LTCH Provider Training

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7500 Security Blvd., Baltimore, MD 21244-1850

Contents

LTCH CARE Data Set:
Sections A and Z

Section A. Administrative Information

◊ Objectives

- State the intent of Section A: Administrative Information.
- Describe the information required to complete Section A.
- Learn how to code Section A correctly and accurately.

◊ Intent of Section A

- Obtain key information on
  - Each patient
  - LTCH where patient has been admitted
  - Reasons for assessment
  - Items to be completed vary by reason for assessment.

Turn to Section A in the LTCH CARE data set for Admission since it includes the most comprehensive set of Section A items.

A0050 Type of Record

- Documents the action requested for this LTCH CARE Data Set Assessment record:
  - Add a new assessment/record
  - Modify existing record
  - Inactivate existing record
- This item is included on the Admission, Expired, Planned Discharge, and Unplanned Discharge data sets.

◊ Add New Assessment/Record

- Used for a new record that has not been previously submitted and accepted into the QIES ASAP system.

◊ Modify Existing Record

- Used to correct errors on records already submitted and accepted into QIES ASAP.
- Modification request record should include correct values for *all* LTCH CARE Data Set items, not just those previously in error.
- Inactivates existing record.
- Used to request the inactivation of a record that has already been submitted and accepted into QIES ASAP system.

- Providers should submit an inactivation request when an event that was reported did *not* occur.
  - Example: Discharge was reported but the patient was not discharged.

◊ **Inactivation request is *required* if incorrect information was submitted for…**

- A0210 Assessment Reference Date
- A0220 Admission Date (on Admission record)
- A0250 Reason for Assessment
- A0270 Discharge Date (on a discharge or expired record)
- More than one patient identifier (e.g., first name, last name, SSN) is inaccurate
- Any of these items that were submitted as part of the original record must also be submitted as part of this inactivation request. Values for each item must match across the original record and the inactivation request record, except for the corrected items.

◊ **A0050 Coding Instructions**

- Enter the code number that corresponds to the purpose of this submission.
  - Code **1.** Add new assessment/record
  - Code **2.** Modify existing record
  - Code **3.** Inactivate existing record

A0100 Facility Provider Numbers

- Document the LTCH's facility provider numbers.
  - National Provider Identifier (NPI)
  - CMS Certification Number (CCN)
  - State Medicaid Provider Number (optional)
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

National Provider Identifier (NPI): A unique Federal number that identifies providers of health care services. The NPI applies to the LTCH and all of its patients.

CMS Certification Number (CCN): Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities.

◊ **A0100 Coding Instructions**

- Enter identification numbers in the spaces provided.
- Enter one number per space.
- Left-justify (start with left space).

- Leave extra spaces blank.
- Leave blank if not available or not known.

A0200 Type of Provider Coding Instructions

- Designates type of provider.
  - Long-term care hospitals (LTCHs) and long-term acute care hospitals (LTACs) are different names for the same type of hospital.
  - If a hospital is classified as a LTCH for purposes of Medicare payments (as denoted by the last four digits of its six-digit CCN in the range of 2000–2299), it is subject to the requirements of the LTCH Quality Reporting (LTCHQR) Program.

A newly established LTCH will be required to collect and submit data (using admission, unplanned discharge, planned discharge, and expired LTCH CARE Data Set and CDC NHSN) on patients admitted beginning on the date that the LTCH's CCN is issued, which licenses the hospital as a long-term care hospital.

- Allows the QIES ASAP system to match records.
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.
- Coding instructions
  - Enter **3** to indicate long-term care hospital.

A0210 Assessment Reference Date

- Records the assessment reference date (ARD).
- The ARD designates the end of the assessment period so that all assessment items refer to the patient's status during the same period.
- Information from an assessment done after the ARD will not be captured on that particular LTCH CARE data set.
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

Assessment reference date (ARD): The endpoint of the assessment period for the LTCH CARE data set assessment record.

◊ Determining the Assessment Reference Date

- Determined by the reason for the assessment
- The ARD for an admission record is at most the third calendar day of the patient's stay (admission date plus 2 calendar days)
- The ARD for discharge and expired assessments is the date of discharge or expiration.

- The ARD may not be extended because the patient receives services elsewhere during the assessment period.

For example, if the date of admission to the LTCH is December 3, 2012, assessment information would be based on the time period starting with the date of admission and ending at the ARD, which is 11:59 pm on December 5, 2012 (admission date plus 2 calendar days). If the patient is absent during December 3 or December 4, 2012, for any reason, the ARD remains December 5, 2012.

- Admission assessments: The ARD must be the same as the discharge or expired date if patient is discharged or dies before completion.

◊ A0210 Coding Instructions

- Enter the ARD.
- Use the format MM–DD–YYYY.
- Do not leave any spaces blank.
- Use a leading zero for one-digit months and days.

A0220 Admission Date

- Documents the date of admission into the LTCH.
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

Admission Date: The date a person enters the LTCH and is admitted as a patient. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the day of admission.

- Coding instructions
  - Enter the date of this admission to the LTCH.
  - Use the format MM–DD–YYYY.
  - Use leading zero for one-digit months and days.

A0250 Reason for Assessment

- Documents reason for completing assessment:
  - Admission
  - Planned discharge
  - Unplanned discharge
  - Expired
- Each LTCH CARE data set includes different items.

- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

◊ A0250 Coding Instructions

- Enter the code corresponding to the reason for completing the assessment:
  - Code **01.** Admission
  - Code **10.** Planned discharge
  - Code **11.** Unplanned discharge
  - Code **12.** Expired

Please refer to the discharge data sets for the following items.

Planned Discharge: A planned discharge is one in which the patient is non-emergently, medically released from care at the long-term care hospital because of some reason arranged for in advance.

Unplanned Discharge: An unplanned transfer of the patient to be admitted to another hospital/facility that results in the patient's absence from the LTCH for longer than 3 days (including the date of transfer);
or
Is a transfer of the 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 3 days;
or
When a patient unexpectedly decides to go home or to another setting (e.g., the patient decides to complete treatment in an alternate setting).

Does not include planned transfers to an acute-care inpatient hospital facility for a planned intervention, treatment, or procedure unless the patient does not return to the LTCH within 3 days.

A0270 Discharge Date

◊ A0270 Discharge Date

- This item is included on the planned discharge, unplanned discharge, and expired data sets.
- Documents the patient's discharge date or date of death.

◊ A0270 Coding Instructions

- For discharge: Enter date the patient was discharged (date the patient leaves the LTCH).
- For expired: Enter date of death.
- Format MM–DD–YYYY.

- For discharge assessments, the discharge date (A0270) and ARD (A0210) must be the same date.

Please turn back to Section A in the LTCH CARE admission data set.

Items A0500–A1200 Patient Demographic Information

◊ A0500–A1200 Patient Information

- Documents personal data about patient.
- Allows multiple records for the same patient to be matched in the system.

◊ A0500 Legal Name of Patient

- Enter the patient's name as it appears on the patient's Medicare card, Medicaid card, or other government-issued document:
  - Driver's license
  - Birth certificate
  - Passport
  - Social Security card
  - This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

◊ A0500 Coding Instructions

- Enter the patient's name:
  - First name
  - Middle initial
  - Last name
  - Suffix (e.g., Jr., Sr.)

If no middle name, leave blank; if more than one middle name, use initial of first middle name.

◊ A0600 Coding Instructions

- Enter patient's Social Security Number (SSN).
- Leave blank if patient does not have a SSN.
- Enter the patient's Medicare Number.
- Enter one digit or letter per space.
- Left-justify (start with left space).

- If no Medicare number is available, can use RRB Number.
- Confirm that the patient's legal name on the LTCH CARE data set assessment record (item A0500) matches the patient's legal name on the Medicare or RRB card.
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

Medicare Number (or comparable Railroad Insurance Number): An identifier assigned to an individual for participation in a national health insurance program. The Medicare Number identifier may differ from the patient's SSN and may contain both letters and numbers. For example, many patients receive Medicare benefits on the basis of a spouse's Medicare eligibility. This number may also be referred to as a Health Insurance Claim (HIC) number.

◊ A0700 Medicaid Number

- Record a Medicaid number if the patient is a Medicaid recipient.
- Obtain the number from patient's Medicaid card, admission or transfer records, or medical record.
- Confirm that the patient name on the LTCH CARE data set matches the name on the Medicaid card.
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

◊ A0700 Coding Instructions

- Enter one digit per space, starting in the leftmost space.
- Enter "+" in the leftmost space if the number is pending.
- Enter "N" in the leftmost space if not applicable.

◊ A0800 Gender

- Assists in correctly identifying patient in QIES ASAP.
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.
- Coding instructions
  - Enter code for patient's gender.
    - Code **1.** Male
    - Code **2.** Female

◊ A0900 Birth Date

- Allows determination of age.

- Assists in correctly identifying patient in QIES ASAP.
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

◊ A0900 Coding Instructions

- If the patient's birth date is known:
  - Enter the patient's birth date in the spaces.
  - Use the format MM–DD–YYYY.
  - Use a leading zero for a single-digit month or day.
  - Do not leave any boxes blank.
- If the patient's birth date is unknown:
  - Enter the fields that are known.
  - Leave unknown fields blank.
- If patient indicates that his or her birth date is different from that recorded in the medical record, always record the birth date as stated by the patient.

◊ A1000 Race/Ethnicity

- Indicates a patient's race/ethnicity.
- Categories in this item follow the common uniform language approved by the Office of Management and Budget (OMB).
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

◊ Assessing Race/Ethnicity

- Ask the patient to select race/ethnicity from categories in A1000.
- Use suggested language.
- If the patient is unable to respond, ask a family member, significant other, guardian, or legally authorized representative.
- Check the medical record only if necessary.

Suggested language for race/ethnicity question: Individuals may be more comfortable if this question is introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and racial background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care" (Baker et al., 2005).

◊ A1000 Coding Instructions

- Check all that apply.

- More than one category may be checked.

◊ A1100 Language

- Language barriers can interfere with accurate assessment of the patient's condition, treatment planning, and health care delivery.
- The inability to make needs known and to engage in social interaction because of a language barrier
  - can be very frustrating and
  - can result in isolation, depression, and unmet needs.
- The LTCH should make sure that an interpreter is available.
- The LTCH should also make alternative methods of communication available.
- This item is included only on the admission data set.

◊ Assessing the Need for an Interpreter

- To determine if an interpreter is needed:
  - Ask patient if he/she needs or wants an interpreter.
  - Consult a family member or significant other.
  - Review the medical record if no other source is available.
- Ask for the preferred language if needed.
- A family member or significant other can be an interpreter only under certain conditions.

For more information on who can serve as an interpreter, please refer to Chapter 3, Section A of the LTCHQR Program Manual.

◊ A1100A and A1100B Coding Instructions

- Enter code that reflects whether the patient wants or needs an interpreter.
  - Code **0.** Interpreter not wanted or needed.
  - Code **1.** Interpreter is wanted or needed.
  - Code **9.** Unable to determine.
- A1100B Coding instructions
  - If an interpreter *is* needed or wanted, enter the preferred language.

◊ A1200 Marital Status

- Completed for admission data set only.
- Allows understanding of any current formal relationship the patient may have.
- Can be important for care and discharge planning.

- Assessing marital status:
  - Ask the patient.
  - Ask a family member or significant other.
  - Review the medical record.
- This item is included only on the admission data set.

◊ A1200 Coding Instructions

- Enter the code that reflects the patient's current marital status:
  - Code **1.** Never married
  - Code **2.** Married
  - Code **3.** Widowed
  - Code **4.** Separated
  - Code **5**. Divorced

A1400 Payer Information

◊ A1400 Payer Information Coding Instructions

- Documents the patient's source of payment for services received in the LTCH.
- Coding instructions
  - Check the boxes that correspond to the patient's current payment sources.
  - Check all that apply.

◊ A1400 Payer Information Coding Options

- Code **A.** Medicare (traditional fee-for-service)
- Code **B**. Medicare (managed care/Part C/Medicare Advantage)
- Code **C.** Medicaid (traditional fee-for-service)
- Code **D.** Medicaid (managed care)
- Code **E.** Workers' compensation
- Code **F.** Title programs (e.g., Title III, V, or XX)
- Code **G.** Other government (e.g., TRICARE, VA)
- Code **H.** Private insurance/Medigap
- Code **I.** Private managed care
- Code **J.** Self-pay
- Code **K.** No payer source
- Code **X.** Unknown

- Code **Y.** Other

A1802 Admitted From

- Documents the patient's setting immediately before admission to the LTCH.
- Informs care planning as well as discharge planning and discussions.
- Completed for the admission data set only.

◊ Assessing A1802 Admitted From

- Review transfer and admission records.
- Ask the patient.
- Ask family members, significant others, guardians, or legally authorized representatives.

◊ Item A1802 Coding Instructions

- Enter the **two-digit code** that best describes the setting in which the patient was staying immediately before admission to the LTCH.
  - Code **01.** Community residential setting
  - Code **02.** Long-term care facility
  - Code **03.** Skilled nursing facility (SNF)
  - Code **04.** Hospital emergency department
  - Code **05.** Short-stay acute hospital (IPPS)
  - Code **06.** Long-term care hospital (LTCH)
  - Code **07.** Inpatient rehabilitation facility or unit (IRF)
  - Code **08.** Psychiatric hospital or unit
  - Code **09.** ID/DD facility
  - Code **10.** Hospice
  - Code **99.** None of the above

For definitions of each of these settings, please refer to the LTCHQR Program Manual, Chapter 3, Section A.

Please turn back to the Planned Discharge Data Set for the following items.

A2110 Discharge Location

- Indicates discharge location (type of facility to which a patient is discharged) at time of discharge.
- Review the medical record, including the discharge plan and discharge orders, for documentation.

- Item is included on planned and unplanned discharge data sets.

A2500 Program Interruption(s)

- Identifies the existence of program interruptions during the patient's stay.
- Allows CMS to evaluate the effect of program interruptions on quality of care.
- Complete for both planned and unplanned discharge data sets.

Program Interruption: refers to an interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per contractual agreement for services. Such an interruption must not exceed 3 calendar days, with day 1 being the day of transfer.

◊ A2500 Coding Instructions

- Review medical record for documentation of program interruptions.
- Enter the one-digit code to indicate whether or not there were program interruptions during the patient's stay:
  - Code **0, No,** if there were no program interruptions.
  - Code **1, Yes,** if there was at least one program interruption during this patient's current stay in this facility.

A2510 Number of Program Interruptions During This Stay in This Facility

- Determines the number of program interruptions during the patient's stay.
- Allows CMS to evaluate the association of program interruptions with quality of care.
- Complete for both planned and unplanned discharge data sets.
- A2510 coding instructions
  - Enter the number of program interruptions during this stay in this facility (using two digits).

A2520 Program Interruption Dates

- Allows CMS to evaluate the association of program interruptions with quality of care.
- Determines the dates of the program interruptions during the patient's current stay.
- Complete for both planned and unplanned discharge data sets.
- A2520 coding instructions
  - Using MM–DD–YYYY format, enter the start and end dates of the three most recent program interruptions.

Program Interruption Start Date: The day the patient leaves the LTCH. It is considered calendar day 1.

Program Interruption End Date: the day the patient returns to the LTCH. An absence from the LTCH is considered a program interruption when the program interruption end date is no later than calendar day 3 of the patient's absence.

Section Z. Assessment Administration

◊ Objectives

- State the intent of Section Z: Administrative Administration.
- Describe the information required to complete Section Z. Learn how to complete Section Z correctly and accurately.

◊ Z0400 and Z0500 Signatures

- Capture signatures of the LTCH staff members who completed the LTCH CARE data set assessment (Z0400) and of the person verifying assessment completion (Z0500).
- Signatures are not transmitted to CMS in LTCH submission files. CMS strongly suggests that you retain what you submit to CMS, in addition to the signatures in Section Z, according to your facility and State and Federal regulations and requirements.
  - Facilities that use electronic health records should comply with any additional requirements they may have.

◊ Z0400 & Z0500 Coding Guidelines

- Obtain signatures of all persons who completed any part of the LTCH CARE data set.
  - You are certifying that, to the best of your knowledge, the information you entered on the LTCH CARE data set reflects most accurately the patient's status.
- Accurately completing and submitting the LTCH CARE data set forms the basis for information used by CMS for payment update determination. When finalized, it will inform quality measure calculations for public use.

◊ Z0400 Signatures of Persons Completing Assessment

- Persons completing the assessment must provide the following information:
  - Signature
  - Title
  - Sections contributed to
  - Date of assessment
- Read the attestation statement carefully.
- Two or more staff members may complete the same section. Specify which items a staff member completed within a section in Z0400.
- This item is included on the admission, expired, planned discharge, and unplanned discharge data sets.

LTCH CARE Data Set: Section M

Introduction

◊ Objectives

- Identify the items to be documented in Section M.
- Describe guidelines for assessing and coding each item in Section M.
- Code Section M items correctly and accurately.

◊ LTCH CARE Data Set Sections

- This presentation addresses a critical section of the LTCH data set items: Section M, Skin Conditions.
- The *Introduction to Pressure Ulcers* presentation covered some basic concepts associated with pressure ulcers and other skin conditions.
- This presentation will focus on assessment guidelines and coding of the specific items in Section M.

Please turn to Section M in the LTCH CARE data set planned discharge assessment because it (and the unplanned discharge set) includes the most comprehensive set of Section M items.

◊ Overview of Section M Items

- The LTCH data sets for Section M include the following items:
  - M0210. Unhealed Pressure Ulcer(s)
  - M0300. Current Number of Unhealed Pressure Ulcers at Each Stage
  - (Discharge sets only) M0800. Worsening in Pressure Ulcer Status Since Prior Assessment

◊ Importance of Clinical Skin Assessment

- A complete and ongoing skin assessment guided by clinical standards is essential to an effective pressure ulcer prevention and skin management program for all patients.
- This assessment, which identifies and evaluates all areas at risk for constant pressure and determines the etiology of all skin ulcers, wounds, and lesions, should direct the appropriate skin management interventions.
- Completion of Section M items does not replace LTCH clinical personnel's thorough assessment of each patient's risk factors for developing skin ulcers, wounds, or lesions.

M0210 Unhealed Pressure Ulcer(s)

- The first item in Section M, M0210, indicates whether the patient has any unhealed pressure ulcers at Stage 1 or higher within the 3-day assessment period.

◊ M0210 Coding Guidelines

- Code for the presence of unhealed pressure ulcers.
  - Do not indicate the *number* of pressure ulcers in this item, just *whether an unhealed ulcer is present.*
  - The number of pressure ulcers is coded in the next series of items (M0300A–G).
  - If a pressure ulcer is surgically closed with a flap or graft, it should be considered a surgical wound, rather than a pressure ulcer.
  - A surgically debrided pressure ulcer is still a pressure ulcer.
- The assessment period is *3 days*. Confirm that the wound being assessed is primarily related to *pressure*.
- For the admission assessment, code **0** if the pressure ulcers healed within the last 3 days.
- For the discharge assessment, code **0** if the pressure ulcers healed within the last 3 days and no ulcers were present on the admission assessment.
- Assess and stage skin ulcers that develop in patients who have terminal illness or are at the end of life, unless it is determined that the ulcer is part of the dying process, such as a Kennedy ulcer.
  - Kennedy ulcers can develop from 6 weeks to 2–3 days before death.
  - These ulcers present as pear-shaped purple areas of skin with irregular borders that are often found in the sacrococcygeal areas.
  - When an ulcer has been determined to be a Kennedy ulcer, it should not be coded as a pressure ulcer.
- Mucosal pressure ulcers (e.g., those related to rectal tubes) should not be coded on the LTCH CARE data set.
  - Not staged using the pressure ulcer staging system.
  - Anatomical tissue comparisons cannot be made.

◊ M0210 Coding Instructions

- Code **0, No,** if the patient did not have an unhealed pressure ulcer in the 3-day assessment period.
  - Skip the remainder of Section M.
- Code **1, Yes,** if the patient did have an unhealed pressure ulcer in the 3-day assessment period.

M0300 Current Number of Unhealed Pressure Ulcers at Each Stage

- This item documents the *current number* of unhealed pressure ulcers for each stage.
- For each of the 7 stages (A–G) in M0300, determine the current number of unhealed pressure ulcers.

◊ Staging Definitions

- CMS has adapted the 2007 NPUAP definitions for categories of staging.
- Free diagrams of pressure ulcer stages can be downloaded for educational use at http://www.npuap.org.

◊ Step 1: Determine Deepest Anatomical Stage (Numerically Stage the Pressure Ulcer)

- Determine the deepest anatomical stage of each ulcer, using visual inspection and palpation.
  - Identify the type of tissue in the deepest part of the ulcer that is visible or palpable.
  - This requires visual inspection of the ulcer and the surrounding skin.
  - If the wound bed is partially covered by eschar (tan, black, or brown) or slough (yellow, tan, gray, green, or brown), but the depth of tissue loss can be measured, it must be staged.
- Do not reverse or backstage.
  - Review the history of each pressure ulcer. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at its highest numerical stage.
  - Current standards require that a pressure ulcer continue to be documented at its deepest stage until it has *completely healed*.

◊ Step 2: Identify Unstageable Pressure Ulcers

- If a pressure ulcer cannot be fully assessed, you cannot assign a stage to it. These pressure ulcers are referred to as unstageable.
- There are three types of unstageable ulcers.
  - Unstageable due to slough or eschar: Pressure ulcers covered with slough or eschar so that the tissue layers involved with the ulcer cannot be determined.
  - Unstageable due to suspected deep tissue injury: Discolored intact skin that is purple or maroon due to damage of underlying tissue.
  - Unstageable due to nonremovable dressing or device: Known pressure ulcers covered by a nonremovable dressing or device.

◊ Step 3: Determine "Present on Admission"

- Review the medical record for the history of the ulcer.
- Review for location and stage at the time of admission.
- Code the appropriate section for each stage.

Examples

◊ Example 1

- A pressure ulcer identified as a stage 1 pressure ulcer on admission increases to a stage 3 during the patient's stay at the LTCH.
  - On the discharge assessment, the ulcer is coded as a stage 3 pressure ulcer.
  - This stage 3 pressure ulcer should not be coded as present on admission because it was a stage 1 ulcer when the patient was admitted to the LTCH.

◊ Example 2

- A pressure ulcer identified as unstageable on admission is determined after debridement to be a Stage 2 pressure ulcer (i.e., it becomes numerically stageable).
  - The Stage 2 pressure ulcer is considered present on admission (i.e., the numerical stage identified after debridement).
  - If the pressure ulcer then worsens to a Stage 3, the Stage 3 pressure ulcer is not considered present on admission.

◊ Example 3

- A Stage 2 pressure ulcer develops during the patient's LTCH stay. The patient is subsequently transferred to an acute care hospital for 4 days. When the patient returns to the LTCH, the pressure ulcer has worsened to a Stage 3.
  - Requires a new admission assessment.
  - On new admission assessment, Stage 3 pressure ulcer coded as present on admission.

Coding Guidelines

- Code only wounds that present as a result of pressure, rather than other conditions.
- Code in the appropriate section, M0300A through M0300G, for pressure ulcers in each stage.
- Code only pressure ulcers present in the 3-day assessment period.

M0300A Number of Stage 1 Pressure Ulcers

- Item M0300A documents the current number of Stage 1 pressure ulcers.

◊ Stage 1 Pressure Ulcers

- Intact skin with *nonblanchable redness* of a localized area, usually over a bony prominence.
- *Darkly pigmented skin* may not have visible blanching.
- Color may differ from the surrounding area.

- Temperature may differ from the surrounding area.
- Tissue consistency may differ from the surrounding area
- Patient may experience pain or itching in the area.

◊ M0300A Coding Guidelines

- Differentiate a Stage 1 pressure ulcer from a suspected deep tissue injury.
  - Stage 1 ulcers will *generally lack* the surrounding characteristics found with a deep tissue injury (color change, tenderness, bogginess, etc.).
  - Suspected deep tissue injuries should be coded in M0300G.
- Differentiate Stage 1 pressure ulcers and moisture-associated skin damage (MASD).

◊ M0300A Coding Instructions

- Indicate the *number of* Stage 1 pressure ulcers present in the 3-day assessment period.
  - If none, enter **0** (zero).
  - If a pressure ulcer healed during the 3-day assessment period and was not present on a prior assessment, code **0**.

M0300B Stage 2 Pressure Ulcers

- Item M0300B documents the
  - current number of Stage 2 pressure ulcers and the
  - number of Stage 2 pressure ulcers present on admission.

◊ Stage 2 Pressure Ulcers

- Partial thickness loss of dermis presenting as…
  - Shallow, open ulcer
  - Red or pink wound bed
  - Without slough

Slough: nonviable yellow, tan, gray, green, or brown tissue. Slough is usually moist and can be soft, stringy, and mucinous in texture. Slough may adhere to the base of the wound or present in clumps throughout the wound bed.

If there is any slough, it is not a Stage 2 pressure ulcer.

- May also present as an intact or open or ruptured *blister*.
- Examine the adjacent and surrounding area for signs of deep tissue injury.
- When a deep tissue injury *is* determined, *do not code as a Stage 2.*

◊ M0300B Coding Guidelines

- Differentiate a Stage 2 pressure ulcer from a suspected deep tissue injury.
  - Suspected deep tissue injuries should be coded in M0300G, unstageable because of suspected deep tissue injury.
- Do *not* code skin tears, tape burns, MASD, or excoriation in M0300B.

◊ M0300B1 Coding Instructions

- Enter the *number* of Stage 2 pressure ulcers present in the 3-day assessment period.
- Enter **0** if no Stage 2 ulcers are present.

◊ M0300B2 Coding Instructions

- Enter number of Stage 2 pressure ulcers *present on admission.*

Present on Admission: If the pressure ulcer was present on admission and worsened to a higher numerical stage during the patient's LTCH stay, the higher stage should* not *be coded as "present on admission."

- For patients who return to the LTCH after a stay at another hospital or facility lasting longer than 3 calendar days, a new LTCH CARE data set admission assessment is required. Enter the number of Stage 2 pressure ulcers that are present at this new admission on the new admission assessment.
- The designation of "present on admission" requires that the pressure ulcer be at the *same* location and *not have worsened* to a deeper anatomical stage.
- Enter **0** if no Stage 2 pressure ulcers were present on admission.

M0300C and M0300D Stage 3 and Stage 4 Pressure Ulcers

- Items M0300C and M0300D document the current number of Stage 3 and 4 pressure ulcers and the number present on admission.

◊ Stage 3 Pressure Ulcers

- Full-thickness tissue loss
- Subcutaneous *fat may be visible* but bone, tendon, or muscle is *not* exposed.
- *Slough may be present* but does not obscure the depth of tissue loss.
- *May* include undermining and tunneling.

Undermining: The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the surface.
Tunneling: A passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

◊ M0300C1 Coding Instructions

- Enter the *number* of Stage 3 pressure ulcers.
- Identify all Stage 3 pressure ulcers present in the 3-day assessment period.
- Enter **0** if no Stage 3 ulcers are present.

◊ M0300C2 Coding Instructions

- Enter the *number* of Stage 3 pressure ulcers *present on admission*.
- Code the number of Stage 3 pressure ulcers first noted at time of admission.
- Enter **0** if no Stage 3 ulcers are present at admission.
- For patients who return to the LTCH after a stay at another hospital or facility lasting longer than 3 calendar days, a new LTCH CARE data set admission assessment is required. Enter the number of Stage 3 pressure ulcers that are present at *this* admission on the new admission assessment.
- For you to code a pressure ulcer as present on admission, the pressure ulcer needs to be at the *same* location and should *not have worsened* to a deeper anatomical stage.

◊ Stage 4 Pressure Ulcers

- Full-thickness tissue loss with exposed bone, tendon, or muscle.
- Slough or eschar may be present on some parts of the wound bed.

Eschar: dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan and may appear scab-like. Eschar usually firmly adheres to the base of the wound and often to the sides or edges of the wound.

- Often includes undermining and tunneling.
- Depth varies by anatomical location. (Ulcers on the bridge of the nose, ear, occiput, and malleolus can be shallow.)
- Nonmucosal pressure ulcers that have exposed cartilage should be classified as Stage 4 pressure ulcers.

◊ M0300D Coding Instructions

- Enter the *number* of Stage 4 pressure ulcers present in the 3-day assessment period.
- Enter the number of Stage 4 pressure ulcers *present on admission*.
- If no Stage 4 pressure ulcers were present on admission, code **0**.
- For patients who return to the LTCH after a stay at another hospital or facility lasting longer than 3 calendar days, a new LTCH CARE data set admission assessment is required. Enter the number of Stage 4 pressure ulcers present at *this* admission on the new admission assessment.

Scenarios

◊ M0300 Scenario #1

Note that numerous other scenarios are presented in Section M of the LTCHQR Program Manual.

- At the time of admission, a Stage 2 pressure ulcer was noted and documented in the patient's medical record.
- In the 3-day assessment period, the wound is noted to be a full-thickness ulcer with no exposure of bone, tendon, or muscle.
- How should Item M0300 be coded on the planned discharge assessment?

◊ Scenario #1 Coding

- This is now a Stage 3 pressure ulcer.
- Code M0300C1, Number of Stage 3 Pressure Ulcers, as **1**.
- Code M0300C2 as **0,** Not Present on Admission.
  - The designation of present on admission requires that the pressure ulcer be at the same location and not have worsened to a deeper anatomical stage (as this one did).

◊ M0300 Scenario #2

- While at the LTCH, a patient develops a Stage 2 pressure ulcer.
- He is transferred to a short-stay acute care hospital for 8 days.
- He returns with a Stage 3 pressure ulcer in the same location.
- How should Item M0300 be coded on the patient's new admission assessment?

◊ Scenario #2 Coding

- Code M0300C1, Number of Stage 3 Pressure Ulcers, as **1**.
- Code M0300C2 as **1**, Present on Admission. When the patient returns to the LTCH after his 8-day stay at another facility, the pressure ulcer is a Stage 3. On the new admission assessment, this pressure ulcer should be coded as present on admission (to indicate that it is present on this admission to the LTCH).

M0300E, F, and G Number of Unstageable Pressure Ulcers

- Document the current number of unstageable pressure ulcers and the number present on admission.

◊ Unstageable Pressure Ulcers

- There are three types of unstageable pressure ulcers:

- Unstageable due to nonremovable device or dressing
- Unstageable due to slough and/or eschar
- Unstageable due to suspected deep tissue injury (sDTI)

◊ Unstageable Due to Nonremovable Device or Dressing

- Known but not stageable because of the nonremovable device or dressing
  - There must be documentation that the pressure ulcer exists under the device or dressing.

◊ Unstageable Due to Slough and/or Eschar

- Known but not stageable because of coverage of wound bed by slough, eschar, or both
- Full-thickness tissue loss
- Base of ulcer covered by slough (yellow, tan, gray, green, or brown), eschar (tan, brown, or black), or both in the wound bed

◊ Unstageable Due to Suspected Deep Tissue Injury

- Related to damage of underlying soft tissue from pressure, shear, or both
- Localized area of discolored (darker than surrounding tissue), intact skin
- Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue

◊ M0300E, M0300F, and M0300G Coding Guidelines

- M0300E: Non-Removable Dressing. Review the medical record for documentation of a pressure ulcer covered by a nonremovable dressing.
  - Documentation of an existing pressure ulcer is needed to complete this item. Do not *assume* that there is a pressure ulcer that is covered by a nonremovable dressing**.**
- M0300F: Pressure ulcers formerly unstageable due to slough or eschar can be numerically staged after debridement, when the depth of tissue involved can be assessed.
  - The first time a numerical stage is assigned to an ulcer *post-debridement*, the pressure ulcer at that stage is considered present on admission on the discharge assessment.
- M0300G: Differentiate Unstageable Due to sDTI (coded in M0300G) and Stage 2 pressure ulcers (coded in M0300B).

◊ M0300E, M0300F, and M0300G Coding Instructions

- Code *number* of each type of unstageable pressure ulcer present in the 3-day assessment period.
  - Enter **0** if no ulcers of that type were present.
- Code number of each type of ulcer *present on admission*.

- Enter **0** if no ulcers of that type were present.

◊ Item M0300 Coding Scenario

- Miss J. was admitted with one small Stage 2 pressure ulcer.
- Despite treatment, it is not improving.
- When Miss J. is discharged, the wound bed is still covered with slough.
- How should Item M0300 be coded on the planned discharge assessment?

◊ Scenario Coding

- Code M0300F1 Number of Unstageable Pressure Ulcers Due to Slough and/or Eschar as **1**.
- Code M0300F2 as **0**.
  - It is coded as 0 [i.e., None] because the 1 unstageable pressure ulcer (coded in M0300F1) was not present on admission because it is now covered with slough and hence can no longer be coded as a Stage 2 pressure ulcer (i.e., the stage at which it was present at the time of admission assessment).

M0800 Worsening in Pressure Ulcer Status Since Prior Assessment

- Item M0800 documents whether skin status, overall, has worsened since the last assessment.
  - Documents the number of new pressure ulcers that have presented since the last assessment, and/or
  - Documents the number that have worsened (increased in numerical stage) to a more severe stage since the last assessment

Worsening Pressure Ulcer: A worsening pressure ulcer is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number on an assessment than on a previous assessment. For the purposes of identifying the absence of a pressure ulcer, 0 pressure ulcers is used when there is no skin breakdown or evidence of damage.

◊ M0800 Coding Guidelines

- The assessment period is the length of the patient's stay, beginning with the admission assessment's (i.e,. the prior assessment's) ARD. Complete this item only if
  - A0250 = 10, planned discharge, or
  - A0250 = 11, unplanned discharge.
- For each current staged pressure ulcer, count the number of pressure ulcers that are new or have worsened since the date of most recent prior assessment.

- If a numerically staged pressure ulcer increases in numerical staging, it is considered worsened.
- If a numerically stageable pressure ulcer (that is present on the admission or most recent prior assessment) becomes unstageable and then is debrided sufficiently for it to be numerically restaged, compare its stage before and after it was deemed unstageable. If the pressure ulcer stage has increased in numerical staging, it is considered worsened and should be included in the count for M0800.
- Do not code as worsened
  - Previously staged pressure ulcers that become unstageable due to slough or eschar
  - An unstageable pressure ulcer that is debrided and becomes numerically stageable
    - If subsequent to staging it further deteriorates and is restaged at a higher stage, it *is* considered worsened.
  - Two pressure ulcers that merge but do not increase in stage
  - A pressure ulcer that is acquired worsens during a stay in another facility that is more than 3 calendar days. (Discharge and new admission assessments should be completed and the worsened pressure ulcer should be coded as present on admission on the new admission assessment.)

◊ M0800 Coding Instructions

- Enter the *number* of pressure ulcers that
  - were not present on the prior assessment (new)

    OR
  - were at a lesser stage on the prior assessment (worsened)
- Code **0** if
  - there are no new pressure ulcers

    OR
  - no pressure ulcers have worsened

◊ M0800 Coding Scenario

- A patient's admission assessment documented a Stage 2 pressure ulcer on the right ischial tuberosity.
- Since then, the pressure ulcer has deteriorated to a Stage 3 pressure ulcer.
- How should Item M0800 be coded on the discharge assessment?

◊ Scenario Coding

- Code M0800A, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 2, as **0**.
- Code M0800B, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 3, as **1**.

- Code M0800C, Worsening in Pressure Ulcer Status Since Prior Assessment – Stage 4, as **0**.

LTCH CARE Data Set:
Sections B, GG, H, I, K, and O

Introduction

◊ Objectives

- State the intent of Sections B, GG, H, I, K, and O of the LTCH CARE data set.
- Describe the information required to complete each section.
- Code each item correctly and accurately.

◊ LTCH CARE Data Set Sections

- The sections of the LTCH CARE data set addressed in this presentation document a variety of information about the clinical status of the patient.
- Specifically, these sections address status relating to the following:
  - Section B. Hearing, Speech, and Vision
  - Section GG. Functional Status: Usual Performance
  - Section H. Bladder and Bowel
  - Section I. Active Diagnoses
  - Section K. Swallowing/Nutritional Status
  - Section O. Special Treatments, Procedures, and Programs

Please turn to the LTCH CARE Data Set Admission assessment.

Section B. Hearing, Speech, and Vision

B0100 Comatose

- Item B0100 documents whether the patient is either comatose or in a persistent vegetative state.
- Patients who are in a coma or persistent vegetative state are at risk for the complications of immobility:
  - Skin breakdown
  - Joint contractures
- This item is included only on the admission data set.

Comatose (Coma): A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The patient is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak, and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

Persistent Vegetative State: Sometimes patients who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.

◊ Assessing Comatose State

- To determine if the patient is comatose, review the medical record.
- Determine if a neurological diagnosis of comatose or persistent vegetative state has been documented by one of the following licensed staff as permitted by State law:
  - Physician
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist

◊ B0100 Coding Instructions

- Complete this item only for admission data set.
- Coding options:
  - Code **0, No,** if a diagnosis of coma or persistent vegetative state is not present during the 3-day assessment period

- Code **1, Yes,** If the record indicates that a physician, physician assistant, nurse practitioner, or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state applicable during the 3-day assessment period

For you to code Yes, a diagnosis of coma or persistent vegetative state must be documented in the patient's medical record. Other terms such as "unresponsive" and "severe encephalopathy" should not be used to infer a diagnosis of "comatose" or "persistent vegetative state."

Section GG. Functional Status: Usual Performance

GG0160 Functional Mobility

- Item GG0160 documents the patient's ability to
  - roll left and right,
  - move from a sitting to a lying position, and
  - move from a lying position to sitting on the side of the bed.
- It assesses the level of independence/dependence with which the patient can perform these activities.
- This item is included only on the admission data set.

◊ Risks of Mobility Limitations

- Many patients in LTCHs have mobility limitations.
- Most are at risk of further functional decline during their stay in the LTCH.
- As inactivity increases, complications may occur, such as the following:
  - Pressure ulcers
  - Falls
  - Contractures
  - Depression
  - Muscle wasting

◊ Assessing Functional Mobility

- Review documentation of patient's mobility status in the medical record for the 3-day assessment period.
- Talk with direct care staff.

Refer to facility or State policy to determine which LTCH staff members may complete an assessment. Patient assessments are to be done in compliance with facility or State requirements. State laws provide guidance on who may complete assessments of patients. All health professionals assessing functional status should have training.

  - Ask what the patient does for himself or herself during each episode of each mobility activity, as well as the type and level of staff assistance provided.
  - Consult staff from across all shifts.
  - Remind staff that the focus is on the 3-day assessment period only. If the patient's functional status varies during the assessment period, staff should report the patient's usual status.

- Observe the patient as he/she performs each mobility activity.
- Be specific in evaluating each component.
  - For example, when assessing *Roll Left and Right*, determine the level of assistance required to roll from lying on one's back to the left side, then to the right side, and ending with a return to lying on the back.
- To clarify your own understanding and observations about a patient's performance of an activity, ask probing questions.
  - Begin with general questions and proceed to more specific ones.

Example of a Probing Conversation With Staff

This is an example of a probing conversation between the nurse (RN) determining the patient's score and a certified nursing assistant (CNA) about the patient's Lying to Sitting on Side of Bed mobility assessment:

RN:"Describe to me how Mrs. L. moves herself in bed. By that, I mean once she is in bed, how does she move from lying on her back to sitting up on the side of the bed?"

CNA: "She can sit up by herself."

RN:"She sits up without any instructions or physical help?"

CNA: "No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed. But once I tell her to check her arm, she can do it herself."

In this example, the nurse inquired specifically how Mrs. L. moves from a lying position to a sitting position. The nurse specifically asked about instructions and physical assistance.

If the nurse had not probed, he/she would not have received enough information to make an accurate assessment of actual assistance Mrs. L. was receiving.

◊ GG0160 Coding Guidelines

- Code for each functional activity listed in the item:
  - Roll left and right: The ability to roll from lying on the back to the left and right sides and roll back to back.
  - Sit to a lying position: The ability to move from sitting on the side of a bed to lying flat on the bed.
  - Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor and no back support.
- Record the patient's *actual* ability to perform each activity. Do *not* record the staff's assessment of the patient's *potential capability* to perform it.
- If more than one helper is required to assist the patient in completing the activity, code as **01, Dependent.**

◊ GG0160 Coding Instructions

- Enter the code that best reflects the patient's ability to complete each activity.
  - Code **06, Independent,** if the patient completes the activity by himself/herself with no assistance from a helper.
  - Code **05, Setup or clean-up assistance,** if the helper sets up or cleans up; patient completes activity. Helper assists only before or following the activity.
  - Code **04, Supervision or touching assistance,** if the helper provides verbal cues or touching/steadying assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
  - Code **03, Partial/moderate assistance,** if the helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
  - Code **02, Substantial/maximal assistance,** if the helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
  - Code **01, Dependent,** if the helper does all of the effort. Patient does none of the effort to complete the task.
  - Code **07, Patient refused,** if the patient refused to complete the activity.
  - Code **09, Not applicable,** if the patient did not perform this activity before the current illness, exacerbation, or injury.
  - Code **88, Not attempted,** if the patient's medical condition or concerns for his or her safety prevented assessing the activity.

◊ Key Questions

- Does the patient need assistance (physical, verbal/non-verbal cueing, setup/clean-up) to complete the activity?
  - If no, Level 6, Independent
  - If yes…
- Does the patient need only setup or clean-up assistance?
  - If yes, Level 5, Setup or cleanup
  - If no….
- Does the patient need only verbal/cueing, or steadying/touching assistance?
  - If yes, Level 4, Supervision or touching assistance
  - If no…
- Does the patient need lifting assistance or trunk support with the helper providing *less* than half of the effort?
  - If yes, Level 3, Partial/moderate assistance
  - If no…

- Does the patient need lifting assistance or trunk support with the helper providing *more* than half of the effort?
  - If yes, Level 2, Substantial/maximal assistance
  - If no….
- Does the helper provide *all* of the effort to complete the activity?
  - If yes, Level 1, Dependent

◊ Coding Issues

- If more than one helper provides assistance, score level 1, Dependent.
- If the activity was *not* completed, indicate the reason:
  - Code **07.** Patient refused
  - Code **09.** Not applicable (not attempted)
  - Code **88.** Not attempted due to medical condition or safety concerns

Scenarios

◊ Coding Scenario #1: GG0160A Roll Left and Right

- Mr. C.'s medical issues include cellulitis, nonhealing ulcers, COPD, morbid obesity, and uncontrolled diabetes.
- Mr. C. is lying on his back and will roll to his left and right side.
- The therapist instructs Mr. C. to bend his right leg and roll to his left side. Mr. C. bends his right leg, but he is unable to roll onto his left side or back to the supine position. The therapist completes the task for Mr. C.
- When rolling to the right side, Mr. C. bends his left leg and the therapist completes the task for Mr. C.
- Coding options:
  - 06. Independent
  - 05. Setup or clean-up assistance
  - 04. Supervision or touching assistance
  - 03. Partial/moderate assistance
  - 02. Substantial/maximal assistance
  - 01. Dependent

How should Scenario #1 be coded?

◊ GG0160 Scenario #1 Coding

- The correct code is 02, Substantial/maximal assistance.

- Rationale: Mr. C. only bends his legs. The therapist performs more than half of the effort.

◊ GG0160 Scenario #2: Sit to Lying

- Mr. L. has two Stage 3 pressure ulcers and one Stage 2 pressure ulcer, osteomyelitis, and severe malnutrition.
- He uses an air-fluidized bed, so the therapists and nurses are unable to assess his bed mobility skills, including his ability to roll onto his left side and his ability to roll onto his right side.
- Coding options:
  - 06. Independent
  - 05. Setup or clean-up assistance
  - 04. Supervision or touching assistance
  - 03. Partial/moderate assistance
  - 02. Substantial/maximal assistance
  - 01. Dependent
  - 07. Patient refused
  - 09. Not applicable (not attempted)
  - 88. Not attempted due to medical condition/safety concerns

How should Scenario #2 be coded?

◊ GG0160 Scenario #2 Coding

- The correct code is 88 – Not attempted due to medical condition/safety concerns.
- Rationale: Staff are unable to assess Mr. L.'s ability to roll left and right due to his need for a specialized bed.

◊ GG0160 Scenario #3: Sit to Lying

- Mr. S.'s admitting diagnoses include incomplete tetraplegia and brain injury.
- To move Mr. S. from a sitting to lying position, the assistance of two staff members is required. One therapist provides lifting assistance as the nurse provides steadying assistance.
- Coding options:
  - 06. Independent
  - 05. Setup or clean-up assistance
  - 04. Supervision or touching assistance
  - 03. Partial/moderate assistance
  - 02. Substantial/maximal assistance

- 01. Dependent
- 07. Patient refused
- 09. Not applicable (not attempted)
- 88. Not attempted because of medical condition/safety concerns

How should Scenario #3 be coded?

◊ **GG0160 Scenario #3 Coding**

- The correct code is 01, Dependent.
- Rationale: The assistance of two staff members is needed.

◊ **GG0160 Scenario #4: Lying to Sitting on Side of Bed**

- Mr. B. was admitted with a diagnosis of acute respiratory failure, protein calorie malnutrition, and chronic kidney disease. By discharge, Mr. B. has been weaned from the ventilator but continues to have generalized weakness.
- Mr. B. pushes up on the bed to get himself from a lying to a seated position.
- The helper provides steadying (touching) assistance as Mr. B. scoots himself to the edge of the bed and lowers his feet to the floor.
- Coding options:
  - 06. Independent
  - 05. Setup or clean-up assistance
  - 04. Supervision or touching assistance
  - 03. Partial/moderate assistance
  - 02. Substantial/maximal assistance
  - 01. Dependent

How should Scenario #4 be coded?

◊ **GG0160 Scenario #4 Coding**

- The correct code is 04, Supervision or touching assistance.
- Rationale: The helper provides touching assistance as Mr. B. moves from a lying to sitting position.

Section H. Bladder and Bowel

H0400 Bowel Continence

- This item gathers information on the patient's bowel continence.
- This item is included only on the admission data set.

◊ Importance of Bowel Continence

- Bowel incontinence can
  - interfere with participation in activities,
  - be socially embarrassing and lead to increased feelings of dependency,
  - increase risk of long-term institutionalization,
  - increase risk of skin rashes and breakdown, and
  - increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

◊ Assessing Bowel Continence

- Review the medical record for
  - bowel incontinence flow sheets,
  - nursing assessments and progress notes,
  - physician history, and
  - physical examination.
- Interview the patient to determine whether he or she is capable of reliably reporting on bowel habits.
- Speak with family members or significant others if the patient is unable to report on bowel continence.
- Ask direct care staff on all shifts who routinely work with the patient about incontinence episodes.

◊ H0400 Coding Instructions

- Code based on the number of episodes of bowel incontinence during the 3-day assessment period.
  - Code **0, Always continent,** if during the 3-day assessment period, the patient has been continent for all bowel movements, without any episodes of incontinence.
  - Code **1, Occasionally incontinent,** if during the 3-day assessment period, the patient was incontinent of stool once. This includes incontinence of any amount of stool at any time.

- Code **2, Frequently incontinent,** if during the 3-day assessment period, the patient was incontinent of bowel at least twice, but also had at least one continent bowel movement. This includes incontinence of any amount at any time.
- Code **3, Always incontinent,** if during the 3-day assessment period, the patient was incontinent for all bowel movements and had no continent bowel movements.
- Code **9, Not rated,** if during the 3-day assessment period the patient had an ostomy or did not have a bowel movement for the entire 3 days.

Note that these patients should be checked for fecal impaction and evaluated for constipation.

◊ H0400 Coding Issues

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.
- Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, or enema) would be considered continent of bowel.
- This item is strictly limited to capturing information on patient's bowel continence without the use of a fecal management system or rectal tube.

Section I. Active Diagnoses

Items I0900, I2900, I5600 Active Diagnoses

- These items identify active diseases that are associated with increasing the risk of developing or worsening of pressure ulcers.
- Items I0900, I2900, and I5600 relate to active diagnoses for three conditions:
  - I0900 Peripheral Vascular or Arterial Disease (PVD or PAD)
  - I2900 Diabetes Mellitus (DM)
  - I5600 Malnutrition (protein or calorie) or at risk for malnutrition.
- The items in Section I are intended to be coded only for *active diseases*.
- These items are included only on the admission data set.

Assessing Active Diagnoses

- Step 1: Identify any of the three diagnoses that are applicable to the patient.
  - A diagnosis must be *documented* by a physician or other licensed, authorized staff as permitted by State law.
- Step 2: Determine if each diagnosis is active.
  - Determine if the diagnosis is active or inactive over the *3-day* assessment period.

◊ Step 1: Identify Diagnoses

- This requires a *documented* diagnosis from authorized, licensed staff as permitted by State licensure laws.
  - Physician
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist
- Review medical record for documentation of the diagnosis in
  - progress notes,
  - most recent history and physical,
  - transfer documents,
  - discharge summaries,
  - diagnosis/problem list,
  - medication sheets,
  - physician orders,
  - consults and official diagnostic reports,

- other resources as available.

- Only diagnoses confirmed by the physician or other authorized, licensed staff should be considered when coding this section.

◊ Step 2: Determine If Diagnosis Is Active

- A diagnosis is active if it has a direct relationship to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death during the 3-day assessment period.
- Do not include diseases or conditions that have been resolved or that no longer affect the patient's current status.
- There must be specific *documentation* of diagnoses in the *medical record* (progress notes, physical, discharge summary, etc.) made by a physician, nurse practitioner, physician assistant, clinical nurse specialist, or other authorized, licensed staff as permitted by State law.

◊ Section I Coding Guidelines

- Documentation in the medical record by a physician or other licensed, authorized staff of an active diagnosis must be used to code the diagnosis as active.
- Documentation that the specific diagnosis is active.
- Documentation that, for example, diabetes was inadequately controlled would also be sufficient documentation.

◊ Section I Coding Instructions

- Check each of the three conditions to determine whether it is *documented* as active.
- Check all that apply for the patient.

◊ Section I Scenario

- A patient is prescribed insulin for DM.
- The patient requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen.
- Physician progress note documents diagnosis of Diabetes Mellitus.
- Coding options:
  - Check I2900 Diabetes Mellitus
  - Check I5600 Malnutrition
  - Do not check any items in Section I

How should Section I be coded?

◊ Section I Scenario Coding

- Check I2900 Diabetes Mellitus.
- This would be considered an active diagnosis because a physician progress note documents DM.

Section K. Swallowing/Nutritional Status

K0200 Height/Weight

- This item assesses a patient's body mass index (BMI) using the patient's height and weight.
- This item is included only on the admission data set.

◊ Importance of Height/Weight

- Diminished nutritional and hydration status can lead to debility that can adversely affect wound healing and increase risk for the development of pressure ulcers.
- Height and weight measurements assist staff with assessing the patient's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time.

◊ Assessing Height

- Measure height in accordance with the LTCH's policies and procedures, which should reflect current standards of practice (shoes off, etc.).
- Measure and record height in inches.

◊ K0200A Coding Instructions

- Record height to the nearest whole inch.
- Use mathematical rounding.
  - If height measurement is X.5 inches or greater, round height upward to the nearest whole inch.
  - If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch.
- For example:
  - A height of 62.5 inches would be rounded to 63 inches.
  - A height of 62.4 inches would be rounded to 62 inches.

◊ K0200A Scenario

- Ms. G. underwent bilateral lower extremity amputations.
- Before the amputations, her height was recorded as 65.4 inches. After the amputations, her height was measured as 47.0 inches.
- Coding options:
  - Code K0200A as 65 inches
  - Code K0200A as 47 inches

◊ K0200A Scenario Coding

- Code K0200A as 47 inches.
- For the purposes of the LTCH CARE data set, the patient's current height (height after the amputations) should be used.

◊ K0200B Coding Instructions

- Use mathematical rounding.
  - If weight is X.5 pounds or more, round weight upward to the nearest whole pound.
  - If weight is X.1 to X.4 pounds, round down to the nearest whole pound.
- If a patient cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (—) and document rationale on the patient's medical record.

Section O. Special Treatments, Procedures, and Programs

O0250 Influenza Vaccine

- This item assesses the influenza vaccination status of patients.
- For the 2014–2015 influenza season, the influenza vaccination season is defined as beginning October 1, 2014, or when the influenza vaccine becomes available (whichever comes first) through March 31[1], 2015.

  For the 2015–2016 influenza season, the influenza vaccination season is defined as beginning October 1, 2015, or when the influenza vaccine becomes available (whichever comes first) through March 31[1], 2016.

  For subsequent influenza seasons, the influenza vaccination season is defined as beginning October 1 or when the influenza vaccine becomes available (whichever comes first) through March 31[1].
- This item is included only on the admission, planned discharge, and unplanned discharge data sets.

◊ Importance of Influenza Vaccination

- Older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization when infected with influenza.

◊ Assessing Influenza Vaccination Status

- Review the medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If vaccination status unknown, then…
- Ask the patient if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. When available, review the patient's medical record from previous setting(s). If vaccination status still unknown, then…
- Ask the patient's responsible party or legal guardian, primary care physician, or both. If vaccination status still unknown, then…
- Refer to standards of clinical practice to determine whether or not to administer the vaccine to the patient.

[1] Please refer to FY2015 IPPS/LTCH Notice of Proposed Rule, which will be available upon publication, by following the link titled *FY 2015 IPPS/LTCH PPS Notice of Proposed Rule*, under the Related Links section of the LTCHQR Program Website at http://www.cms.gov/LTCH-Quality-Reporting.

◊ O0250A Coding Instructions

- Enter the code that best reflects the patient's influenza vaccine status.
- Code **0, No,** if the patient did not receive the influenza vaccine in this facility during this year's influenza vaccination season.
- Code **1, Yes,** if the patient did receive the vaccine in this facility during this year's influenza vaccination season.
- Code with a **dash** if patient's influenza vaccination status cannot be determined.

◊ O0250B Coding Instructions

- If vaccine was received, enter date received,
- Use MM–DD–YYYY format. If the month or day contains a single digit, fill the first box with 0.
  - e.g., 10-06-2014
  - e.g., 01-07-2014

◊ O0250C Coding Instructions

- Enter the code that best reflects the reason the influenza vaccine was not received.
- Code **1**, **Patient Not in Facility During This Year's Influenza Vaccination Season,** if patient was not in the facility during this year's influenza vaccination season.
- Code **2, Received Outside This Facility,** if vaccine administered in any other setting (e.g., including physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season.
- Code **3, Not Eligible—Medical Contraindication,** if not received due to medical contraindications, including allergic reaction to eggs or other vaccine component(s), a physician order not to immunize, or an acute febrile illness is present.
- Code **4, Offered and Declined,** if patient or responsible party/legal guardian has chosen not to accept the influenza vaccine.
- Code **5, Not Offered,** if patient or responsible party/legal guardian was not offered the influenza vaccine.
- Code **6, Inability to Obtain Vaccine due to Declared Shortage,** if vaccine unavailable at the facility due to a declared vaccine shortage. Patient should be offered vaccine once the facility receives it.
- Code **9, None of the Above,** if none of the above reasons describe why the influenza vaccine was not administered. Code can also be used if the answer is unknown.