ATTENTION Long Term Care Hospitals!
Special Open Door Forum
August 30, 2012
2:00 pm – 3:30pm, EST

Please join CMS for an LTCH Special Open Door Forum during which we will discuss the following:

- **Section M Skin Conditions** – proper coding of this section will be reviewed with opportunity for providers to ask questions
- **FAQs** – CMS will review most frequently asked questions related to the LTCH QR Program
- **Review of important upcoming dates**
- **Division of National Systems** – DNS will make announcements related to the technical submission of the LTCH CARE Data Set.

All LTCH providers and vendors and encouraged to attend this forum. Slides for this open door call will be posted on the CMS Special Open Door Forum Website which can be accessed at:
http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODFSpecialODF.html
Participant Dial in Number: (800)-837-1935
Conference ID Number: 20497757
Note: In order to join the conference call, you will be required to provide the Conference ID Number listed above.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/083012LTCHSODFAudioID20497757.mp3

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Charles Padgett
August 30, 2012
2:00 p.m. ET

Operator: Good afternoon. My name is (Sally) and 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 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, press the pound key. Thank you.

Matthew Brown, you may begin your conference.

Matthew Brown: Thank you, (Sally). Good afternoon and good morning to those joining us on the West Coast. As (Sally) stated, welcome to the Long Term Care Hospital Quality Reporting Program, Special Open-Door Forum.

Matthew Brown, I'm with the Office of Public Engagement. I will help moderate this call and I want to begin, first, thank you for your patience. I want to share an open enrollment message.

The Medicare open enrolment period is October 15 through December 7, when all people with Medicare can change their Medicare health plan and prescription drug coverage for 2013. Please advise your patients that information on 2013 plans will be available beginning in October.

They can call 1-800-Medicare or visit www.medicare.gov for plan information. If they are satisfied that their current plan will meet their needs for next year, they don't need to do anything. Thank you.

And, with that, I will turn the call over to our call lead, Charles Padgett, who will give speaker introductions and begin the call. Charles?

Charles Padgett: Hi. Thank you, Matthew. Good afternoon. I'd just like to welcome all of the LTCH providers and vendors who have joined us today on the call with this special open-door forum we're holding today.

We are going to be covering a few things. We're going to have an announcement from the Division of National Systems. We're specifically going to be going over updates to Section M of the LTCH CARE data set which is the skin – the section on skin. And we'll end the call with a question

and answer period and just before we have the question and answer period, I'll be going over some frequently asked questions that have been submitted to the LTCH quality reporting program mailbox.

So, to begin things here, we're going to start with the announcement from the Division of National Systems. And the representative I have from DNS today is (Lori Grocholski) and I'm going to turn it over to her at this point. (Lori)?

(Lori Grocholski): Thank you, Charles. Good morning and good afternoon to everyone. We want to remind providers that the provider user I.D. registration WebEx training is available for you to review.

You may begin the process to register for your CMS net user I.D. When completing the CMS net access request form, please complete accurately and thoroughly. And you must provide an e-mail address. Again, I can't emphasize that enough. You must provide an e-mail address.

Once your request is approved, you will receive your CMS net user I.D. via the e-mail address you entered on the request form. After you are registered with CMS net, you will then be able to request a key user I.D. A demonstration version of LASER has been posted to the QTSO, that's qtso.com Web site, along with four WebEx's related to the LASER application tool.

Lastly, two final WebEx trainings will be posted on QTSO related to LTCH CARE data set submission process and LTCH assessment and validation reports by next week.

At this time, I'm going to turn the presentation back over to Charles Padgett. Again, we will be accepting questions at the end of this presentation. Thank you.

Charles Padgett: Thank you very much, (Lori). OK. Now, we're going to begin our presentation with Section M. I would like to introduce to you, (Terri Mota).

She is a registered nurse and a – she is also a certified wound nurse. She is with (RTI) International and she is one of the advisers to CMS for the LTCH quality reporting program. (Terri)?

(Terri Mota): Thank you, Charles and good afternoon and good morning to those on the West Coast. I know that there were some slides posted up on the special open-door forum Web site, so if you're following the slides, we're going to start at slide three and go over the objectives for today's presentation.

So the objectives for the presentation today are to understand clarifications and changes made to Section M and to code Section M items correctly and accurately, as well review answers to commonly asked questions.

On slide four, we have some key updates to Section M. But the first two are not only changes that have been made to Section M, but are also global updates in the LTCH quality reporting program manual.

So the first is that references to 72 hours have been changed to three calendar days. The look-back period has been changed to assessment period. And specifically to Section M, there is clarification on numerical staging and unstageable pressure ulcers and regarding the necrotic tissues, slough and eschar, since they are both considered necrotic tissue, we have a designation on the item set that says "necrotic eschar" and that has just been changed to "eschar" in the manual.

On slide five, there's an overview of Section M items. Section M, item M0210 documents the existence of one or more unhealed pressure ulcers that are stage one or higher. M0300 documents the number of unhealed pressure ulcers at each numerical stage and for unstageable pressure ulcers. M0610 provides the length, width and depth of unhealed stage three and four pressure ulcers and the length and width of unstageable pressure ulcers due to slough or eschar.

M0700 identifies the most severe tissue type of any pressure ulcer. And M0800, which is only available on the discharge LTCH CARE data set, identifies new pressure ulcers or pressure ulcers that have increased in numerical stage since the prior assessment.

The slides following will focus on areas within Section M of the LTCH QRP manual that have had updates and clarifications added. So starting on slide seven, we're going to jump directly into item M0300 which, as I said just a moment ago, documents the number of unhealed pressure ulcers at each numerical stage and the number of unstageable pressure ulcers. For each of these ulcers identified, the LTCH is also required to document if the ulcers identified for each stage were also present on admission.

Going on to slide eight, there are two clarifying statements that have been added to item M0300 general instructions relating to present-on-admission pressure ulcers which can be found on page M-5 of the LTCH QRP manual.

The first includes information related to the fact that clinical assessments performed on patients in the LTCH should be completed according to accepted clinical practice and comply with facility policy, state and federal regulation. For example, a general standard of practice for newly-admitted patients is that clinical admission assessments are conducted within the first 24 hours of admission.

It's the expectation that the information required in the LTCH CARE data set admission assessment will be coded based on that assessment and coincides with the findings that were completed within that same timeframe.

The second clarifying statement refers to the three-day assessment period used in the LTCH CARE data set. This three-day assessment period is not intended to replace the timeframe that is required for the clinical admission assessment. So purposes of coding the LTCH CARE data set admission assessment, it is the skin assessment as documented on the initial admission clinical assessment that is used.

So, for example, if a stage two pressure ulcer was identified on the LTCH's initial clinical admission skin assessment and the pressure ulcer increases in numerical stage, that has worsened within the three-day assessment period to a stage three, it would be the initial stage of the pressure ulcer that gets documented on the LTCH CARE data set admission assessment that's present on admission.

So let's look at an M0300 scenario on slide nine. Per facility policy, an initial clinical admission skin assessment was competed on new patient, Miss J, on day one of her stay. It was identified that Miss J has one stage two pressure ulcer.

By day three, the wound is noted to be worsened and is numerically restaged to a stage three pressure ulcer. The question is, then, how should item M0300B1 and M0300B2 be coded on the LTCH CARE data set admission assessment.

On slide 10, we see that the coding for M0300B1 and for M0300B2 would both be one. The rationale for this coding is that the stage two pressure ulcer is the ulcer that was initially staged on the clinical admission skin assessment as present on admission and, therefore, is what should be coded on the LTCH CARE data set admission assessment.

The next item where there has been clarification is in item M0700 which documents the most severe tissue type for any pressure ulcer. On slide 12, we speak about the fact that each tissue type is listed in M0700 that refers to tissue that's visible in different stages as wounds evolve and heal, and that they are arranged from the healthiest types of tissue to the most devitalized.

We're going to focus specifically on necrotic tissue. There are two types of necrotic tissue; slough, which is non-viable, yellow, tan, grey-green or brown tissue that is usually moist and can be soft, stringy and mucinous with adherence in the base of the wound or presence in clumps in the wound bed.

The other type of necrotic tissue is eschar. Eschar is dead or devitalized tissue that is hard or soft in texture, usually black, brown or tan. It may appear scab-like and is usually firmly adhered to the base of the wound and often to the sides and edges of the wound.

Sometimes, there are questions that have come in that speak to the difference – what the difference is between a scab and eschar. It's important to remember that scab and eschar are different both physically and chemically.

A scab is made up of dry blood cells and serum and sits on the top of the skin and forms over exposed wound, such as wounds with granulating surfaces like pressure ulcers. A scab is evidence of wound healing, so a pressure ulcer that was staged as a two and now has a scab indicates it is a healing stage two and should remain staged as such.

Eschar is a collection of dead tissue within the wound that's flushed with the surface of the wound. Eschar's characteristics and the level of damage it causes to tissues is what makes it easier to distinguish from a scab. So it's extremely important for staff who are staging wounds to understand the differences between these types of tissues.

Let's look at an M0700 scenario. We're on slide 15. A patient has two pressure ulcers; one is a stage two pressure ulcer on the right ischial tuberosity that is healing. It has epithelial tissue that has resurfaced up to 25 percent of the ulcer. The second is a stage three pressure ulcer on the sacrum that is filled with 75 percent granulation tissue. How should item M0700 be coded?

For M0700, remember that each pressure ulcer and the wound bed must be looked at to determine the most severe type of tissue. So for this particular example, M0700 should be coded with a two (2) - granulation tissue as the coding is based on the sacral ulcer which has the most severe tissue type of the two pressure ulcers present.

Moving on to slide 18, we're going to be looking at item M0800 which is the worsening pressure ulcer status item. M0800 documents, on the discharge assessment, the number of pressure ulcers that have worsened as compared to the prior assessment. The worsened definition includes the number of pressure ulcers that are new since the prior assessment and/or the number of pressure ulcers that have increased in numerical stage that is – have worsened since the prior assessment.

In M0800 coding guidelines, there was text added to item M0800 to further clarify coding for numerically-staged present-on-admission pressure ulcers that become unstageable or debrided and can be numerically restaged as well

as further guidance on unstageable pressure ulcers and worsening is determined.

With regards to worsening, it is important to remember that, although it is clinically known that when a stage two pressure ulcer is covered with slough and is deemed unstageable, that the pressure ulcer has indeed worsened to at least a three – stage three. However, CMS acknowledges that since the wound bed cannot be seen, the LTCH cannot commit to a numerical stage for this type of ulcer.

This is why, for example, if a stage two pressure ulcer is present on admission and covered with slough, and for some reason is never debrided, and on discharge remains unstageable, item M0800 would not document this as a worsened pressure ulcer because it has not been numerically staged even though, clinically, we know that it is worsened.

A similar situation occurs the first time an unstageable pressure ulcer is numerically staged. If it is the first time you are numerically staging an unstageable pressure ulcer that was present on admission, it is not considered worsened and is still considered present on admission. If subsequent to this first numerical staging, the pressure ulcer further deteriorates and is restaged at a higher numerical stage, it is then that the pressure ulcer would be considered worsened and not be considered present on admission.

We have one last scenario here for M0800. A patient's admission assessment documented an unstageable pressure ulcer due to slough on the right ischial tuberosity. Five days into the LTCH stay, the patient's pressure ulcer was debrided and was numerically staged as a stage three.

At this point, we would still consider this pressure ulcer not worsened and present on admission, but let's continue on. On discharge, it's noted that the pressure ulcer was reassessed and has increased in numerical stage, that is, it has worsened to a stage four. How should item M0800 be coded?

For codes M0800A and M0800B, stage two and stage three, respectively, the code is zero. The code for M0800C is one. The rationale for this coding is that the stage three pressure ulcer is not considered worsened because it was

the first numerical staging of that unstageable pressure ulcer after debridement.

Subsequently, the pressure ulcer did increase in numerical stage to a stage four and is therefore considered worsened on the LTCH CARE data discharge assessment. It would also be considered not present on admission at this point.

Let's move on to some Section M frequently asked questions on slide 22. Why has CMS adapted National Pressure Ulcer Advisory Panel Guidelines related to blisters and deep tissue injury?

CMS consulted subject matter experts for clinical validation of pressure ulcer coding. At the time these items were finalized, it was determined that there was much that current science was unable to confirm regarding deep tissue injury. CMS opted for a holistic approach to pressure ulcer assessment that includes characteristics of surrounding skin instead of a pure focus on what color is visible inside of an intact blister.

Interestingly, there has been a recent study conducted by Karin Farid that's available in this month's Ostomy Wound Management Journal related to the fact that the validity of the definition of the pressure ulcer related discolored areas such as those seen in tissue injury has not been formally tested.

Slide 23, another Section M FAQ and this has to do with present-on-admission pressure ulcers. Present-on-admission pressure ulcers are only allowed to be coded in acute hospitals when physicians or those with legal authority to make medical diagnoses have documented a present-on-admission pressure ulcer.

So why is nurse and documentation allowed in the LTCH for coding present-on-admission pressure ulcers? Present-on-admission coding for short-stay acute hospitals focuses on billing codes specifically for purposes of Medicare payment under the (ITTS). There are no CMS (TOA) regulations related to Medicare payment in LTCHs at this time.

Further, on slide 24, state nurse practice acts differ among states as to who can stage pressure ulcers. Also, the American Nurses Association has confirmed that it is within the scope of the nurse to stage pressure ulcers.

We're on slide 25 now, another Section M FAQ. Why are pressure ulcers that have been repaired with grafting procedures considered surgical wounds and not considered pressure ulcers?

Due to the surgical intervention, tissue has been moved from the patient to close the pressure ulcer. Grafting provides the tissue to assist in that closure. Therefore, this is a surgical closure of the wound and no longer able to be staged or classified as a pressure ulcer if the surgical wound dehisced. Therefore, for purposes of coding the LTCH CARE data assessment, pressure ulcer that has been repaired by a grafting procedure is considered a surgical wound and would not be coded as a pressure ulcer.

On slide 26, how are Kennedy ulcers to be documented on the LTCH CARE data set? Kennedy ulcers are pressure ulcers that some individuals get as they are dying. They are a type of pressure ulcer – a sub-type of pressure ulcer and, therefore, they should be coded as a pressure ulcer at the stage that it is seen in the LTCH CARE data set at the appropriate stage.

The next Section M FAQ is on slide 27. If a patient had an identified stage two pressure ulcer on the clinical admission assessment and on day two the pressure ulcer was now a stage three, as I understand it, it is coded as a stage three not present on admission. Is this correct?

No, this is not. The LTCH CARE data set requires the skin condition documented be from the skin assessment obtained as close to the time of admission as possible. So, in this case, a stage two is what would be coded on the admission assessment as present on admission. If on the discharge assessment this pressure ulcer is still stage three, it would be coded as a stage three worsened and not present on admission.

Next Section M FAQ, 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?

A patient assessment reflected in the admission assessment data set should coincide with the patient's admission assessment for the purposes of determining if a pressure ulcer was present on admission. A wound determined to be present on admission would specifically need to be on admission. Thus, if a present-on-admission wound worsened during the three days, the admission assessment record should capture the wound stage on the admission record, as well as the stage to which it worsened, providing the wound remains at a stage three upon discharge.

It's on the discharge record. The wound would be captured in the stage to which it worsened if it had not healed and this would be considered not present on admission.

Slide 29. On day two of the three-day assessment period, a pressure ulcer was assessed as unstageable. On day five, the wound was debrided and staged as a stage three. On day 24, the day of discharge, the wound was restaged as a stage four. How would this scenario be coded on the admission and discharged assessments?

On the admission assessment, it would be coded as unstageable and present on admission. On the discharge assessment, it would be coded as a stage four, worsened; not present on admission. This is because the first time it was able to be medically staged after debridement, it was staged as a stage three and then subsequently increased in numerical staging to a stage four prior to discharge.

This is the last slide in Section M for the FAQs. So I'm going to hand the presentation back over to Charles.

Charles Padgett: All right. Thank you so much, (Terri). I really appreciate it. I'm going to continue and just go over some frequently asked questions that we've received – that we've been receiving in the LTCH quality reporting program mailbox.

We looked through the majority of questions that we've received and tried to just pull out some of the repeating themes that we're seeing and the areas that we feel people are having some trouble understanding or just need some further clarification on. So I'm going to review a few of these and then we will – I'll give everybody a chance to ask questions.

So the first one I'm going to start with is on slide 30. And the question that was asked said, I need clarification on the definition of LTCH. Are these long term acute care hospitals or long term care hospitals?

And the answer was Long Term Care Hospitals, or LTCHs, and Long Term Acute Care Hospitals are different names for the same type of hospital. Medicare uses the term "Long Term Care Hospitals". These hospitals are certified as 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 the purposes of Medicare payments, as denoted by the last four digits of its six-digit CMS Certification Number or CCN number, in the range of 2000 to 2299, it is subject to the requirements of the LTCH quality reporting program. If your critical access hospital has long term care beds and either provides skilled nursing facility level or nursing facility level care, it is not required to comply with the requirements that was mandated for LTCHs which are hospitals.

Moving on to slide 31, where can I find the definitions for the LTCH quality measures? For most – I'm sorry, for most current and – the most current and up-to-date definitions for the three outset quality measures which are catheter-associated urinary tract infection or CAUTI, central-line associated bloodstream infection or CLABSI and the pressure ulcer measure; we're asking that you refer to the LTCH quality reporting program manual which is available for download at the LTCH quality reporting program Web site. And that is www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html . We also invite you to visit the Web site for updates to measure specifications for each of these measures

that may result from the National Quality Forum's (NQF's) review of these measures.

Next question on page 32, do we report patients with all payer sources for CAUTI, CLABSI and pressure ulcers for LTCH or just patients admitted with Medicare payer source?

And the answer is for the pressure ulcer measure, the LTCH CARE data set applies to all patients receiving in-patient services in a facility certified as a hospital and designated as an LTCH under the Medicare program.

Data collection using the LTCH CARE data set applies regardless of the patient's age, diagnosis, length of stay or payment or payer source. You can find more information related to this in Chapter Two Section 2.1.

For the CAUTI and the CLABSI measures, each LTCH must submit data for these measures on all patients from all in-patient locations regardless of payer source. And more information about those two measures is found in chapter five of the LTCH quality reporting program manual, in section 5.1.

Next page, 33, we have some similar questions. The first of which is, are all demographic information items required and the second of which are (GGO 160), functional mobility, lying to sitting on the side of the bed, bowel incontinence, peripheral vascular disease or peripheral arterial disease, diabetes and height and weight required only for admission assessments?

And we're asking, in reference to this type of question, that you please refer to the LTCH quality reporting program manual which, again, is available for download on the LTCH quality reporting program Web site. And, specifically, we're asking that you look to appendix E if you're interested in required – what's required specifically item by item. So we provide in appendix E, item-by-item guidance on the requirements for the completion of the LTCH CARE data set.

Next page, 34, what is the definition for planned discharge? A planned discharged is one where the patient is non-emergently medically released from

care at the long term care hospital due to some reason arranged or in advanced.

And the next question was the opposite of that. What is the definition for unplanned discharged? And the answer to that is an unplanned discharge is defined as a transfer of the patient to be admitted to another hospital or facility that results in the patient's absence from the LTCH for longer than three calendar days, including the date of transfer.

Or a transfer of a patient to an emergency department of another hospital in order to either stabilize a condition or to determine if an acute care admission is required based on emergency department evaluation which results in the patient's absence from the LTCH for greater than three days or when a person is unexpectedly – unexpectedly leaves the LTCH against medical advice, when a patient unexpectedly decides to go home to another setting or to another setting, I'm sorry; for example, due to the patient deciding to complete treatment in an alternate setting.

Also, unplanned discharged does not include planned transfers to an acute care hospital for admission for planned intervention, treatment or procedure unless the patient does not return to the LTCH within three days.

We're going to turn to page 36 now. This question states, can CMS please clarify whether there is a 72-hour rule or a three-calendar-day rule in the following instances – when a patient leaves and LTCH to go to another facility and then returns to the LTCH for purposes of determining whether to submit a discharge assessment and, two, when a patient dies within 72 hours or three days after leaving an LTCH for another facility?

And the three-day interrupted stay is in accordance with the payment policies that have been established at CMS. If the policy states that one – day one of three begins on the day of transfer, then the – then that day plus two would dictate the definition of three days. So, for instance, if a patient is transferred on August 1st, that date plus two calendar days would be August 3rd.

If a patient dies during an interrupted stay, then the LTCH should submit an expired data set. So if a patient is transferred out of an LTCH and is expected

back, say, they're transferred for a planned procedure at another facility, and they're expected to return to your facility and they die at the other facility, we would expect that you would fill out an expired assessment on – expired data set on that patient.

If the patient dies afterwards, the LTCH should have submitted a discharge item set because the patient did not return within three days. So, for instance, this patient is transferred outside an LTCH and is gone longer than three days, at that point, the LTCH would be responsible for filling out a discharge on that patient. However, we would not hold them responsible for knowing about a patient death beyond that time period.

We're going to move to page 37. If a patient's planned discharge is Friday, but the discharge is delayed until Sunday, what should the assessment reference date be otherwise known as the ARD?

The ARD on discharge assessment will always be the patient's actual discharge date. And more information related to this is found in chapter two of the LTCH quality reporting program manual. And the LTCH also has five days to complete the discharge assessment. So after the ARD that's established on discharge, the LTCH will have five days to complete the discharge assessment from that date.

If the patient – another question, if the patient dies during the assessment period, should you fill out both admission and expired assessments?

And the answer to this question is yes. Both admission and expired assessments should be completed. The ARD for expired assessments would be the date of death.

OK. Moving to page 38, let me go over a question that was asked pertaining to section Z. The question is, should the signature sections be filed and held at the hospital. If so, how long should they be kept? And a similar question, do I have to retain section Z?

And our answer to that is CMS will not be receiving the signatures provided in section Z under items Z0400 and Z0500. We receive only the submission

date when you submit the data set. We are strongly – we strong suggest that you retain what you submit to CMS, including section Z, according to your facility and state regulations and requirements. And facilities should comply with the requirements pertaining to electronic signatures if they require them.

So if a facility is going to use electronic signatures, we're asking that you follow your own facility policy and state regulations surrounding the use of electronic signatures and the protection of the signatures.

Moving on to page 39. Question, does the LTCH CARE data set require the signature of a registered nurse?

The answer is no. CMS has removed the language surrounding, and the requirement for a registered nurse's signature for the LTCH CARE data set submission.

Does the LTCH CARE data set require that an LTCH have an assessment coordinator on staff? And the answer to this question as well is no. CMS has removed the language pertaining to an assessment coordinator.

Lastly, on page 40, I'm just going to review, the presentation slides will eventually be posted on the LTCH quality reporting program Web site. They are – right now, they are posted on the CMS open-door forum Web site. And transcript and audio file will also be posted on the CMS open-door forum Web site. I'll go over that right now.

That's www.cms.gov/outreach-and-education/outreach/opendoorforum/odfspecialods.html . And, again at that Web site, you will be able to find a transcript and audio file for this special open-door forum and be able to find that presentation slides that we're using today. And, eventually, next week, we'll be posting the slides on our LTCH quality reporting Web site.

We really want to thank all of those who have taken time to submit questions and comments and feedback CMS received is really highly appreciated. It's useful to us and we've taken all of these comments and questions into consideration in the work that we're doing in updating our program manual

and helping to make sure that providers have what they need to begin submitting data for this program.

We've used all questions from the conference and our quality reporting program mailbox to guide our decisions to the changes that we've made to the manual and to some of the policies and also we've used these – some of these questions during the frequently asked questions set we've reviewed today on the LTCH quality reporting or the special open-door forum.

So that's all we have today. We are going to turn it over for question and answer period. And we will try to answer your questions as best we can.

Matthew Brown: Thank you, Charles. (Sally), at this point, would you remind the callers how to enter the queue to ask their questions?

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star, then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow up to allow other participants time for questions. If you require any further follow up, you may press star one again to rejoin the queue.

Your first question comes from the line of Roberta Steinhauser with Madonna Rehabilitation Hospital. Your line is now open.

Roberta Steinhauser: We're just a little bit confused on part of the definition for an unplanned discharge. So if we discharged the patient, say, to a short-term acute care hospital for an intervention like a surgical intervention and the planned stay was five days, so it was past the three days, according to the last bullet point, it appears that that would be an unplanned discharge, when essentially it was planned – it's just that the stay was planned to be more than three days.

Charles Padgett: Yes. Thank you for the question. That's a good question. It would be considered a planned discharge. That is something – that's a procedure that was planned for in advanced, we would consider that a planned discharge.

Robert Steinhauser: OK. So my follow up would be that last bullet point on the unplanned discharged, when you say it does not include planned transfers to an acute care in patient hospital for admission for a planned intervention treatment or procedure unless it – the patient doesn't return within three days. You just have to base it on whether the plan was for the patient to stay more than three days and if the plan was really to stay two days? That's where I'm confused.

Charles Padgett: Exactly. Yes, exactly. You're basing it on what was planned. So if you sent a patient out for a surgical procedure and they were – you plan for them to be away for five days that would be considered a planned discharge.

Roberta Steinhauser: Thank you.

Charles Padgett: Yes.

Operator: Your question comes from the line of Gary Williams with Kindred Healthcare. Your line is now open.

Gary Williams: Thank you very much. First of all, I'd like to say thank you for having this forum. It's very helpful.

Charles Padgett: Sure.

Gary Williams: Sure. My question is regarding data gathering for the care data set. In the manual, you refer to different methods of data collection – those being objective, looking to the patient's medical record; and also, subjective data, either through interviewing the patient's family or other caregivers.

My question is this, does the patient information that you obtain from any of those, primarily, subjectively; does it have to be also documented in the patient record?

Charles Padgett: OK. So our answer to that question would be yes. We would – we would (say) that there should be support of your answer within the medical records.

Gary Williams: OK. So if I obtain information by interviewing a patient's family member, that information I need – as the caregiver, I need to also document that in the – in the medical record as well as the care data set?

(Stacey): Hi. This is (Stacey) at CMS. What you document in the LTCH CARE data set ought to reflect – be reflected in the medical record, you know, in a comprehensive kind of way.

Gary Williams: OK.

(Stacey): What you would be doing – you know, taking (tons of) care, you would have some kind of, you know, some documentation of, you know, what you're doing with your patient. So it should – it should all knit together.

Gary Williams: OK. Thank you very much.

Operator: Your next question comes from the line of (Bettai Larson-Jones) with (inaudible). Your line is now open.

(Bettai Larson-Jones): Hi. My question has to do with the data submission. There's – I think it's appendix E that came with the manual. I wouldn't swear to it, but there's a timeline for submission of data for pressure ulcers, CAUTI and CLABSI. And this is the timeline that says that quarter four calendar year data should be submitted by May 15.

And then there is also another calendar that talks about the assessment data that we submit sort of concurrently for the pressure ulcer patients and that's so many days after admission, et cetera, et cetera. So I'm a little bit confused about these two different timelines and I was wondering if you could clarify.

Charles Padgett: OK. Sure. Thank you very much for your question. That's a great question. So the guidance that we give, as far as the concurrent timeline where we're asking you to submit kind of on an ongoing basis, LTCH CARE data sets seven days from the date of completion, we ask to have things submitted that way so that we are not receiving everything from every provider on one day.

So, essentially, we're asking you submit concurrently those LTCH CARE data sets. The time we give from the end of the quarter until May 15 essentially is a chance for you to submit corrections to the – to the record or data that you didn't realize was missing and you may discover was missing or something –

you know, say, there's a data set that you realized wasn't submitted. You would have a chance to submit that. And that's the reason we give that extra time until May 15 to submit.

Ultimately, because we do give that, you do have until May 15 to submit your data. So that's kind of …

(Bettai Larson-Jones): You should be submitting it all along for your – all the assessments that you're doing for pressure ulcers?

Charles Padgett: Right.

(Bettai Larson-Jones): OK.

Charles Padgett: Yes.

(Bettai Larson-Jones): For the – for the CAUTI and the CLABSI, CMS is going to be pulling the data that's in the (NDS) – NHSN tool, right? It's already in the tool and you're just pulling it out. Is that – am I correct?

Charles Padgett: You (won't) be receiving the data from the CDC.

(Bettai Larson-Jones): OK. All right. Thank you. That helps.

Operator: Your next question comes from the line of Nancy Blackburn with Maury Regional. Your line is now open.

Nancy Blackburn: If a patient who's a Medicare patient is transferred for services outside of the hospital, either to acute care, emergency room or for outpatient services not available at the LTCH, if that patient returns within 24 hours to the LTCH, is that billed to Medicare or is it billed to the LTCH?

Charles Padgett: Yes. Unfortunately, I'm going to ask that you submit your question to the billing department here at the Centers for Medicare. We don't answer billing questions.

We're really the quality reporting program here. And if you like you can even submit that question to our LTCH quality reporting program mailbox and I'd be happy to forward it to the appropriate person to give you an answer.

Nancy Blackburn: OK. Thank you very much.

Charles Padgett: You're quite welcome.

Operator: Your next question comes from (James Mikes) with Missouri Heartland Long Term Acute Care Hospital. Your line is now open.

(James Mikes): Thank you. My question is related to the discharge location section on the care data sets. Specifically, there are two additional discharge locations, hospital emergency department and ID/DD facility, that are not part of the standard Medicare discharge status codes.

I just wonder if there's any particular reason for that. Specifically, we're trying to automate this process as much as we can. And we don't want to have to create additional fields for non-regulatory reasons if it's not necessary.

Charles Padgett: All right. Thank you for your question. I'm going to ask that you submit that question to our mailbox, if you would, and we'll give you a written answer on that. And for those of you that are interested in the response, we will – we can post that response as well.

(James Mikes): OK.

Charles Padgett: Thank you.

Operator: Your next question comes from the line of (Josoa Pagulayan) with Holy Family Medical Center. Your line is now open.

(Josoa Pagulayan): Hi. My question is for Lori for the processing of the CMS net user I.D. We submitted our application a week ago and I thought it will take one day if you (send) it before 3 o'clock p.m., but I haven't received any e-mail as of yet.

(Lori Grocholski): Hi. This is Lori. Yes, you are correct that it did indicate that you would receive a response back within a period of time. What I'm going to recommend is if you have not received confirmation by September 20, that you contact the CMS net helpdesk, OK? So it's just to give us a little extra time there.

(Josoa Pagulayan): OK. Because I called …

(Lori Grocholski): OK?

(Josoa Pagulayan): … I called them back because they said if you don't receive it within four days to call (inaudible) and I tried to call …

(Lori Grocholski): You are – sure, you are correct that that is what is indicated. It's just going to take a little bit more time and, again, if you haven't received the confirmation by September 20, please contact the CMS net helpdesk. Thank you.

(Josoa Pagulayan): Thank you.

(Lori Grocholski): You're welcome.

Operator: Your next question comes from (Mary Dalrymple) with (ALPRAX). Your line is now open.

(Mary Dalrymple): Hi. My question is about the required fields and you listed a bunch that are required for calculating the measure. And the appendix E – so I'm talking about like lying to sitting outside of bed, bowel, PVD – and the manual in appendix E says it's a required for admission and voluntary with the default on discharge.

But the submission specifications say that if you don't put an answer other than "not assessed" on any of the assessments for the valid – for the questions that you will get a warning saying "This field is needed" or, you know, you'll get that warning that says if you don't answer this question it may affect your payment. So if wondering if the manual, since it came out later, is what we should follow or the transmission specifications.

Female: Hi. We are going to ask to go ahead and submit that question into the LTCH technical mailbox. And, also, you should – it was indicated that you should follow the technical submission specifications.

(Mary Dalrymple): OK.

Female: OK. And that there are fields that are voluntary and a default response is required for the submission.

(Mary Dalrymple): Right.

Female: Maybe a dash – depending on the question, it may be dash; it may be a 99; it may be z. And those are the default responses so that the data can be submitted.

Charles Padgett: And the reason we do that is that lets us know that a provider did not accidentally miss a question.

(Mary Dalrymple): Right.

Charles Padgett: But did consider the question and either could not answer it, one, or decided not to answer it, number two.

(Mary Dalrymple): Right.

Charles Padgett: Either of which can be indicated by a dash or the code of 99 that is listed under the – as a – as a choice there.

Female: Right. And if they elect to not answer the question but the systems require some type of response in order to be submitted electronically, those are the sort of default responses.

(Mary Dalrymple): OK. So, for now, we should go with the transmission specifications and I'll send that question to the LTCH technical mailbox.

Female: If – yes.

(Mary Dalrymple): OK. Great.

Charles Padgett: Yes. But do send that question to ask, Mary, if you would, and we'll certainly get a written answer out to you.

(Mary Dalrymple): OK. Thank you.

Charles Padgett: You're welcome.

Operator: Your next question comes from the line (Christina Wang) with Fundamental Administrative Services. Your line is now open.

(Christina Wang): Hi. Good afternoon. Thank you very much for hosting this forum. It's very helpful.

I'd like to verify with – just a few things here please. This is concerning the discharge date. First of all, how do we define a date? It's from midnight until 11:59 p.m.?

Charles Padgett: That's correct.

(Christina Wang): Yes. So, hypothetically, we have an unplanned discharge. This patient goes to an ER, return anticipated – the discharge took place at 11:59 p.m. on day one. So that's day one. The three-day period will end at day three, 11:59 p.m.

Charles Padgett: Yes, correct.

(Christina Wang): Yes. And if this patient – so if this patient returns within – by the end of day three, it's considered interrupted stay. We don't need to submit a discharge assessment or – right, it is considered interrupted stay.

But if this patient returns on day four at 12:01 a.m. then it's not an interrupted stay. We will need to do the discharge assessment as well as the admission assessment. Am I correct?

Charles Padgett: Yes, you are correct.

(Christina Wang): OK. Yes. Thank you.

Charles Padgett: No problem. Thank you.

(Christina Wang): I just want to clarify. Thank you.

Operator: Your next question comes from (Averill Edwards) with HealthEast Care System. Your line is now open.

(Averill Edwards): You were – you were speaking about a definition for LTCH quality measures in the manual and you gave a fairly lengthy Web address. Could you repeat that please?

Charles Padgett: Sure. I'm sorry? Which Web address are you asking for again?

(Averill Edwards): It was the one where we can find the manual definitions for LTCH quality measures and it was the cms.gov/Medicare and that was as far …

Charles Padgett: Sure, absolutely. I'll give it again for you. And this is our LTCH quality reporting program Web site. So the address is www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html .

And, for those of you listening, also, I'm going to give you an easy way to find our LTCH quality reporting Web page is you can just – if you Google LTCH – LTCH quality reporting, our Web page, both the technical and the main quality reporting Web page are probably one of the first three that come up when you Google LTCH quality reporting. That's an easy way to find it if you can't remember the address or you can't remember where you wrote it down. It's easy to get to from there. Did you get that?

(Averill Edwards): I did. Thank you very much.

Charles Padgett: Absolutely. No problem.

Operator: Your next question comes from Joan Carson with Gaylord Hospital. Your line is now open.

Joan Carson: OK. Thank you. I am – my question is related to the CMS net user I.D. I'm wondering is there one per provider or does each user that might be entering data require they have a separate CMS net user I.D.?

(Jack): This is Jack (inaudible). Yes. They – each user from the provider must have their own I.D.

Joan Carson: And that – OK. So that applies to the CMS net user I.D. as well as the QIES user I.D.?

(Jack): That is correct.

Joan Carson: OK. Thank you very much.

Operator: Your next question comes from the line of Becky Fowler with Baptist Restorative Care Hospital. Your line is now open.

Becky Fowler: My question has to deal with section I on active diagnosis and I understand the guidelines to say that needs to be physician documented. How close to those specific words that the physician documentation need to be, the example being malnutrition when there is a weight loss, lab, a new PEG? Can those be interpreted as malnutrition or does it have to be that exact wording in physician diagnosis – documentation?

Charles Padgett: Thank you for the question. And we are asking for that exact working in diagnosis. You know, we've had people submit similar questions where they say, you know, often a physician will write that somebody is cachectic or, you know, losing weight and stuff like that. But we need an actual diagnosis of malnutrition and not an interpreted diagnosis.

Becky Fowler: Thank you.

Charles Padgett: You're welcome.

Operator: Your next question comes from the line of Amanda Dawson with Select Medical. Your line is now open.

Amanda Dawson: Yes. In the phrase, "planned in advance", what past event or time point does the word "advance" refer to?

Charles Padgett: Yes.

(Stella Mandl): That's a good question.

Charles Padgett: Yes.

(Stella Mandl): So, number one, we're going to go ahead and ask that you submit that question. For – you're referring to, I assume, to planned discharges.

Amanda Dawson: Yes. That's correct.

(Stella Mandl): So, generally, when a patient is – there's a situation where they are – the team facility is planning on discharging a patient to another setting, potentially home, there – they work on that process together or, I would imagine, in advance. So it would be a known situation as opposed to the unplanned which is, obviously, abrupt, you know, emergent transfer to an emergency department, leaving AMA, that kind of thing.

Charles Padgett: But if you submit your question, we will give you a formal written answer to that. That's a good question.

Amanda Dawson: OK. Thank you.

Charles Padgett: You're quite welcome.

Operator: Your next question comes from Barbara Smith with Specialty Hospital. Your line is now open.

Barbara Smith: Hello. Thank you for this conference today. My question deals with when the first staging is being done, and I know you're saying it follows the hospital guidelines for admission assessment. We have specific people who do our staging and measuring. And my question is does the staging have to be done within the first 24 hours if that's what our admission assessment says?

(Stella Mandl): It should be in sync with that.

Barbara Smith: OK. That's what I wanted to clarify. Thank you so much.

Operator: Your next question comes from (Karen Venity) with RML Specialty Hospital. Your line is now open.

(Karen Venity): Thank you. We just wanted to ask for clarification, if the patient is transferred out of the LTCH to another level of care, say, a short-term acute care hospital for services not provided in the LTCH and returns within two days to the LTCH with a new pressure ulcer, is that pressure ulcer coded as facility-acquired new for the LTCH?

(Stella Mandl): If, by the time that the patient is discharged from the LTCH it has not resolved, it would be considered new.

(Karen Venity): Do you have to complete a new admission assessment on that patient and submit the data when the patient returns to you if it's within those three days?

Charles Padgett: No. Only if it's been four days or more.

(Karen Venity): So if it's four days or more and the patient comes back with a new pressure ulcer, do you count the pressure ulcer to you at that point?

Charles Padgett: So, at that point, you would – you would be filling out a new admission assessment. And, at that point, that pressure ulcer would become present on admission.

(Karen Venity): Very good. That's the way we understood it. We just wanted to hear the clarification. Thank you.

Charles Padgett: OK. No problem. You're welcome.

Operator: Your next question comes from (Kim Fisher) with Kindred Healthcare. Your line is now open.

(Kim Fisher): Yes. My question is for Lori with the CMS net access.

(Lori Grocholski): Yes?

(Kim Fisher): There's supposed to be third-party access to that. Do you know when that will be available for registration on the QTSO Web site?

(Lori Grocholski): I'm sorry, I don't. Could – would you be willing please to submit that into the mailbox?

(Kim Fisher): Sure.

(Lori Grocholski): OK. Thank you.

(Kim Fisher): (Inaudible) on the QTSO Web site on the LTCH it says, "Note, if you need corporate or third-party access, do not register for multiple individuals. Separate forms for the corporate or third-party user registration will be posted at the QTSO Web site when they are available," and I was just curious if you had a date for that, so …

(Lori Grocholski): Yes. If you would submit that, I'll be glad to get a response back to you.

(Kim Fisher): Thank you.

(Lori Grocholski): Thank you.

Operator: Your next question comes from Amanda Dawson with Select Medical. Your line is now open.

Amanda Dawson: Yes. I wanted to ask about the question having to do with the primary diagnosis treated in the previous setting. We were wondering whether that had to do with the primary diagnosis that's being billed from the previous hospital or whether it has to do with the reason that the patient came to – the initial admission to that initial hospital.

(Laurie Groholski): OK. Can you repeat the question?

Amanda Dawson: Certainly. The – it has to do within the CARE tool, the A1820, what was the primary diagnosis being treated in the previous setting, whether – and you're supposed to put an (ICD-9) code in for that. We're wondering whether that had to do with – if we ask the hospital that, you know, sent us the patient what the – you know, what the diagnosis was, it's going to be a billing code typically.

We weren't sure if that's what you were looking for here. Or, according to the documentation, it looked like you were looking for the reason that the patient initially went to that hospital which might not be the same thing as the billing code that the hospital used.

(Stella Mandl) Right. That's a very good question. Can you please submit that question to the quality reporting mailbox?

Amanda Dawson: Sure. Thank you.

(Stella Mandl): Thank you.

Operator: Your next question comes from the line of Jennifer Trallo with Acuity Specialty Hospital. Your line is now open.

Jennifer Trallo: Hi. Good afternoon. I was wondering if you could elaborate a little bit on the – on slide 28 where it says in the last sentence, "the wound as described on that slide because it worsened would no longer be captured as present on admission", I'm having just a little bit of trouble getting my head around that.

(Stella Mandl): (Terry)?

Charles Padgett: Sure, (Terry). Do you want to talk about that a little bit?

(Terri Mota): Sure. So you are concerned about the last portion of it "not being captured as present on admission"?

Jennifer Trallo: Right.

(Terri Mota): Right.

Jennifer Trallo: Right.

(Terri Mota): Well, because the wound worsened, it would not be considered present on admission. If it had stayed the same, then that will be a different story. But since the wound worsened while at the LTCH, it would no longer be captured as present on admission.

Jennifer Trallo: OK. I guess it's just – it's hard to understand because there's a big clinical difference between someone coming in with no breakdown and developing a breakdown than having, you know, severe breakdown and having it devolved to even more severe breakdown. It's just …

(Terri Mota): Right. Remember, you're capturing this at two points in time. You're capturing it at the admission assessment and the discharge assessment, so lots of things can happen in between. And this question was specifically what happens within those first three days if the wound worsened.

So there are things that do evolve over the course of the stay as you suggested. But, remember, you're coding on admission and on discharge and sometimes many things happen in between.

Jennifer Trallo: OK. OK. Thank you.

(Terri Mota): You're welcome.

Operator: Your next question from (Christina Wang) with Fundamental Administrative Services. Your line is now open.

(Christina Wang): Hi. Good afternoon. I have another question please regarding the pressure ulcer. This is a follow up of the previous question that someone already asked.

Hypothetically, if a patient was just discharged on day one and returned on day three and what with the discharge the patient has a – say, a stage two pressure ulcer and the patient returns on day three with a stage three pressure ulcer, say, he spent two days at the ER.

How do we – is there a way to document this? I understand, in this case, it's considered an interrupted stay. But is there a way to document this worsened pressure ulcer that took place somewhere else, not at our facility?

Charles Padgett: As far as the LTCH CARE data set is concerned, there is – there is not a way to document that. We consider that pressure's – that pressure ulcer worsening as the responsibility of the LTCH if it happened within the three-calendar-day

period. If it's beyond that, you, then, will complete a new admission and it would become present on admission there.

(Christina Wang): Right. So during that three-day window, it's considered the LTCH's responsibility?

Charles Padgett: That's correct. And we think of this as really a care coordination issue if it's just something that is happening a lot between hospitals that you're transferring patients to. You know, we certainly encourage you to stay in communication with them and work with them to solve this problem, but, yes, you are correct.

(Christina Wang): Yes. Thank you.

Charles Padgett: You're quite welcome.

Operator: Your next question comes from Amanda Dawson with Select Medical. Your line is now open.

Amanda Dawson: Sorry. This is my last question. I was wondering – it now says that the CARE tool needs to be printed and part of the medical record. And this is more of a concern than a question, but if nurses are allowed to do present-on-admission documentation that's printed and it becomes part of the medical record, it becomes a legal document even if the hospital has a policy that nurses cannot make a medical diagnosis. So it's a legal document, it's discoverable, admissible and so forth and I just – I don't know how to address that issue.

Female: Yes. Can you – can you just repeat that? That's a good question, trying to …

Amanda Dawson: Yes. Some of the updated information we got about the CARE tool says it needs to be printed as part of the medical record – you actually print the CARE tool itself. Not to mention, you have the documentation. But you have, in the CARE tool, the nurses make a present-on-admission documentation of the pressure ulcer and that documentation becomes part of the legal document – as part of the medical record. So it could be used as – yes?

(Terri Mota): I'm sorry. This is Terri. That would be similar to writing, you know, an assessment of a pressure ulcer within a nurses note. That's …

Amanda Dawson: Right.

(Terry Moda): … should be a part of the legal document. And, nurses, when they are staging pressure ulcers, are not diagnosis them.

Amanda Dawson: OK.

(Terry Moda): They are merely stating what they're identifying and what they see as visible on skin assessment which is within their scope of practice.

Amanda Dawson: OK. Thank you. I just wanted to make sure it did not come across as a diagnosis.

(Terry Moda): Right, right. No. It would come across as part of the health assessment that nurses are allowed to do.

Amanda Dawson: OK. Thank you.

(Terry Moda): Yes.

Operator: Your next question comes from (Sherry Schuman) with Ernest Health, Incorporated. Your line is now open. (Sherry Schuman), your line is open.

Matthew Brown: Take the next caller, (Sally).

Operator: Your next question comes from (Mary Dalrymple) with (ALPRAX). Your line is now open.

(Mary Dalrymple): Hi. I had a question about that May 15 deadline for sending the final data (inaudible). Is that …

Charles Padgett: Sure.

(Mary Dalrymple): … cut off-date? In other words, if there are assessments from this first quarter, you do not want them after that date?

Charles Padgett: When you say the first quarter what are you talking about?

(Mary Dalrymple): I mean, so for this – for this October 1 to December 31 quarter, there is that …

Charles Padgett: Yes. So exactly. What will happen is anything you submit after that date will not be considered in consideration of compliance versus non-compliance.

Female: For the – for the fiscal year '14 payment update.

(Mary Dalrymple): Right.

Female: So, in other words, that May 15 cutoff …

(Mary Dalrymple): Yes.

Female: … if you haven't submitted any of your data for the last quarter, October through December, (that may) have changed …

(Mary Dalrymple): Yes.

Female: … that will determine your (APU) reduction or non-reduction. So you have up until that point in time to submit data for the purposes of, you know, correcting any of that data. You have up until that date.

You know, at some point, we have to have sort of a line in the sand from which you make decisions. Data, obviously, is going to be coming in, you know, after December 31 for another APU update cycle. But for the data that comes in between October and December of calendar year 2012, you have until May 15 to get it in, get it right.

(Mary Dalrymple): Got you.

Female: Does that help?

(Mary Dalrymple): Yes, thank you.

Female: There's a lot of dates, aren't there?

(Mary Dalrymple): Yes, sure.

Female: I also want to clarify back to information or the questions related to CAUTI and CLABSI NHSN reporting and the pressure ulcer data. So, obviously, there's the LTCH CARE data set coming in through QIES and then there is the CDC NHSN reporting coming in through the NHSN.

Reporting for CAUTI and CLABSI events ought to be reported to the NHSN as close to the time of the event as possible because it's part of surveillance. They do – if that's not doable, then, there's a certain monthly timeframe close to that even that is provided in the NHSN guidance. And if there are no infections that data should be coming in monthly as well.

Charles Padgett: Meaning you should be reporting zero.

Female: Yes. You either must be reporting the infections or zero monthly. And if you need to correct any of that information, you have up until May 15.

The LTCH CARE data set is submitted – should be submitted seven days – by seven days after it's been completed. And if, for some reason, you're not able to submit it, things happen, then you do have the padding this year to – up until May 15 to get it in. I hope that helps. I think I put everybody to sleep.

Operator: Your next question comes from the line of (Christie Apshire) with Kindred Hospital. Your line is now open. (Christie Apshire), your line is open.

(Christie Apshire): I'm sorry. I think I'm thoroughly confused now regarding dates. We start reporting for – starting on October 1st and we start reporting with those admits, correct?

Charles Padgett: That's correct.

(Christie Apshire): OK. So anything before October 1st is not reported. What about the patients that are discharged after October 1st that were not admitted before October 1st?

Charles Padgett: You would not report them. We want any patient that has been admitted after October 1. If they had not had an admission after 12:01 a.m. on October 1st, then you do not report their data.

(Christie Apshire): OK.

Charles Padgett): Does that make sense?

(Christie Apshire): Yes. Thank you.

Charles Padgett: You're quite welcome.

Operator: Your next question comes from Mary Dawson with Regional Hospital. Your line is now open.

Mary Dawson: Hi. Say, we are diligently entering data and we missed an assessment, say, an unplanned discharge and then we readmit him and then end up actually discharging him. If we somehow missed a particular assessment but have got it right 99.9 percent of the time, is that going to impact our reimbursement?

Charles Padgett: OK. First of all, I just want to say that, if you're – when you're submitting your data sets to the QIES ASAP system, if you – if you make a submission out of order, that is, you submit an admission data set and then, say, you forget to submit your discharge and then they're readmitted and you submit another admission dataset, you're going to get a message that says, "This has been submitted out of order. There's a sequencing problem here." And that will alert you to the fact that you have forgotten to submit something or that there's a problem and it will allow you to reconcile that problem.

Mary Dawson: OK. And what – where I'm looking at is if we – if we do the admission assessment they go out on an unplanned and then we miss the readmission – we had miss the readmission, so you don't get a discharge from us and you don't get a readmission from us, but then you get a discharge. If that – I mean – if we – am I – if we're doing diligence as best we know …

Charles Padgett: I see what you're saying. So you're saying to us it would just look like an admission and a discharge and it would look probably like a longer stay than normal.

Mary Dawson: Exactly.

Charles Padgett: Yes. We just encourage you to correct it if you – if you find the mistake. I mean, quite honestly, we would have no way of knowing beyond you telling us.

Mary Dawson: OK. I just wasn't sure if this was reconciling with the billing information and if – you know, if – you know, the best effort is going to be the due diligence.

Charles Padgett: Yes.

Mary Dawson: OK. Thank you.

Charles Padgett: You're quite welcome.

Operator: Your next question comes from the line of (Sherry Schuman) with Ernest Health, Incorporated. Your line is now open.

(Sherry Schuman): Yes. This is in regards to the planned and unplanned discharge. I'm looking at a patient who was discharged from the LTCH to the short-term acute for a procedure and then the plan was to discharge that patient home from the short-term acute. Would that be considered a planned discharge?

Female: They're not returning back to the LTCH?

(Sherry Schuman): No.

Female: And they left your facility with a plan to go to the acute care hospital?

(Sherry Schuman): Yes. So like this is the example, the patient is going for a pain pump prior to, you know, final discharge to home or …

Female: That would be considered planned.

Charles Padgett: Yes. That would be considered a planned discharge.

(Sherry Schuman): OK. All right. Thank you.

Charles Padgett: You're quite welcome.

Operator: Your next question comes from the line of (Josoa Pagulayan) with Holy Family Medical. Your line is now open.

(Josoa Pagulayan): Thank you. On chapter two, "Signature pages not transmitted to QIES ASAP and it should," – it says, "It should be retained within the patient's medical record." We are not electronic record yet so are you suggesting we should retain this section to our – to the patient's medical record – the signature page?

Charles Padgett: Yes.

(Josoa Pagulayan): OK. All right. Thank you.

Charles Padgett: You're quite welcome.

Operator: There are no further questions at this time. Let me turn the call back over back to the presenters.

Matthew Brown: Charles, would you like to offer any closing remarks?

Charles Padgett: Sure. Again, I just want to thank everybody for taking the time to join us today. I really appreciate all the questions. You know some great questions out there. And if you think of any more, you know, we certainly encourage you to submit to our LTCH quality reporting mailbox.

We are making certain – we are getting answers out to you now. And, again, we will be posting the slides from this open-door forum on our LTCH quality reporting program next week. Today, they're available on the CMS open-door forum Web site on which the transcripts and recording will be posted as well.

And I just want to continue to remind you to check out – the LTCH quality reporting program Web site frequently for updates, upcoming trainings,

upcoming open-door forums and we will continue to get as much information out to the providers as possible and hope to get all your questions answered.

That's it. Thank you so much. Have a great day.

Matthew Brown: Thank you, Charles. And, with that, I'll turn it over to our operator who has instructions on the Encore feature.

Operator: Thank you for participating in today's Long-Term Care Hospital Special Open-Door Forum Conference Call. This call will be available for replay beginning at 5:30 p.m. Eastern Standard Time, today, August 30th, 2012 through midnight on September 1st, 2012. The conference I.D. number for the replay is 20497757. The number to dial for the replay is 855-859-2056. Thank you.

Matthew Brown: Thank you. And this concludes our call. You may hang up now.

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