

Centers for Medicare and Medicaid Services
Special Open Door Forum:
Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Provider Training

Moderator: Jill Darling
May 7, 2014
1:00 p.m. CT

Operator: Good afternoon. My name is (Sherilyn). I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Long Term Care Hospital Quality Reporting Program Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Jill Darling, you may begin your conference ma'am.

Jill Darling: Thank you very much and welcome everyone to the Special Open Door Forum for Long Term Care Hospital Quality Reporting Program Provider Training. We apologize for the delay. We are, like always, we're waiting for other folks to get in. So, to begin, we'll keep this scheduled until 2:30 Eastern Time. So we'll keep it to 2:30 – keep on schedule.

So now, I will turn the call over to Charles Padgett to begin the Special Open Door Forum.

Charles Padgett: Hi. Thank you for joining. This is Charles Padgett and I am the lead for the LTCH Quality Reporting Program at CMS. And today's presentation is related to training for the LTCH – for LTCH related to the Quality Reporting Program.

I just want to begin by apologizing that the posting of the materials was delayed because of technical difficulties. They are (posted) now – so if you haven't been able to download these materials prior to now, they are from the LTCH quality reporting Web site and they are available for download and that is at www.cms.gov/ltch-quality-reporting/ . Again that's www.cms.gov/ltch-quality-reporting/ – I'm sorry – ltch-quality-reporting/ and they're under the download section on our training web page. And you can access them there.

Also prior to beginning, I just want to give a reminder to all LTCHs that on May 15, which is just next week, just around the corner, that is the deadline for submitting quality data to CMS and – because of the change in our quarterly deadline that is finalized in the Fiscal Year 2014 IPPS/LTCH PPS Final Rule, this actually happens to be a dual deadline. So this May 15th, 2014 is the deadline for submitting our quality data collected during Quarter 4 of 2013, but it is additionally the deadline for submitting quality data collected during Quarter 1 of 2014. So, important deadline is up coming, I just wanted to give a reminder.

So to begin this presentation, there's a little bit of review that goes on here with all the measures that we've previously finalized. So, I'll work my way through this. After we get through the PowerPoint presentation, I'm going to move over to the FAQ, ask questions and review those questions and then we will open it up for questions and answers.

I'm going to ask that during the question and answer session that you limit your questions to previously finalized and adopted measures and new measures -- the newly proposed measures that are proposed rule that was just released by CMS.

So, I'm going to go and begin on page 2 at the PowerPoint presentation titled Affordable Care Act Section 3004. Again the LTCH quality reporting program was created by Section 3004 of the Affordable Care Act in CMS required measure of certified long term care hospital to submit quality data on all patient admission or discharges. Failure to submit that data; may reduce annual payment update by two percent.

We initially adopted three quality measures for data collection and reporting for Fiscal Year 2014, and Fiscal Year 2015, two additional measures for Fiscal Year 2015, three additional measures for Fiscal Year 2017, and one additional measure for Fiscal Year 2018 payment update determination.

The requirements for Fiscal Year '14 payment determination were that LTCH's were to submit quality data on three quality measures, Catheter Associated Urinary Tract Infection or CAUTI, Central Line-Associated Bloodstream Infection or CLABSI, and Percentage of Residents with Pressure Ulcers that are New or Worsened (short stay). And that data was collected of course from October 1st 2012 when the first program was initiated to December 31st 2012 on these three measures and it's applicable to Fiscal Year 2014 payment determination. The data reporting and submission period for the 2014 APU closed on May 15th of 2013.

We have some – we updated the names of three measures in the Fiscal Year 2013 Final Rule and the change has been (unnamed to) resulted from a NQF review of these measures and expansion of these measures to the Post-Acute care settings including IRFs and LTCHs. And the CAUTI measure changed to Catheter Associated Urinary Tract Infection Outcome measure. The CLABSI measure was changed to Central Line-Associated Bloodstream Infection Outcome measure and the pressure ulcer measure was changed to Percent of Residents or Patients with Pressure Ulcers that are New or Worsened.

Our requirements for the Fiscal Year 2015 payment determination that is data; that was reported during calendar year 2013. These requirements were finalized in the 2012 final rule and we stated that LTCHs should have continued to report data on the same three measures, the CAUTI measure, CLABSI measure, and the pressure ulcer measure through calendar year 2013 and that data would have affected the Fiscal Year 2015 annual payment update determination. And it's here. I'm on page 5 (inaudible) there is ...

(Audio Gap)

Operator: Ladies and gentlemen, this is the operator. Today's conference is scheduled to continue momentarily.

Ladies and gentlemen, this is the operator. Today's conference is scheduled to continue momentarily.

Ms. Darling, you may begin.

Jill Darling: Thank you. Sorry everyone. Our call was dropped. So, we apologize for the slight little mini heart attack. So Charles, you may continue.

Charles Padgett: All right. Sorry about that. We're going through following the presentation. I'm now on page 6 of the PowerPoint presentation.

In our Fiscal Year 2013 Final Rule, we retained three quality measures affecting the Fiscal Year 2015 APU and we also finalize two additional measures for the Fiscal Year 2015 APU. The two additional measures were Percent of Residents or Patients who were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) measure and Influenza Vaccination Coverage Among Healthcare Personnel.

And there is the link to the Fiscal Year 2013 Final Rule at the bottom of page 6 if you need – if you would like to reference any of that. And those measures for data collection that's affecting the Fiscal Year 2013 payment determination for the CAUTI, CLABSI, and pressure ulcer measures, we list a quarterly deadlines for submission of these measures. So, for the Fiscal Year 2016, these measures will be collected and submitted to CMS during calendar year 2014. Quarter 1 of 2014, January through March, must be submitted to CMS by May 15th 2014, that's next week.

Quarter 2, collection of quality data, April 1st to June 30th 2014, must be submitted to CMS no later than August 15th 2014. Quarter 3, July 1st to September 30th 2014, quality data must be submitted to CMS by November 15th 2014. And Quarter 4 quality data must be collected and submitted to CMS no later than February 15th of 2015. Now, we adapted these new quarterly submission deadlines for Fiscal Year 2016 payment determination. And we stated that beginning in calendar year 2014, the submission deadline

would be 45 days after each data collection timeframe in place of the 135 days after each quarter.

So, for each quarter, it used to be that you'd have four and a half months or 135 days (during) which to submit data or corrections to that data. And, in that – and we previously finalized though that – as of calendar year 2014, that deadline would change and be reduced to 45 days. And the first quarter that's affected would be Quarter 1 of 2014. And again, as I mentioned at the beginning of the presentation, May 15th 2014 will be the first deadline associated with that. We also proposed a new timeline for NQF 0680 which is Percent of Residents or Patients Who are Assessed and Appropriately Given the Seasonal Influenza Vaccine.

And we did that in the Fiscal Year 2015 LTCH PPS – IPPS/LTCH PPS proposed rule which was just released. And I want to mention this specifically because it affects the collection and submission of data for this measure that's coming up beginning October 1st 2014. So, previously we said that LTCHs would collect and submit this data between October 1st 2014 and April 30th of 2015 and then October 1st through April 30th of any given year thereafter. However, we realized that we did have quarterly deadlines in place and asked folks to follow those quarterly deadlines and without speaking to them ourselves.

So, we proposed to change the submission, the timeframes, the deadlines for this measure, Percent of Residents or Patients Who are Assessed and Appropriately Given the Seasonal Influenza Vaccine so that the first quarter is reported October 1st through December 31st 2014 or Quarter 4 of 2014. The submission deadline for that quarter would February 15th of 2015. And then data collected between January 1st and March 31st, or Quarter 1 of 2015 would have a deadline of May 15th 2015. So, and – essentially, what we've done is we've aligned the data collection of this measure with our other quarterly deadlines. And that said rule is viewable now. And we have a link posted on the bottom of page 8 that you can use to view that proposed language.

We also – we adopted a new timeline for NQF 0431 influenza vaccination coverage among healthcare personnel in the Fiscal Year 2015 IPPS/LTCH PPS Final Rule. And that is October 1st 2014 to March 31st 2015, and then October 1st through March 31st of any subsequent Influenza vaccination season. And that the deadline for that since this measure is only reported once a year would be May 15th 2015. So that the measure influenza vaccination coverage among healthcare personnel is only reported once a year, it's reported via the CDC's NHSN. And you would collect data between October 1st or – and May – I'm sorry October 1st and March 31st and then submitted by May 15th following that particular Influenza vaccination season.

To continue with data submission requirements for the quality reporting program measures for the Fiscal Year 2015 payment updates determination. The pressure ulcer and patient seasonal influenza vaccination measures that were added, submit data using the LTCH Continuity Assessment Record and Evaluation or the LTCH CARE Data Set and CAUTI, CLABSI, Healthcare Personnel Vaccination, all you – all are collected and submitted via the CDC's National Healthcare Safety Network. And there is a link to that on page 10.

OK. I'm going to go into the LTCH CARE Data Set itself a little bit. Just want to remind LTCHs that this applies to all patients receiving inpatient services and a facility that is certified under – under Medicare as a short term acute care hospital and designated as an LTCH. For information on data collection submission for measures using the LTCH CARE Data Set, we refer you to Chapters 2, 3 and 4 of the LTCH quality reporting program manual version 2.0 which is available for download on the main CMS LTCH quality reporting program web page. And also you will continue to use the LTCH CARE Data Set version 1.01 to submit pressure ulcer data to CMS through June 30th 2014.

Then beginning July 1st 2014, you'll begin using the LTCH CARE Data Set version 2.01 to submit pressure ulcer data as well as patient seasonal influenza vaccine data to CMS. Although items for patient seasonal influenza vaccine measure are included in the LTCH CARE Data Set version 2.01, we are only requiring providers to submit data for these items beginning October 1st of any given year to March 31st of the following year. And again, that particular

measure that the patient seasonal influenza vaccination measure, excuse me, we proposed to change the timeline that's here on the Fiscal Year proposed rule, and the timeline has been changed, so that the end date is March 31st as opposed to the previously finalized April 30th.

Now, I'm going to move into our program requirements for Fiscal Year 2017, Fiscal Year 2018 payment determinations. So in the Fiscal Year 2014 Final Rule, CMS adopted four additional quality measures. For affecting Fiscal Year 2017, we adopted NHSN Facility-Wide Inpatient Hospital Onset MRSA Bacteremia Outcome measure, NHSN Facility-wide Inpatient Hospital Onset CDI Outcome measure. All-Cause Unplanned Readmission Measure for 30 days Post-discharge from Long Term Care Hospitals. And in that same rule, we affected one measure effecting, initially effecting Fiscal Year 2018 which is Application of the Percent of Resident Experiencing One or More Falls with Major Injury.

And at the bottom of page 13, slide 13, there's a link to the Fiscal Year 2014 Final Rule for reference.

Data collection timeframes and submission deadlines for Fiscal Year 2017 payment determination. And I'm going to go over the timeframes for measures 0138, 0139, 0678, 1716 and 1717. Those are CAUTI, CLABSI, the pressure ulcer measure, MRSA, and C. diff. And those are collected and submitted quarterly. And Quarter 1 of 2015 will be – have a deadline of May 15th 2015, Quarter 2 of 2015, will have a deadline for submission and correction of August 15th 2015, Quarter 3 of 2015, will have a collection and correction deadline of November 15th, 2015, and Quarter 4, will have a collection and correction deadline in February 15th 2016.

Additionally, for the two other measures that are required, Percent of Residents or Patients Who are Assessed and Appropriately Given a Seasonal Influenza Vaccine – actually, this is – I'm just referring to the Patient Influenza measure here, number 0680, that that measure is required to be collected and reported between October 1st and March 31st of the following year. So, from October 1st of 2015 through December 31st of 2015, which is Quarter 4 of 2015, you have a deadline of February 15th of 2016, and for a

Quarter 1 of 2016, you have a deadline of May 15th 2016. And then lastly, the Influenza Vaccination Coverage Among Healthcare Personnel which again is collected between October 1st and March 31st, but only submitted once a year, you simply have a deadline of May 15th for that whole six months.

OK. I'm on page 17 now for those of you that are following along with the PowerPoint. In the – this talks a little bit about the proposed rule that was just released. And its Fiscal Year 2015 proposed rule, CMS proposed three additional quality measures for the Fiscal Year 2018 payment determination. Those are National Healthcare Safety Network Ventilator-Associated Event (VAE) Outcome measure. The second is functional status quality measure, Percent of Long Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function. And the third measure is that functional outcome measure Change in Mobility Among Long Term Care Hospital Patients requiring Ventilator Support. And the Fiscal Year 2015 IPPS/LTCH PPS proposed rule is viewable by following the link at the bottom of slide 17.

And again, in the Fiscal Year 2015 proposed rule, we proposed a revised timeline for the measure Application of Percent of Residents Experiencing One or More Falls with Major Injury. And the revised timeline – it was initially proposed to begin – to have LTCHs begin collecting and submitting data as of January 1st 2016. We have now revised that begin date to April 1st of 2016. So, for the Falls with Major Injury, you'll begin reporting April 1st 2016, and that's Quarter 2. So for Quarter 2, you'll have collection and correction deadline of August 15th 2016. For Quarter 3 of 2016, you'll have collection and correction deadline of November 15th 2016, and then finally, for Quarter 4 of 2016, you'll have a collection and correction deadline of February 15th 2017. And again, at the bottom of page 18, there is a link to the rule there.

Moving on to slide 19, I'm going to touch on a little bit the LASER software. LASER is the free – or first of all, LASER stands for LTCH Assessment Submission Entry and Reporting software. It's a free Java-based application for LTCHs to collect and submit data using the LTCH CARE Data Set. The

new release of LASER is scheduled for June 2014. For further information, you cannot select “LASER software” under the related links section of the LTCH quality reporting Web site. So, you can just go to the main page, the LTCH quality reporting Web site at the bottom there. You see useful links, the related links and you can select LASER software and that will link you to further information about that. Information on data collection and submission using the LTCH CARE Data Set also was available at – on our main Web site, LTCH quality reporting Web site, additionally available on our LTCH quality reporting technical page which is accessible by just going and selecting the link of the same title on the upper left hand corner of the main web page.

Measures that are reported through the CDC's NHSN, the CDC's NHSN is used as the data submission mechanism for NQF measures CAUTI and CLABSI. CDC's NHSN will be used as the data submission mechanism for Influenza Vaccination Coverage for Healthcare Personnel starting October 1st 2014 or when the vaccine becomes available. Beginning on January 1st 2015, NHSN will also be used as the data submission mechanism for MRSA and CDI or C. diff. And then for further information on data collection submission for these measures, you can see Chapter 5 of the LTCH quality reporting program manual version 2.0, which is available for download at our Web site, it's also available – information about this – NHSN measures is available on the CDC's NHSN Web site which is <http://www.cdc.gov/nhsn/>.

We also have previously finalized reporting for the All-Cause Unplanned Readmission Measure for 30-Days Post-Discharge from Long Term Care Hospitals. NQF review of this measure is pending. So it has been submitted to NQF for endorsement. This particular measure, the LTCH Readmission measure does not require data submission by LTCHs. It's been adopted for use beginning January 1st 2015 and it finalized in the Fiscal Year 2014 Final Rule. We just want to make sure that that's clear. Well, you know, eventually, we will be calculating this measure and submitting your performance record back to you and eventually it will be used for public recording. In the meantime, we will begin using data to calculate this measure January 1st of 2015.

And I just want to say so nobody's nervous about it. There has not been a date set for public reporting for the LTCH setting. Information will be reported, I mean, I encourage you to continue to check our Web site for information related to that. But any data that is, we're planning on publicly reporting – will first be reported back to LTCH so that you're able to view your data and you're able to – also able to question anything that you feel is in error there.

Back to the NHSN. We just want to make sure all LTCH have to enroll in the NHSN center, the National Healthcare Safety Network with the CDC and complete online training modules prior to preceding reporting permissions from NHSN. If you have not yet enrolled your LTCH, contact – we ask that you contact the CDC's NHSN by e-mail. You could do that by e-mailing mnhsn@cdc.gov. There are also a list of frequently asked questions about the enrollment process and procedures. And those are available on the CDC's NHSN Web site again at <http://www.cdc.gov/nhsn/>.

LTCH provider training documents are posted on the LTCH quality reporting Web site. Our first provider training ever was held in May of 2012 to support the October 1st 2012 implementation. Since then, we've had several Special Open Door Forums since the program began. The most recent one was held in November of 2013. And those open door forum presentation materials are also available for download. We want to let you know, on our LTCH quality reporting Web site. A good source of information for new LTCHs for understanding history of this program – of this young program, I should say. A lot of good information there. You can download the transcripts which we have posted on our Web site.

And in addition to today's Open Door Forum, we do have an upcoming Special Open Door Forum on June 12th 2014. Details about that particular Open Door Forum will be forthcoming. We encourage you to continue to check our Web site. I will say, during that call, we will have that CDC folks present with us to review the measures we've finalized – the NHSN measures we've finalized. And in particular, the upcoming Health Care Worker vaccination, Influenza vaccination measure, and so that LTCHs can feel that they have a good understanding of that measure and ask questions pertaining to that measure. So you can look forward to that on June 12. Again, details

about the June 12th special open door forum will be forthcoming. Please check our Web site.

I'm now on page 25, slide 25. Just to review some helpful resources for LTCHs. Of course our LTCH quality reporting Web site is listed on page 25. And we also have a help desk e-mail that you can e-mail, any questions any time. And that is ltchqualityquestions@cms.hhs.gov. And you can also sign up to receive e-mail announcements about the program. And there's a link to do that at the bottom of page slide on the bottom of slide 25. On slide 26, we list additional links and resources for collecting data and submitting data on the CLABSI quality healthcare personnel vaccination and MRSA, C. diff measures, which are all submitted to the CDC's NHSN and there is a link for each particular measure there as well as guidance about the enrollment processes and who you should contact if you're having any difficulties with that.

Any questions or comments on technical issues regarding the LTCH CARE Data Set problems – submission problems, problem of understanding would be these data submission specifications, those sorts of issues. We ask that you send your questions to LTCHTechIssues@cms.hhs.gov. That's at the top of page or slide 27. Any questions regarding access to QIES, data submission, and CASPER, we ask that you submit to the QIES Technical Support Office and that e-mail address is help@qtso.com. Also there's a 800 toll free number that you can call which is 800-339-9313. And in addition to that, we have in the past posted several documents pertaining to frequently asked questions about the LTCH quality reporting program. They are posted and available at present on our main quality reporting web page.

All right. Now that's some of the basics of submission and timeframe and so forth. I am going to move over to the frequently asked questions. That document was also posted today as of 12:30. It's available on the LTCH quality reporting Web site on the training page under the download section.

OK. The first question that we had received and we thought it was a good question to include here, was a provider that needed a simple clarification on the definition of an LTCH. I know that frequently LTCHs are listed different

or they are referred too differently. Some people say LTCH, other say LTACH which stand for Long Term Acute Care Hospitals. I know that CDC refers to LTCH like that. But for CMS purposes, long term care hospitals or LTCHs and long term acute care hospitals are different names for the same type of hospital. Medicare uses this term, long term care hospitals.

These hospitals are certified as short term acute care hospitals that treat patients requiring extended hospital level care typically following an initial treatment at a general acute care hospital. If a hospital is classified (as an LTCH for purposes of Medicare payments as denoted by the last four digits of a six-digit CMS certification number or CCN in the range of 2000 to 2299), it is subject to the requirements of the LTCH quality reporting program.

Next question asks. When is a new LTCH required to begin reporting data under the CMS quality reporting program? If I interpret the language in the program manual correctly, LTCH would start reporting, once it has been surveyed by Medicare and received a CCN number and has been designated as an LTCH, which may not be until a few months after the hospital opens its doors and begins accepting patients, is this correct?

And the response to that, we've said a facility is required to begin reporting quality data to CMS under the LTCH quality reporting program from the day it is formally designated as an LTCH by CMS. This formal designation happens when a facility receives that CCN from CMS licensing a facility as a Medicare certified LTCH. The facility will receive notification and the LTCH will be assigned as CCN with the last four digits in the range of 2000 through 2299. CMS does not require a facility to begin reporting quality data under the LTCH quality reporting program until that time.

Next question asks for a full list of quality measures for all LTCH facilities and asked where they can find definitions for quality measures. And at the present time, if you're looking for the most current information including a list of quality measures adopted for our program, data collection, and submission deadlines for each of the quality measures, we refer you to the Fiscal Year 2014 IPPS/LTCH PPS Final Rule which is available – and we give a link here, I'm not going to repeat it here because it's very long. It won't make any sense

on the phone but we do provide a link to the 2014 final rule here and also in the PowerPoint presentation I just went over. And we also go to specific page numbers that you can refer to.

We also ask that in order to look at the most current information and current definitions you refer to this Fiscal Year 2015 proposed rule. And again, that was just recently released. We have the link here where you can look at that. We also have several links in the PowerPoint presentation to help you get to that. For further details, the measure definitions for the five LTCH quality measures, CAUTI, CLABSI, the Pressure Ulcer measure, Percent of Residents and Patients who were Assessed and Appropriately Given the Seasonal Influenza Vaccine measure, and the Influenza Vaccination Coverage Among Healthcare Personnel.

And we refer you to the LTCH QR program manual version 2.0 which is available for download on our Web site, specifically, Chapter 1 and Chapter 5 of the program manual version 2.0. We also invite you to visit our Web site for updates and specifications for each of these measures that may result from the NQF review. And then lastly, details about the NHSN MRSA measure and the C. diff measure, we refer you to Chapter 1 again and Chapter 5 of the LTCH QR program manual.

OK. I'm moving on the question four, that's on page 2 of the FAQ document. What is the definition of planned discharge? We're going over this because we're often – I have this question submitted to us by different providers. It's probably one of the absolute most frequently asked questions.

And a planned discharge is one in which the patient is non-emergently medically released from care at the LTCH because of some reason arranged or in advance. So that is – for example, the hospital was planning that this patient was going to be released home. They are ready to go home or they were ready to be discharged to a lower level of care. And – so they wrote their discharge instructions in papers and this patient was in fact discharged. That LTCH would be required to then fill out a planned discharge. It was a planned event. There was nothing emergent about it. It was not a last minute decision. It was planned for in advance.

And then also the definition of an unplanned discharge. And an unplanned discharge is an unplanned transfer of the patient to be admitted to another hospital or facility that results in the patient's absence from the LTCH for a longer than three days including the date of transfer. Or a transfer of the patient to an emergency department of another hospital in order to either stabilize the condition or to determine whether an acute care admission is required based on an emergency – based on the emergency department evaluation which results in the patient's absence from the LTCH for longer than three days. Or when a patient is unexpectedly – I'm sorry. A patient unexpectedly decides to go home or to another setting or to complete treatment in an alternate setting.

Unplanned discharges do not include planned transfers to acute care inpatient hospitals for planned interventions, treatments, or procedures, unless the patient does not return to the LTCH within three days. Again, we ask you to see Appendix A of the LTCH program manual for more information on that.

Lori Grocholski: Hi. This is Lori Grocholski. I'm going to read some of the Q and A here along with Charles. Right now, we are at number six. If a patient planned discharge is Friday, but the discharge is delayed until Sunday, what should the assessment reference date be? The assessment reference date on the discharge assessment of the LTCH CARE Data Set is the patient's actual discharge date. Please see Chapter 2 of the LTCH quality reporting program manual version 2.0. In the example provided above, the answer would be Sunday.

Number seven, can CMS – please clarify whether there is a 72-hour rule or three calendar-day rule in the following instances. When the patient leaves in LTCH to go to another facility and then return to the LTCH for purposes of determining whether to submit a discharge – to submit a discharge assessment and when a patient dies within 72 hours or three days after leaving in LTCH for another facility.

An interrupted stay occurs when a patient discharges from an LTCH for treatment and service that is not available in the LTCH, and after a specific number of days away from the LTCHs, readmitted to that same LTCH for

further medical treatment. The three day interrupted stay is in accordance with the payment policies that have been established. If the policy states that day one of three begins on day of transfer, then that day plus two calendar days would dictate the definition of the three days. If a patient died during an interrupted stay, then the LTCH may submit the expired assessment data set. If the patient died afterward, the LTCH should have submitted a discharge assessment data set because the patient did not return within the three days.

Please note that 72 hours has been replaced by three calendar days throughout the LTCH quality reporting manual version 2.0 that is available for download and that the Q and A here lists where you can find that.

Number eight, if a patient dies during the assessment period, should you fill out both an admission and an expired assessment?

Yes, both in admission and expired assessment would be completed. The assessment reference date for the expired assessment would be the date of death.

Number nine, a patient came to our facility and was discharged the next day. We assumed that patient is (exempt) from reporting. Do we need to track those cases in some way just to – so there is no question regarding our full reporting?

In example you provide, you stated the patient was discharged the day following his or her admission to the LTCH. In this instance, the LTCH would be responsible for submitting to CMS an admission assessment followed by a planned or unplanned discharge assessment using the appropriate LTCH Care Data Set depending on the circumstances surrounding the patient's discharge. For more information regarding planned versus unplanned discharge, consult the LTCH quality reporting program manual version 2.0 and that is available for download at <http://www.cms.gov/medicare/medicaid-support/ltch/> – actually, I won't read this Web site, but it is listed here.

Number 10, are all demographic information items required are GG0160C which is functional mobility, lying to sitting on side of bed, H0400 bowel

incontinence, K0200A height and K0200B weight, required only for admission assessment?

Please refer to the LTCH quality reporting program manual version 2.0 which is available at – for download. Appendix (D) provides item specific guidance on requirements for the completion of the LTCH CARE Data Set. It is extremely important that Appendix (D) be provided to illustrate which items are required which can be voluntarily submitted and when each type of LTCH CARE Data Set assessment records should be submitted. However, Appendix (D) is not to be used as a replacement for the data submission specs. For data submission, the LTCH CARE Data Set must follow the LTCH CARE data submission specs version 1.01.1 which is posted on the CMS Web site.

According to the specifications of the percent of residents or patients with pressure ulcers that are new or worsened which is NQF 0678 height and weight, diabetes mellitus, peripheral vascular disease and peripheral arterial disease, bowel incontinence, and functional mobility are used as covariance or risk adjustment to calculate the percentage of patients with pressure ulcers that are new or worsened. Data for these risk adjustment items are derived from the admission assessment. Therefore, the provider must submit these risk adjustment items on the admission assessment. These items are not used in the major calculation as discharge and therefore are not required on the discharge assessment. If providers do not want to provide an actual assessment based response on these items at the time for discharge, for example, if providers do not provide the functional mobility of the patient, they must enter default code for some items. The default codes vary according to the data item. Appendix (D) provides item specific information on which items are voluntary but require a default code. We refer you to the LTCH care data submission specs version 1.01.1 as the primary source for these codes including when they are to be used.

Number 11, I recently submitted an admission data set for a patient admitted to my facility. The patient was very large and not stable on admission. After five days at our facility, she was transferred back to the acute care hospital

because of her condition. And the nurses at our facility were unable to get an admission weight for the patient. I used the dash as I was instructed to use.

My certification and survey provider enhancement report or otherwise known as CASPER states that the admission data set was accepted but I get a payment reduction warning. The dash submitted to this quality measure item may result in a payment reduction for your facility of 2 percentage points with F.Y. 2014 payment determination. After seeing the warning, I do not understand why we are penalized for not being able to get an admission weight.

The warning is issued by the quality improvement evaluation system assessment submission and processing that's known – which is otherwise known as the QIES ASAP system. To notify LTCH providers that a dash was entered for a required item and the warning is generated every time a default response, in this case a dash, is entered for a required item (although the use of dash for this item may affect annual payment update, and hence, the warning that LTCH providers receive in the QIES ASAP system when a dash is entered for quality item which is required, for example, K0200B), CMS will take into account that there are instances when a dash is appropriate. CMS (expects) that instances of coding with a dash for quality items on the LTCH CARE Data Set would occur infrequently. For a list of required and voluntary items, please refer to Appendix (D) version 1.1 which is available in the download section of the LTCH quality report program Web site. We also refer you to the LTCH CARE data submission specs V1.01.1 as a primary source for these codes and when they're to be used.

Number 12, do we report patients with all payer sources for pressure ulcers, CAUTI, CLABSI, influenza vaccination coverage among healthcare personnel, and percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine for LTCH or just patient admitted with Medicare payer source.

The LTCH CARE Data Set applies to all patients receiving inpatient services in a facility certified as the hospital and designated as an LTCH under Medicare. Data collection using the LTCH CARE Data Set applies regardless

of a patient's age, diagnosis, length of stay, or payment payer source. See Chapter 2 section 2.1 of the LTCH quality reporting program manual version 2.0. LTCHs must also submit data on all patients from inpatient locations regardless of payer source to the NHSN. You can note that at Chapter 5, section 5.1 of the LTCH quality reporting program manual version 2.0 and that's available for download.

Number 13, none of our patients had pressure ulcers, CAUTI, or CLABSI, seasonal influenza vaccine, or vaccination coverage among healthcare personnel during January 1st 2014 through March 31st 2014 reporting period. Do we need to submit data on these measures to comply with the LTCH reporting program for this quarter?

Compliance with the LTCH quality reporting program requires submission of quality data irrespective of whether your patient has pressure ulcers, CAUTI, CLABSI, or an Influenza vaccination. And LTCHs are required to submit “no event” for the catheter-associated urinary tract infection or CAUTI outcome measure NQF (0138) and the central line-associated bloodstream infections, often known as CLABSI, outcome measure NQF (0139) for the month of January 1st 2014 through March 31st 2014, and the influenza vaccination coverage among healthcare personnel, NQF 0431 by May 15th 2014 through the Center for Disease Control and Prevention, CDC or otherwise CDC's NHSN.

Further, your LTCH is required to submit and LTCH CARE Data Set, admission, discharge which can be unplanned or planned and an expired assessments for all patients irrespective of their pressure ulcer status or their influenza vaccinations status to CMS. Please refer to the LTCH quality reporting program manual version 2.0 available for download. Check the site for details on submission of the CAUTI, CLABSI, and Influenza Vaccination Coverage Among Healthcare Personnel data and check your survey for details on submission of the Pressure Ulcer data and Percent of Residents or Patients Who were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay), NQF 0680 data.

Starting in calendar year 2015, this information will also apply to NHSN Facility-wide Inpatient Hospital Onset MRSA Bacteremia Outcome measure NQF 1716. And NHSN Facility-wide Inpatient Hospital Onset CDI or C. diff Outcome measure, NQF 1717. Please refer to the LTCH quality reporting program manual version 2.0 for further information about these two measures.

Number 14, what do we do if a pressure ulcer worsens during the first three days of the patient's admission to the LTCH? How do we code the wound? The patient's skin condition reflected on the admission assessment data set should match the patient's admission assessment for the purposes of determining whether a pressure ulcer was present on admission or POA. A wound determined to be POA would specifically need to be on admission. Thus, if a POA wound worsened during the first three days, the admission assessment record should capture the wound stage at admission based on the admission skin assessment close to the actual time, closest to the actual time of the admission as possible. See Chapter 3 section M of the LTCH quality reporting program version 2.0.

Number 15, on day two of the three-day assessment period, a pressure ulcer was assessed as unstageable. On day five, the wound was debrided and assessed and as a stage three. On day 24, the day of discharge, the wound was assessed as a stage four. How would this scenario be coded on the admission and the discharge assessment?

On the admission assessment, the pressure ulcer would be coded as unstageable and present on admission. On the discharge assessment, it would be coded as stage four worsened not present on assessment. This is because the first time the pressure ulcer was able to be numerically staged after debridement, it was staged as a stage three then it subsequently increased in numerical staging or worsened to be a stage four prior to discharge. You can see Chapter 3 section M of the LTCH quality reporting program manual version 2.0.

Number 16, we entered in admission assessment on a patient who went to another facility for five days. The patient had zero wounds when he left us. The patient was not discharged from our facility. He was on bed-hold. Upon

return from the other facility, he had two significant pressure ulcers that remained until discharge. How do we report wounds at discharge that were not caused by our facility that will appear to be?

In this scenario you outlined, if a patient returns to the LTCH after more than three calendar days at another hospital facility or location, a planned or unplanned discharge assessment should be completed depending on the circumstances surrounding the patient's discharge in addition to an admission assessment. Further, when the patient returned to the LTCH after stay of three calendar days at another hospital facility or location, a new admission assessment should be completed.

For the purpose of the LTCH quality reporting program, this admission would be considered a new admission and the date for this admission for the LTCH should be used as admission date. For this patient, you will also complete a planned or unplanned discharge assessment depending on the circumstances surrounding the patient's discharge. Please consult the LTCH quality reporting program manual version 2.0 available for download.

At this time, I'm going to return this back over to Charles Padgett.

Charles Padgett: OK. Thank you Lori. So, I think we're going to stop there so that providers have a chance to ask questions that they have. And I just want to say that there are about nine or 10 more questions here. Again, this is the frequently asked questions document. It's available on the main LTCH quality reporting program Web site. And you can easily get to that just by Googling CMS LTCH quality reporting. It's usually the first or the second hit that comes up or you can simply go to www.cms.gov – OK, I'll go over that shortly.

So at this time, I think we're going to turn it over to Jill and the operator will go over instructions for submission of questions.

Jill Darling: Yes. Thank you Charles. And we'll go right into our Q&A session now please.

Operator: As I remind ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would

like to withdraw question, please press the pound sign. Please limit your questions to one question and one follow up to allow other participant's time for question. If you require any further follow up, you may press star 1 again to rejoin the queue.

Our first question comes from the line of (Meredith Disharoon) from Shepherd Center. Your line is open.

(Meredith Disharoon): Hi. So, I think we have a question about (inaudible) minute, it was kind of addressed a little bit before but, if somebody is here just as a 24-hour observation patient, do we have to submit an admission assessment and a discharge assessment on them.

Charles Padgett: So there – an observation patient at your LTCH?

(Meredith Disharoon): Yes. We're little bit – we're kind of unconventional LTCH. We're actually – we have facility for spinal cord injury and brain injury patients but we have a unit that the surgery – we're not – we don't do surgery but we do wound care basically after surgery. On some days we'll get – sometimes, we'll get people just for observation. I don't really understand the medical reason for it, but we do occasionally have people like that.

Charles Padgett: Yes. I mean, you know what, I'm just going to ask that you submit that kind of (inaudible) scenarios specifically to the LTCH quality questions mailbox so I can respond to you with a more comprehensive answer. Just – I never understood that there were any observations stays with LTCHs. So I'll need to look into that. And it may be that the model you're using and (inaudible) is different because of the type of the patient that you can take care of. But, if could just submit that to us at the LTCH quality questions mailbox, we'll be happy to get back to you and certainly willing to share that answer also with both in the next FAQ.

(Meredith Disharoon): Can I do a follow up, but a different line?

Charles Padgett: Sure.

(Meredith Disharoon): On a different track, is there any concept in the future to include a reporting section in the LASER software? It's really hard for us to kind of keep track of patients on data in what we've submitted and have it without being able to look at it in the – as a report inside LASER program.

Charles Padgett: To keep track of what it is, do you submit it to CMS?

(Meredith Disharoon): Not yet. So we have about 1,700 records that we submit between 1,700 and 2,000 records that we submit every year to you all and just that amount of record that's hard for us to keep track of knowing how many patients we've had in making sure everything is – has been done correctly. Because we have to look at it in LASER on a record by record base as we can, ever look at it and kind of a report format, but where we can look at summary level detail.

Charles Padgett: Yes. So have you ever access the CASPER reports?

(Meredith Disharoon): The CASPER reports don't give you that kind of information either. It's all – we just got our first version of summary level detail back and it was the official report that came back.

Charles Padgett: Yes.

(Meredith Disharoon): But it's three ...

Charles Padgett: OK. So I will say this. I mean, I don't ever think that that's going to particularly be a functionality of LASER. However, we are working to design and offer a greater number of reports that are available to providers related to the LTCH quality reporting program. So, they are in development as we speak and we're working with our, you know, the kinds (inaudible) to create those reports and make those reports available to providers. So – and those reports will, you know, are on many different topics and will allow you to kind – gain a greater understanding at a much greater level of detail sort of thing. But, there will be CASPER reports, and while they may not be available right now, we are certainly are moving towards that. It just won't be a functionality of the LASER software. So, that you will be able to look at

what you submitted and who you submitted on in many different ways in the future.

(Meredith Disharoon): Thanks.

Operator: Our next question comes from the line of Karen Finerty from RML Specialty Hospital. Your line is open.

Karen Finerty: Hi. Thank you so much, first of all, for doing this open door forum. It's always a great learning opportunity for us. And my question is regarding the July 1st start of the LTCH CARE Data Set version 2.01. My understanding is that at this time, I'm reading your site and hearing you correctly Charles. You're saying that we do not have to submit the influenza vaccination data for our patients until October 1st. But yet, we're to begin using the CARE Data Set 2.0 as of July 1st, is that correct?

Charles Padgett: That's correct.

Karen Finerty: Is there any other difference in the CARE Data Set between version 1.0 and 2.0 other than section O with the flu?

Charles Padgett: So, there are some differences. Of course, the patient influenza items that we've added to that. But there are also some questions surrounding interrupted stays, the number of interrupted stays that a particular patient has had. And then we allow you to give the dates of those – of the three most recent ...

Karen Finerty: Got you.

Charles Padgett: ... up to three of those stays.

Karen Finerty: Got you.

Charles Padgett: And that is in response to provider requests to be able to provide that sort of information to CMS so they can truly see, you know, how often these stays occur and so forth. But these are the two biggest differences. There are some other small changes that we've made to the data set. But those are the two major differences.

Karen Finerty: OK. And then ...

Charles Padgett: Yes. So, it will be a very familiar data set to you, you know. And then once October comes around, you will begin reporting on the section O items.

Karen Finerty: So, my follow up question then is from July 1st to October 1st, do we leave that section O with that flu questions are blank or how do we handle that?

Charles Padgett: So, what'll I ask you to do is you can refer to Appendix (D) which will cover what's required versus what's voluntary. And also the submissions – the data submission specifications is going to be your best source for understanding which item – if you're not answering it, what kind of default code needs to be entered there whether it's a dash, whether it's ... does whether–

Karen Finerty: Yes. (Top or) whatever.

Charles Padgett: Yes. So, I wouldn't want to go over them one by one here. I just don't have them in front of me. So ...

Karen Finerty: OK. When we come back then. Thanks.

Charles Padgett: ... will be your best bet for determining how to respond if your outside the days that are required for responding.

Karen Finerty: OK. All right. Thank you very much.

Charles Padgett: You're quite welcome.

Operator: Our next question comes from the line of (Randall Bilberry) from Lake Taylor Hospital. Your line is open.

Female: Hi I was reading over the new changes in the A2510 where the interruptions and you have to document how many interruptions the person had in their stay. How far do we go back, say someone who've been here for 10 years, do we just go back in the past year?

Female: It's possible.

Charles Padgett: Yes. You know what? I don't know the answer to that right off the bat.

Female: I don't even know if we have the information, you know, I mean, we have it, but (inaudible).

Charles Padgett: Yes, yes, yes. I understood. You know, so that – so this is a patient whose one stay has – I mean, they've been in your facility for 10 years.

Female: We have set – we have many that have been here ...

Charles Padgett: Yes.

Female: ... for a little while. So, then I don't know how to answer that question. Do we just go back to when this was implemented or do we ...

(Inaudible)

Charles Padgett: Yes. So, what I would do is just have you –if you could just submit that question to us to the LTCH quality question mailbox.

Female: OK.

Charles Padgett: And let me just find the answer to that. And I certainly will respond to you and also share it with other LTCH providers by our next Special Open Door Forum in June.

Female: OK. Quality question. All right. Thank you.

Female: Thank you.

Charles Padgett: Thank you. We like those questions.

Operator: Our next question comes from the line of Stacey Williams from Spartanburg Hospital. Your line is open.

Stacey Williams: Yes. My question is related to planned discharge versus an unplanned discharge. If just say in a scenario, we have a patient that is – went out for planned procedure. He was the planned surgery to an acute care hospital. And in the progress note to the patient's chart, it says that he will probably

stay out five to seven days and then return. Do we submit an unplanned because it is a planned procedure but he's going to be gone over the three-day or do we complete a plan because we know we've going and we hope that he's coming back?

Charles Padgett: Well, since in this case, you are – you know that this patient is going to be gone more than three calendar days. I would submit that that's a planned discharge. The situation we would want you to submit an unplanned discharge was it if you were sending a particular patient to an acute care hospital for a procedure, say they were getting an MRI or they were having sutures removed or something that you expected them back inside that three calendar-day timeframe, but they did not come back inside that three calendar-day time limit. It took longer than you expected. You expected them back, but they've gone past to three calendar days now. Because you expected them back initially inside the three days, you would still have an unplanned discharge.

Stacey Williams: OK.

Charles Padgett: Does that makes sense?

Stacey Williams: It does. So, if we know for sure documented in the patient's record that they are going for a planned procedure and if they will stay in that acute care facility a few days post op and they will return back to us hopefully, you know, once everything is stabilized then we would do a planned because we know that's what's going to happen.

Charles Padgett: Exactly

Stacey Williams: Even though they (do look) for that three calendar-day?

Charles Padgett: Exactly.

Stacey Williams: OK. Thank you.

Charles Padgett: You're welcome.

Operator: As a reminder, if you would like to ask a question, please press star then the number one on your telephone keypad.

There are no further questions.

I apologize. Our next question does come from (Clementine Johnson) from Specialty Hospital. Your line is open.

(Clementine Johnson): Yes. I have a question about your LASER under your MO 700 question where it says (one) of the best description of (most) severe tissue type in any (problem) of (all civilians). Is this really gives us a (true) description for suspected deep tissue injury? Then if you right now (assess) a new information, you do have the information but it's not really a clear description for suspected deep tissue injury.

Charles Padgett: (Terry Mota), are you on, can you speak to this?

(Terry Mota): Hi. Yes, I'm here. So, can you repeat the question that has to do with MO 700 you're saying?

(Clementine Johnson): Right. It says that – so that's your best description for your most severe tissue type present in the (womb area). Well, the suspected deep tissue injury there is not always a break in the skin, but it's obvious that it's suspected deep tissue injury because it's purple, it's dark, and for me to learn (these four) descriptions, gives us the accurate description of suspected deep tissue injury. If you put not (accessible) information, that's not (proves) us we're looking at it and you have an information.

(Terry Mota): Right, so for ...

(Clementine Johnson): It should be another answer and (inaudible).

(Terry Mota): So, for that particular item, you would just enter a dash.

(Clementine Johnson): OK. Usually, when you enter a dash, you get in trouble.

(Terry Mota): OK. I don't think for this one, you'd get in trouble for this.

Charles Padgett: Yes. You will not get in trouble.

(Terry Mota): There's no appropriate answer there. So, if you're looking at suspected deep tissue injury, it would be a dash.

(Clementine Johnson): OK. All right. Thank you.

(Terry Mota): You're welcome.

Charles Padgett: Thank you (Terry).

Operator: There are no further questions in queue at this time. I do turn the call back over to Mr. Darling.

Jill Darling: Well, thank you everyone for joining today's Special Open Door Forum. And I'll give it over to Charles for some closing remarks.

Charles Padgett: Yes, I agree. I really appreciate that everybody's attendance, and all of your great questions. I really want to encourage you to review the LTCH QR program manual that's posted on the Web site now, version 2.0, as well as the data submission specifications and the training material -- today's PowerPoint and the frequently asked questions. And submit any questions you have about these materials or any other questions you have about the upcoming release of the LTCH CARE Data Sets. Really important to us, we want to make sure we're getting your questions answered and that you feel comfortable with the material.

And what we'll do is compile, you know, a list of these questions, you know. And base our presentation somewhat on the questions that we've received as well as include some of those questions and a release of the FAQ document at the -- after that, the June 12 Special Open Door Forum. So, I really appreciate it if you'd do that. And as I said, you can continue to check the LTCH Quality Reporting Program web page. For more information on the June 12 Special Open Door Forum, we'll be posting time and calling number for that here in the near future. And we look forward to seeing you there also.

Jill Darling: All right. Thank you everyone, have a wonderful day.

Operator: This concludes today's conference call, you may now disconnect.

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