CHAPTER 3: OVERVIEW OF THE ITEM-BY-ITEM GUIDE TO THE LTCH CARE DATA SET

This chapter provides item-by-item coding instructions for long-term care hospital (LTCH) staff members to complete each section of the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS). The goal of this chapter is to provide LTCH staff with the rationale and guidance necessary to accurately complete each item of the LCDS.

3.1 Using This Chapter

The order of information presented for each section of the LCDS is as follows:

- **Intent.** States the reason(s) for including this set of assessment items in the LCDS.
- **Item Display.** Each assessment section displays the item from the LCDS.
- **Item Rationale.** Explains the purpose of documenting particular facility characteristics, patient demographics, and/or clinical or functional status.
- **Steps for Assessment.** Provides sources and methods for determining the correct response when coding each LCDS item.
- **Coding Instructions.** Outlines the proper method of recording each response, with explanations of individual response categories.
- **Coding Tips.** States clarifications, issues of note, and conditions to be considered when coding each LCDS item.
- **Examples.** Illustrates examples of appropriate coding for several of the LCDS sections/items.

Additional layout characteristics to note include the following:

- Important terms are defined in a box next to the item throughout this Manual. These and other definitions of interest are also included in Appendix A: Glossary and Common Acronyms.
- When an item needs to be completed only in certain situations (e.g., only at admission), the item's coding instructions note this information in italics.

Table 3-1 provides the title and intent for each section of the LCDS.

Table 3-1
LCDS Sections

Section	Title	Intent
A	Administrative Information	This section obtains key information that uniquely identifies each patient, the LTCH in which they receive health care services, and the reason(s) for assessment.
B	Hearing, Speech, and Vision	The intent of these items is to document the patient's ability to hear (with assistive devices, if they are used), understand and communicate with others, process health information, and see objects nearby in their environment.
C	Cognitive Patterns	The items in this section are intended to determine the patient's attention, orientation, and ability to register and recall new information and if the patient has signs and symptoms of delirium.
D	Mood	The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the LTCH and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among LTCH patients because these signs and symptoms can be treatable.
GG	Functional Abilities	This section includes items about functional abilities. It includes items focused on prior functioning, admission performance, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.
H	Bladder and Bowel	The intent of the items in this section is to gather information on bladder and bowel continence.
I	Active Diagnoses	The items included in this section are intended to indicate the presence of select diagnoses that influence a patient's functional outcomes, ventilator liberation outcomes, or a patient's risk for the development or worsening of pressure ulcers/injuries. This section captures active diagnoses that are associated with a patient's LTCH stay. Active diagnoses include a patient's primary medical condition category and any comorbidities and co-existing conditions.
J	Health Conditions	The intent of the items in this section is to document patient falls, assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities.
K	Swallowing/Nutritional Status	This section covers height and weight, and nutritional approaches.
M	Skin Conditions	The items in this section document the presence, appearance, and change of pressure ulcers/injuries.
N	Medications	The intent of the Drug Regimen Review data elements is to document that an LTCH provider conducted a drug regimen review upon the patient admission and whether clinically significant medication issues were addressed in a timely manner when identified throughout the patient stay. The items in this section also document high risk drug classes and their indication.
O	Special Treatments, Procedures, and Programs	The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient, along with patient vaccinations.
Z	Assessment Administration	The items in this section provide the signatures of individuals completing the LCDS and the signature of the individual verifying completion of the LCDS assessment for a patient record.

3.2 Becoming Familiar with the LCDS-Recommended Approach

1. **Read this manual. It is essential.**
   - The CMS LCDS Manual is your *primary* source of information for completing the LCDS.
   - Familiarize yourself with how this manual is organized.
   - Use the information in this chapter correctly to increase the accuracy of your facility's LCDS patient assessment records.
   - Be certain that you understand the intent and rationale for coding items on the LCDS.
   - LTCHs should also become familiar with the content of Chapters 1, 2, 4, and 5. These chapters provide the framework and supporting information for data collected and submitted using the LCDS for the LTCH Quality Reporting Program (QRP).
   - For updates, check the LTCH QRP Web site regularly at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html
   - If you require further assistance (e.g., clarifications, questions, or issues), submit your inquiry to the appropriate Centers for Medicare & Medicaid Services (CMS) contact listed in Appendix B or to the LTCH Quality Questions Help Desk at LTCHQualityQuestions@cms.hhs.gov
2. **Review the LCDS.**
   - Notice how the sections are organized and where information should be recorded.
   - Work through one section at a time.
   - Examine the item wording and response categories as provided on the LCDS. For definitions and coding instructions for each item, refer to the appropriate Chapter 3 section.
3. **Complete a thorough review of Chapter 3.**
   - Review procedural instructions, timeframes, and general coding conventions.
   - Become familiar with each item's intent, rationale, and steps for assessment.
   - Become familiar with the item itself and with its coding choices and responses, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item.
   - Consider completing a paper version of the LCDS as a test case for a patient at your facility by entering the appropriate codes on the LCDS. Make a note of where your understanding could benefit from additional information, training, and use of the varying skill sets of the staff at your facility. Be sure to explore all resources available to you.
   - Read through the instructions that apply to each section as you are completing this test case. Work through the manual and the LCDS one section at a time until you are comfortable coding items. Make sure you understand the information in each before proceeding to the next section.

- Review the test case once it is completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code Skin Conditions items?
- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this manual where you need further clarification or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.
- Would you now complete any items on your initial test case differently?

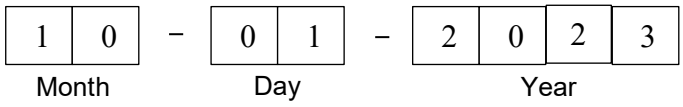
4. **Use the information in this chapter.**
   - Where clarification is needed, review the intent, rationale, and specific coding instructions for each item in question.

3.3 Coding Conventions

Several standard conventions should be used when completing the LCDS:

- The standard assessment period for the LCDS begins **2 calendar days** prior to the Assessment Reference Date (ARD) and ends on the ARD, for a total assessment period of 3 days, unless otherwise stated.
- If the patient leaves the LTCH during the assessment period, the assessment period will include the stay at another hospital/facility, provided the patient returns to the LTCH within 3 calendar days.
    - Example: A patient is admitted to the LTCH on October 1, 2023 at 7:00 p.m. On October 2, 2023, at 8:00 a.m., the patient is transferred to a short-term acute-care hospital. The patient returns to the LTCH on October 4, 2023, at 6:00 p.m. The assessment period for the patient's admission assessment will be the day of admission (October 1, 2023) through the ARD (which can be no later than October 3, 2023, at 11:59 p.m.), even though the patient was not in the LTCH during part of the assessment period.
- In a few instances, coding one item will govern whether coding is necessary for one or more additional items. This is called a *skip pattern*. The instructions direct the assessor to skip over the next item (or several items) and go on to another area of the item set. When you encounter a skip pattern, leave the item blank, and move on to the next item as directed.
    - Example: On a Planned Discharge assessment, if item **M0210, Unhealed Pressure Ulcers/Injuries** is **coded as 0, No** (the patient does not have one or more unhealed pressure ulcers/injuries), the admission assessment form directs the assessor to skip to **N0415, High-Risk Drug Classes: Use and Indication**. In this case, the intervening items (M0300A through M0300G) would not be coded (i.e., left blank) because a skip pattern is created. If M0210 is **coded as 1, Yes** (the patient has one or more unhealed pressure ulcers/injuries), then the assessor would continue to code the next LCDS item, **M0300A**.
- When coding instructions direct the assessor to "check all that apply," use a check mark to indicate which condition(s) are met (e.g., **A1005, Ethnicity**, boxes A–X). Be aware that a "check all that apply" item may have a checkbox for "Other," indicating that none of the other options apply.
- Use a numeric response (a number or preassigned value) in blank boxes (e.g., **A0800, Gender**).
- Each response box should contain only one character (numeric or alphabet). For example, you should enter only the number 2 in a box, not 02, or .2.

  When recording month, day, and year for dates, enter two digits for the month, two digits for the day, and four digits for the year. For example, the first day of October in the year 2023 is recorded as:



- CMS is aware that there are circumstances in which LTCHs may not be able to complete every item on the LCDS assessment. In these cases, refer to the applicable sections of this manual, and code the item set accordingly. For example, if you are unable to assess the patient on a particular item and therefore unable to enter a response on the LCDS, code the item with the default response of a dash (-). CMS expects dash use to be a rare occurrence. The -3900 edit (warning) is in place as a helpful reminder to staff completing the assessment that the item is required and not completing the item may result in a 2 percent reduction to the LTCH's applicable fiscal year Annual Payment Update (APU).
    - A dash value indicates that an item was not assessed or that no information is available to complete the item.
    - A few items where a dash value is not allowed include identification items in Section A (e.g., **A0250, Reason for Assessment** and **A0210, Assessment Reference Date**).
    - To determine whether a specific item allows a dash value, refer to the LCDS Data Submission Specifications and associated errata files, at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Technical-Information
- When the term *physician* is used in this manual, it should be interpreted as including providers such as nurse practitioners, physician assistants, and clinical nurse specialists, if allowable under State licensure laws.
- The word *significant* is used several times throughout the manual. The term may have different connotations depending on the circumstances in which it is used. For the LCDS, the term *significant*, when discussing clinical, medical, or laboratory findings, refers to supporting evidence that is considered when selecting or coding a diagnosis, and therefore reflects clinical judgment. When the term is used to refer to relationships between people, as in "significant other," it means a person, such as a family member or a close friend who is important or influential in the life of the patient.
- When completing the LCDS, some items require a count or measurement; however, there are instances in which the actual results of the count or measurement are greater than the number of available boxes—for example, number of pressure ulcers/injuries. In these cases, maximize the count or measurement by placing a "9" in each box. The correct number should be documented in the patient's medical record.
    - Example: If a patient has 10 Stage 2 pressure ulcers, the LTCH would enter 9 in **M0300B1, Number of Stage 2 pressure ulcers.** The LTCH should document 10 Stage 2 pressure ulcers in the patient's medical record.