption, how is the pressure ulcer/injury attributed?	For a pressure ulcer/injury that occurred during a program interruption (i.e., in the case where the patient did not have the pressure ulcer/injury prior to the program interruption but returned to the facility with a new pressure ulcer/injury) and remained present at discharge, code the pressure ulcer/injury on the discharge assessment (M0300x1 = 1) and do not code as present on admission (M0300x2 = 0). For example, as depicted in training slides, if the patient returns to the LTCH or IRF from the acute care hospital within 3 calendar days with a Stage 2 pressure injury that was not observed when the patient was transferred from the LTCH or IRF, you would code M0300B1 = 1 and M0300B2 = 0 on the discharge assessment if the Stage 2 pressure injury is present when the patient is discharged from the LTCH or IRF.
42	Section M: Skin Conditions	How is low body mass index (BMI) defined for Section M coding?	Section M does not require coding BMI. For purposes of risk adjustment for the pressure ulcer quality measure, BMI is calculated using the items height and weight in the formula: BMI = (weight * 703 / height^2). Low BMI is defined as a BMI between 12 and 19. A value lower than 12 would reflect invalid height or weight data.
43	Section M: Skin Conditions	Wound, ostomy, and continence nurse pressure ulcer staging guidelines sometimes do not correspond to CMS guidelines. How should such discrepancies be handled?	IRFs and LTCHs must code the IRF-PAI or LTCH CARE Data Set Section M items according to the instructions and definitions in Section M of the IRF-PAI QRP Training Manual or the LTCH QRP Manual. The pressure ulcer definitions used in the CMS IRF-PAI Training Manual and LTCH QRP Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Stages and in consultation with nationally recognized pressure ulcer experts.
44	Section M: Skin Conditions	Our wound nurses do not stage but primarily use descriptors, which seems to be a trend in wound care. Please provide suggestions on how to reconcile CMS coding requirements with how pressure wounds are documented.	Section M of the IRF-PAI Training Manual and the LTCH QRP Manual provide descriptions of each stage of pressure ulcer/injury. Please refer to Section M of the manual to reconcile coding.

#	Question Category	Question	Proposed Response
45	Section N: Medications	Does the two-way communication between the clinician(s) and the physician or physician-designee need to be documented in the electronic medical record?	Data in the LTCH CARE Data Set/IRF Patient Assessment Instrument (IRF-PAI) should be consistent with information reported in the patient's medical record.
46	Section N: Medications	Is CMS suggesting that a facility's patient documentation practices be changed to meet the drug regimen review (DRR) measurement requirements?	Each facility delivers patient care according to their unique characteristics and standards (e.g., patient population). Thus, each facility self-determines their policies and procedures for patient documentation practices and completing the assessments in compliance with State and Federal requirements. Data in the LTCH CARE Data Set/IRF-PAI should be consistent with information reported in the patient's medical record. The necessary information needed and used to code the items should be recorded in the patient's medical records.
47	Section N: Medications	Does CMS expect the pharmacist to document the medication review in the patient's medical record?	CMS does not provide guidance on who can or cannot code the DRR items. Please refer to facility, Federal, and State policies and procedures to determine which LTCH or IRF staff members may complete a DRR. Data in the LTCH CARE Data Set/IRF-PAI should be consistent with information reported in the patient's medical record. The necessary information needed and used to code the items should be recorded in the patient's medical records. Each facility determines its policies and procedures for completing the assessments. Each facility provides patient care according to its unique characteristics and standards (e.g., patient population).
48	Section N: Medications	If a physician orders medications on admission, and the pharmacist contacts the physician prior to developing the medication profile and resolves the questions/potential issues, is this still considered an issue?	If the issue was determined to be clinically significant, then the issue identified by the pharmacist and communicated to the physician and resolved by midnight of the next calendar day meets the requirements for coding N2001. Yes, issues found during review and N2003. Yes, medication follow-up on the admission assessment.

#	Question Category	Question	Proposed Response
49	Section N: Medications	If the physician-designee (such as an Advanced Practice Registered Nurse (APRN)) identified a potential or actual clinically significant medication issue and resolved it without registered nurse (RN) or licensed practical nurse input, would this still need to be coded in items N2001 and N2003?	We interpret this question to mean that a facility-based physician-designee performed the DRR, identified a medication issue, and addressed it without needing to communicate with another physician/physician-designee. In this scenario, the APRN identified and resolved a medication issue and therefore it did not require two-way communication with facility staff. The definition of a clinically significant medication issue requires the identification of a medication issue that warrants contacting a physician or physician-designee, two-way communication, in a timely manner and addressing all physician (or physician-designee) prescribed /recommended actions by midnight of the next calendar day at the latest. If no clinically significant medication issues were identified, then N2001 would be coded 0 and N2003 would be skipped.
50	Section N: Medications	Please clarify the term physician-designee. Can this include RNs or pharmacy technicians, or nurse practitioners and pharmacists only?	The role of a physician-designee is defined by Federal and State licensure regulations. CMS does not provide guidance on who can or cannot code the DRR items. Each facility determines its policies and procedures for completing the assessments. Please refer to facility, Federal, and State policies and procedures to determine which LTCH or IRF staff members may complete a DRR.
51	Section N: Medications	If a medication-related order (e.g., Vancomycin peak/trough) is not appropriate to be completed by midnight of the next calendar day, does the order serve as a response to a potential or actual clinically significant medication issue?	If the provider followed the physician's order that included an action after midnight of the next calendar day, this would meet the requirement of coding N2003, Yes, as the potential or clinically significant medication issue was addressed in accordance with the ordered timeframe.
52	Section N: Medications	What do you mean by timely?	Timely for the DRR refers to midnight of the next calendar day at the latest.
53	Section N: Medications	There are codes for LTCH planned, unplanned, and expired assessments. What assessment should an IRF use to code an unplanned discharge or if the patient expires?	Data element, N2005. Medication Intervention is coded for patients with planned and unplanned discharges and for patients who expire in the IRF/LTCH. This data element is included on the IRF-PAI in the Discharge Section. These data elements are included on the LTCH Planned and Unplanned Discharge, and Expired Assessments.

#	Question Category	Question	Proposed Response
54	Section N: Medications	When does data collection begin for the DRR quality measure?	Data collection begins July 1, 2018, for LTCHs and October 1, 2018, for IRFs and SNFs.
55	Section N: Medications	What is the rationale for coding 0, No for N2003 in scenario number 3 if the physician ordered the international normalized ratio (INR) laboratory test within the first calendar day? Why would the nurse need to request the laboratory test? Does CMS expect the results of the INR by midnight of the next calendar day or that the laboratory order is requested prior to midnight of the next calendar day?	The intent of coding N2003 is to determine if the facility contacted a physician or physician-designee by midnight of the next calendar day and completed prescribed/ recommended actions in response to the identified/potential clinically significant medication issues. In this scenario, the expectation is that the physician ordered an INR and the nurse would implement the physician's order (submitted the request for the laboratory test) by midnight of the next calendar day at the latest. For this scenario, and for coding N2003, it is not the intent that the laboratory result be available by midnight of the next calendar day.

#	Question Category	Question	Proposed Response
56	Section N: Medications	How does CMS define clinically significant medication issues?	A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest. Potential or actual clinically significant medication issues may include, but are not limited to: • Medication prescribed despite medication allergy documented in the patient's medical record. • Adverse reactions to medications. • Ineffective drug therapy. • Drug interactions (serious drug–drug, drug–food, and drug–disease interactions). • Duplicate therapy (e.g., generic name and brand name equivalent drugs are co-prescribed). • Wrong patient, drug, dose, route, and time errors. • Omissions (drugs missing from a prescribed regimen). • Nonadherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record. This information may be found on page N-2 of the LTCH QRP Manual Version 4.0 and the IRF-PAI Training Manual Section 4 Quality Indicators Version 2.0.

#	Question Category	Question	Proposed Response
57	Section N: Medications	For the DRR items, when you refer to clinician's professional judgment, what level of clinician are you referring to?	CMS does not provide guidance on who can or cannot code the DRR items. Please refer to facility, Federal, and State policies and procedures to determine which LTCH or IRF staff members may complete a DRR. Each facility determines its policies and procedures for completing the assessments.
58	Section N: Medications	If a dash is used to code N2003, does this count against the 95-percent IRF-PAI completion requirement and the 2-percent APU penalty, or is it similar to the current use of dashes for the Section GG discharge codes?	Yes, coding the three DRR items with a dash would count against the APU requirement.
59	Section N: Medications	Does Section N need to be completed within the 3-day admission assessment timeframe?	A DRR should be completed upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. Patient assessments are to be completed in compliance with facility, State, and Federal requirements. Each facility delivers care according to its unique characteristics and standards. Thus, each facility establishes its policies and procedures for completing assessments and data collection.
60	Section N: Medications	The clinical scenarios presented during the LTCH and IRF training refer only to acute care hospital discharge documents as the source of information to compare to PAC orders. Is CMS suggesting that this represents a complete medication reconciliation process in the absence of other information sources?	No, the DRR clinical scenarios presented during the LTCH and IRF training were examples of patients who are admitted from an acute care hospital. These scenarios depicted a source of information to review when a patient is admitted to an LTCH or IRF to reconcile the patient's medications. CMS recognizes that patients may be admitted from another type of facility to an LTCH or IRF, and the information that is transferred from that facility is a source of information for completing the DRR upon admission. Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the DRR, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.

#	Question Category	Question	Proposed Response
61	Section N: Medications	How do I code the DRR items if there are no potential or clinically significant medication issues?	A DRR is completed upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. For N2001, Drug Regimen Review, if no actual or potential clinically significant medication issues were identified upon admission, then N2001 is coded 0, No issues found during review or 9, NA, the patient was not taking any medications upon admission. If N2001 is coded as 0, No, or 9, NA, at admission then you would skip N2003 and go to O0100, Special Treatments, Procedures, and Programs. If there were no potential or actual clinically significant medication issues identified throughout the stay (admission through discharge) and/or the patient was not taking any medication at any time during the stay then N2005, Medication Intervention, would be coded 9, NA - Not applicable.
62	Section N: Medications	How do I code N2003, Medication Follow-up, if N2001, Drug Regimen Review, was coded 0, No issues found during review?	If N2001 is coded as 0, No, or 9, NA, at admission then you would follow the skip pattern according to your PAC setting admission assessment, LTCH CARE Data Set, or IRF-PAI. For the LTCH CARE Data Set and IRF-PAI, you would skip to O0100, Special Treatments, Procedures, and Programs. In this scenario, you would not need to code N2003, Medication Follow-up, due to the skip pattern.
63	Section N: Medications	Are patient stays the number of patient days?	A patient stay is the period of time between a patient's admission date into an LTCH or IRF and date of discharge. Interrupted stay(s) of 3 calendar days or less are included as part of the patient stay.
64	Section N: Medications	How would you code N2003 and N2005 if a clinician identifies a potential clinically significant medication issue and notified the physician within the appropriate timeframe. However, the physician's response, within the appropriate timeframe, was that no action was necessary. Would you code both items as "yes" a potential clinically significant medication issue occurred?	N2003, Medication Follow-up, and N2005, Medication Intervention, would both be coded as 1, Yes, in this scenario if the following occurred: 1. At admission and at any time throughout the patient stay, the clinician(s) contacted the physician/physician-designee regarding all identified potential or actual clinically significant medication issues. 2. The physician/physician-designee communicated to the clinician(s) that no actions were necessary regarding the reported issues. 3. All communications took place by midnight of the next calendar day.

#	Question Category	Question	Proposed Response
65	Section N: Medications	How would you code the DRR items if the patient does not adhere to their prescribed medications and is not taking any medications prior to admission? Is this considered not applicable?	We interpret this question to mean that the patient refused to take medications that were prescribed prior to the admission. The clinician should use clinical judgement to determine if the patient's refusal to take the prescribed medications would be considered a clinically significant medication issue that would require following the requirements of the measure. N2001. Drug Regimen Review, may be coded using the following responses: • Yes, if the patient's refusal to take the medications, based on clinical judgement, identified a potential or actual clinically significant medication issue. • No, if the patient's refusal to take the medications, based on clinical judgement, identified no potential or actual clinically significant medication issue. • 9. NA, if the patient was not taking any medications which includes prescribed and over the counter, total parenteral nutrition, and oxygen.
66	Section N: Medications	During the admission process, defining "current medication therapy" is not always clear cut. We are using multiple sources of information to best determine this. Would we report a potential or actual clinically significant medication issue even if we have not confirmed that it is included in the patient's current medication therapy? For example, a patient may be a poor historian.	We interpret this question to mean how would you code N2001, Drug Regimen Review, on the admission assessment if the information you have is not confirmed in the patient's current medication therapy? You would code N2001, Drug Regimen Review, based on all available information, in this scenario patient reported information, and use clinical judgement to determine if there is a potential or actual clinically significant medication issue.

#	Question Category	Question	Proposed Response
67	Section N: Medications	A DRR includes all medications. When you state nutritional supplements, are you referring to nutrition products that are provided to the patient on meal trays, such as Ensure nutritional supplement? Or are you only referring to vitamins, minerals, and or protein powder ordered?	Nutritional supplements, such as Ensure, are considered medications for the purposes of coding the DRR items. The DRR includes all medications, prescribed and over-the-counter (including nutritional supplements, vitamins and homeopathic and herbal products), administered by any route (e.g., oral, topical, inhalant, injection, sublingual, parenteral, and by infusion).
68	Section O: Special Treatments, Procedures & Programs	We have a patient who was admitted to the LTCH on full-time invasive mechanical ventilator support. The patient was successfully weaned during the day and required invasive ventilator support at night 2 days prior to discharge. Would this patient be considered a weaning patient? Would this patient count as liberated?	In this scenario, the patient is not considered fully liberated because the patient must be entirely liberated from the ventilator for 2 days prior to the discharge day. Patients who require invasive mechanical ventilation at night are considered partially liberated. The patient would be considered as weaning if the patient was assessed and performed spontaneous breathing trial (SBT) by day 2 of the LTCH stay, and the patient was progressively liberated off the ventilator throughout the stay.
69	Section O: Special Treatments, Procedures & Programs	How would the SBT items (O0150) in the LTCH CARE Data Set be coded if SBTs were completed prior to admission to the LTCH?	Patients should be assessed for readiness and performed SBT by day 2 of the LTCH stay even if SBTs were performed prior to LTCH admission. You would code the O0150 items accordingly. If SBTs were completed prior to the LTCH admission and SBT was not performed by day 2 of the LTCH stay, then O0150E would be coded as 0 (No). The LTCH would need to perform SBT again by day 2 of the LTCH stay for O0150E to be coded as 1 (Yes).

#	Question Category	Question	Proposed Response
70	Section O: Special Treatments, Procedures & Programs	For patients with an interrupted stay (less than 10 days away from LTCH and then readmitted back to the LTCH), is this considered one or two admissions for the ventilator liberation rate measure?	If the patient was away for more than 3 days, then the LTCH must complete an LTCH CARE Data Set discharge assessment (Planned or Unplanned). If the patient was readmitted after being away for more than 3 days, then the LTCH must complete an LTCH CARE Data Set admission assessment. Therefore, this would be considered a second patient stay for the ventilator liberation rate measure. For the purposes of the LTCH QRP, a program interruption refers to an interruption in a patient's care provided 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 assessment (Planned or Unplanned). If a patient stay contains one or more program interruptions, then this would be considered one patient stay for the ventilator liberation rate measure.
71	Section O: Special Treatments, Procedures & Programs	If a patient is not receiving invasive mechanical ventilation upon admission, but the patient is intubated within the first 48 hours, would this patient be part of the population for the ventilator liberation measures?	In this scenario, the patient was not on invasive mechanical ventilation support upon admission to the LTCH because the patient was intubated during the LTCH stay. This means that item O0150A would be coded as 0, No, not on invasive mechanical ventilation support. Subsequently, O0200A would be coded as 9, NA, since the patient was not ventilated on admission. Patients who were not on mechanical ventilation on admission are excluded from both ventilator liberation quality measures.
72	Section O: Special Treatments, Procedures & Programs	Does a progressive ventilator weaning plan that is initiated within 2 days of admission to the LTCH meet the criteria for SBTs?	If the progressive ventilator weaning plan includes assessing the patient's ability to breathe on his or her own without ventilator support, then this meets the criteria for a SBT. The goal of the new ventilator liberation items is to implement evidence-based weaning guidelines as early as is beneficial to the patient during the LTCH stay. SBT is the general term used in the LTCH CARE Data Set for a progressive ventilator weaning plan and can include but is not limited to Tracheostomy Collar or Continuous Positive Airway Pressure (CPAP) Breathing Trial.
73	Section O: Special Treatments, Procedures & Programs	If the pulmonologist documents that the patient is not medically stable (medically unready) for a SBT, would this be considered specific documentation that the patient was deemed medically unready for a SBT?	The documentation from the pulmonologist that the patient is not medically stable for SBT qualifies as "specific documentation." As a result, O0150D would be coded as 1 (Yes).

#	Question Category	Question	Proposed Response
74	Section O: Special Treatments, Procedures & Programs	Slide 91 indicates that a patient does not need to be liberated from ventilator support for 2 full consecutive calendar days, but that liberation must have occurred on the day that is 2 or more days prior to the discharge day. Is this correct?	Correct, it does not necessarily mean 48 hours. For example, if a patient was liberated off the ventilator any time on Wednesday and discharged anytime on Friday, then this would qualify for at least 2 calendar days prior to the date of discharge.
75	Section O: Special Treatments, Procedures & Programs	What was the fourth intravenous (IV) vasoactive medication the speaker mentioned other than dopamine, dobutamine, and norepinephrine?	Examples of IV vasoactive medications may include, but are not limited, to dopamine, dobutamine, norepinephrine, and milrinone.
76	Readmissions	What is the difference between the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge measure and the Potentially Preventable 30-Days Post-Discharge Readmission measure?	The All-Cause Readmission measure captures all unplanned readmissions to hospitals following discharge from a PAC setting. The Potentially Preventable Readmission measure subsets the patients included in the All-Cause Readmission measure by capturing patients readmitted to a hospital with a diagnosis deemed potentially preventable, such as infections or complications of chronic conditions. For more information about the determination of what constitutes a potentially preventable readmission, please see the measure specifications from the FY 2017 IPPS/LTCH PPS final rule, page 17: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf. This is also available at FY 2017 IRF PPS final rule, page 17: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf. The development of the Potentially Preventable 30-Days Post-Discharge Readmission Measure was mandated by the IMPACT Act of 2014.

#	Question Category	Question	Proposed Response
77	Section I: Active Diagnoses	What ICD-10 diagnosis codes should be considered to accurately code the patient's primary medical condition category (Section I I0050, Indicate the patient's primary medical condition category) on the LTCH CARE Data Set?	The four primary medical condition categories (I0050) (Acute Onset Respiratory Condition, Chronic Respiratory Condition, Acute Onset and Chronic Respiratory Conditions, and Chronic Cardiac Condition) refer to groups of medical diagnoses that are classified into HCCs. The following are HCCs for each of the primary condition categories and examples of diagnoses included in the HCC: **Chronic Respiratory Conditions:** Chronic Obstructive Pulmonary Disease (HCC 111) includes, but is not limited to, simple chronic bronchitis; unspecified chronic bronchitis; unilateral pulmonary emphysema (MacLeod's syndrome); chronic obstructive pulmonary disease with acute lower respiratory infection; and chronic obstructive pulmonary disease, unspecified. Fibrosis of Lung and Other Chronic Lung Disorders (HCC 112) includes, but is not limited to, bronchiectasis; coal worker's pneumoconiosis; pneumoconiosis due to asbestos and other mineral fibers; unspecified pneumoconiosis; pneumoconiosis associated with tuberculosis; and chronic respiratory conditions due to chemicals, gases, fumes and vapors. **Acute Respiratory Conditions:** Aspiration and Specified Bacterial Pneumonias (HCC 114) includes, but is not limited to, pneumonitis due to solids and liquids, and ventilator-associated pneumonia. Pneumococcal Pneumonia, Empyema, Lung Abscess (HCC 115) includes, but is not limited, salmonella pneumonia; amebic lung abscess; pulmonary anthrax; and pulmonary actinomycosis. Viral and Unspecified Pneumonia, Pleurisy (HCC 116) includes, but is not limited, pleurisy; adenoviral pneumonia; and pneumonia due to SARS-associated coronavirus. Pleural Effusion/Pneumothorax (HCC 117) includes, but is not limited to, pleural effusion; spontaneous tension pneumothorax; and chronic pneumothorax. **Chronic Cardiac Conditions:** Congestive Heart Failure (HCC 85) includes, but is not limited, rheumatic heart failure; hypertensive heart failure; obstructive hypertrophic cardiomyopathy; and pulmonary hypertension due to left heart disease.

#	Question Category	Question	Proposed Response
78	Training Resources	Could you provide the URL for these slides to access today?	Inpatient Rehabilitation Facility (IRF) materials for today's event can be found at the bottom of this page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html. LTCH materials for today's event can be found at the bottom of this page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
79	Training Resources	When will we receive copies of the rationale slides for all scenarios?	Presentations with answers to scenarios will be posted to the IRF and LTCH QRP Training websites shortly following the training. The URL for the IRF QRP Training web page is https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html. The URL for the LTCH QRP Training web page is https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.