State of Tennessee
Division of TennCare
Enhanced Respiratory Care
Frequently Asked Questions

REFERRAL INFORMATION

Social Security Number:
What do we do if a referral is received without the social security number?

For the purposes of reporting ERC data, a referral without the social security number is not considered a true referral. Therefore, the referral information would not need to be entered in this case.

PATIENT INFORMATION

Admission Date to ERC:
Is this the original date of admission or the most recent date of admission?

The date entered should be either: 1) the original date of admission, or 2) the most recent admission date whereby the resident was **readmitted** after at least a 30 day absence.

Non-Weaning Exclusion:
How can a member qualify for the non-wean exclusion?

The resident must meet the criteria set forth in the ERC Manual in Section C.8, which states the resident must meet **at least one of criteria listed in Criteria Set 1 and all of the criteria listed in Criteria Set 2**.

Criteria Set 1: a resident must meet **at least one (1) of the following**:

- Have a diagnosis of Amyotrophic Lateral Sclerosis (ALS), Duchenne Muscular Dystrophy (DMD), or other progressive neuromuscular disease documented in the resident's original permanent legal medical record, **OR**
- Have an irreversible neurological injury or disease or dysfunction such as high spinal cord injury (C2) in which weaning may be detrimental to survival, **OR**
- Have end stage renal disease and are undergoing dialysis treatment, **OR**
- Receive end of life hospice care as a result of resident or family choice

Criteria Set 2: a resident must meet **ALL of the following**:

- Have documentation in the resident's original permanent legal medical record of communication with the resident or family upon admission or determination that the resident meets the non-weaning exclusion, **AND**
- Have documentation in the resident's original permanent legal medical record of agreement by the attending physician AND consulting pulmonologist upon admission or determination that the resident meets the non-weaning exclusion, **AND**
- Have a documented MD order for non-weaning care.

NOTE:

- Advance directive code status is not a consideration in determining the non-weaning care plan.
- In the event that an ERC facility accepts transfers from another ERC facility as a result of licensure, certification or other quality concerns, the receiving facility will not have chronic, non- weanable cases counted against them in determining their quality scores. These would be reported as non- wean exclusion admissions with special circumstances. The details of the circumstance should be documented in the comment section of the QA system. As always each admission should still be evaluated for weaning potential with the hope of improved outcomes.

State of Tennessee
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Enhanced Respiratory Care Review
Frequently Asked Questions

CARE DAYS DURING MONTH

What guidelines should I use when reporting care days?

Facilities should report data, for all residents, regardless of pay source, utilizing Medicaid guidelines.

Days in Reporting Month Prior to Admission:
Are these inclusive of days prior to readmission from acute care facilities?

This only applies to new admissions. For example, if the resident was hospitalized the previous month for **less than 30 days** and the hospitalization lasts into the current reporting month, the "Days in Reporting Month Prior to Admission" will be zero because the admission date will not have changed.

Total Care Days:

Is the day of admission and the day of discharge credited to the facility according to the QA system?

The day of admission is credited to the facility but the day of discharge is not. For example, if you are reporting October and you have a resident that was admitted 6/29/17 who had 10 vent days, 5 wean days, no hospital or tracheal suctioning days of either type and was discharged on 10/16/17 without returning, then there are:

- 31 days in October
- 0 days prior to admit (since they were admitted prior to October)
- 15 days after discharge + 1 day for the day of discharge
- 0 hospital days
- 15 days of care (10 vent + 5 weaning = 15)

So, 15 days after discharge + 1 (day of discharge) + 15 care days equals 31 days. Please keep in mind that all days in the month must be accounted for.

If a resident is discharged to the hospital, are the days after counted as hospital care days?

No. Hospital Care Days refer to days spent in the hospital, without being discharged from the ERC unit, during the reporting month. If a resident is discharged to the hospital, then the hospital days would be zero. As you see in the previous example, the hospital care days was listed as zero.

Sub-Acute Tracheal Suctioning Care Days:

Does this count "reset" after the resident was off of the ventilator for 30 days and then has to go back on the ventilator?

Yes, as long as the resident meets sub-acute criteria. For example, a resident is weaned from the ventilator and: 1) remains off for 30 days, 2) readmits to ERC requiring ventilator services, and 3) the facility obtains a PAE for ventilator (chronic or weaning) status. In this case, based on MCO authorization, the facility would qualify for sub-acute payment if the resident was to be weaned again.

Do sub-acute care days only cover residents for a short period of time? Is sub-acute tracheal suctioning only valid for the first 7 days after ventilator weaning has been completed? How long can the sub-acute authorization last?

Yes, this is meant to cover a short term time frame post weaning; however, the facility should bill as approved by the MCO. The MCO may authorize additional sub-acute care days as the resident continues to progress toward decannulation.

Is sub-acute tracheal suctioning reimbursement meant for both post-ventilator weaning AND tracheal weaning?

Yes. Page 17 of the ERC Manual states "If a resident successfully decannulates, the three consecutive days after the removal of the artificial airway should be reported as sub-acute tracheal suctioning care days – this assumes the resident remains in the facility under the ERC program.

NOTE: The seven day period following the last day on the ventilator prior to "successful" weaning may be billed/recorded as ventilator weaning. This would also apply to a resident who weaned from the ventilator at a hospital but still required trach weaning until decannulation.

Is there written clarification for sub-acute tracheal suctioning?

Yes. Criteria can be found in the Rules of TennCare 1200-13-01.02(204) (b) [pages 66, 67] (http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-01.20171001.pdf). In addition, specific MCO requirements can be obtained by contacting Eventa LLC.

Respiratory Therapy Notes:

Are these required in order to receive credit for a day of ventilator, weaning, sub-acute, or secretion management service(s)?

Yes. If respiratory therapist notes are not available for a day of service, that day will not be allowable for facility billing purposes.

Ventilator Weaning Care Days:

Is ventilator weaning reimbursed on daily events? Are ventilator weaning days viewed as a singular event or as a process? For example, a resident progresses very well to trach collar of 16 hours. The next day the resident is too fatigued to perform weaning trials, but they are able to perform weaning trials on the subsequent day. Is the day without weaning reimbursable at the vent weaning rate?

No, ventilator weaning is a process, not an episodic event. A member may progress very well one day, but be unable to tolerate as much (or any) weaning the next day due to fatigue from therapies, previous weaning, clinical presentation, etc. The ventilator weaning process must be observed on a larger scale than day by day.

OUTCOMES

Successful Wean:
Should "Was the Resident off the Ventilator for at Least 7 Consecutive Days during the Reporting Month" be "Yes" if the resident was never on the ventilator while in the facility?

No. If the resident was never on the ventilator then this question should be checked "No."

NOTE:

- If the resident was successfully weaned and then had to go back on the ventilator within the same month – this answer would be checked "Yes."
- If the resident was a terminal wean (anticipated outcome is death upon ventilator removal as a result of resident or family choice), this answer would be checked "No" ***AND*** non-weaning exclusion would be checked "Yes."

EVENTS

New URIs:
How are the number of infections counted for each member?

If the resident is re-cultured and discovered to continue to have the same organism would that continue to be counted as a new URI?

No

How long between the end of antibiotic treatment and collecting another culture that shows the same bacteria would qualify as one infection? At what time frame would it be considered two different infections?

Seven (7) days would substantiate a new infection if the member was asymptomatic for the 7 day timeframe. If the member continues to be symptomatic, then it would be a continuation of the initial infection.

If upon re-culture the resident has a new organism, but the URI has never ceased to be treated, would that be considered a new URI?

Yes. The new organism would indicate a need for a different treatment regimen

Is there a recommended set of guidelines to utilize for infection(s)?

TennCare does not recommend any set of guidelines for use, this is per facility choice.

If a resident is being treated for a URI but all tests are negative or inconclusive, does this count as a new URI? For example, a resident displays some symptoms of infection so the MD ordered an antibiotic as well as a chest x-ray. The antibiotic was started before the chest x-ray was completed. The first x-ray was inconclusive so we repeated the next day. The second x-ray did not

indicate any infection; however, antibiotic therapy continued until the end of prescribed treatment for 5 days.

This situation describes very poor antibiotic stewardship but not an actual infection.

Are the number of infections determined by the number of antibiotics prescribed to the member? Even if the same infection is treated with different antibiotics, is that considered 1 or 2 new URIs?

The number of infections are quantified by the organism treated with antibiotics. For example, a member demonstrates Pseudomonas in a sputum culture. The member is treated initially with intravenous meropenem but does not improve. The member is then prescribed inhaled tobramycin. Since the organism causing the infection remains the same (Pseudomonas), only 1 infection is counted.

If the resident was admitted with a URI (confirmed by culture or other testing), would that URI be reported here?

No. Only URIs with cultures or other tests performed **4 or more calendar days after admission or readmission** are reported in this area.

Unplanned Hospitalizations:

What should be included in this field?

- Any ER visit for **unplanned emergency** treatment or services (whether or not the resident is admitted to the acute care facility).
- Any hospital admission that was not previously planned for receipt of acute care services.
- Any unplanned hospital admission after a planned MD visit or appointment.

Are events which are not emergent, such as PEG tube replacement, considered to be an unplanned hospitalization because they are not planned?

No. PEG tube replacements require scheduling ahead of time to ensure the receiving hospital has the appropriate medical staff to perform the procedure. Members with chronic anemia may require frequent blood transfusions, which may also require scheduling ahead of time.

Unexpected Death:

Can the wording in the first sentence of the ERC manual in the area of "Unexpected Death" be clarified?

This area is checked "Yes" or "No" to report residents who die in the facility as a result of one or more of the following:

- Unexpected adverse event,
- Death not related to the normal course of the resident's disease process
- Does not meet all requirements as outlined in the non-weaning exclusion.

Are all "Unexpected Deaths" considered sentinel events? If not, when would an unexpected death not be a sentinel event?

No. A resident's death may be expected or unexpected but due to their medical condition. They may die of natural causes – this would not be considered a sentinel event. This may occur even when the resident does not meet all criteria for a non-weaning exclusion.

NOTE: If "Unexpected Death" is checked "Yes," then Non-Weaning Exclusion must be checked "No."

ERC Discharge:

Does this refer to discharge from the facility or from the ERC unit?

The ERC program allows for 3 days of coverage beyond the date of decannulation. Thereafter, if the resident is no longer receiving ERC services but is being monitored to ensure the stoma heals, the resident is considered to be on the respiratory unit, and should be discharged from ERC services. For residents who have had a long-term tracheostomy, this process may take weeks and while this monitoring is necessary, it is not an ERC service. For most of these residents, the facility should be able to convert the resident to a standing Level II or Level I PAE.

What if the resident is "discharged" to the hospital for less than 30 days?

If the resident is "discharged" to the hospital for 30 days or less, during which time they are classified as a bed hold and for which a new PAE and a new authorization are not required, this is not considered an ERC discharge and thus does not require a new admission date (see ERC manual).

TECHNOLOGY

Are the technology measures to be checked "Yes" if they are used OR if they are available?

Technology measures are to be checked "Yes" if they are available under the General Facility Information tab. Technology measures are to be checked "Yes" if they are utilized for the individual resident under the Patient Information tab.

NOTE: Residents who utilize mobile equipment, but who are not removed from the room due to their condition, should be checked "Yes" in this area as they are utilizing the mobile equipment.

If a resident is not ventilator dependent, but utilizes mobile monitoring technology, should this technology be checked "Yes"?

Yes.

Is there a minimum number of days that technology measures must be utilized in order to check "Yes" for that technology measure?

No. Utilization must only occur one time during the reporting month in order to code a technology measure.

Does the facility have to own the equipment in order to code use of a technology measure?

No. The facility is able to code the use of technology if the equipment is on loan, being utilized as a demo, or have otherwise obtained.

If the facility has an alarm system, but does not have a paging system that is specific to alert staff for ventilator issues, would that be sufficient to code for use of Alarms/Paging systems?

Yes. Facilities with alarms and/or paging systems that are specific to alert staff to ventilator operation would meet the requirements. The intent for this is redundant alarms, not depending only on alarms built into the ventilator unit.

Should alarms/paging systems be coded if the resident is NOT on a ventilator?

Yes. Alarms/paging systems that are utilized to alert staff of abnormal vital signs may be coded even if the resident is not ventilator-dependent. This means tracheostomized members (sub-acute tracheal suction and tracheal suction secretion management) are eligible for the alarm/paging technology when the devices are applicable. Although redundancy is required for all mechanically ventilated members, tracheostomized members are also able to receive said services.

Is a suction machine considered a type of mechanical airway clearance device (see ERC Manual)?

No. A suction machine would not be included in the mechanical airway clearance device category.

CLINCAL PATIENT INFORMATION

Care Status Change within the Reported Month:

Is this limited to respiratory issues?

Yes. The goal of this measure is to track care status changes related to the ERC program.

ERC Discharge Date:

Is a patient required to be discharged from the ERC program no later than 3 days after decannulation?

No. The date of discharge is the date at which a resident's condition would no longer require them to receive ERC services as applicable under the ERC program. If after the required three day period following the removal of the artificial airway, the resident no longer requires any ERC services, they are to be discharged from the ERC unit.The ERC program allows for 3 days of coverage beyond the date of decannulation. Thereafter, if the resident is no longer receiving ERC services but is being monitored to ensure the stoma heals, the resident is considered to be on the respiratory unit, and should be discharged from ERC services. For residents who have had a long-term tracheostomy, this process may take weeks and while this monitoring is necessary, it is not an ERC service. For most of these residents, the facility should be able to convert the resident to a standing Level II or Level I PAE.

Does the "ERC Discharge Date" refer to discharge from the facility or from the ERC unit?

This refers to the discharge from the ERC unit. This will only apply if a resident leaves the ERC unit to return home, are hospitalized for more than 30 days, go to another facility or any other situation which requires a new PAE and a new authorization in order for them to return to your facility.

What if the resident is "discharged" to the hospital for 30 days or less?

If the resident is "discharged" to the hospital for 30 days or less, during which time they are classified as a bed hold and for which a new PAE and a new authorization are **not** required, this is not considered an ERC discharge and thus does not require a new admission date (see ERC manual).

Where should the "Discharge Reason" be documented in the resident's medical record?

The discharge reason must be documented in the resident's original permanent legal medical record during the reporting month in the facility's choice of location; however, documentation must be easily obtainable by the individual completing the data submission to TennCare and to all ERC reviewers.

Sentinel Event:

Is a "Sentinel Event" only checked "Yes" if the facility contributed harm to the event?

No. A facility should check "Yes" regardless of whether the facility contributed to the harm or not.

NOTE: A sentinel event is a patient safety event that reaches a patient and results in any of the following:

- ✓ Death
- ✓ Permanent Harm
- ✓ Severe temporary harm and intervention is required to sustain life

Such events are termed "sentinel" because they indicate the need for immediate investigation and response.

Are "Sentinel Events" only related to respiratory issues?

No. Any event that meets the "Type of Sentinel Event" criteria (below) should be reported:

- ✓ Unexpected Death (death not associated with non-weaning exclusion)
- ✓ Serious Injury
- ✓ Required Emergency Intervention
- ✓ Death within 72 Hours of Hospitalization
- ✓ Other

Are events which are not emergent, such as PEG tube replacement, considered to be sentinel event because they are not planned?

No. PEG tube replacements require scheduling ahead of time to ensure the receiving hospital has the appropriate medical staff to perform the procedure. Members with chronic anemia may require frequent blood transfusions, which may also require scheduling ahead of time.

Are DNR comfort care deaths considered to be sentinel events?

No. Although the death may not have occurred within a non-wean exclusion of palliative care or hospice, the member elected for the comfort measures. The death is expected and not a sentinel event.

FACILITY PARTICIPATION REQUIREMENTS

Do licensed "Internal Medicine" physicians qualify as medical directors for ERC facilities?

Only if they are board certified in pulmonary disease or critical care medicine as recognized by either the American Board of Medical Specialties or American Osteopathic Association, as applicable.

Do licensed "Osteopathic Physicians" qualify as medical directors for ERC facilities?

Yes, but they must also be board certified in pulmonary or critical care medicine.

Do facilities have to bill according to MCO authorization?

Yes, facilities should bill according to MCO authorization for approved care days during the month. MCO authorization should be readily available.

Do status changes (e.g. ventilator to weaning) require additional authorization from the MCO?

Yes. Ventilator weaning requires authorization from the MCO. Eventa evaluations/recommendations are provided to the MCOs for clinical validation.

Are MCO authorizations time limited?

MCOs authorize approved times frames for ERC coverage; these time frames are determined by clinical assessment for each resident and indicated on the MCO authorizations.