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

The LTCH CARE Data Set, Version 1.01 contains items identified as necessary or relevant to the Pressure Ulcers that are New or Worsened quality measure. This chapter provides item-by-item coding instructions to the long-term care hospital (LTCH) to inform the completion of each section of the LTCH CARE Data Set, Version 1.01, including individual items within each section. The goal of this chapter is to provide LTCH staff with the rationale and guidance to optimize the accurate completion of each item of the LTCH CARE Data Set.

3.1 Using This Chapter

Throughout this chapter, sections of the LTCH CARE Data Set are presented using a standard format for ease of review by LTCH staff. In addition, screen shots of each item are included for illustration purposes. Note: Images of the LTCH CARE Data Set are embedded in this manual. If you are using a screen reader to access the content of the manual, refer to the LTCH CARE Data Set (Appendix C) to review the items of the LTCH CARE Data Set included in this manual.

The order of information presented for each section of the LTCH CARE Data Set is as follows:

- Intent. The reason(s) for including this set of assessment items in the LTCH CARE Data Set.
- Item Display. Each assessment section is accompanied by screen shots, which display the item from the LTCH CARE Data Set.
- Item Rationale. Explains the purpose of documenting particular facility characteristics, patient demographics, and/or clinical or functional status.
- Steps for Assessment. Provides resources and methods for determining the correct response when coding each LTCH CARE Data Set item. This information is not relevant for some sections and hence, NOT included for these sections (for example, Section A).
- Coding Instructions. Outlines the proper method of recording each response, with explanations of individual response categories.
- Coding Tips and Special Populations. States clarifications, issues of note, and conditions to be considered when coding each LTCH CARE Data Set item.
- Examples. Illustrates examples of appropriate coding for several of the LTCH CARE Data Set sections/items.

Additional layout characteristics to note include the following:

- Important terms are defined in a box next to the item throughout the *CMS LTCH Quality Reporting Program Manual*. These and other definitions of interest are also included in Appendix A, Glossary and Common Acronyms.

- When an item need be completed only in certain situations (e.g., only at admission), the item's coding instructions note this information in italics.

Table 1 provides the title and intent for each section of the LTCH CARE Data Set, Version 1.01.

Table 1 LTCH CARE Data Set, Version 1.01 Sections

Section	Title	Intent
A	Administrative Information	This section obtains key information that uniquely identifies each patient, the LTCH in which he or she receives health care services, and the reason(s) for assessment.
B	Hearing, Speech, and Vision	For the October 1, 2012, release of the LTCH CARE Data Set, Version 1.01, only one item (B0100: Comatose) is included in this section. The intent of this item is to document the status of a patient who is in a coma, or persistent vegetative state.
GG	Functional Status: Usual Performance	For the October 1, 2012 release of the LTCH CARE Data Set, Version 1.01, only three items (GG0160A, GG0160B, and GG0160C: Functional Mobility) are included in this section. This section assesses the need for assistance with mobility activities.
H	Bladder and Bowel	For the October 1, 2012, release of the LTCH CARE Data Set, Version 1.01, only one item (H0400: Bowel Continence) is included in this section. This item gathers information on bowel continence.
I	Active Diagnoses	For the October 1, 2012 release of the LTCH CARE Data Set, Version 1.01, only three items (I0900: Peripheral Vascular Disease or Peripheral Arterial Disease; I2900: Diabetes Mellitus; and I5600: Malnutrition) are included in this section. The items in this section are intended to code select diagnoses that increase a patient's risk for the development or worsening of pressure ulcer(s).
K	Swallowing/ Nutritional Status	For the October 1, 2012 release of the LTCH CARE Data Set, Version 1.01, only two items (K0200A, Height and K0200B, Weight) are included in this section. These items assess patient's body mass index using the patient's height and weight.
M	Skin Conditions	The items in this section of the LTCH CARE Data Set document the presence, appearance, and change of pressure ulcers.
Z	Assessment Administration	The items in this section provide signatures of individuals completing the LTCH CARE Data Set assessment.

3.2 Becoming Familiar with the LTCH CARE Data Set—Recommended Approach

1. **Read this manual. It is essential.**
   - The *CMS LTCH Quality Reporting Program Manual* is your primary source of information for completing the LTCH CARE Data Set.
   - Familiarize yourself with how this manual is organized.
   - Use the information in this chapter correctly to increase the accuracy of your facility's patient assessment records.
   - Be certain you understand the intent and rationale for coding items on the LTCH CARE Data Set.
   - 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 LTCH CARE Data Set for the LTCH Quality Reporting (LTCHQR) Program.

- For updates, check the LTCHQR Program web site regularly at: http://www.cms.gov/LTCH-Quality-Reporting/.
- If you require further assistance (e.g. clarifications, questions or issues), submit your inquiry to the appropriate CMS LTCH CARE Data Set contact listed in Appendix B or to the LTCH CARE Data Set Q&A mailbox at LTCHQualityQuestions@cms.hhs.gov**.**

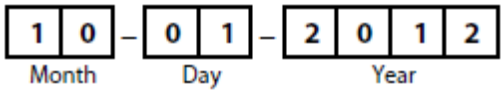
2. **Review the LTCH CARE Data Set.**
   - Notice how sections are organized and where information should be recorded.
   - Work through one section at a time.
   - Examine the item wording and response categories as provided on the LTCH CARE Data Set. For definitions and coding instructions for each item, refer to the appropriate Chapter 3 section.
3. **Complete a thorough review of Chapter 3.**
   - Review procedural instructions, time frames, and general coding conventions.
   - Become familiar with the 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.
   - Complete a paper (non-electronic) version of the LTCH CARE Data Set as a test case for a patient at your facility by entering the appropriate codes on the LTCH CARE Data Set assessment record. Make a note 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 LTCH CARE Data Set 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.**
   - Keep this chapter with you during the assessment process.

- 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 LTCH CARE Data Set assessment, as follows.

- The standard assessment period for the LTCH CARE Data Set is **3 calendar days** from the assessment reference date (ARD) 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 December 1, 2013, at 7:00 p.m. On December 2, 2013, at 8:00 a.m., the patient is transferred to a short-term acute care hospital. The patient returns to the LTCH on December 4, 2013, at 6:00 p.m. The assessment period for the patient's admission assessment will be the date and time of admission (December 1, 2013, at 7:00 p.m.) through the ARD (December 3, 2013, at 11:59 p.m. at the latest), even though the patient was not in the LTCH during part of the assessment period.
- In a few instances, coding on one item will govern whether coding is completed 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 assessment. When you encounter a skip pattern, leave the item blank and move on to the next item as directed
    - Example: If item **M0210, Unhealed Pressure Ulcer(s)** is **coded as 0, No** (the patient does not have 1 or more unhealed pressure ulcers), the admission assessment form directs the assessor to skip to **Z0400, Signature of Persons Completing the Assessment**. In this case, the intervening items (M0300 through M0700) would not be coded (i.e. left blank). If M0210 is **coded as 1, Yes** (the patient has 1 or more unhealed pressure ulcers), then the assessor would continue to code the next active LTCH CARE Data Set item, M0300A.
- When coding instructions instruct to "check all that apply," use a check mark to indicate which condition(s) are met (e.g., **A1000, Race/Ethnicity**, boxes A–F). If none of the conditions are met, these boxes remain blank. Be aware that a "check all that apply" item may have a checkbox for "None of the above."
- Use a numeric response (a number or pre-assigned value) in blank boxes (e.g., **A0800, Gender**).
- Each response box should contain only one character (numeric or alphabet). For example you should only enter 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 2012 is recorded this way:



- Almost all LTCH CARE Data Set items allow a dash (-) value to be entered and submitted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.
    - A dash value indicates that an item was not assessed.
    - Several date items can be dash filled. For example, item **M0300B, Date of Oldest Stage 2 Pressure Ulcer**, can be dash filled if the date is unknown. Dashes must be inserted into each of the eight available boxes.
    - A few items that do not allow dash values include identification items in Section A (e.g., reasons for assessment, patient name, and assessment reference date).
    - To determine whether a specific item allows a dash value, refer to the LTCH CARE Data Submission Specifications at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html.
- When the term *physician* is used in this manual, it should be interpreted as including nurse practitioners, physician assistants, or clinical nurse specialists, if allowable under state licensure laws and Medicare.
- 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 LTCH CARE Data Set, the term *significant*, when discussing clinical, medical, or laboratory findings, refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment. When the term is used in discussing relationships between people, as in "significant other," it means a person, such as a family member or a close friend that is important or influential in the life of the patient.
- When completing the LTCH CARE Data Set, 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, or weight. 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 record.
    - Example: If a patient's weight is 1010 pounds, the assessor would **enter 999** in **K0200B**, **Weight,** even though the number is not exact. The LTCH should document the 1010 pounds in the patient's medical record.