Centers for Medicare & Medicaid Services

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD AND EVALUATION (CARE) DATA SET (LCDS)

CHANGE TABLE SUMMARIZING REVISIONS TO THE LCDS VERSION 5.0

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Contents

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LCDS Version 5.0 Item Set

Below are a list of items added to LCDS Version 5.0

Section	Item #	At Admission/Planned Discharge/Unplanned Discharge	Item Description
Section A	A1005	At Admission	Ethnicity
Section A	A1010	At Admission	Race
Section A	A1110	At Admission	Language
Section A	A1250	At Admission, Planned Discharge	Transportation
Section A	A1805	At Admission	Admitted From
Section A	A1990	Unplanned Discharge	Patient Discharged Against Medical Advice?
Section A	A2105	Planned Discharge, Unplanned Discharge	Discharge Location
Section A	A2121	Planned Discharge, Unplanned Discharge	Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Section A	A2122	Planned Discharge, Unplanned Discharge	Route of Current Reconciled Medication List Transmission to Subsequent Provider
Section A	A2123	Planned Discharge, Unplanned Discharge	Provision of Current Reconciled Medication List to Patient at Discharge
Section A	A2124	Planned Discharge, Unplanned Discharge	Route of Current Reconciled Medication List Transmission to Patient
Section B	B0200	At Admission	Hearing
Section B	B1000	At Admission	Vision
Section B	B1300	At Admission, Planned Discharge	Health Literacy
Section C	C0100	At Admission, Planned Discharge	Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Section C	C0200	At Admission, Planned Discharge	Repetition of Three Words
Section C	C0300	At Admission, Planned Discharge	Temporal Orientation
Section C	C0400	At Admission, Planned Discharge	Recall
Section C	C0500	At Admission, Planned Discharge	BIMS Summary Score
Section C	C1310	At Admission, Planned Discharge, Unplanned Discharge	Signs and Symptoms of Delirium
Section D	D0150	At Admission, Planned Discharge	Patient Mood Interview (PHQ-2 to 9)
Section D	D0160	At Admission, Planned Discharge	Total Severity Score
Section D	D0700	At Admission, Planned Discharge	Social Isolation
Section J	J0510	At Admission, Planned Discharge	Pain Effect on Sleep
Section J	J0520	At Admission, Planned Discharge	Pain Interference with Therapy Activities
Section J	J0530	At Admission, Planned Discharge	Pain Interference with Day-to-Day Activities
Section K	K0520	At Admission, Planned Discharge, Unplanned Discharge	Nutritional Approaches
Section N	N0415	At Admission, Planned Discharge, Unplanned Discharge	High-Risk Drug Classes: Use and Indication
Section O	O0110	At Admission, Planned Discharge, Unplanned Discharge	Special Treatments, Procedures, and Programs O0110A1 to O0110O1

Note: Guidance has been added to the Manual pages for all the new items listed above.

All Sections

Edit #	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	LCDS Manual Version 5.0 – Effective October 1, 2022	Description of Change
0.1	All sections	**N/A**	Where applicable the manual is edited for the following: formatting, grammar, pronouns, stylistic edits, to improve clarity, updated email ID, updated phone numbers, updated dates, updated references, updated resources, reorganized information, updated version number from 4.0 to 5.0.	--
0.2	All sections	Revised Version 4.0, Effective July 1, 2018	Version 5.0, Effective October 1, 2022	Updated version and date in the bottom header.
0.3	All sections	LTCH CARE Data Set	LCDS	Replaced "LTCH CARE Data Set" with "LCDS" where applicable.
0.4	All sections	Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system QIES ASAP system	• Internet Quality Improvement and Evaluation System (iQIES) • iQIES	All "Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system" were replaced with "internet Quality Improvement and Evaluation System (iQIES)". Similarly, "QIES ASAP system" was replaced with "iQIES."
0.5	Appendix D	**Appendix D**: Long-Term Care Hospital Quality Reporting Program Technical Specifications for Reporting Assessment-Based Measures for LTCH CARE Data Set Version 4.00	**Removed**	Removed an appendix.
0.6	Appendix E	Measure Specifications for Quality Measures Reported Using the LTCH CARE Data Set	**Appendix D:** Measure Specifications for Quality Measures Reported Using the LCDS	Updated appendix letters to reflect changes in the manual.

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0.7	Appendix F	**References**	**Appendix E:** References	Updated appendix letters to reflect changes in the manual.

Note: Through this documents substantive changes from LCDS Version 4.0 to LCDS Version 5.0 are reflected in red font.

Chapter 1

Chapter 1				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
1.1	Chapter 1, Section 1.1, Page 1-1	**Did not exist**	This manual is intended to provide guidance on use of the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) instrument. Content contained in this document may be superseded by guidance published by CMS at a later date. Please refer to the following webpage to obtain the most recent updates: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual	Added a disclaimer.
1.2	Chapter 1, Section 1.1, Page 1-1	• Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) • This measure was finalized for removal from the LTCH QRP, effective with patients admitted or discharged on or after October 1, 2018, in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41632 through 41633). Please see: https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf	**Removed**	Removed measure.

Chapter 1				
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1.3	Chapter 1, Section 1.1, Page 1-2	**Did not exist**	1) Transfer of Health • Transfer of Health Information to the Provider – Post Acute Care (PAC) • Transfer of Health Information to the Patient – Post Acute Care (PAC) 2) Use of the LCDS to collect and submit standardized patient assessment data with respect to the following categories as specified in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act: • Functional status • Cognitive function • Special services, treatments, and interventions • Medical conditions and co-morbidities • Impairments • New category: Social determinants of health	Added two measures and a section.
1.4	Chapter 1, Section 1.1, Page 1-2	• National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) • This measure was finalized for removal from the LTCH QRP, effective with patients admitted or discharged on or after October 1, 2018, in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41628 through 41630). Please see: https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf … • National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure (NQF N/A) • This measure was finalized for removal from the LTCH QRP, effective with patients admitted or discharged on or after October 1, 2018, in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41630 through 41632). Please see: https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf	**Removed**	Removed measures.

Chapter 1				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
1.5	Chapter 1, Section 1.1, Page 1-2	**Did not exist**	**COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)** All information added regarding this information is new	Added measure.
1.6	Chapter 1, Section 1.2, Pages 1-4 to 1-5	• National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure: http://www.cdc.gov/nhsn/ltach/vae/index.html		Updated dates, removed MRSA and VAE measures, and added the COVID-19 Vaccination Coverage among HCP measure.
1.7	Chapter 1, Section 1.2, Page 1-5	**Did not exist**	• FY 2022 Inpatient Prospective Payment System (IPPS)/LTCH Prospective Payment System (PPS) final rule (86 FR 45341 through 45342 and 45437 through 45460: https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf • FY 2020 IPPS/LTCH PPS final rule (84 FR 42524 through 42591): https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf • FY 2019 IPPS/LTCH PPS final rule (83 FR 41624 through 41634): https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf	Added bullets for FY 2019, FY 2020, and FY 2022 Final Rules, and reordered rules by descending year (2020-2012).
1.8	Chapter 1, Section 1.3, Page 1-6	**Did not exist**	**Updated table**	Added table cell for Version 5.0 and effective end date for Version 4.0.

Chapter 2

Chapter 2				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
2.1	Chapter 2, Section 2.4, Page 2-10	• If the patient did not return to the LTCH by day 3 of the transfer, it is no longer considered an "interrupted stay," and the LTCH should complete an LTCH CARE Data Set Planned or Unplanned Discharge Assessment as appropriate.	**Removed**	Removed bullet that did not align with assessment of expired patient.

Chapter 3
Chapter 3, Intro

Chapter 3, Intro				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
3.0.1	Chapter 3, Intro, Page 3-6	**Coding Conventions** • Several 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. CMS allows the use of a dash for some items, so as we do not want to force providers to provide data to which they do not have access, because we want data to be as accurate as possible. CMS realizes that the use of a dash is sometimes necessary, but LTCHs should limit the use of the dash to only those items for which they were unable to obtain assessment data, or for items that were intentionally left unanswered by the LTCH. When a provider enters a dash for an item that is necessary to calculate the quality measure, a warning will be issued that states the use of a dash may subject the LTCH to a 2 percentage point reduction to their applicable annual payment update (APU). Please note that we issue this warning as a courtesy and reminder that a given item is required to help ensure that providers have entered the default response of a dash intentionally.	**Coding Conventions** • 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% reduction to the LTCHs applicable fiscal year annual payment update (APU).	Revised to align with a similar paragraph in Chapter 2 regarding dash use.
3.0.2	Chapter 3, Intro, Page 3-6	**Coding Conventions** • Some items may be completed with a dash. For example, item **A1000, Race/Ethnicity,** may be completed with a dash if ethnicity is unknown. • Please also refer to **Appendix D** of this LTCH QRP Manual for more information regarding the overview of data elements used for reporting assessment-based quality measures for the LTCH CARE Data Set.	**Coding Conventions** **Removed**	Removed two coding conventions.

Chapter 3, Section A

Chapter 3, Section A				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
3.A.1	Chapter 3, Section A, Page A-1	**Item Rationale** A special Manual Record Deletion Request is only necessary when there has been an error in a record that has been accepted into the QIES ASAP system that cannot be corrected with an automated Modification or Inactivation Request. There are only two items to which this applies.	**Item Rationale** **Removed**	Removed a part of Item Rationale for A0050.

Chapter 3, Section A				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
3.A.1 (cont.)	Chapter 3, Section A, Page A-1	**Item Rationale** A Manual Record Deletion Request must be performed when the record has the wrong state code and/or facility ID in the control items STATE_CD and FAC_ID. Control items are items created by the file submission software. These error(s) most likely occurred at the time of software development, or when initializing the software, and not during the entry of the provider's administrative or patient's data. If a QIES ASAP system record has the wrong state code or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record must be resubmitted with the correct STATE_CD and/or FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record. In the event that this error has occurred, the provider must contact the QTSO Help Desk at help@qtso.com or 1-877-201-4721 to obtain the LTCH CARE Manual Assessment Deletion Request form. The provider is responsible for completing the form. The provider must submit the completed form to the QTSO Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The QTSO Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the QTSO Help Desk will work through the request with the provider.	**Item Rationale** **Removed**	Removed a part of Item Rationale for A0050.
3.A.2	Chapter 3, Section A, Page A-3	**Item Rationale** **Did not exist**	**Item Rationale** **Note:** Specific user roles within iQIES will allow the provider to modify or inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.	Edited to improve clarity for A0050.

Chapter 3, Section A				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
3.A.3	Chapter 3, Section A, Page A-13	**Coding Instructions** • In an effort to fight identity theft for Medicare beneficiaries, CMS is replacing the SSN-based Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI).	**Coding Instructions** • In an effort to fight identity theft for Medicare beneficiaries, CMS is replacing the SSN-based Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI). After December 31, 2019, only the MBI will be accepted. Do not report the patient's SSN-based HICN.	Edited to improve clarity for A0600.
3.A.4	Chapter 3, Section A, Page A-13	**Coding Instructions** • If the patient does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. These RRB numbers contain both letters and numbers. To enter the RRB number, enter the first letter of the code in the left-most space, followed by one letter/digit per space. • If the person has neither a Medicare number nor an RRB number, the item may be left blank.	**Coding Instructions** ▪ Railroad Retirement Medicare Beneficiaries (RRB) have a Medicare card with an MBI. • To enter the MBI number, enter the first letter of the code in the left-most space, followed by one letter/digit per space. • If the patient does not have a Medicare/MBI number, the item may be left blank.	Edited to improve clarity for A0600.
3.A.5	Chapter 3, Section A, Page A-13	**Coding Instructions** • Prior to April 1, 2018: Enter the HICN, identified as the Medicare Claim Number on the patient's Medicare card. The HICN may differ from the patient's SSN. For example, many patients receive Medicare benefits based on a spouse's Medicare eligibility. • April 1, 2018–December 31, 2019: Enter the patient's HICN, or the patient's new MBI. • After December 31, 2019: Enter the MBI. Do not report the patient's SSN-based HICN.	**Coding Instructions** **Removed**	Removed a coding instruction for A0600.

Chapter 3, Section A				
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3.A.6	Chapter 3, Section A, Page A-13	**Did not exist**	**Definition** **Medicare Beneficiary Identifier (MBI)** A MBI is 11 characters in length and made up of only numbers and uppercase letters. This identifier is used for Medicare transactions like billing, eligibility status, and claim status, and should be treated as Personally Identifiable Information.	Added a new definition.
3.A.7	Chapter 3, Section A, Page A-18 to A-19	**Did not exist**	**A1005. Ethnicity**	Added a new assessment item.
3.A.8	Chapter 3, Section A, Page A-20 to A-22	**A1000. Race/Ethnicity** **Replaced with new item**	**A1010. Race**	Replaced A1000. Race/Ethnicity with A1010. Race. All content under A1010 is new.
3.A.9	Chapter 3, Section A, Page A-23 to A-24	**A1100. Language** **Replaced with new item**	**A1110. Language**	All content under A1110. is new.
3.A.10	Chapter 3, Section A, Page A-29 to A-31	**A1802. Admitted From** **Replaced with new item**	**A1805. Admitted From**	All content under A1805 is new.
3.A.11	Chapter 3, Section A, Page A-33	**A2110. Discharge Location** **Replaced with new item**	**A2105. Discharge Location**	All content under A2105 is new.

Chapter 3, Section B				
Edit	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
3.B.1	Chapter 3, Section B, Page B-1	**Intent**: The intent of these items is to document the patient's ability to understand and communicate with others.	**Intent:** 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 and the patient's ability to see objects nearby in their environment.	Edited to improve clarity for Section B.
3.B.2	Chapter 3, Section B, Page B-11	**Coding Instructions** Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.	**Coding Instructions** Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge. Complete during the 3-day admission assessment period and within 3 days of discharge.	Added time point for BB0700.
3.B.3	Chapter 3, Section B, Page B-14	**Coding Instructions** Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.	**Coding Instructions** Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge. Complete during the 3-day admission assessment period and within 3 days of discharge.	Added time point for BB0800.

Chapter 3, Section C

Chapter 3, Section C				
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3.C.1	Chapter 3, Section C, Page C-19 to C-24	**C1610. Signs and Symptoms of Delirium (from CAM©)** **Removed**	**C1310. Signs and Symptoms of Delirium (from CAM©)** **Replaced with C1310**	Item removed and replaced with C1310.

Chapter 3, Section D

Chapter 3, Section D				
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3.D.1	Chapter 3, Section D, Page D-1 to D-12	**Did not exist**	**Section D: Mood** D0150: Patient Mood Interview (PHQ-2 to 9) D0160. Total Severity Score D0700. Social Isolation	Added new section. All items and content under this section are new.

Chapter 3, Section GG				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
3.GG.1	Chapter 3, Section GG, Page GG-1	**Coding Instructions** *Complete during the 3-day admission assessment period.* • Code 3, Independent: if the patient completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper. • Code 2, Needed Some Help: if the patient needed partial assistance from another person to complete the activities. • Code 1, Dependent: if the helper completed the activities for the patient, or the assistance of two or more helpers was required for the patient to complete the activities.	**Coding Instructions** *Complete during the 3-day admission assessment period.* • **Code 3, Independent,** if the patient completed all the activities by themself with or without an assistive device, with no assistance from a helper. • **Code 2, Needed Some Help**, if the patient needed partial assistance from another person to complete any activities. • **Code 1, Dependent,** if the helper completed all the activities for the patient, or the assistance of two or more helpers was required for the patient to complete the activities.	Additional guidance added for coding accuracy for GG0100 codes 3, 2, and 1.
2.GG.2	Chapter 2, Section GG, Page G-2	**Coding Tips** • Record the patient's usual ability to perform self-care, indoor mobility (ambulation), stairs and functional cognition prior to the current illness, exacerbation, or injury.	**Coding Tips** • Record the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is most recent, that initiated this episode of care.	Added guidance at end of coding tip to specify timeframe.
3.GG.3	Chapter 3, Section GG, Page GG-2	**Coding Tips** **Did not exist**	**Coding Tips** • For GG0100. Prior Functioning: o If a patient completed all of the activities by him/herself, with or without an assistive device, with no assistance from a helper, code as 3, Independent. o If a patient needed partial assistance from another person to complete any of the activities, code as 2, Needed Some Help. o If a helper completed all of the activities for the patient because the patient could not assist, code as 1, Dependent.	Added coding tips for GG0100.

Chapter 3, Section GG				
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3.GG.4	Chapter 3, Section GG, Page GG-3	**Coding Instructions** *Complete only if A0250 = 01 Admission.*	**Coding Instructions** *Complete only if A0250 = 01 Admission.* *Complete during the 3-day admission assessment period.*	Updated time point guidance for GG0100.
3.GG.5	Chapter 3, Section GG, Page GG-3	**Coding Tips** **Did not exist**	**Coding Tips** • Report the devices used by the patient prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is more recent, that initiated this episode of care. • For the response categories in GG0110 (e.g., Mechanical lift), CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use. • For GG0110C, Prior Device Uses: Mechanical lift: "Mechanical lift" includes any device a patient or caregiver requires for lifting or supporting the patient's bodyweight. Examples include, but are not limited to: stair lift, Hoyer lift, bath tub lift, sit-to-stand lift, stand assist, electric recliner, and full-body style lifts. Clinical judgment may be used to determine whether other devices meet the definition provided. • Devices may have been be used indoors and/or outdoors.	Added coding tips for GG0110.
3.GG.6	Chapter 3, Section GG, Page GG-5	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** 1. Assess the patient's mobility performance based on direct observation, as well as the patient's self-report, and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** 1. Assess the patient's self-care and mobility performance based on direct observation, incorporating the patient's self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.	Revised to reflect updates to guidance.

Chapter 3, Section GG				
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3.GG.6 (cont.)	Chapter 3, Section GG, Page GG-5	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** 2. Patients should be allowed to perform activities as independently as possible, as long as they are safe. 4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity. *Assessment period:* The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. Clinicians should code the patient's admission functional status, based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The admission functional assessment, when possible, should occur prior to the patient benefiting from treatment interventions in order to determine the patient's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** 2. Allow the patient to complete each activity as independently as possible, as long as they are safe, regardless of how the patient performed the activity prior to the current illness, exacerbation, or injury. Activities may be completed with or without an assistive device. This includes the use of any new or previously utilized assistive device(s) or equipment. Use of a device or equipment may result in the patient needing less assistance from a helper. Assessment period: The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. At admission assessment, the self-care or mobility performance code is to be based on a functional assessment that occurs soon after the patient's admission and reflects the patient's baseline ability to complete the activity. This functional assessment must be completed within the first 3 days (3 calendar days). The assessment should occur, when possible, prior to the patient benefiting from services. Treatment should not be withheld in order to conduct the functional assessment.	Revised to reflect updates to guidance.

Chapter 3, Section GG				
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3.GG.7	Chapter 3, Section GG, Page GG-5 to GG-6	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** The patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, prior to the benefit of services provided by your facility staff. If the patient was not able to complete an activity (e.g., go up and down the stairs) prior to the benefit of services and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities use the appropriate "activity not attempted" code. Assessment of the GG self-care and mobility items is based on the patient's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking may be assessed for a patient who did/does/will use a wheelchair as their primary mode of mobility, stair activities may be assessed for a patient not routinely accessing stairs). "Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding. Introducing a new device should not automatically be considered as "providing a service." Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility.	Added new Steps for Assessment for GG0130/GG0170.

Chapter 3, Section GG				
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3.GG.7 (cont.)	Chapter 3, Section GG, Page GG-5 to GG-6	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** Communicating an activity request to the patient (e.g., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity ("Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Section GG Decision Tree.	
3.GG.8	Chapter 3, Section GG, Page GG-6	**GG0130. Self-Care & GG0170. Mobility** **Coding Instructions** Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.	**GG0130. Self-Care & GG0170. Mobility** **Coding Instructions** Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge. If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.	Updated coding instructions for GG0110.

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3.GG.9	Chapter 3, Section GG, Page GG-7	**GG0130. Self-Care & GG0170. Mobility Coding Instructions** • **Code 04, Supervision or touching assistance** • **Code 03, Partial/moderate assistance** • **Code 01, Dependent** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility Coding Instructions** • **Code 04, Supervision or touching assistance**: …Code 04, Supervision or touching assistance if the patient requires only verbal cueing to complete the activity safely. • **Code 03, Partial/moderate assistance**: … o Code 03 – Partial/moderate assistance, if the patient performs exactly half of the effort required to complete an activity. • **Code 01, Dependent:** … o Code 01, Dependent, if two helpers are required for the safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands on assistance. o Code 01, Dependent, if a patient requires the assistance of two helpers to complete an activity (one to provide support to the patient and a second to manage the necessary equipment to allow the activity to be completed).	Revised for clarity for GG0130 and GG0170.
3.GG.10	Chapter 3, Section GG, Page GG-7	**GG0130. Self-Care & GG0170. Mobility Coding Instructions** • **Code 88, Not attempted due to medical condition or safety concerns**, if the activity was not attempted due to medical condition or safety concerns.	**GG0130. Self-Care & GG0170. Mobility Coding Instructions** Use of an "activity not attempted" code should occur only after determining that an activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities. • **Code 88, Not attempted due to medical condition or safety concerns**: if the activity was not attempted due to medical condition or safety concerns, but the patient could perform the activity prior to the current illness, exacerbation, or injury.	Revised for clarity for GG0130 and GG0170.

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3.GG. 11	Chapter 3, Section GG, Page GG-8	**GG0130. Self-Care & GG0170. Mobility** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Decision Tree**	Added a section for GG0130 and GG0170.
3.GG. 12	Chapter 3, Section GG, Page GG-8	**GG0130. Self-Care & GG0170. Mobility** **Admission & Discharge Performance Coding Tips** **General coding tips:** • To clarify your own understanding of the patient's performance of an activity, ask direct care staff probing questions about the patient's abilities, beginning with the general and proceeding to the more specific. See examples of using probing questions when talking with staff at the end of this section. • Licensed clinicians may assess the patient's performance based on direct observation as well as reports from patient's self-report, clinicians, care staff, or family during the 3-day assessment period. We anticipate that a multidisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period. • If two or more helpers are required to assist the patient in completing the activity, code as 01, Dependent.	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips:** **Removed**	Removed a general coding tip.

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3.GG. 12 (cont.)	Chapter 3, Section GG, Page GG-8	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips** • If the patient does not attempt the activity and a helper does not complete the activity for the patient during the entire 3-day assessment period, code the reason the activity was not attempted. For example, code as 07 if the patient refused to attempt the activity during the entire 3-day assessment period, code as 09 if the activity is not applicable for the patient (the activity did not occur at the time of the assessment, and prior to the current illness, injury, or exacerbation), code as 10 if the patient was not able to attempt the activity due to environmental limitations, or code as 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips** **Removed**	Removed a general coding tip.
3.GG. 13	Chapter 3, Section GG, Page GG-8 to GG-9	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips** **Did not exist**	**GG0130. Self-Care and GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips**: • When an activity is not completed entirely during one clinical observation (e.g., a patient transfers bed-to-chair in the morning, and transfers chair-to-bed at night), code based on the type and amount of assistance required to complete the ENTIRE activity.	Added new coding tips.

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3.GG. 13 (cont.)	Chapter 3, Section GG, Page GG-8 to GG-9	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips** • If the patient only completes a portion of the activity (e.g., performs a partial upper body wash or transfers into but not out of a vehicle) and does not complete the entire activity during the assessment time period, use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines the partial activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code. • For GG0130 and GG0170, the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely, not based on the availability of such assistance. • CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Clinical assessments may include any device or equipment that the patient can use to allow them to safely complete the activity as independently as possible. o Do not code self-care and mobility activities with use of a device that is restricted to patient use during therapy sessions (i.e., parallel bars, exoskeleton, or overhead track and harness systems).	Added new coding tips.

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3.GG. 14	Chapter 3, Section GG, Page GG-9	**GG0130. Self-Care & GG0170. Mobility** **Coding tips for coding the patient's usual performance** • Assess the patient's mobility performance based on direct observation, as well as the patient self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period. • If the helper needs to retrieve the device/adaptive equipment, such as an adaptive eating utensil, then enter code 05, Setup or clean-up assistance.	**GG0130. Self-Care & GG0170. Mobility** **Coding tips for coding the patient's usual performance** **Removed**	Removed a coding tip.
3.GG. 15	Chapter 3, Section GG, Page GG-10	**GG0130. Self-Care & GG0170. Mobility** **Coding tips for patients with incomplete stays** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Coding tips for patients with incomplete stays** • Patients who meet the criteria for incomplete stays are: o Patients who are transferred to another hospital or facility that results in the patient's absence from the LTCH for longer than 3 calendar days (including the day of transfer); o Patients who die; o Patients who leave an LTCH against medical advice; o Patients with a length of stay less than 3 days. • If a patient's LTCH stay is less than 3 days (incomplete stay), and the patient is discharged before an admission assessment is completed, code GG0130 and GG0170 admission performance to the best of your abilities. If you are unable to assess the patient because of medical issues, enter code 88, Not assessed due to medical condition or safety concerns. • The self-care and mobility data elements are not included on the Unplanned Discharge Assessment or the Expired Assessment.	Added a coding tip.

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3.GG. 16	Chapter 3, Section GG, Page GG-11	**GG0130. Self-Care & GG0170. Mobility** **Definition** **Qualified Clinician** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Definition** **Qualified Clinician** Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.	Added a new definition.
3.GG. 17	Chapter 3, Section GG, Page GG-11	**GG0130. Self-Care & GG0170. Mobility** **Discharge Goal(s)** **Coding Tips** • If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a discharge goal may be entered using the 6-point scale if the patient is expected to be able to perform the activity by discharge.	**GG0130. Self-Care & GG0170. Mobility** **Discharge Goal(s)** **Coding Tips** • If the performance of an activity was coded as an "activity not attempted" code during the admission assessment, a discharge goal may be coded using the 6-point scale if the patient is expected to be able to perform the activity by discharge.	Revised for clarity.
3.GG. 18	Chapter 3, Section GG, Page GG-11	**GG0130. Self-Care & GG0170. Mobility** **Discharge Goal(s)** **Coding Tips** **Did not exist**	**GG0130. Self-Care and GG0170. Mobility** **Discharge Goal(s)** **Coding Tips** • Once a discharge goal is established on the LCDS, there is no need to update it if circumstances change or additional information becomes available either within or after the 3-day admission time period. However, the patient's care plan may need to be updated. • If an activity was not completed prior to the current illness, exacerbation, or injury, and is not expected to occur for the patient, even with assistance and/or an assistive device, the discharge goal would be Code 09 – Not applicable.	Added a coding tip.

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3.GG. 19	Chapter 3, Section GG, Page GG-15	**GG0130. Self-Care** **Coding Tips for GG0130A, Eating** **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130A, Eating** • The intent of GG0130A, Eating is to assess the patient's ability to use suitable utensils to bring food and /or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient. • The administration of tube feedings and parenteral nutrition is not considered when coding this activity. • If a patient requires assistance (e.g., supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding and safe swallowing. • If a patient swallows safely without assistance, exclude swallowing from consideration when coding GG0130A, Eating. • If the patient eats finger foods using their hands, then code GG0130A, Eating based on the type and amount of assistance required. If the patient eats finger foods with their hands independently, for example, the patient would be coded as 06, Independent. • For a patient taking only fluids by mouth, the item may be coded based on ability to bring liquid to mouth and swallow liquid, once the drink is placed in front of the patient.	Added new coding tips for GG0130A.
3.GG. 20	Chapter 3, Section GG, Page GG-18	**GG0130. Self-Care** **Coding Tips for GG0130B, Oral hygiene** **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130B, Oral hygiene** • For a patient who is edentulous (without teeth), code Oral hygiene based on the type and amount of assistance required from a helper to clean the patient's gums.	Added a new coding tip for GG0130B.

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3.GG. 21	Chapter 3, Section GG, Page GG-19 to GG-20	**GG0130. Self-Care** **Coding Tips for GG0130C, Toileting hygiene** • Toileting hygiene includes the tasks of managing undergarments, clothing and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the patient does not usually use undergarments, then assess the patient's need for assistance to manage lower-body clothing and perineal hygiene. • If the patient has an indwelling urinary catheter and has bowel movements, code the Toileting hygiene item based on the amount of assistance needed by the patient when moving his or her bowels.	**GG0130. Self-Care** **Coding Tips for GG0130C, Toileting hygiene** • Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal. If the patient completes a bowel toileting program in bed, code the item Toilet hygiene based on the patient's need for assistance for managing clothing and perineal cleansing. • If the patient has an indwelling urinary catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment. o For example: if the patient has an indwelling urinary catheter and has bowel movements, code GG0130C, Toileting hygiene based on the type and amount of assistance needed by the patient before and after moving their bowels. This may necessarily include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.	Revised for clarity for GG0130C.
3.GG. 22	Chapter 3, Section GG, Page GG-19 to GG-20	**GG0130. Self-Care** **Coding Tips for GG0130C, Toileting hygiene** **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130C, Toileting hygiene** • Includes: o Performing perineal hygiene. o Managing clothing (including undergarments and incontinence briefs) before and after voiding or having a bowel movement. o Adjusting clothing relevant to the individual patient. • The toileting hygiene activity can be assessed and coded regardless of the patient's need to void or have a bowel movement at the time of the assessment. • When the patient requires different levels of assistance to perform toileting hygiene after voiding vs. after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity.	Added new coding tips.

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3.GG. 22 (cont.)	Chapter 3, Section GG, Page GG-19 to GG-20	**GG0130. Self-Care** **Coding Tips for GG0130C, Toileting hygiene** **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130C, Toileting hygiene** • If the patient manages an ostomy, toileting hygiene includes wiping the opening of the ostomy or colostomy bag, but not management of the equipment.	Added new coding tips.
3.GG. 23	Chapter 3, Section GG, Page GG-21	**GG0130. Self-Care** **Examples for GG0130C, Toileting hygiene** Example #6	**GG0130. Self-Care** **Examples for GG0130C, Toileting hygiene** **Removed**	Removed an example for GG0130C.
3.GG. 24	Chapter 3, Section GG, Page GG-28	**GG0170. Mobility** **GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed** **Coding Tips** **Did not exist**	**GG0170. Mobility** **GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed** **Coding Tips** • For GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for the patient. For example, a clinician could determine that a patient's preferred slightly elevated resting position is "lying" for a patient. • If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns. For example, if a clinician determines that a patient's new medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170A, Roll left and right as 88, Not attempted due to medical or safety concerns. If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions and could not perform the activity prior to the current illness, exacerbation, or injury, code 09, Not applicable. • If the patient does not sleep in a bed, assess bed mobility activities using the preferred or necessary sleeping surface used by the patient.	Added new coding tips for GG0170A, GG0170B and GG0170C

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3.GG. 25	Chapter 3, Section GG, Page GG-28	**GG0170. Mobility** **Coding Tip for GG0170A, Roll left and right** • If the clinician determines the patient's medical condition does not allow for the patient to complete all tasks of the activity (roll left, roll right, roll to back) for the entire 3-day assessment period then code Roll left to right as 88, Not attempted due to medical condition or safety concerns. This can include patient refused due to intolerable pain for any tasks required of the activity.	**GG0170. Mobility** **Coding Tips for GG0170A, Roll left and right** **Removed**	Removed coding tip for GG0170A.
3.GG. 26	Chapter 3, Section GG, Page GG-28	**GG0170. Mobility** **Coding Tip for GG0170A, Roll left and right** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170A, Roll left and right** • The activity includes the patient rolling to both the left and to the right while in a lying position, on their preferred or necessary sleeping surface. • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated due to the patient's medical condition, code GG0170A, Roll left and right using the appropriate "activity not attempted" code. • If the patient does not sleep in a bed, assess the patient rolling to both the left and to the right while in a lying position, and returning to lying on their back on their preferred or necessary sleeping surface.	Added new coding tips for GG0170A.
3.GG. 27	Chapter 3, Section GG, Page GG-29	**GG0170. Mobility** **Examples for GG0170A, Roll left and right** Example #4	**GG0170. Mobility** **Examples for GG0170A, Roll left and right** **Removed**	Removed an example for GG0170A.

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3.GG.28	Chapter 3, Section GG, Page GG-29 to GG-30	**GG0170. Mobility** **Examples for GG0170A, Roll left and right** **Did not exist**	**GG0170. Mobility** **Examples for GG0170A, Roll left and right** 4. Roll left and right: Example of a probing conversation between a nurse determining a patient's score for roll left and right and a certified nursing assistant regarding the patient's bed mobility: Nurse: "Describe to me how the patient usually moves themself in bed. Once they are in bed, how do they turn from lying on their back to lying on their left and right sides and then return to lying on their back?" Certified nursing assistant: "The patient can roll to their sides by themself." Nurse: "The patient rolls from side to side and returns to lying on their back without any instructions or physical help?" Certified nursing assistant: "No, I have to remind the patient to bend their left leg and roll to their right side, and then to roll to their back and then to do the same on their left side and back to their back, but once I remind them, they can do it themself." In this example, the nurse inquired specifically about how the patient moves from lying on their back to lying on their sides and then returns to lying on their back. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, the nurse would not have received enough information to make an accurate assessment of the actual assistance the patient received. **Coding:** GG0170A, Roll left and right would be **coded 04, Supervision or touching assistance**. **Rationale**: The certified nursing assistant provides verbal instructions as the patient moves from lying on their back to lying on their sides and then returns to lying on their back.	Added probing conversation example for GG0170A.

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3.GG. 29	Chapter 3, Section GG, Page GG-30	**GG0170. Mobility** **Coding Tip for GG0170B, Sit to lying** • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.	**GG0170. Mobility** **Coding Tip for GG0170B, Sit to lying** **Removed**	Removed coding tip for GG0170B.
3.GG. 30	Chapter 3, Section GG, Page GG-30	**GG0170. Mobility** **Coding Tip for GG0170B, Sit to lying** **Did not exist**	**GG0170. Mobility** **Coding Tip for GG0170B, Sit to lying** • The activity includes the ability to move from sitting on the side of bed to lying flat on the bed, or on their preferred or necessary sleeping surface • If the patient does not sleep in a bed, assess the patient's ability to move from sitting on the side of the patient's preferred or necessary sleeping surface to lying flat on the patient's preferred or necessary sleeping surface. • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activity GG0170B, Sit to lying using the appropriate "activity not attempted" code.	Added new coding tips for GG0170B.
3.GG. 31	Chapter 3, Section GG, Page GG-30	**GG0170. Mobility** **Examples for GG0170B, Sit to lying** Examples #1 and #3	**GG0170. Mobility** **Examples for GG0170B, Sit to lying** **Removed**	Removed examples from GG0170B.

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3.GG. 32	Chapter 3, Section GG, Page GG-30 to GG-31	**GG0170. Mobility** **Examples for GG0170B, Sit to lying** **Did not exist**	**GG0170. Mobility** **Examples for GG0170B, Sit to lying** 2. Sit to lying: The patient had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). The patient can maneuver themself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task. **Coding**: GG0170B, Sit to lying would be **coded 04, Supervision or touching assistance**. **Rationale**: A helper provides verbal cues in order for the patient to complete the activity of sit to lying.	Added a new example.
3.GG. 33	Chapter 3, Section GG, Page GG-31	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** • If the patient's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment is required to accommodate foot placement on the floor. If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** **Removed**	Removed coding tips.

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3.GG. 34	Chapter 3, Section GG, Page GG-31	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** • The activity includes patient transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support. The patient's ability to perform each of the tasks within this activity and how much support the patient requires to complete the tasks within this activity is assessed.	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** • The activity includes the patient transitioning from lying on their back to sitting on the side of the bed and sitting upright on the bed, or alternative sleeping surface, without back support.	Edited coding tip for GG0170C.
3.GG. 35	Chapter 3, Section GG, Page GG-31	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, code the activity GG0170C, Lying to sitting on side of bed using the appropriate "activity not attempted" code.	Added new coding tip.
3.GG. 36	Chapter 3, Section GG, Page GG-33	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** • If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer, and the patient is not able to complete Sit to stand due to medical condition or safety issues, then GG0170D, Sit to stand would be coded 88, Not attempted due to medical condition or safety issues. However, if the patient did not attempt to perform sit to stand during the assessment and did not perform this activity prior to the current illness, exacerbation, or injury, then use code 09, Not applicable.	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** **Removed**	Removed coding tip for GG0170D.

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3.GG. 37	Chapter 3, Section GG Page GG-33	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** • The activity includes the patient coming to a standing position from any sitting surface. • If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer, and even with assistance the patient is not able to complete the sit to stand activity, code GG0170D, Sit to stand with the appropriate "activity not attempted" code. • Code 05, Setup or clean-up assistance, if the only help a patient requires to complete the sit to stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle foot orthosis.	Added new coding tips.
3.GG. 38	Chapter 3, Section GG Page GG-33	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** If a sit to stand lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** If a sit to stand lift is used and the patient requires the assistance of two helpers to get from a sitting to standing position, code as 01, Dependent.	Edited coding tips for GG0170D.
3.GG. 39	Chapter 3, Section GG, Page GG-34	**GG0170. Mobility** **Examples for GG0170D, Sit to stand** Example #4	**GG0170. Mobility** **Examples for GG0170D, Sit to stand** **Removed**	Removed an example for GG0170D.

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3.GG. 40	Chapter 3, Section GG, Page GG-34	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** • Item GG0170E, Chair/bed-to-chair transfer, begins with the patient sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying and GG0170C, Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E. • If a patient performs a stand pivot transfer due to inability to fully stand upon rising and instead rises to a squat, then pivots, turns and sits, this style of chair/bed-to-chair transfer is acceptable and should be coded based upon the amount of assistance required to perform this style of transfer.	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** **Removed**	Removed coding tips for GG0170E.
3.GG. 41	Chapter 3, Section GG, Page GG-34 to GG-35	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** • Depending on the patient's abilities, the transfer may be a stand-pivot, squat-pivot, or a slide board transfer. • For item GG0170E, Chair/bed-to-chair transfer: o When assessing the patient getting out of bed, the assessment begins with the patient sitting at the edge of the bed (or alternative sleeping surface) and ends with the patient sitting in a chair or wheelchair. o When assessing the patient getting from the chair to the bed, the assessment begins with the patient sitting in a chair or wheelchair and ends with the patient returning to sitting at the edge of the bed (or alternative sleeping surface). o The activities of GG0170B, Sit to lying and GG0170C, Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E.	Added new coding tips for GG0170E.

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3.GG. 41 (cont.)	Chapter 3, Section GG, Page GG-34 to GG-35	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** • When possible, the transfer should be assessed in an environmental situation where taking more than a few steps would not be necessary to complete the transfer.	Added new coding tips for GG0170E.
3.GG. 42	Chapter 3, Section GG, Page GG-36 to GG-37	**GG0170. Mobility** **Coding Tips for GG0170F, Toilet transfer** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170E, Toilet transfer** • The Toilet transfer activity can be assessed and coded regardless of the patient's need to use a toilet or commode to void or have a bowel movement in conjunction with the toilet transfer assessment. • Code 01, Dependent, if the patient requires assistance from two or more helpers to get on and off the toilet or commode.	Added new coding tips for GG0170F.
3.GG. 43	Chapter 3, Section GG, Page GG-38	**GG0170. Mobility** **Examples for GG0170F, Toilet transfer** Example #8	**GG0170. Mobility** **Examples for GG0170E, Toilet transfer** **Removed**	Removed an example.
3.GG. 44	Chapter 3, Section GG, Page GG-39 to GG-40	**GG0170. Mobility** **GG0170G, Car transfer** **Did not exist**	**GG0170. Mobility** **GG0170G, Car transfer**	Added new item. All content under this section is new.

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3.GG. 45	Chapter 3, Section GG, Page GG-40	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet, GG0170J, Walk 50 feet with two turns, GG0170K, Walking 150 feet, GG0170L, Walking 10 feet on uneven surfaces** • Walking activities do not need to occur during one session. Allowing a patient to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities. • The turns included in the items GG0170J (walking 50 feet with two turns) are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane, wheelchair).	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet, GG0170J, Walk 50 feet with two turns, GG0170K, Walking 150 feet, GG0170L, Walking 10 feet on uneven surfaces** **Removed**	Removed coding tips for GG walking items.
3.GG. 46	Chapter 3, Section GG, Page GG-40	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet, GG0170J, Walk 50 feet with two turns, GG0170K, Walking 150 feet, GG0170L, Walking 10 feet on uneven surfaces** • When coding GG0170 walking items, do not consider the patient's mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet, GG0170J, Walk 50 feet with two turns, GG0170K, Walking 150 feet, GG0170L, Walking 10 feet on uneven surfaces** • Do not code walking activities with the use of a device that is restricted to patient use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).	Edited a coding tip for GG walking items.

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3.GG. 47	Chapter 3, Section GG, Page GG-40 to GG-41	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet, GG0170J, Walk 50 feet with two turns, GG0170K, Walking 150 feet, GG0170L, Walking 10 feet on uneven surfaces** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet, GG0170J, Walk 50 feet with two turns, GG0170K, Walking 150 feet, GG0170L, Walking 10 feet on uneven surfaces** • Assessment of the walking activities starts with the patient in a standing position. • A walking activity cannot be completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance. A helper cannot entirely complete a walking activity for a patient. • During a walking activity, a patient may take a brief standing rest break. If the patient needs to sit to rest during a GG walking activity, consider the patient unable to complete that walking activity. • Clinicians can use clinical judgment to determine how the actual patient assessment of walking is conducted. If a clinician chooses to combine the assessment of multiple walking activities, use clinical judgment to determine the type and amount of assistance needed for each individual activity. Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type and amount of assistance needed for each individual activity. • If the patient, who participates in walking, requires the assistance of two helpers to complete the activity, code 01, Dependent. • If the only help a patient required to complete the walking activity is for a helper to retrieve and place the walker and/or put it away after patient use, then enter code 05, Setup or clean-up assistance.	Added new coding tips.
3.GG. 48	Chapter 3, Section GG, Page GG-41	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet** • Starting from standing, the activity includes the patient's ability to walk 10 feet.	Added new coding tip.

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3.GG. 49	Chapter 3, Section GG, Page GG-43	**GG0170. Mobility** **Coding Tip for GG0170J, Walk 50 feet with two turns** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170J, Walk 50 feet with two turns** • Starting from standing, the activity includes the patient's ability to walk 50 feet, making two turns. • The turns included in the items GG0170J, Walk 50 feet with two turns are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).	Added new coding tips for GG0170J.
3.GG. 50	Chapter 3, Section GG, Page GG-44	**GG0170. Mobility** **Coding Tip for GG0170K, Walk 150 feet** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170K, Walk 150 feet** • Starting from standing, the activity includes the patient's ability to walk 150 feet. • When coding GG0170K, Walk 150 feet if the patient's environment does not accommodate a walk of 150 feet without turns, but the patient demonstrates the ability to walk with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.	Added new coding tips for GG0170K.
3.GG. 51	Chapter 3, Section GG, Page GG-45	**GG0170. Mobility** **Examples for GG0170K, Walk 150 feet** **Did not exist**	**GG0170. Mobility** **Examples for GG0170K, Walk 150 feet** 3. Walk 150 feet: The patient has an unsteady gait due to balance impairment. The patient walks the length of the hallway using their quad cane in their right hand. The physical therapist supports the patient's trunk, helping them to maintain their balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance. **Coding:** GG0170K would be **coded 03, Partial/moderate assistance**. **Rationale:** The helper provides less than half of the effort for the patient to complete the activity of walking at least 150 feet.	Added a new example.

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3.GG. 52	Chapter 3, Section GG, Page GG-46	**GG0170. Mobility** **GG0170L, Walking 10 feet on uneven surfaces** **Did not exist**	**GG0170. Mobility** **GG0170L, Walking 10 feet on uneven surfaces**	Added new item in the manual. All content under this item is new.
3.GG. 53	Chapter 3, Section GG, Page GG-46 to GG-48	**GG0170. Mobility** **GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps** **Did not exist**	**GG0170. Mobility** **GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps**	Added new items in the manual. All content under this item is new.
3.GG. 54	Chapter 3, Section GG, Page GG-48 to GG-49	**GG0170. Mobility** **GG0170P, Picking up object** **Did not exist**	**GG0170. Mobility** **GG0170P, Picking up object**	Added new item in the manual. All content under this item is new.
3.GG. 55	Chapter 3, Section GG, Page GG-49	**GG0170. Mobility** **Coding Tips for Wheelchair Items** • The intent of the wheelchair mobility items is to assess the ability of patients who are learning how to self-mobilize using a wheelchair or those who used a wheelchair prior to admission. Use clinical judgment to determine whether a patient's use of a wheelchair is for self-mobilization as a result of the patient's medical condition or safety, or used for convenience. • Do not code wheelchair mobility if the patient uses a wheelchair only when transported between locations within the facility for staff convenience (e.g. because the patient walks slowly). Only code wheelchair mobility based on an assessment of the patient's ability to mobilize in the wheelchair.	**GG0170. Mobility** **Coding Tips for Wheelchair Items** **Removed**	Removed coding tips.

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3.GG. 56	Chapter 3, Section GG, Page GG-49	**GG0170. Mobility** **Coding Tips for Wheelchair Items** • If the patient walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the patient use a wheelchair/scooter?—as 0, No, and skip all remaining wheelchair questions. • Admission assessment for wheelchair items should be coded for patients who used a wheelchair prior to admission. • If a wheelchair is used for transport purposes only, then GG0170Q1 and/or GG0170Q3, Does the patient use a wheelchair or scooter is coded as 0, No, then follow the skip pattern to continue coding the assessment. – Example of using a wheelchair for transport convenience: A patient is transported in a wheelchair by staff between her room and the therapy gym or by family to the facility cafeteria, but the patient is not expected to use a wheelchair after discharge.	**GG0170. Mobility** **Coding Tips for Wheelchair Items** **Removed**	Removed coding tips.
3.GG. 57	Chapter 3, Section GG, Page GG-49	**GG0170. Mobility** **Coding Tips for GG0170Q. Does the patient use wheelchair and/or scooter?** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170Q. Does the patient use wheelchair and/or scooter?** • The intent of GG0170Q, Does the patient use a wheelchair and/or scooter? is to assess the ability of patients who are using a wheelchair under any condition • Only code 0, No, if at the time of the assessment the patient does not use a wheelchair or a scooter under any condition. • The responses for the gateway wheelchair items (GG0170Q1 and GG0170Q3) might not be the same on the admission and discharge assessment.	Added new coding tips for GG0170Q.

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3.GG. 58	Chapter 3, Section GG, Page GG-50	**GG0170. Mobility** **Coding Tips for GG0170R, Wheel 50 feet with two turns, GG0170RR, Indicate the type of wheelchair or scooter used, GG0170S, Wheel 150 feet, GG0170SS, Indicate the type of wheelchair or scooter used** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170R, Wheel 50 feet with two turns, GG0170RR, Indicate the type of wheelchair or scooter used, GG0170S, Wheel 150 feet, GG0170SS, Indicate the type of wheelchair or scooter used** • Clinicians can use clinical judgment to determine how the actual patient assessment of wheelchair mobility is conducted. If a clinician chooses to combine the assessment of multiple wheelchair activities use clinical judgment to determine the type and amount of assistance needed for each individual activity. • A helper can assist a patient to complete the wheelchair distance or make turns if required. When a patient is unable to wheel the entire distance themself the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity. • If a patient uses both a manual and a motorized wheelchair or scooter at the time of the assessment, code the activity based on the type of wheelchair/scooter with which the patient requires the most assistance.	Added a new section and its respective content.
3.GG. 59	Chapter 3, Section GG, Page GG-50	**GG0170. Mobility** **Coding Tips for GG0170R, Wheel 50 feet with two turns** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170R, Wheel 50 feet with two turns** • The turns included in the items GG0170R, Wheel 50 feet with 2 two turns are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level.	Moved the coding tip to the GG0170R coding tip.

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3.GG. 60	Chapter 3, Section GG, Page GG-52	**GG0170. Mobility** **Coding Tip for GG0170S, Wheel 150 feet** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170S, Wheel 150 feet** • If the patient's environment does not accommodate wheelchair/scooter use of 150 feet without turns, but the patient demonstrates the ability to mobilize the wheelchair/scooter with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale. • A helper can assist a patient to complete the wheelchair distance or make turns if required. When a patient is unable to wheel the entire distance themself the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.	Added new coding tips.
3.GG. 61	Chapter 3, Section GG, Page GG-54	**GG0130. Self-Care & GG0170. Mobility** **Examples for Unplanned Discharge** Example #4	**GG0130. Self-Care & GG0170. Mobility** **Examples for Unplanned Discharge** **Removed**	Removed an example.

Chapter 3, Section H				
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3.H.1	Chapter 3, Section H, Page H-2	**Coding Instructions** Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.	**Coding Instructions** Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge. Complete during the 3-day admission assessment period and within 3 days of discharge.	Added time point instructions for H0350.
3.H.2	Chapter 3, Section H, Page H-2	**Coding Instructions** • Code 2, Incontinent less than daily, if during the 3-day assessment period the patient was incontinent of urine once or twice. • Code 3, Incontinent daily, if during the 3-day assessment period the patient was incontinent of urine at least once a day. • Code 4, Always incontinent, if during the 3-day assessment period the patient had no continent voids.	**Coding Instructions** • **Code 2, Incontinent less than daily,** if during the 3-day assessment period the patient was incontinent of urine once or twice, and had at least one continent void during the 3-day assessment period. • **Code 3, Incontinent daily,** if during the 3-day assessment period the patient was incontinent of urine at least once a day, and had at least one continent void during the 3-day assessment period. • **Code 4, Always incontinent,** if during the 3-day assessment period the patient had no continent voids and no catheterization.	Updated coding instructions for clarity.
3.H.3	Chapter 3, Section H, Page H-5	**Coding Instructions** Complete only if A0250 = 01 Admission.	**Coding Instructions** Complete only if A0250 = 01 Admission. Complete during the 3-day admission assessment period and within 3 days of discharge.	Added time point for H0400.
3.H.4	Chapter 3, Section H, Page H-6	**Coding Instructions** • Code 1, Occasionally incontinent, if during the 3-day assessment period the patient was incontinent for bowel movement once. This includes incontinence of any amount of stool at any time	**Coding Instructions** • **Code 1, Occasionally incontinent,** if during the 3-day assessment period the patient was incontinent for bowel movement once but also had at least one continent bowel movement. This includes incontinence of any amount of stool at any time.	Updated coding instructions for H0400.

Chapter 3, Section I				
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3.I.1	Chapter 3, Section I, Page I-1	**I0050 Steps for Assessment** • Acute onset respiratory condition (e.g., aspiration and specified bacterial pneumonias) • Chronic respiratory condition (e.g., chronic obstructive pulmonary disease) • Acute onset and chronic respiratory condition • Chronic cardiac condition (e.g., heart failure) • Other medical condition. If "other medical condition" is selected, enter the International Classification of Diseases (ICD) code in the boxes	**I0050 Steps for Assessment** **Removed**	Removed Category list in steps for assessment due to redundancy.
3.I.2	Chapter 3, Section I, Page I-1	**I0050 Coding Instructions** Complete only if A0250 = 01 Admission	**I0050 Coding Instructions** Complete during the 3-day admission assessment period.	Revised coding instruction.
3.I.3	Chapter 3, Section I, Page I-5	**Active Diagnosis Coding Instructions** Complete only if A0250 = 01 Admission	**Active Diagnosis Coding Instructions** Complete during the 3-day admission assessment period.	Revised coding instruction.
3.I.4	Chapter 3, Section I, Page I-7	**Nutritional** • Check I5602, At Risk for Malnutrition, if the patient is at risk for malnutrition.	**Removed**	Removed a coding instruction for Nutritional, Active Diagnoses.

Chapter 3, Section J				
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3.J.1	Chapter 3, Section J, Page J-9	**Definition** **Fall** An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall. CMS understands that challenging a patient's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.	**Definition** **Fall** An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall.	Edited to improve clarity for clarity for J1800.
3.J.2	Chapter 3, Section J, Page J-9	**Coding Instructions** Complete only if A0250 = 10 Planned Discharge, A0250 = 11 Unplanned Discharge, or A0250 = 12 Expired.	**Coding Instructions** Complete only if A0250 = 10 Planned Discharge, A0250 = 11 Unplanned Discharge or A0250 = 12 Expired. Complete at time of discharge.	Added "complete at time of discharge" to the time point statement.
3.J.3	Chapter 3, Section J, Page J-10	**Examples -3** **Rationale:** The patient stumbled, which was not anticipated by the therapist, and the therapist intervened to prevent a fall. An intercepted fall is considered a fall.	**Examples - 3** **Rationale:** The patient unexpectedly stumbled, which was not anticipated by the therapist, and the therapist intervened to prevent a fall. An intercepted fall is considered a fall if it is not an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training.	Edited to improve clarity for J1800.
3.J.4	Chapter 3, Section J, Page J-11	**Coding Instructions for J1900** Complete only if A0250 = 10 Planned Discharge, A0250 = 11 Unplanned Discharge or A0250 = 12 Expired.	**Coding Instructions for J1900** Complete only if A0250 = 10 Planned Discharge, A0250 = 11 Unplanned Discharge or A0250 = 12 Expired. Complete at time of discharge.	Added "complete at time of discharge" to the time point statement.
3.J.5	Chapter 3, Section J, Page J-12	**Coding Tip** **Did not exist**	**Coding Tip** • For item J1900, include all falls that occurred since the time of admission. This would include any falls that occurred during a program interruption.	Added a coding tip statement for J1900.

Chapter 3, Section K				
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3.K.1	Chapter 3, Section K, Page K-1	**Intent:** These items assess the patient's body mass index (BMI) using the patient's height and weight.	**Intent:** The items in this section are intended to assess the many conditions that could affect the patient's ability to maintain adequate nutrition and hydration. This section covers height and weight, and nutritional approaches.	Edited to improve clarity.
3.K.2	Chapter 3, Section K, Page K-1	**Coding Instructions for K0200A, Height** **Did not exist**	**Coding Instructions for K0200A, Height** • Only enter a height that has been directly measured by your facility staff. Do not enter a height that is self-reported or derived from documentation from another provider setting. • When reporting height for a patient with bilateral lower extremity amputations, measure and record the patient's current height (i.e., height after bilateral amputations).	Added new coding instructions.
3.K.3	Chapter 3, Section K, Page K-2	**Steps for Assessment for K0200B, Weight** 3. If the patient has been weighed multiple times during the assessment period, use the first weight.	**Steps for Assessment for K0200B, Weight** **Removed**	Removed a step for assessment.
3.K.4	Chapter 3, Section K, Page K-2	**Coding Instructions for K0200B, Weight** **Did not exist**	**Coding Instructions for K0200B, Weight** • Only enter a weight that has been directly measured by your facility staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.	Added new coding instruction.

Chapter 3, Section M				
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3.M.1	Chapter 3, Section M, Page M-1	**Item Rationale** • Throughout Section M, terminology referring to "healed" versus "unhealed" ulcers refer to whether the ulcer is "closed" versus "open." When considering this, recognize that Stage 1, Deep Tissue Injury (DTI), and unstageable pressure ulcers, although closed, (i.e., may be covered with tissue, eschar, slough), would not be considered healed.	**Item Rationale** **Removed**	Removed an item for M0210.
3.M.2	Chapter 3, Section M, Page M-2	**Item Rationale** • For the LTCH CARE Data Set assessment, the initial (at admission) numerical staging of pressure ulcers/injuries and the initial numerical staging of ulcers/injuries after debridement, or a DTI that declares itself, should be coded in terms of what is assessed (i.e., seen and palpated, such as visible tissue, palpable bone) as close to admission as possible.	**Item Rationale** • For the LCDS assessment, the initial (at admission) numerical staging of pressure ulcers/injuries should be coded in terms of what is assessed (i.e., seen and palpated, such as visible tissue, palpable bone) as close to admission as possible.	Edited to improve clarity for M0210.
3.M.3	Chapter 3, Section M, Page M-3	**Coding Instructions** Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 3 days • **Code 0, No,** if the patient did not have a pressure ulcer/injury in the 3-day assessment period. • **Code 1, Yes,** if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 3-day assessment period.	**Coding Instructions** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible. • **Code 0, No,** if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day assessment period (or the last skin assessment in the 3-day assessment period at discharge). • **Code 1, Yes,** if the patient had any pressure ulcer/injury (stage 1, 2, 3, 4, or unstageable) on the first skin assessment in the 3-day assessment period (or on the last skin assessment in the 3-day assessment period at discharge).	Edited to improve clarity for M0210.

Chapter 3, Section M				
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3.M.4	Chapter 3, Section M, Page M-3 to M-4	**Coding Tips** **Did not exist**	**Coding Tips** • Review for location and stage at the time of admission. If the pressure ulcer/injury was observed at the time of admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer/injury is coded at the initial stage on the Admission assessment, and the higher stage should not be coded on the Admission assessment.	Added coding tips for M0210.
3.M.5	Chapter 3, Section M, Page M-5	**Steps for Completing M0300A–G** **Step 1: Determine Deepest Anatomical Stage** 3. Review the history of each pressure ulcer/injury in the medical record. If the pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage until healed. LTCHs that carefully document and monitor pressure ulcers/injuries will be able to code these items more accurately. 5. …Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed.	**Steps for Completing M0300A–G** **Step 1: Determine Deepest Anatomical Stage** At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. 3. Review the history of each pressure ulcer/injury in the medical record. If the stageable pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, it should continue to be classified at a higher numerical stage until healed, unless it becomes unstageable. LTCHs that carefully document and monitor pressure ulcers/injuries will be able to code this item more accurately. 5. …Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed, unless it becomes unstageable.	Edited to improve clarity.
3.M.6	Chapter 3, Section M, Page M-6	**Steps for Completing M0300A–G** **Step 1: Determine Deepest Anatomical Stage** **Did not exist**	**Steps for Completing M0300A–G** **Step 1: Determine Deepest Anatomical Stage** 6. A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.	New step added for clarity.

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3.M.7	Chapter 3, Section M, Page M-6	**Step 2: Identify Unstageable Pressure Ulcers/Injuries** 2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.	**Step 2: Identify Unstageable Pressure Ulcers/Injuries** 2. If a pressure ulcer's/injury's anatomical tissues are obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.	Revised for clarity for M0300A-G.
3.M.8	Chapter 3, Section M, Page M-6	**Step 3: Determine "Present on Admission"** 1. Review for location and stage of pressure ulcers/injuries at the time of admission. If the pressure ulcer/injury was observed at the time of admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer/injury is coded at the initial stage on the Admission assessment, and the higher stage should not be coded on the Admission assessment. 2. For each pressure ulcer/injury identified on admission, code the number of pressure ulcers/injuries at each stage in items M0300A-G1 on the Admission assessment. Any pressure ulcer/injury identified and coded in M0300A-G1 on the Admission assessment, is assumed to have been present on admission.	**Step 3: Determine "Present on Admission"** **Removed**	Removed steps from Step 3 for M0300A-G.
3.M.9	Chapter 3, Section M, Page M-6 to M-7	**Step 3: Determine "Present on Admission"** **Did not exist**	**Step 3: Determine "Present on Admission"** 2. If a patient has a pressure ulcer that was documented on admission, and at discharge is documented at the same stage, it would be considered as "present on admission." • This guidance is true even if during the stay the original pressure ulcer healed and reopened at the same stage and remained at that stage at discharge. 7. If a patient is admitted to an LTCH with a healed pressure ulcer/injury, and a pressure ulcer/injury occurs in the same anatomical area, and remains at discharge, it would be coded as observed at discharge and would not be coded as present on admission on the discharge assessment. Therefore, this pressure ulcer/injury would be considered new, or facility acquired.	Added a step and new sub-bullet under 3rd step for M0300A-G.

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3.M. 10	Chapter 3, Section M, Page M-11	**Coding Instructions for M0300B2**: Number of these Stage 2 pressure ulcers that were present upon admission • **Enter 0**, if no Stage 2 pressure ulcers were first noted at the time of admission.	**Coding Instructions for M0300B2:** Number of these Stage 2 pressure ulcers that were present upon admission • **Enter 0**, if the Stage 2 pressure ulcer(s) present at discharge was/were not noted at the time of admission.	Edited to improve clarity for M0300B2.
3.M. 11	Chapter 3, Section M, Page M-11	**Coding Tips** • When a pressure ulcer/injury presents as an intact blister, examine the adjacent and surrounding area for signs of DTI. When a DTI is determined, do not code as a Stage 2.	**Coding Tips** • When a pressure ulcer/injury presents as an intact serum-filled blister, examine the adjacent and surrounding area for signs of DTI. When a DTI is determined, do not code as a Stage 2.	Edited to improve clarity for M0300B.
3.M. 12	Chapter 3, Section M, Page M-13	**Coding Instructions for M0300C2: Number of these Stage 3 pressure ulcers that were present upon admission** • **Enter 0**, if no Stage 3 pressure ulcers were first noted at the time of admission.	**Coding Instructions for M0300C2: Number of these Stage 3 pressure ulcers that were present upon admission** • **Enter 0,** if the Stage 3 pressure ulcer(s) present at discharge was/were not noted at the time of admission.	Edited to improve clarity for M0300C.
3.M. 13	Chapter 3, Section M, Page M-20	**Coding Instructions for M0300D2: Number of these Stage 4 pressure ulcers that were present upon admission** • **Enter 0**, if no Stage 4 pressure ulcers were first noted at the time of admission.	**Coding Instructions for M0300D2: Number of these Stage 4 pressure ulcers that were present upon admission** • **Enter 0,** if the Stage 4 pressure ulcer(s) present at discharge was/were not noted at the time of admission.	Edited coding instruction for M0300D.
3.M. 14	Chapter 3, Section M, Page M-22	**Coding Instructions for M0300E2: Number of these unstageable pressure ulcers/injuries due to a non-removable dressing/device that were present upon admission** • **Enter 0**, if no unstageable pressure ulcers/injuries due to a non-removable dressing/device were first noted at the time of admission.	**Coding Instructions for M0300E2**: **Number of these unstageable pressure ulcers/injuries due to a non-removable dressing/device that were present upon admission** • **Enter 0**, if the unstageable pressure ulcer(s)/injury(ies) due to a non-removable dressing/device present at discharge was/were not noted at the time of admission.	Edited coding instructions for M0300E.
3.M. 15	Chapter 3, Section M, page M-26	**Coding Instructions for M0300F2: Number of these unstageable pressure ulcers due to slough and/or eschar that were present upon admission** • **Enter 0,** if no unstageable pressure ulcers due to slough and/or eschar were first noted at the time of admission.	**Coding Instructions for M0300F2: Number of these unstageable pressure ulcers due to slough and/or eschar that were present upon admission** • **Enter 0,** if the unstageable pressure ulcer(s) due to slough and/or eschar present at discharge was/were not noted at the time of admission.	Edited coding instruction for M0300F.

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3.M. 16	Chapter 3, Section M, Page M-26	**Coding Tips** • If a Stage 3 or 4 pressure ulcer observed on admission is unstageable due to slough or eschar on discharge, the unstageable pressure ulcer would be coded on the Discharge assessment and would not be coded as present on admission, so M0300F2 would be coded 0.	**Coding Tips** **Removed**	Removed coding tip.
3.M. 17	Chapter 3, Section M, Page M-26 to M-27	**Coding Tips** • Once the pressure ulcer is debrided of enough slough and/or eschar such that the extent of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for reclassification of the ulcer to occur.	**Coding Tips** • Even in the presence of slough and/or eschar if the anatomic depth of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for classification of the ulcer to occur.	Revised for clarity for M0300F.
3.M. 18	Chapter 3, Section M, Page M-26 to M-27	**Coding Tips** • If a Stage 1 or 2 pressure ulcer/injury observed at the time of admission further deteriorates and eventually becomes unstageable due to slough or eschar at discharge, the unstageable pressure ulcer would be coded on the Discharge assessment and would not be considered as present on admission, so M0300F2 would be coded 0. This is because the pressure ulcer/injury that is assessed on discharge was not present on admission at the same stage it is observed at the time of discharge.	**Coding Tips** • If a stageable pressure ulcer/injury observed at the time of admission further deteriorates and eventually becomes unstageable due to slough or eschar at discharge, the unstageable pressure ulcer would be coded on the Discharge assessment and would not be considered as present on admission, so M0300F2 would be coded 0. This is because the pressure ulcer that is assessed on discharge was not present on admission at the same stage it is observed at the time of discharge.	Edited to improve clarity for M0300F.
3.M. 19	Chapter 3, Section M, Page M-31	**Definition** **Deep Tissue Injury (DTI)** Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.	**Definition** **Deep Tissue Injury (DTI)** Purple or maroon area of discolored intact skin or partial thickness tissue loss due to pressure damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.	Edited to improve clarity for M0300G.

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3.M. 20	Chapter 3, Section M, Page M-32	**Coding Instructions for M0300G2: Number of these unstageable pressure ulcers presenting as deep tissue injury that were present upon admission** • **Enter 0,** if no unstageable pressure injuries presenting as a DTI were first noted at the time of admission.	**Coding Instructions for M0300G2: Number of these unstageable pressure ulcers presenting as deep tissue injury that were present upon admission** • **Enter 0,** if the unstageable pressure injury(ies) presenting as a DTI at discharge was/were not noted at the time of admission.	Edited coding instruction for M0300G.
3.M. 21	Chapter 3, Section M, Page M-32 to M-33	**Coding Tips** **Did not exist**	**Coding Tips** • A pressure ulcer/injury presenting with characteristics of a DTI is reported as a DTI unless full thickness tissue loss is present. For example, a DTI presenting as purple localized discoloration with tenderness caused by pressure, but without full thickness tissue loss would be coded as a DTI, even though the wound is not completely intact. • If a DTI that was observed on admission evolves and is subsequently able to be numerically staged, and remains at the same stage at discharge, it would be considered and coded as present on admission on the discharge assessment at the stage at which it first becomes numerically stageable (M0300x1=1 and M0300x2=1). • If a DTI that was observed on admission does not evolve to be numerically staged, but is subsequently classified as another type of unstageable pressure ulcer/injury, it would be considered and coded as present on admission on the discharge assessment in that unstageable pressure ulcer/injury category (M0300x1=1 and M0300x2=1).	Added coding tips for M0300G.
3.M. 22	Chapter 3, Section M, Page M-32	**Coding Tips** • Once a DTI has opened to an ulcer, the ulcer should be reassessed, staged numerically, and coded on the LTCH CARE Data Set at the appropriate stage.	**Coding Tips** • Once a DTI has fully opened, exposing the level of tissue damage, reassess the wound via observation and/or palpation and code based on clinical assessment and staging criteria.	Edited to improve clarity for M0300G.

Chapter 3, Section N				
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3.N.1	Chapter 3, Section N, Page N-5	**Steps for Assessment** **Did not exist**	**Steps for Assessment** 4. Potential or actual clinically significant medication issues may include, but are not limited to: • Medication prescribed despite documented medication allergy or prior adverse reaction. • Excessive or inadequate dose. • Adverse reactions to medication (such as a rash). • Ineffective drug therapy (such as an analgesic that does not reduce pain). Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic-name and brand-name equivalent drugs are both prescribed). • Wrong patient, drug, dose, route, and time errors. • Medication dose, frequency, route, or duration not consistent with patient's condition, manufacturer's instructions, or applicable standards of practice. • Use of a medication without evidence of adequate indication for use. • Omissions (medications missing from a prescribed regimen). • Nonadherence (purposeful or accidental). • Any of the circumstances listed above must reach a level of clinical significance that warrants notification of the physician (or physician-designee) for orders or recommendations by midnight of the next calendar day, at the latest. • Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.	New step added for N2001.

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3.N.2	Chapter 3, Section N, Page N-6	**Coding Instructions** • **Code 0. No - No issues found during review,** if a drug regimen review was conducted upon admission and no potential or actual clinically significant issues were identified • **Code 1. Yes - Issues found** during review, if a drug regimen review was conducted upon admission and potential or actual clinically significant issues were identified.	**Coding Instructions** • **Code 0, No**, no issues found during review, if a drug regimen review was conducted upon admission and based on the assessing clinician's professional judgment, no potential or actual clinically significant issues were identified. • **Code 1, Yes**, issues found during review, if a drug regimen review is conducted and based on the assessing clinician's professional judgment, potential or actual clinically significant medication issues are identified.	Revised for clarity for N2001.
3.N.3	Chapter 3, Section N, Page N-9	**Item Rationale** • A critical time and opportunity for identifying potential and actual clinically significant medication issues occurs when the patient is admitted to the LTCH.	**Item Rationale** **Removed**	Removed for N2003.
3.N.4	Chapter 2, Section N, Page N-9	**Item Rationale** • Physician (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a timeframe that reduces the risk for medication errors and patient harm.	**Item Rationale** • Physician (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician by midnight of the next calendar day at the latest to reduce patient harm.	Edited to improve clarity for N2003.
3.N.5	Chapter 3, Section N, Page N-10	**Coding Instructions** • **Code 0. No**, if all identified potential or actual clinically significant medication issues were not addressed by midnight of the next calendar day. • **Code 1, Yes**, if the two-way communication AND completion of the prescribed/recommended actions occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified.	**Coding Instructions** • **Code 0, No**, if the facility did not contact the physician and complete prescribed/recommended actions in response to each identified potential or actual clinically significant medication issue by midnight of the next calendar day. • **Code 1, Yes,** if the facility contacted the physician AND completed the prescribed/recommended actions by midnight of the next calendar day after each potential or actual clinically significant medication issue was identified.	Revised for clarity for N2003.

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3.N.6	Chapter 3, Section N, Page N-13	**Item Rationale** • Every time a clinically significant medication issue is identified throughout the patient stay, the clinically significant medication issue must be communicated to a physician (or physician-designee), and the physician (or physician-designee) prescribed/recommended actions must be completed by the clinician in a timeframe that reduces the risk for medication errors and patient harm.	**Item Rationale** **Removed**	Removed from item rationale for N2005.
3.N.7	Chapter 3, Section N, Page N-13	**Item Rationale** • Physician (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a timeframe that reduces the risk for medication errors and patient harm.	**Item Rationale** • Physician (or physician-designee)-prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician by midnight of the next calendar day at the latest to reduce patient harm.	Replaced part of item rationale for N2005.
3.N.8	Chapter 3, Section N, Page N-17 to N-19	**Did not exist**	**Additional Coding Scenarios**	Added additional coding scenarios for clarity. This entire section is new.

Chapter 3, Section O				
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3.O.1	Chapter 3, Section O, Page O-1	**Intent:** The intent of the items in this section is to identify any special treatments, procedures, and programs that the patient received during the stay, including spontaneous breathing trial (SBT) for ventilator liberation, intravenous (IV) vasoactive medication, and influenza vaccination status.	**Intent:** The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient/resident.	Revised item intent.
2.O.2	Chapter 2, Section O, Page O-1 to O-10	**O0100. Special Treatments, Procedures, and Programs**	**O0100 Special Treatments, Procedures, and Programs** **Item is removed**	Item number O0100 has been removed.
3.O.3	Chapter 3, Section O, Page O-10	**Coding Instructions** **Did not exist**	**Coding Instructions** O0150A2. Ventilator Weaning Status 0. No, determined to be non-weaning upon admission 1. Yes, determined to be weaning upon admission	Added guidance for the new item, O0150A2.
3.O.4	Chapter 3, Section O, Page O-11	**Coding Tips** • If item O0150A is marked either "No" or "Yes, non-weaning" then completion of items O0150B through O0150E is not required for the patient. If item O0150A is marked "Yes, weaning," then proceed to item O0150B.	**Coding Tips** • If O0150A is marked "No, not on invasive mechanical ventilation support upon admission" or O0150A2 is marked "No, determined to be non-weaning upon admission" then completion of items O0150B through O0150E is not required for the patient. • If O0150A is marked "Yes, on invasive mechanical ventilation support upon admission" and O0150A2 is marked "Yes, determined to be weaning upon admission," then proceed to O0150B.	Revised to reflect the new item, O0150A2, added a new coding tip.
3.O.5	Chapter 3, Section O, Page O-17	**Did not exist**	**O0200. Ventilator Liberation Rate** **Coding Instructions** Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge.	Added additional timepoint guidance for O0200.

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3.O.6	Chapter 3, Section O, Page O-17	**O0200A. Invasive Mechanical Ventilator: Liberation Status at Discharge** **Coding Instructions** • Code 9, NA, if this item does not apply. This code only applies if the patient was non-weaning or not on invasive mechanical ventilation support on admission (O0150A = 2 or 0 on Admission Assessment).	**O0200A. Invasive Mechanical Ventilator: Liberation Status at Discharge** **Coding Instructions** • Code 9, Not applicable, if this item does not apply. This code only applies if the patient was not on invasive mechanical ventilation support on admission (O0150A = 0) or the patient was determined to be non-weaning upon admission (O0150A2 = 0).	Revised for new structure of O0150, O0200.
3.O.7	Chapter 3, Section O, Page O-18 to O-19	**O0250. Influenza Vaccine**	**O0250. Influenza Vaccine** **Removed**	Removed section.

Chapter 3, Section Z

Chapter 3, Section Z				
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3.Z.1	Chapter 3, Section Z, Page Z-2	**Z0400. Signatures of Persons Completing the Assessment** **Coding Instructions** • Please refer to Section 2.2, of Chapter 2 of this manual for information on using electronic signatures.	**Z0400. Signatures of Persons Completing the Assessment** **Coding Instructions** • Please refer to Section 2.2, Maintenance of Electronic LCDS Records of Chapter 2, LCDS Requirements of this manual for information on using electronic signatures.	Edited to improve clarity.

Chapter 4

Chapter 4				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
4.1	Chapter 4, Section 4.1, Page 4-1	Providers must establish communication with the QIES ASAP system to submit a file. This is accomplished by using specialized communications software installed on their computer to access the CMS secure wide area network (WAN). Details about how to obtain the WAN software and access are available on the QIES Technical Support Office (QTSO) Web site at https://www.qtso.com Once communication is established with the QIES ASAP system via the CMS WAN, the provider can access the Welcome to the CMS QIES System for Providers page in the QIES ASAP system. This site allows providers to register for QIES user IDs, submit LTCH CARE Data Set records, and access reports. Other information such as user's guides and bulletins can also be found on this same welcome page. The LTCH Submission User's Guide located on the LTCH welcome page provides more detailed information about the QIES ASAP system. This User's Guide is also available on the QTSO Web site at https://www.qtso.com/ltchtrain.html. Additional recorded Webinar training for user ID registration, submission, and Certification And Survey Provider Enhanced Reports (CASPER) is also available at https://www.qtso.com/webex/qiesclasses.php	**Removed**	Removed outdated information.
4.2	Chapter 4, Section 4.4, Page 4-6	**4.4 LTCH CARE Data Set Correction Policy** **Did not exist**	**4.4 LCDS Correction Policy** Specific user roles within iQIES will allow the provider to modify or inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.	Added for clarity.

Chapter 4				
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4.3	Chapter 4, Section 4.6, Page 4-9	**4.6.1 Modification Requests** **Did not exist**	**4.6.1 Modification Requests** Note: Specific user roles within iQIES will allow the provider to modify assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.	Added for clarity.
4.4	Chapter 4, Section 4.6, Page 4-11	**4.6.2 Inactivation Requests** **Did not exist**	**4.6.2 Inactivation Requests** Note: Specific user roles within iQIES will allow the provider to inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.	Added for clarity.

Chapter 5

Chapter 5				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
5.1	All of Chapter 5	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure	**Removed**	Removed these measures and their related content throughout this section, where applicable.
5.2	Chapter 5	**Did not exist**	**Added COVID-19 Vaccination Coverage among Healthcare Personnel data under the LTCH QRP information.**	Updated to accommodate new measure.
5.3	Chapter 5, Section 5.3, Page 5-9	**5.3 Basic Steps to NHSN Enrollment and Data Submission** c) Fill out a Ventilator-Associated Event form for each VAE identified in the LTCH location(s). The form can be found here: www.cdc.gov/nhsn/forms/57.112_VAE_BLANK.pdf Instructions for completing the form can be found here: www.cdc.gov/nhsn/forms/instr/57_112_VAE.pdf	**5.3 Basic Steps to NHSN Enrollment and Data Submission** **Removed**	Removed items specific to measures from this section.
5.4	Chapter 5, Section 5.3, Page 5-10	**Did not exist**	**5.3 Basic Steps to NHSN Enrollment and Data Submission** 16. Fill out the Healthcare Personnel COVID-19 Vaccination Cumulative Summary form. This form can be found here: https://www.cdc.gov/nhsn/forms/57.219-p.pdf Instructions for completing the form can be found here: https://www.cdc.gov/nhsn/hps/weekly-covid-vac/index.html	Updated with new measure information.

Appendix A

Appendix A				
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A.1	Appendix A, Page A-1	Acute Onset Admission and Discharge Reporting Assessment Submission and Processing (ASAP) System	**Removed**	Removed definitions.
A.2	Appendix A, Page A-1	**Did not exist**	Assessment Time Frame Board and care, assisted living, group home	Added a definition.
A.3	Appendix A, Page A-2	Browser Code of Federal Regulations (CFR)	**Removed**	Removed a definition.
A.4	Appendix A, Page A-2	**Did not exist**	Completion Date Confusion Assessment Method (CAM) Contact with Physician (or Physician-Designee)	Added definitions.
A.5	Appendix A, Page A-3	**Did not exist**	Critical Access Hospital (CAH) Deep Tissue Injury (DTI)	Added definitions.
A.6	Appendix A, Page A-4	**Did not exist**	Drug Regimen Review Electronic Health Record (EHR)/Electronic Medical Record (EMR)	Added definitions.
A.7	Appendix A, Page A-6	Influenza Vaccination Season (IVS)	**Removed**	Removed a definition.
A.8	Appendix A, Page A-6	**Did not exist**	Injury (except major) Injury Related to a Fall Interoperable/Interoperability	Added definitions.
A.9	Appendix A, Page A-7	LTCH Assessment Submission Entry and Reporting (LASER) LTCH CARE Data Set Assessment Scheduling LTCH CARE Data Set Assessment Submission LTCH CARE Data Set Assessment Time Frame LTCH CARE Data Set Completion Date LTCH CARE Data Set Submission Date	**Removed**	Removed definitions.
A.10	Appendix A, Page A-7	**Did not exist**	Major Injury Medication Follow-Up	Added definitions.
A.11	Appendix A, Page A-8	Monitoring	**Removed**	Removed a definition.

Appendix A				
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A.12	Appendix A, Page A-8	**Did not exist**	No Injury Portal (e.g., patient or provider portal) Potential (or Actual) Clinically Significant Medication Issue Private home or apartment	Added definitions.
A.13	Appendix A, Page A-8	Persistent Vegetative State (PVS): PVS is an enduring situation in which an individual has failed to demonstrate meaningful cortical function but can sustain basic body functions supported by noncortical brain activity.	Persistent Vegetative State (PVS): 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.	Edited to improve clarity.
A.14	Appendix A, Page A-8	Pressure Ulcer/Injury: Localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.	Pressure Ulcer/Injury: Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.	Edited to improve clarity
A.15	Appendix A, Page A-9	Program Interruption End Date Program Interruption Start Date Quality Improvement and Evaluation System (QIES) Assessment	**Removed**	Removed definitions.
A.16	Appendix A, Page A-10	Deep Tissue Injury System of Records	**Removed**	Removed definitions.
A.17	Appendix A, Page A-9	Stage 2 Pressure Ulcer: Partial-thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.	Stage 2 Pressure Ulcer: Partial-thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.	Edited to improve clarity
A.18	Appendix A, Page A-10	**Did not exist**	Submission Date	Added a definition.
A.19	Appendix A, Page A-10	**Did not exist**	Usual Performance	Added a definition.

Appendix A				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
A.20	Appendix A, Page A-11	ADLs ASL CASPER CFR CHPW LASER LTCH CARE Data Set QIES ASAP System	**Removed**	Removed common acronyms.
A.21	Appendix A, Page A-11	**Did not exist**	LCDS iQIES QIES	Added common acronyms

Appendix B

Appendix B				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
B.1	Appendix B, Page B-1	• Questions related to the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) should be directed to PACQualityInitiative@cms.hhs.gov	**Removed**	Removed information.

Appendix D

Appendix D				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
D.1	Appendix D, Page D-1	Appendix E	Appendix D	Renamed Appendix from E to D.

Appendix E

Appendix E				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
E.1	Appendix E, Page E-1	Appendix F	Appendix E	Renamed Appendix from F to E.
E.2	Appendix E, Page E-1 to E-4	-	Updated references	Added new references.

Supplements

Supplements				
Edit #	**Chapter, Section, Page**	**LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**Description of Change**
S.1	Supplements, Supplement A, Page S-1 to S-2	**Did not exist**	Supplement A: Guidance for Completing the BIMS	Added a new supplement to Section C.
S.2	Supplements, Supplement B, Page S-3 to S-4	**Did not exist**	Supplement B: Interviewing to Increase Patient Voice in BIMS	Added a new supplement to Section C.
S.3	Supplements, Supplement D, Page S-11 to S-15	**Did not exist**	Supplement D Scoring Rules: Patient Mood Interview Total Severity Score D0160	Added a new supplement to Section D.