LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM
PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON DECEMBER 6 AND 7, 2017

Current as of January 2018

#	Question Category	Question	Proposed Response
1	Section A - Administrative Info	During the training, it was mentioned that the dash should be used only as appropriate, that dash use is expected to be a rare occurrence, and that overuse of the dash may result in a 2% payment penalty. How is "rare" quantified in this instance; what threshold must be reached before the 2% penalty would be applied?	The Centers for Medicare & Medicaid Services (CMS) is aware that there are circumstances in which long-term care hospitals (LTCHs) may not be able to complete every item on the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set assessment (e.g., for patients admitted to and discharged from the LTCH on the same day). For the purposes of the LTCH Quality Reporting Program (QRP), the 2% annual payment update (APU) penalty is related to the completeness of data submission for the quality measures. LTCHs must meet or exceed two separate data completeness thresholds: one threshold set at 80% for completion of quality measures data collected using the LTCH CARE Data Set submitted through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system and a second threshold set at 100% for quality measures data collected and submitted using the Centers for Disease Control and Prevention National Healthcare Safety Network. Specifically, CMS assesses the completeness of submitted data by verifying that for all LTCH CARE Data Set Assessments submitted by any given LTCH in a given calendar year, at least 80% of those LTCH CARE Data Set Assessments must have 100% of the mandatory items completed, where "completed" is defined as having provided actual patient data as opposed to a noninformative response, such as a dash (–), which indicates the LTCH was unable to provide patient data. For more information on verifying data submissions to CMS and data completion thresholds, we refer you to the LTCH QRP Quick Reference Guide available for download on the LTCH Quality Reporting Data Submission Deadlines website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Data-Submission-Deadlines.html

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2	Section A - Administrative Info	If a discharge to a skilled nursing unit or nursing home was intended to be the final discharge destination and the patient returns within 3 days, is this considered a program interruption or two separate stays?	If the intended (planned) discharge destination for this patient was to a skilled nursing facility or nursing home and the patient returned to the LTCH within 3 days of discharge, this would be considered a discharge. In this case, 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.
3	Section A - Administrative Info	What is the rationale for transitioning to the new Medicare Beneficiary Identifier (MBI) if the Social Security Number (SSN) is still required in A0600A? How is the SSN used, and what is the implication for leaving it blank?	The primary reason that SSNs will be removed from Medicare cards is to protect Medicare beneficiaries from identity theft by reducing the accessibility and exposure of a patient's SSN. The SSN item, A0600A, remains an important tool for matching patient records in the QIES ASAP system. This item should be completed unless the patient does not have a SSN. If the patient does not have a SSN or the SSN is unavailable, the item may be left blank. A gradual transition from use of the SSN-based Health Insurance Claim Number (HICN) to use of the new MBI number is intended to allow patients adequate time to receive their new Medicare card. Medicare cards with the new MBI number will be mailed to patients beginning in April of 2018. Between April 1, 2018, and December 31, 2019, it is acceptable to enter the patient's HICN or the patient's new MBI. After December 13, 2019, providers should enter the patient's MBI and not report the patient's SSN-based HICN.

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4	Section A - Administrative Info	How should a provider complete item A0600B, Medicare number, if the patient is not a Medicare beneficiary? How will MBI impact patients who are not Medicare beneficiaries? Should the patient's SSN be recorded if they have commercial insurance?	If the person is not a Medicare beneficiary and thus does not have a Medicare number or comparable railroad insurance number, this item should be left blank. Information about MBI for patients who are not on Medicare can be found on the following CMS website: https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Other-payers.html. The SSN should be completed for patients who do not have Medicare or Medicaid benefits. To avoid inaccuracies in patient record matching, item A0600 should only be left blank if the patient does not have a SSN or in rare instances when the SSN is unavailable. If the patient does not have a SSN or the SSN is unavailable, the item may be left blank.
5	Section A - Administrative Info	Sometimes item A1000, Race/Ethnicity, is left blank because patients identify as mixed race. It would be helpful to have a mixed-race option.	The race/ethnicity codes in item A1000 use the common uniform language approved by the Office of Management and Budget (OMB) to report racial and ethnic categories. The guidance provided in Chapter 3, Section A of the LTCH QRP Manual explains that in coding this section, the provider should ask the patient to select the category or categories that most closely correspond to his or her race/ethnicity from the list in item A1000. You can also offer the option of selecting one or more racial designations. If the patient chooses not to provide an answer, it is allowable to use a dash (–) for this item.
6	Section A - Administrative Info	Why is "Single" not listed as a response option for item A1200. Marital Status?	The categories for this item are designed to be mutually exclusive; in other words, we don't want a person in one group to also be categorized in another group. Please choose the answer that best describes the current marital status of the patient for item A1200. For example, if a patient has never been married and is currently single, code 1, Never married. Alternatively, if a patient was divorced and is currently single, code 5, Divorced.

#	Question Category	Question	Proposed Response
7	Sections B, C, H, J, O - Influenza	Please explain further why in Coding Scenario 1 Mr. T would not be coded as "usually understands" when the staff reports that they use simplified communication so that he does usually understand communications.	The training scenario presented was: • Mr. T sustained an acquired brain injury and is on an invasive mechanical ventilator. Mr. T uses an electronic communication device to respond to staff and family questions. • Staff members report that he only understands basic conversations. The staff need to simplify all communication for him to understand what is being asked. • The family reports that simple and short messages are necessary during their conversation to elicit accurate responses. In this scenario, the correct code for item BB0800. Understanding Verbal and Non-Verbal Content, is code 2, Sometimes Understands. The rationale is that the patient understands only basic conversations or simple, direct phrases. In contrast, code 3, Usually Understands, is used if the patient usually understands most conversations, including complex content, but misses some part/intent of the message or requires cues at times to understand.
8	Sections B, C, H, J, O - Influenza	On an unplanned discharge, please describe how to code C1610 A, B, C, and D for a patient who is unconscious or in a coma.	If the patient was in a coma or unconscious at the time of admission and remained unconscious or in a coma at the time of the Unplanned Discharge Assessment, then code: C1610A. Acute Onset = 0, No C1610B. Fluctuating Course = 0, No C1610C. Inattention = 0, No C1610D. Disorganized Thinking = 0, No C1610E. Altered Level of Consciousness C1610E1 = 0, No C1610E2 = 1, Yes
9	Sections B, C, H, J, O - Influenza	For the Confusion Assessment Method (CAM), how is a day defined? Does it include a 24-hour day?	Correct, a day is considered a 24-hour day.

#	Question Category	Question	Proposed Response
10	Section GG - Functional Abilities & Goals	What defines “poor quality” as it relates to the activities included in GG0130/GG0170? For instance, if a patient can feed her/himself without assistance but food drops on their face or clothes, how would GG0130A be coded? Are there other examples you could provide to clarify what is meant by “poor quality”?	When coding Section GG items, GG0130 Self-Care and GG0170 Mobility, use clinical judgment to determine if a patient’s performance for an activity is considered to be of poor quality and that helper assistance is required. Determine the amount of helper assistance needed based on patient safety and completion of the intended activity. If the quality of the patient’s performance is considered poor due to safety considerations or inadequate based upon the intent of the activity, then code the item based on the assistance provided by the helper for the patient to safely and adequately complete the activity. For example, a patient’s performance while eating may be affected by hand tremors and food drops from the eating utensil rather than being placed into his/her mouth. In this scenario, the helper may provide steadying assistance to help the patient to complete the activity of eating, and the code would reflect the type and amount of assistance provided by the helper.
11	Section GG - Functional Abilities & Goals	GG0100B. Indoor Mobility (Ambulation): In the past, we have coded this item based on walking only. This item does not appear to include wheelchair mobility, because ambulation refers to walking. Is that correct?	You are correct that item GG0100B only pertains to Indoor Mobility (Ambulation) and does not consider mobility via wheelchair, whereas specified GG0170 mobility items do include either ambulation or wheelchair mobility.
12	Section GG - Functional Abilities & Goals	If the patient did not walk prior to the illness and the patient was pushed in a wheelchair, should 9 be reported for GG0100? or 1, Dependent?	For the scenario you describe, GG0100B. Prior Functioning: Everyday Activities – Indoor Mobility (Ambulation) is coded 9, Not Applicable, because the patient did not ambulate prior to the current illness, exacerbation, or injury.

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13	Section GG - Functional Abilities & Goals	We do not understand fully why an LTCH is not expected to use code "10."	Code 10, Not attempted due to environmental limitations, is used if the patient did not attempt an activity due to environmental limitations. Examples include lack of equipment, weather constraints. The newly added code 10, Not attempted due to environmental limitations, may be used in an LTCH setting and is expected to be used infrequently. Because this is a standardized cross-setting measure, we have included all Section GG items that appear on the 2018 PAC QRP assessment instruments. Code 10 may be used for items on other PAC QRP assessment instruments (e.g., on Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) car transfer or walking 10 feet on uneven surfaces items).
14	Section I - Active Diagnosis	In Section I, item I0050, can we just select code 5, Other Medical Condition, and enter the ICD-10 code even if it is Acute Onset and Chronic Respiratory Conditions (I0050 = 3).	You would only use code 5, Other Medical Condition, if the patient's primary medical condition category is not one of the four categories included on the LTCH CARE Data Set (1, Acute Onset Respiratory Condition; 2, Chronic Respiratory Condition; 3, Acute Onset and Chronic Respiratory Condition; 4, Chronic Cardiac Condition).
15	Section M - Skin Conditions	Most of our patients come from our acute care hospital. We have an electronic medical record (EMR) in which we have the ability to look into the acute care hospital medical record for such things as pressure injuries. If a pressure injury is documented in the acute care hospital medical record (and is being managed by wound care), can this documentation be used when assessing pressure injuries for Section M?	Yes, you can use documentation from the previous setting to inform about the original stage of a pressure ulcer/injury. You should review the history of each pressure ulcer/injury in the patient's medical record. If the pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage until healed. LTCHs that carefully document and monitor pressure ulcers/injuries will be able to code these items more accurately. The LTCH should continue to conduct a complete skin assessment for effective pressure ulcer/injury prevention and skin treatment. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

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16	Section M - Skin Conditions	Does documentation of the known ulcer under the dressing/device have to be part of the LTCH record or can it be gleaned from a verbal transfer report or pre-admission assessment?	Per the requirements of the LTCH QRP, "known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device. The presence of the pressure ulcer/injury should be documented somewhere in the medical record. This documentation could have been part of the pre-admission assessment or documented in the medical record from a verbal report from the previous setting.
17	Section M - Skin Conditions	A patient is admitted to the LTCH with a non-removable cast on an extremity, and the skin cannot be assessed under it. When the cast is removed 2 weeks later, there are pressure-related areas under the cast. Are these areas documented as not present on admission? Please explain how this information would be classified on the Admission and Discharge Assessments.	For the LTCH CARE Data Set Version 4.00, known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. "Known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device. Review the patient's medical record for documentation that a pressure ulcer/injury exists under the dressing/device. Do not assume that a pressure ulcer/injury exists under the dressing/device. If there is no record of a pressure ulcer/injury in the patient's medical record at the time of admission, and if a clinician later removes a dressing/device and a pressure ulcer/injury is identified upon removal of the dressing/device, that ulcer/injury is coded in Section M at the appropriate stage on the Discharge Assessment if the ulcer/injury is still present at discharge. In the example presented, since there is no documentation of a pressure ulcer/injury at the time of admission, and a pressure ulcer/injury is observed when the non-removeable cast is removed, and the ulcer remains until discharge without worsening, the pressure ulcer would be considered new for the LTCH stay. The clinician would then code the pressure ulcer/injury at the appropriate stage on the Discharge Assessment, and it would not be considered present on admission.

#	Question Category	Question	Proposed Response
18	Section M - Skin Conditions	Are pressure ulcers/injuries coded as new wounds if the pressure ulcers/injuries are found after removal of a non-removeable dressing/device and were present on admission, but weren't known to exist at the time of admission?	If there was no documentation of a pressure ulcer/injury under a dressing/device on admission, and there is an ulcer identified after the dressing/device is removed on discharge, it is not considered present on admission. This ulcer/injury, if assessed at discharge, would be coded at the appropriate stage and not present on admission on the Discharge Assessment.
19	Section M - Skin Conditions	We are confused about how to code M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission. The answer is different for different clinical scenarios. The confusion is where it states to determine whether the wound was present upon admission. If the skin status changed during the stay, why is it no longer present on admission?	The intent of this item is to document whether skin status, overall, has worsened since admission. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have increased in numerical stage (i.e., worsened) since the Admission Assessment. Any pressure ulcer/injury identified and coded on the Admission Assessment is assumed to be "present on admission," per the definition of "on admission." The provider is essentially reviewing all documentation of skin assessments performed throughout the patient's LTCH stay (from admission to discharge). The provider would be looking at current pressure ulcers/injuries and what was coded on the Admission Assessment. If the current pressure ulcer was not coded on the Admission Assessment, or has worsened since what was coded on the Admission Assessment, it is not considered present on admission and would not be coded on the discharge assessment for this item as present on admission.

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20	Section M - Skin Conditions	If upon admission a wound assessment was NOT completed within the 3-day period and was coded with a dash/incomplete, and a wound was documented on Day 4, would the discharge present on admission data item be completed with a dash/unknown or not present on admission?	If there is no documentation in the LTCH medical record of a wound assessment at the time of admission, facility policy should be followed regarding missing assessment information. If the wound assessment was not completed within the 3-day assessment period and item M0300B1 was coded with a dash (–) on the LTCH CARE Data Set Admission Assessment, and then on Day 4 a Stage 2 pressure ulcer was identified, you would code the Stage 2 Pressure Ulcer for item M0300B1 as 1 and item M0300B2, "Number of these Stage 2 pressure ulcers that were present upon admission" as a dash (–) on the LTCH CARE Data Set Discharge Assessment. While CMS realizes the use of the dash (–) is sometimes necessary, as in the case that an item was not assessed or that no information is available to complete the item, LTCHs should limit the use of the dash to only those items for which they were unable to obtain assessment data, or for items that were intentionally left unanswered by the LTCH. Please be advised that failure to submit required quality data may result in a 2% reduction in the LTCH's APU.
21	Section M - Skin Conditions	Please clarify "non-removable"—is a wound vacuum-assisted closure (VAC) non-removable if it is not to be removed? Is an order required to validate that a dressing cannot be removed?	A non-removable device refers to a dressing or device that may not be removed from the patient per physician's order such as those used in negative-pressure wound therapy, an orthopedic device, or a cast. A wound VAC could be considered non-removable if it is not to be removed per physician's order. If there is a dressing or device with an order not to remove it until a time outside of the 3-day assessment period, this also would be considered a non-removable dressing/device. In the absence of a specific order to not remove a dressing or device, your facility policy should be followed.
22	Section M - Skin Conditions	If a physician refuses to document ulcers as Kennedy ulcers on a dying patient, does the LTCH have to identify these as pressure ulcers?	You should follow your facility's policies and procedures when there is a documentation discrepancy or disagreement between clinicians.

#	Question Category	Question	Proposed Response
23	Section M - Skin Conditions	How will short-stay acute care hospitals (STACHs) be held accountable for worsened wounds admitted from LTCHs if the interruptions are being removed from the LTCH QRP? With this change, LTCHs will be penalized if patients at STACHs are not cared for properly and wounds are worsened within 2 days of returning to the LTCH.	The interrupted stay policy has not been changed for LTCHs. If a patient was discharged from the LTCH and the patient returned to the LTCH in less than 3 calendar days, the patient's return to the LTCH is not considered a new admission and would be considered a program interruption. For coding pressure ulcers/injuries that occurred during a program interruption (i.e., where the patient didn't have the pressure ulcer/injury prior to the program interruption but returned to the LTCH with a new pressure ulcer/injury) you would code the pressure ulcer/injury on the Discharge Assessment when the patient is discharged from the LTCH if the pressure ulcer/injury is still present at discharge (i.e., not healed). For example, if the patient returns to the LTCH from the acute care hospital within 3 calendar days with a Stage 2 pressure ulcer that was not coded when the Admission Assessment was completed, you would code M0300B1 = 1 and M0300B2 = 0 on the Discharge Assessment if the Stage 2 pressure injury is still present when the patient is discharged from the LTCH.
24	Section M - Skin Conditions	Are there any plans to capture pressure ulcers that develop after admission but heal before discharge? The current/new measure does not fully reflect the care given patients by missing these.	Currently if a pressure ulcer/injury develops after admission and heals prior to discharge, this wound would not be captured in the LTCH CARE Data Set.
25	Section M - Skin Conditions	Please consider including "hemodialysis" as a risk adjustment covariate for new or worsened pressure ulcer rate.	CMS welcomes the opportunity to improve upon all of our measures and appreciates this feedback. We will take your suggestion into consideration.

#	Question Category	Question	Proposed Response
26	Section N - Medication	Is there an estimated time for reviewing the medical record to locate proof of follow-up on prescribed/recommended actions by the next calendar day for the patient's entire stay? Our LTCH patient stays are at least a month or longer. The provided list of potential clinically significant issues and clinician communication methods are varied. This may present a challenge for capturing on electronic health record (EHR) metric reports, and some facilities may require a manual review of each patient's record.	Each facility has varying census, complexity of patients, length of stays, and methods for tracking the drug regimen review (DRR) data. As such, it is not possible to state the specific time required to collect data for item N2005. Each facility will determine the method for capturing all data necessary to support coding of the DRR items. LTCH CARE Data Set data should be consistent with data reported in the patient's medical record. In preparation for implementing data collection processes, LTCHs may want to develop specific action plans. Issues that providers may want to consider include: 1. Determining the appropriate healthcare personnel, consistent with facility and State standards, regarding who will collect and enter DRR data/documentation into the medical record. 2. Identifying staff who need to be included in training on the measure items. 3. Developing processes and protocols used for tracking clinical data collection, tracking documentation, and coding DRR items. 4. Identifying where the DRR data will be located to facilitate comprehensive use and support of DRR clinical coding accuracy. Some providers have discussed various methods they intend to use to record, track, and apply relevant data to code the DRR items. Some providers plan to use software programs to track and use the DRR data, while others plan to integrate the data elements into their existing EHR system.

#	Question Category	Question	Proposed Response
27	Section N - Medication	Is there specific documentation that is required/expected to be located within the medical record verifying that the DRR activities were completed? Or can it be assumed that the DRR was done when N2001 is coded as 0, indicating that no problems were found?	Clinical documentation in the medical record is used to support clinical assessment coding. LTCH CARE Data Set data should be consistent with data reported in the patient's medical record. Data in the medical record can be documented by appropriate healthcare personnel, consistent with facility and State standards.
28	Section N - Medication	How do we code orders given prior to urgent/emergent transfer to the STACH if the clinical condition requires discharge prior to medication orders being carried out?	If the patient was discharged before the DRR Admission Assessment items were completed, then N2001 and N2003 are coded with a dash (–). A dash value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.
29	Section N - Medication	How would the DRR data items be coded if a physician receives a patient's blood culture results and orders antibiotics, but the patient is discharged (before midnight of the next calendar day) for sepsis before antibiotics are administered? Does an order change to address an issue count toward timely follow-up of an issue or does the intervention need to be in MD notes as well?	In this scenario, the LTCH provider conducted the DRR and identified a potential clinically significant medication issue and the patient was discharged before the physician follow-up recommended actions could be implemented. The clinician communication to the LTCH physician (or physician-designee), should take place as soon as possible, even if the patient was urgently discharged. The LTCH clinician should then complete the LTCH physician's recommended actions by midnight of the next calendar day (e.g., this may include communications with the next facility receiving the patient). Clinical documentation in the medical record is used to support clinical assessment coding. LTCH CARE Data Set data should be consistent with data reported in the patient's medical record. Data in the medical record can be documented by appropriate healthcare personnel, consistent with the facility and State standards.

#	Question Category	Question	Proposed Response
30	Section N - Medication	How would N2003 and N2005 be answered if the LTCH cannot follow up on a potential or clinically significant medication issue due to patient refusal?	If the patient refuses to take a prescribed medication, and it is determined that not taking the medication presents a clinically significant medication issue, the clinician should contact the physician (or physician-designee). The clinician should follow the facility's medication policy and procedure when a patient refuses a medication and follow the physician (or physician-designee's) recommendations for resolving the issue. If the actions and procedures recommended by the physician (or physician-designee) were followed by midnight of the next calendar day, and no other clinically significant medication issues were identified, then the items N2003 or N2005 would be coded as 1, Yes.
31	Section N - Medication	Is it required that the two-way communication from clinician to physician and back again be documented? Or is it just recommended for the provider to code Section N without recording evidence of these communications in the medical record?	Clinical documentation in the medical record is used to support clinical assessment coding. LTCH CARE Data Set data should be consistent with data reported in the patient's medical record. Data in the medical record can be documented by appropriate healthcare personnel, consistent with the facility and State standards. Determine if your LTCH's policies and procedures include documenting the communication between the clinician and physician.

#	Question Category	Question	Proposed Response
32	Section N - Medication	If the nurse takes a verbal order from a physician regarding patient medication and the EMR System identifies a significant drug interaction between the ordered medication and medication the patient is currently taking, would verbally informing the physician about the issue be enough to support the requirements of the DRR measure? Do we need additional documentation in the patient's EMR? There is frequent, daily communication between the physicians and LTCH staff regarding patients.	In this scenario N2001 would be coded as 1, issues found during review, and you would proceed to N2003, Medication Follow-up. N2003 would be coded as 1, Yes if you contacted the physician (or physician-designee) by midnight of the next calendar day AND completed prescribed/recommended actions in response to this actual clinically significant medication issue. Verbally informing the physician of the issue is only one component in support of the requirements of the DRR measure. The other component is receiving physician orders for AND completing the prescribed/recommended actions in response to this actual clinically significant medication issue by midnight of the next calendar day. Clinical documentation in the medical record is used to support coding of data elements. LTCH CARE Data Set data should be consistent with data reported in the patient's medical record. Data in the medical record can be documented by appropriate healthcare personnel, consistent with the facility and State standards. Some providers have discussed various methods they intend to use to record, track, and apply data to code the DRR items. Some providers plan to use software programs to track and use the drug regimen review data, while others plan to integrate the data elements into their existing EHR system. You should follow your LTCH's policy for what is required documentation in your EMR.
33	Section N - Medication	Regarding Practice Coding Scenario #1: Why is a registered nurse determining that there are no identified potential or actual clinical significant medication issues?	Please refer to facility, Federal, and State policies and procedures to determine which LTCH staff members may complete the DRR items at your facility.

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34	Section N - Medication	Does the "clinician" referred to in Section N need to have any particular qualifications?	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 staff members may complete a DRR. Each facility delivers patient care according to their unique characteristics and standards (e.g., patient population). Each facility determines their policies and procedures for completing the assessments.
35	Section N - Medication	Can you please define a "physician-designee" per CMS guidelines? Would a physician assistant or nurse practitioner be considered a physician-designee?	Please refer to Federal and State licensure regulations to determine which clinicians are licensed to act as a physician-designee.
36	Section N - Medication	Based on the definition of "potential or actual clinically significant medication issue" in Section N, if the clinician believes there needs to be follow-up on a medication issue before midnight of the following calendar day, is the issue automatically considered clinically significant?	If a medication issue (in the clinician's professional judgment) warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (or before), then this medication issue would be considered a clinically significant medication issue and coded as such in the DRR data elements.
37	Section N - Medication	If N2003 is coded 0, No, indicating the required follow-up did not take place for the potential clinically significant issue(s) identified at admission, in accordance with the DRR measure requirements, then the DRR item N2005 that includes admission and throughout the patient stay, must also be coded 0, No. Is there a way for a hospital to "recover" on the patient's drug review during the stay to be able to answer "yes" for N2005?	No, even if only one of multiple potential clinically significant medication issues at admission was not followed up by midnight of the next calendar day, the facility must code N2003 (admission) as 0, No and N2005 (admission through discharge) as 0, No. The rationale for coding N2005 as 0 at discharge is that follow-up for all identified potential or actual clinically significant medication issues was not completed by midnight of the next calendar day.
38	Section O - Special Treatments	If a patient was coded as non-weaning at admission (i.e., O0150A = 2), improved unexpectedly, and is fully liberated at discharge, then do you code item O0200A with 1, Fully liberated at discharge or 9, NA since this patient was excluded from the denominator?	If the patient was non-weaning on admission (O0150A = 2) then the patient would be coded 9, NA for item O0200A and is excluded from the denominator even though they improved unexpectedly and were fully liberated at discharge. Patients identified as non-weaning on admission are excluded from both measures.

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39	Section O - Special Treatments	How are patients included/excluded in the measure denominator if they are transferred to an intensive care unit for sepsis before they are ready or even weaned at all?	Patients are only excluded from the denominator if they were not on invasive mechanical ventilation support at admission (O0150A = 0) or were on invasive mechanical ventilation support and identified as non-weaning (O0150A = 2). Otherwise, all LTCH stays of patients for whom weaning attempts were expected or anticipated at admission (O0150A = 1) are included in the denominator.
40	Section O - Special Treatments	If the patient is deemed medically unready for the spontaneous breathing trial (SBT) by Day 2 of the stay, does the necessary documentation also need to be in the patient's medical record by Day 2 of the patient's stay?	Yes, the necessary documentation is needed by Day 2 of the LTCH stay. The purpose of item O0150D (Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by Day 2 of the LTCH stay?) is to identify whether the reason(s) that the patient is deemed medically unready for SBT by Day 2 of the LTCH stay is documented by the LTCH by the end of Day 2 of the LTCH stay. The specific reason(s) are not required in the assessment. Item O0150D also captures documentation in the medical record indicating explicit physician, registered nurse (RN), or respiratory therapist (RT) documentation of the reason that a patient was not deemed medically ready for SBT by Day 2 of the LTCH stay. All items within O0150 should be completed by Day 2 of the LTCH stay.
41	Section O - Special Treatments	If a patient received an influenza vaccination in September while in an acute care hospital and was admitted to the LTCH in October, how is O0250C coded, since the vaccine was received outside of the LTCH facility and not during the immunization vaccination period?	The influenza vaccination season is defined as beginning October 1 of the current year or when the influenza vaccine becomes available, whichever comes first. For item O0250C, code 2, Received outside of this facility, as the patient was assessed for receiving the influenza vaccination during the current influenza vaccination season, the vaccine was available, and the patient received the influenza vaccine outside the LTCH facility.
42	Section O - Special Treatments	What are the SBT criteria or assessment of readiness for SBT?	The SBT criteria or assessment of readiness for SBT is determined by the patient's physician and facility weaning protocols.

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43	Section O - Special Treatments	If a patient requires intubation after the first 48 hours of their stay but is completely weaned by discharge, how do we enter those data to CMS?	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.
44	Section O - Special Treatments	If a patient elects to be terminally weaned from a ventilator but they survive beyond 48 hours, does this count as a successful vent wean?	A patient is considered successfully liberated if they were fully liberated and alive at discharge. In this scenario, if the patient elected to be terminally weaned and was alive at discharge and fully liberated for 2 consecutive calendar days prior to the day of discharge, this would be counted as successfully weaning from the ventilator. If the patient expires prior to discharge, then the LTCH CARE Data Set Expired Assessment should be completed. The patient's stay is excluded from the measure calculation as the ventilator weaning items are not included on the Expired Assessment.
45	Section O - Special Treatments	It was stated that the ventilator liberation quality measures are calculated based on rolling 12 months. Does this mean these are calculated based on rolling 4 quarters?	The measures are calculated quarterly using a rolling 12 months of data.
46	Section O - Special Treatments	Does the 2 days prior to discharge for weaning include the discharge date or is it the 2 calendar days prior to the calendar date of discharge?	It is 2 consecutive days prior to the calendar date of discharge. This aligns with the assessment period for the Planned and Unplanned Discharge Assessments.
47	Section O - Special Treatments	Is it correct that 2 calendar days prior to the date of discharge does not mean 48 hours?	Correct, 2 consecutive calendar days does not mean 48 hours. For example, if a patient was liberated from the ventilator any time on Wednesday and discharged any time on Friday, then this would qualify as at least 2 consecutive calendar days (Wednesday–Thursday) prior to the date of discharge.

#	Question Category	Question	Proposed Response
48	Section O - Special Treatments	Does the day of discharge count as the second calendar day?	No, it is 2 consecutive calendar days plus the date of discharge.
49	Section O - Special Treatments	Are patients who are placed on invasive mechanical ventilation after admission to the LTCH excluded from the ventilator liberation quality measures?	Yes, patients who are placed on mechanical ventilation after admission to the LTCH are excluded from both ventilator liberation measures.
50	Section O - Special Treatments	Why do the majority of the LTCH CARE Data Set data elements focus on a 3-day assessment period following admission while the Compliance for Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay items focus on a 2-day timeframe?	Published results of an international task force about weaning from mechanical ventilation, which included international scientific experts and advisors, recommended that liberation be considered as soon as possible for patients to reduce risk of complications and mortality. After extensive discussion, the ventilator liberation quality measure technical expert panel recommended the 2-day timeframe as the standard of care to increase the practice of assessing and determining a patient's readiness for mechanical ventilation liberation earlier when medically appropriate and as beneficial to the patient.
51	LTCH Public Reporting	When will we be able to run Quality Measure Patient-Level Reports for custom date ranges? Currently we can only get a full year of data at a time, which, given the size of our facility, makes the report 400 pages long.	Thank you for your question and recommendation regarding the Quality Measure Patient-Level Reports. The ability to run these reports on less than a full year of data is not available for the current reports or planned for in the 2018 reports. However, CMS appreciates your input and seeks to make the confidential feedback reports user-friendly and valuable to our providers. We will take your suggestion into consideration as we plan for future report updates.
52	General	IMPACT Act quality measure data points promote interoperability. However, many of the LTCHs are paper-based. Does CMS have any future plans to allow the QIES ASAP system to be queried? It would allow the user to see if the person had the flu vaccine at another location.	Typically, PAC providers obtain flu vaccination and other information at the time of care transitions from the care setting from which the patient is coming. There are no plans at this time to allow the QIES ASAP system to be queried.
53	General	Would it be possible to have a test/sandbox setup so we can see skips, etc.? This way we can, in turn, ask programmers to write in the EMR as such? It's too late at go-live; however, it helps to just play with and show respiratory therapists/certified nurses in advance.	Thanks for the suggestion. We appreciate the input. We will take this into consideration for the future.

#	Question Category	Question	Proposed Response
54	General	Would it be possible to upload the complete presentation with the answers and rationale for each of the coding scenarios presented during the training, as they were not included in the original download on the LTCH QRP website?	CMS plans to post the answers to the coding scenarios presented during the December 2017 LTCH QRP Provider Training presentations in the near future.