Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Provider Training

Section A:

Administrative Information

Charles Padgett, RN
November 19, 2015

Section A: Objectives

- Define Section A: Administrative Information.

- Explain new items and/or changes between LTCH CARE Data Set v2.01 and v3.00.

- Explain the intent of Section A.

- Discuss coding instructions and needed information for items.

- Accurately code scenario(s).

Section A: New Items and Changes

NEW:

- Two additional interruption start/end dates added:

  - D1, D2, E1, E2

    - Five interruption start dates (A1 – E1).

    - Five interruption end dates (A2 – E2).

CHANGES:

- A2520 was deleted and replaced with A2525.

Section A: Intent

Obtain information that uniquely identifies:

- Each patient,

- LTCH where patient has been admitted,

- Reasons for the assessment.

Section A: A0050. Type of Record

A0050. Type of Record	
Enter Code ☐	1. Add new assessment/record 2. Modify existing record 3. Inactivate existing record

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Item indicates whether an LTCH CARE Data Set Assessment Record:
  - Is new.
  - Has been previously submitted and accepted in the QIES ASAP system, but requires modification or inactivation.
- No change to A0050.

Section A: A0050. Type of Record (cont.)

MODIFICATION REQUEST:

- Used when the LTCH CARE Data Set Assessment Record has been previously submitted and accepted in the QIES ASAP System with inaccurate information.

- Exceptions to Modification Request:
  - A0210: Assessment Reference Date (ARD),
  - A0220: Admission Date (on Admission Record A0250= 01),
  - A0250: Reason for Assessment,
  - A0270: Discharge Date (on a Planned or Unplanned Discharge or on an Expired Record A0250 = 10, 11, or 12),
  - Changing patient identifiers (i.e., SSN, birth date, etc.).

INACTIVATION REQUEST:

- Used to correct Modification Request Exceptions.

- Corresponding event did not occur (e.g., a Discharge LTCH CARE Data Set Assessment Record was submitted, but the patient was not discharged).

Section A: A0050 Coding Scenario

A patient was discharged from the LTCH but returned 2 days later. During this 2-day interval, the LTCH completed and submitted a Discharge Assessment to CMS. However, because the patient returned 2 days later, this is considered an interrupted stay. How can the original Discharge Assessment for this patient be revised?

How would you code A0050 and correct this error?

What is your rationale?

Section A: A0050 Coding Scenario

CODING: A0050 would be coded as **3. Inactivate existing record.**

RATIONALE: In this scenario, the date of discharge needs to be changed (A0270), which is one of the four Record Event Identifiers that require an inactivation request because the patient was not discharged but rather had an interrupted stay.

Section A: Definition

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 contractual agreement for services.

Such an interruption must not exceed 3 calendar days, with day 1 being the day of transfer.

Section A: A2500. Program Interruptions

A2500. Program Interruption(s)

Enter Code	Program Interruptions
☐	0. **No** → *Skip to B0100. Comatose*
	1. **Yes** → *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*

Applies to Planned Discharge and Unplanned Discharge Assessments.

CODING INSTRUCTIONS:

- **Code 0. No.** Skip to B0100. Comatose.

- **Code 1. Yes.** Continue to A2510. Number of Program Interruptions During This Stay in This Facility.

Section A: A2510. Number of Program Interruptions During This Stay in This Facility

A2510. Number of Program Interruptions During This Stay in This Facility

Enter Number	Number of Program Interruptions During This Stay in This Facility. *Code only if A2500 is equal to 1.*

Applies to Planned Discharge and Unplanned Discharge Assessments.

CODING INSTRUCTIONS:

- Code only if A2500 is equal to 1.

- Enter number of program interruptions.

- Proceed to next item, A2525. Program Interruption Dates.

Section A: A2525.
Program Interruption Dates

Applies to Planned Discharge and Unplanned Discharge Assessment.

- Item number revised to A2525 in v3.00 (formerly A2520).

Section A: A2525

CODING INSTRUCTIONS:

- Code only if A2510 is > 01.

- Enter the start and end dates of the first five program interruptions during the patient's LTCH stay.

- Begin with the interruption closest to the patient's date of admission.

Section A: A2500 Coding Scenario (1)

Ms. A is transferred from our LTCH to the Emergency Department and then returned to our LTCH the next day.

How would you code A2500?

What is your rationale?

Section A: A2500 Coding Scenario (1)

CODING: A2500 would be coded as **1. Yes.**

RATIONALE: If a patient is transferred to another care facility for a period of less than 3 calendar days (including the date of transfer), it is considered a "program interruption."

On the patient's Discharge Assessment, you should indicate there was a program interruption in A2500. Program Interruption(s); indicate the number of program interruptions in A2510; and indicate the start/end date of the program interruption in A2525.

Section A: A2500 Coding Scenario (2)

Mr. P is an LTCH patient who went to an acute-care hospital for hernia repair and returned to the LTCH after a few hours.

How would you code A2500?

What is your rationale?

Section A: A2500 Coding Scenario (2)

CODING: A2500 would be coded as **1. Yes.**

RATIONALE: The interrupted stay lasted fewer than 3 calendar days. The LTCH should not complete a Discharge Assessment for this patient when the patient leaves for the appointment, nor should an admission assessment be completed when the patient returns from the appointment several hours later. The program interruption will be recorded on the Discharge Assessment (LTCH CARE Data Set items A2500, A2510, and A2525).

Section A: A2500 Coding Scenario (3)

Mrs. G is transferred from an LTCH to a short-term acute-care hospital and is gone longer than 3 calendar days. Mrs. G returned to the LTCH 8 days later.

How would you code A2500?

What is your rationale?

Section A: A2500 Coding Scenario (3)

CODING: A2500 would be coded as **0. No.**

RATIONALE: If a patient is transferred to another facility for a period of 3 calendar days or more (including the date of transfer), then a Discharge Assessment must be completed when the patient is transferred to the other facility and an Admission Assessment must be completed when the patient returns to the LTCH.

Section A: Summary

- Section A obtains key information to uniquely identify each patient, the LTCH in which the patient receives health care services, and reasons for assessment.

- Use an Inactivation Request to correct Modification Request Exceptions.

- Use A2510 to indicate total number of program interruptions.

- Use A2525 to document the first five program interruptions during the patient's LTCH stay, beginning with the interruption closest to the patient's date of admission.

Section A: Action Plan

- Review the new A2525 Program Interruption Date items for Planned Discharge and Unplanned Discharge Assessments.

- Practice coding a variety of program interruption scenarios with staff.

- Evaluate if the required data elements can be captured in the timeframe defined.

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Section Z:

Assessment Administration

Charles Padgett, RN

November 19, 2015

Section Z: Objectives

- Define Section Z: Assessment Administration.

- Explain the intent of Section Z.

- Review importance of Section Z.

Section Z: New Items and Changes

There are no new items or changes made in Section Z.

Section Z: Z0400 and Z0500

Z0400. Signatures of Persons Completing the Assessment and Z0500. Signature of Person Verifying Assessment Completion

Z0400. Signature of Persons Completing the Assessment

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. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that submitting false information may subject my organization to a 2% reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Assessment Completion

A. Signature:

B. LTCH CARE Data Set Completion Date:

☐☐ – ☐☐ – ☐☐☐☐
Month   Day   Year

Section Z: Z0400 and Z0500 (cont.)

- Capture signatures of the LTCH staff members who completed the LTCH CARE Data Set Assessment (Z0400) and of the person verifying assessment completion (Z0500).

- Signatures are not transmitted to CMS in LTCH submission files. CMS strongly suggests that you retain what you submit to CMS, in addition to the signatures in Section Z, according to your facility, State, and Federal regulations and requirements. Facilities that use electronic health records should comply with any additional requirements they may have.

Section Z: Z0400 and Z0500 (cont.)

- Obtain signatures of all persons who completed any part of the LTCH CARE Data Set Assessment.

  – Becomes a legal attestation of accuracy/completeness.

- Importance of accurately completing and submitting LTCH CARE data cannot be overemphasized.