Centers for Medicare & Medicaid Services

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

CHANGE TABLE SUMMARIZING REVISIONS TO THE LCDS MANUAL VERSION 5.1

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Contents

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LCDS Version 5.1 Item Set

Below is a list of changes to LCDS Version 5.1

Section	Item #	Added/Removed	Item Description
Section O	O0350	Added	COVID-19 Vaccination Up To Date
Section GG	GG0130D	Removed	Wash Upper Body
Section GG	Discharge Goals	Removed	N/A

Note: Guidance has been modified in the Manual pages based on the added/removed items listed above.

All Sections

Edit #	Chapter, Section, Page	LCDS Manual Version 5.0 – Effective October 1, 2022	LCDS Manual Version 5.1 – Effective October 1, 2024	Description of Change
0.1	All sections	N/A	Where applicable the manual is edited for the following: formatting, grammar, stylistic edits, to improve clarity, updated dates, updated references, updated resources, reorganized information, updated version number from 5.0 to 5.1.	--
0.3	All sections	Revised Version 5.0, Effective October 1, 2022	Version 5.1, Effective October 1, 2024	Updated version and effective date in the footer.
0.4	Appendix A	Revised Version 5.0, Effective October 1, 2022	Version 5.1, Effective October 1, 2024	Updated version and effective date in the footer. No other substantive edits.
0.5	Appendix D	Revised Version 5.0, Effective October 1, 2022	Version 5.1, Effective October 1, 2024	Updated version and effective date in the footer. No other substantive edits.
0.6	Appendix E	Revised Version 5.0, Effective October 1, 2022	Version 5.1, Effective October 1, 2024	Updated version and effective date in the footer. No other substantive edits.

Chapter 1

Chapter 1				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
1.1	Chapter 1 Page 1-1	• Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).	• Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (CMIT Measure ID #00520).	Updated measure ID.
1.2	Chapter 1 Page 1-1	• Application of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). • Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).	**Removed**	Removed measures.
1.3.	Chapter 1 Page 1-1	• Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632).	• Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (CMIT Measure ID #00275).	Updated measure ID.
1.4	Chapter 1 Page 1-2	• Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Long-Term Care Hospital(LTCH) Quality Reporting Program (QRP)	• Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) (CMIT Measure ID #00225).	Updated measure ID.
1.5	Chapter 1 Page 1-2	• Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	• Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (CMIT Measure ID #00121).	Updated measure ID.

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1.6	Chapter 1 Page 1-2	• Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay	• Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay (CMIT Measure ID #00143).	Updated measure ID.
1.7	Chapter 1 Page 1-2	• Ventilator Liberation Rate	• Ventilator Liberation Rate (CMIT Measure ID #00759).	Updated measure ID.
1.8	Chapter 1 Page 1-2	• Transfer of Health Information to the Provider – Post-Acute Care (PAC).	• Transfer of Health Information to the Provider – Post-Acute Care (PAC). (CMIT Measure ID #00728).	Updated measure ID.
1.9	Chapter 1 Page 1-2	• Transfer of Health Information to the Patient – Post-Acute Care (PAC).	• Transfer of Health Information to the Patient – Post-Acute Care (PAC). (CMIT Measure ID #00727)	Updated measure ID.
1.10	Chapter 1 Page 1-2	**Did not exist**	• Discharge Function Score (CMIT Measure ID #01698).	Added new measure.
1.11	Chapter 1 Page 1-2	**Did not exist**	• COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (CMIT Measure ID #01699).	Added new measure.
1.12	Chapter 1 Page 1-2	• National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138).	• National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure. (CMIT Measure ID #00459).	Updated measure ID.
1.13	Chapter 1 Page 1-2	• National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139).	• National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure (CMIT Measure ID #00460).	Updated measure ID.

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1.14	Chapter 1 Page 1-2	• Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431).	• Influenza Vaccination Coverage Among Healthcare Personnel (CMIT Measure ID #00390).	Updated measure ID.
1.15	Chapter 1 Page 1-3	• National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717).	• National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (CMIT Measure ID #00462).	Updated measure ID.
1.16	Chapter 1 Page 1-3	• COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)	• COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (CMIT Measure ID #00180).	Added measure ID.
1.17	Chapter 1 Page 1-4	• Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).	• Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (CMIT Measure ID #00520).	Updated measure ID.
1.18	Chapter 1 Page 1-4	• Application of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). • Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).	**Removed**	Removed measures.
1.19	Chapter 1 Page 1-4	• Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632).	• Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (CMIT Measure ID #00275).	Updated measure ID.

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1.20	Chapter 1 Page 1-4	• Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)	• Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) (CMIT Measure ID #00225).	Updated measure ID.
1.21	Chapter 1 Page 1-4	• Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	• Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (CMIT Measure ID #00121).	Updated measure ID.
1.22	Chapter 1 Page 1-4	• Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay	• Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay (CMIT Measure ID #00143).	Updated measure ID.
1.23	Chapter 1 Page 1-4	• Ventilator Liberation Rate	• Ventilator Liberation Rate (CMIT Measure ID #00759).	Updated measure ID.
1.24	Chapter 1 Page 1-4	• Transfer of Health Information to the Provider – Post-Acute Care (PAC).	• Transfer of Health Information to the Provider – Post-Acute Care (PAC) (CMIT Measure ID #00728).	Updated measure ID.
1.25	Chapter 1 Page 1-4	• Transfer of Health Information to the Patient – Post-Acute Care (PAC).	• Transfer of Health Information to the Patient – Post-Acute Care (PAC) (CMIT Measure ID #00727).	Updated measure ID.
1.26	Chapter 1 Page 1-4	**Did not exist**	• Discharge Function Score (CMIT Measure ID #01698).	Added new measure.
1.27	Chapter 1 Page 1-4	**Did not exist**	• COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (CMIT Measure ID #01699)	Added new measure.

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1.28	Chapter 1 Page 1-5	• National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138).	• National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (CMIT Measure ID #00459).	Updated measure ID.
1.29	Chapter 1 Page 1-5	• National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139).	• National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure (CMIT Measure ID #00460).	Updated measure ID.
1.30	Chapter 1 Page 1-5	• Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431).	• Influenza Vaccination Coverage Among Healthcare Personnel (CMIT Measure ID #00390).	Updated measure ID.
1.31	Chapter 1 Page 1-5	• National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717).	• National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (CMIT Measure ID #00462).	Updated measure ID.
1.32	Chapter 1 Page 1-5	• COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)	• COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (CMIT Measure ID #00180).	Added measure ID.

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1.33	Chapter 1 Page 1-5	• National Quality Forum (NQF) pages for measures that are NQF-endorsed: ○ Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674): http://www.qualityforum.org/QPS/0674 ○ Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631): http://www.qualityforum.org/QPS/2631 ○ Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631): http://www.qualityforum.org/QPS/2631 ○ Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632): http://www.qualityforum.org/QPS/2632	**Removed**	Removed measure references.
1.34	Chapter 1 Page 1-5	• National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138): http://www.qualityforum.org/QPS/0138	• National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (CMIT Measure ID #00459): https://cmit.cms.gov/cmit/#/MeasureView?variantId=1021&sectionNumber=1	Updated measure ID and link.

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1.35	Chapter 1 Page 1-5	• National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139): http://www.qualityforum.org/QPS/0139	• National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure (CMIT Measure ID #0046): https://cmit.cms.gov/cmit/#/MeasureView?variantId=1068&sectionNumber=1	Updated measure ID and link.
1.36	Chapter 1 Page 1-5	• Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431): http://www.qualityforum.org/QPS/0431	• Influenza Vaccination Coverage Among Healthcare Personnel (CMIT Measure ID #00390): https://cmit.cms.gov/cmit/#/MeasureView?variantId=630&sectionNumber=1	Updated measure ID and link.
1.37	Chapter 1 Page 1-5	• National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717): http://www.qualityforum.org/QPS/1717	• National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (CMIT Measure ID #00462): https://cmit.cms.gov/cmit/#/MeasureView?variantId=609&sectionNumber=1	Updated measure ID and link.

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1.38	Chapter 1 Page 1-6	**Did not exist**	• FY 2024 Inpatient Prospective Payment System (IPPS)/LTCH Prospective Payment System (PPS) final rule (88 FR #59232 through #59259): https://www.govinfo.gov/content/pkg/FR-2023-08-28/pdf/2023-16252.pdf • FY 2023 Inpatient Prospective Payment System (IPPS)/LTCH Prospective Payment System (PPS) final rule (87 FR 49314# through #49319): https://www.govinfo.gov/content/pkg/FR-2022-08-10/pdf/2022-16472.pdf	Added latest rules.

Chapter 3

Chapter 3, Overview

Chapter 3, Overview				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.0.1	Chapter 3 Overview Page 3-2	This section includes items about functional abilities and goals. It includes items focused on prior functioning, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.	This section includes items about functional abilities and goals. It includes items focused on prior functioning, admission performance, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.	Removed discharge goals from definition.
3.0.2	Chapter 3 Overview Page 3-2	The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient/resident.	The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient, along with patient vaccinations.	Updated definition.
3.0.3	Chapter 3 Overview Page 3-2	The intent of the items in this section is to assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities.	The intent of the items in this section is to document patient falls, assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities.	Updated definition for accuracy.

Chapter 3, Section A

Chapter 3, Section A				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.A.1	Chapter 3 Section A Page A-10	**Coding Instructions** 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 (-). The -3900 edit (warning) is in place as a helpful reminder to staff completing the assessment that the item is required and may result in a 2% reduction to the LTCH's applicable fiscal year Annual Payment Update (APU).	**Coding Instructions** 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 (-), if allowed. The -3900 edit (warning) is in place as a helpful reminder to staff completing the assessment that the item is required and may result in a 2% reduction to the LTCH's applicable fiscal year Annual Payment Update (APU).	Updated coding instructions for accuracy.
3.A.2	Chapter 3 Section A Page A-19	**Coding Instructions** Complete as close to the time of admission as possible. Check all that apply.	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period. Check all that apply.	Revised to reflect updates to guidance.
3.A.3	Chapter 3 Section A Page A-19	**Coding Tips** **Did not exist**	**Coding Tips** • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.	Added coding tips.
3.A.4	Chapter 3 Section A Page A-22	**Coding Instructions** Complete as close to the time of admission as possible. Check all that apply.	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period. Check all that apply.	Revised to reflect updates to guidance.

Chapter 3, Section A				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.A.5	Chapter 3 Section A Page A-22	**Coding Tips** **Did not exist**	**Coding Tips** • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.	Added coding tips.
3.A.6	Chapter 3 Section A Page A-25	**Coding Tips** Complete as close to the time of admission as possible.	**Coding Tips** Complete based on an assessment that occurs within the 3-day admission assessment time period.	Revised to reflect updates to guidance.
3.A.7	Chapter 3 Section A Page A-25	**Coding Tips** **Did not exist**	**Coding Tips** • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.	Added coding tips.
3.A.8	Chapter 3 Section A Page A-27	**Coding Instructions** Complete as close to the time of admission as possible and within three days of discharge.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.

Chapter 3, Section A				
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3.A.9	Chapter 3 Section A Page A-28	**Coding Tips** **Did not exist**	**Coding Tips** • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.	Added coding tips.
3.A.10	Chapter 3 Section A Page A-30	**Code 01, Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements),** if the patient was admitted from a private home, apartment, board and care, assisted living facility, group home, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the patient or another person, retirement communities, or independent housing for the elderly. Also included in this category are noninstitutionalized community residential settings that provide the following types of services: home health, homemaker/personal care, or meals.	**Code 01, Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements),** if the patient was admitted from a private home, apartment, board and care, assisted living facility, group home, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the patient or another person, retirement communities, or independent housing for the elderly.	Revised for accuracy.
3.A.11	Chapter 3 Section A Page A-31	**Code 12, Home under care of organized home health service organization,** if the patient received skilled services from a Medicare certified home health agency.	**Code 12, Home under care of organized home health service organization,** if the patient received any services from a Medicare certified home health agency.	Revised definition for clarity.

Chapter 3, Section A				
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3.A.12	Chapter 3 Section A Page A-35	**Coding Instructions** **Code 0, No,** if at discharge to a subsequent provider, your facility did not provide the patient's current reconciled medication list to the subsequent provider.	**Coding Instructions** **Code 0, No,** if at discharge to a subsequent provider, your facility did not provide the patient's current reconciled medication list to the subsequent provider. • For planned discharges, skip to B0100, Comatose • For unplanned discharges, skip to C1310, Signs and Symptoms of Delirium	Revised to reflect updates to guidance.
3.A.13	Chapter 3 Section A Page A-39	**Coding Instructions** • **Code 0, No,** if at discharge to a home setting (A2105=01), or a not listed location (A2105=99), your facility did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver. Or the patient was discharged to a subsequent provider.	**Coding Instructions** • **Code 0, No,** if at discharge to a home setting (A2105=01), or a not listed location (A2105=99), your facility did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver. o For planned discharges, skip to B0100, Comatose o For unplanned discharges, skip to C1310, Signs and Symptoms of Delirium	Revised to reflect updates to guidance.
3.A.14	Chapter 3 Section A Page A-42	**DEFINITIONS** **Did not exist**	**DEFINITIONS** **Health Information Exchange (HIE)** An organization used by provider facilities to electronically exchange patients' health information, including medical records, current reconciled medication lists, etc.	Added definition for clarity.
3.A.15	Chapter 3 Section A Page A-45	**DEFINITIONS** **PORTAL** **EHR/EMR**	**Removed Definitions**	Removed due to redundancy.

Chapter 3, Section B

Chapter 3, Section B				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.B.1	Chapter 3 Section B Page B-2	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 see objects nearby in their environment.	The intent of these items is to document the patient's ability to hear (with assistive devices, if they are used), understand and communicate with others, process health information, and see objects nearby in their environment.	Updated intent for accuracy.
3.B.2	Chapter 3 Section B Page B-3	**Coding Instructions** Complete as close to the time of admission as possible.	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period.	Revised to reflect updates to guidance.
3.B.2	Chapter 3 Section B Page B-7	**Coding Instructions** Complete as close to the time of admission as possible.	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period.	Revised to reflect updates to guidance.
3.B.3	Chapter 3 Section B Page B-9	**Coding Instructions** Complete as close to the time of admission as possible and within 3 days of discharge.	**Coding Instructions** Complete during the 3-day admission assessment period and within 3 days of discharge.	Revised to reflect updates to guidance.
3.B.4	Chapter 3 Section B Page B-11	Complete only if A0250 = 01 Admission or 0250	Complete only if A0250 = 01 Admission or A0250	Updated for clarity.

Chapter 3, Section C

Chapter 3, Section C				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.C.1	Chapter 3 Section C Page C-1	**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.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
3.C.2	Chapter 3 Section C Page C-4	**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.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
3.C.3	Chapter 3 Section C Page C-5	**Examples of Incorrect Answers, Refusals, and Nonsensical Responses** Code 0 is used to represent three types of responses: incorrect answers (unless the item itself provides an alternative response code), nonsensical responses, and questions the patient chooses not to answer (or "refusals"). Since zeros resulting from these three situations are treated differently when coding the summary score in C0500, the interviewer may find it valuable to track the reason for the zero reponse to aid in accurately calculating the summary score.	**Examples of Incorrect Answers, Refusals, and Nonsensical Responses** Code 0 is used to represent three types of responses: incorrect answers (unless the item itself provides an alternative response code), nonsensical responses, and questions the patient chooses not to answer (or "refusals"). Since zeros resulting from these three situations are treated differently when coding the summary score in C0500, the interviewer may find it valuable to track the reason for the zero response to aid in accurately calculating the summary score.	Typographical error corrected.

Chapter 3, Section C				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.C.4	Chapter 3 Section C Page C-11	**Coding Tips** • In most instances, it will be immediately obvious which code to select. In some cases, you may need to write the patient's response in your notes and go back later to count days if you are unsure whether the date given is within 5 days.	**Coding Tip** • In most instances, it will be immediately obvious which code to select. In some cases, you may need to write the patient's response in your notes and go back later to count days if you are unsure whether the month given is within 5 days.	Updated guidance for clarity.
3.C.5	Chapter 3 Section C Page C-16	**Item Rationale** **Did not exist**	**Item Rationale** • The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where patients can hear all questions and the patient is not delirious suggest the following distributions: ○ 13-15: cognitively intact ○ 8-12: moderately impaired ○ 0-7: severe impairment	Added item rationale.
3.C.6	Chapter 3 Section C Page C-16	**Coding Instructions** ○ **Code 99, Unable to complete interview,** if (a) the patient chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the patient chose not to answer or gave a nonsensical response, or (c) if any of the BIMS items is coded with a "-" (dash).	**Coding Instructions** ○ Code 99, Unable to complete interview, if a) the patient chooses not to participate in the BIMS, b) four or more items were coded 0 because the patient chose not to answer or gave a nonsensical response, or c) any but not all of the BIMS items are coded with a "-" (dash).	Revised to reflect updates to guidance.

Chapter 3, Section C				
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3.C.7	Chapter 3 Section C Page C-17	**Coding Tips** **Did not exist**	**Coding Tips** • If all of the BIMS items are coded with a "-" (dash), then C0500 - BIMS Summary Score must also be coded with a "-" (dash).	Adding coding tip to reflect updates to guidance.
3.C.8	Chapter 3 Section C Page C-17	**Example #3** **3.** STOP the interview after C0300C if each of items C0200-C0300C are coded as 0, because a patient chose not to participate in the BIMS and/or has provided nonsensical answers and/or does not provide verbal or written responses.	**Example #3** 3. STOP the interview after C0300C if C0200-C0300C are all coded as 0, because a patient chose not to participate in the BIMS and/or has provided nonsensical answers and/or does not provide verbal or written responses.	Revised to reflect updates to guidance.
3.C.9	Chapter 3 Section C Page C-19	**Steps for Assessment** 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.	**Steps for Assessment** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
3.C.10	Chapter 3 Section C Page C-20	**Steps for Assessment** 1. Observe patient behavior during the cognitive assessment (BIMS items [C0200-C0400] or other cognitive assessment for the signs and symptoms of delirium).	**Steps for Assessment** 1. Observe patient behavior during the cognitive assessment [BIMS items (C0200-C0400), if completed, or other cognitive assessment for the signs and symptoms of delirium].	Revised to reflect updates to guidance.
3.C.11	Chapter 3 Section C Page C-20	**Coding Tips** **Did not exist**	**Coding Tips** • At discharge, compare the patient's current mental status to their baseline mental status (prior to the discharge assessment time period).	Adding coding tip to reflect updates to guidance.

Chapter 3, Section D

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3.D.1	Chapter 3 Section D Page D-2	**Steps for Assessment** 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.	**Steps for Assessment** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
3.D.2	Chapter 3 Section D Page D-10	**Coding Instructions** • If the PHQ-9 was completed (that is, D0150C through D0150I were not blank due to the responses in D0150A and B), **and** if the patient answered the frequency responses of at least seven of the nine items on the PHQ-9, add the numeric scores from D0150A2 -D0150I2, following the instructions found in Supplement D, and enter in D0160.	**Coding Instructions** • If the PHQ-9 was completed (that is, D0150C through D0150I were not-blank due to the responses in D0150A and D0150B), **and** if the patient answered the frequency responses of at least seven of the nine items on the PHQ-9, add the numeric scores from D0150A2 -D0150I2, following the instructions found in Supplement D, and enter in D0160.	Updated guidance for clarity.
3.D.3	Chapter 3 Section D Page D-12	**Coding Instructions** Complete as close to the time of admission as possible and within 3 days of discharge.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.

Chapter 3, Section GG

Chapter 3, Section GG				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.GG.1	Chapter 3 Section GG Page GG-1	**SECTION GG: FUNCTIONAL ABILITIES AND GOALS**	**SECTION GG: FUNCTIONAL ABILITIES**	Revised to reflect removal of discharge goals.
3.GG.2	Chapter 3 Section GG Page GG-1	**Intent:** This section includes items about functional abilities and goals. It includes items focused on prior functioning, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.	**Intent:** This section includes items about functional abilities. It includes items focused on prior functioning, admission performance, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.	Revised to reflect removal of discharge goals.
3.GG.3	Chapter 3 Section GG Page GG-9	**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) …	**General Coding Tips** • If the patient only completes a portion of the activity (e.g., transfers into but not out of a vehicle) …	Revised to reflect removal of item GG0130D.
3.GG.4	Chapter 3 Section GG Page GG-10	**Coding tips for coding the patient's usual performance** • When coding the patient's usual performance and patient's discharge goal(s), use the 6-point scale or one of the four "activity not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted.	**Coding tips for coding the patient's usual performance** • When coding the patient's usual performance, use the 6-point scale or one of the four "activity not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted.	Revised to reflect removal of discharge goals.
3.GG.5	Chapter 3 Section GG Page GG-11	**Discharge Goal(s): Coding Tips**	**Removed section**	Removed section.

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3.GG.6	Chapter 3 Section GG Page GG-16	**GG0130A Coding Tips** **Did not exist**	**GG0130A Coding Tips** • The adequacy of the patient's nutrition or hydration is not considered for GG0130A, Eating.	Adding coding tip to reflect updates to guidance.
3.G.7	Chapter 3 Section GG Page GG-16	**GG0130A Coding Tips** o If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, exacerbation, or injury, code GG0130A, Eating as 09, Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.	**GG0130A Coding Tips** o If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, exacerbation, or injury, code GG0130A, Eating as 09, Not applicable.	Revised for accuracy
3.GG.8	Chapter 3 Section GG Page GG-21	**GG0170C, Coding Tips** **Did not exist**	**GG0170C, Coding Tips** o For some patients, this may include assessing the type and amount of assistance needed to complete clothing management and hygiene tasks after episodes of incontinence.	Adding coding tip to reflect updates to guidance.
3.GG.9	Chapter 3 Section GG Page GG-22	**GG0130D, Wash upper body**	**Removed section**	Removed due to reflect removal of activity.

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3.GG.10	Chapter 3 Section GG Page GG-43	**GG0170I, Example #2** **Walk 10 feet:** The patient had bilateral amputations 3 years ago, and prior to the current admission used a wheelchair and did not walk. Currently the patient does not use prosthetic devices and uses only a wheelchair for mobility. The patient's care plan includes fitting and use of bilateral lower extremity prostheses. **Coding:** GG0170I, Walk 10 feet would be **coded 09, Not applicable** - not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. **Rationale:** When assessing a patient for GG0170I, Walk 10 feet, consider the patient's status prior to the current episode of care and current 3-day assessment status. Use code 09, Not applicable, because the patient did not walk prior to the current episode of care and did not walk during the 3-day assessment period. Because GG0170I, Walk 10 feet is coded 09, follow the skip pattern to GG0170M, 1 step (curb). The patient's care plan includes fitting and use of bilateral prostheses and walking as a goal. A discharge goal for any admission performance item skipped may be entered if a discharge goal is determined as part of the patient's care plan.	**GG0170I, Example #2** **Walk 10 feet:** The patient had bilateral amputations 3 years ago, and prior to the current admission used a wheelchair and did not walk. Currently the patient does not use prosthetic devices and uses only a wheelchair for mobility. **Coding:** GG0170I, Walk 10 feet would be **coded 09, Not applicable** - not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. **Rationale:** When assessing a patient for GG0170I, Walk 10 feet, consider the patient's status prior to the current episode of care and current 3-day assessment status. Use code 09, Not applicable, because the patient did not walk prior to the current episode of care and did not walk during the 3-day assessment period. Because GG0170I, Walk 10 feet is coded 09, follow the skip pattern to GG0170M, 1 step (curb).	Example revised to reflect removal discharge goals.

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3.GG.11	Chapter 3 Section GG Page GG-44	**GG0170J, Coding Tips** ○ 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).	**GG0170J, Coding Tips** • The turns included in the items GG0170J, Walk 50 feet with two turns are 90 degree turns. The turns may occur at any time during the 50-foot distance. 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).	Revised to reflect updates to guidance.
3.GG.12	Chapter 3 Section GG Page GG-46	**GG0170K, Example #2** **Walk 150 feet:** The patient has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. The patient has not walked 150 feet or more during the assessment period, including with the physical therapist, who has been working with the patient. The therapist knows that the patient walked long distances prior to their exacerbation and speculates that the patient could walk this distance in the future with additional assistance. **Coding:** GG0170K, Walk 150 feet would be coded 88, Not attempted due to medical or safety concerns. **Rationale:** The activity was not attempted. The patient did not complete the activity,	**GG0170K, Example #2** **Walk 150 feet:** The patient has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. The patient has not walked 150 feet or more during the assessment period, including with the physical therapist, who has been working with the patient. The therapist knows that the patient walked long distances prior to their exacerbation. **Coding:** GG0170K, Walk 150 feet would be coded 88, Not attempted due to medical or safety concerns. **Rationale:** The activity was not attempted. The patient did not complete the activity, and a helper cannot complete the activity for	Example revised to reflect removal discharge goals.

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3.GG.13	Chapter 3 Section GG Page GG-42	**GG170M, GG0170N, GG0170O Coding Tips** **Did not exist**	**GG170M, GG0170N, GG0170O Coding Tips** • While a patient may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means without taking more than a brief rest break in order to consider the stair activity completed. • Do not consider the stand-to-sit or sit-to-stand transfer when coding any of the step activities.	Adding coding tips to reflect updates to guidance.
3.GG.14	Chapter 3 Section GG Page GG-43	**GG170M, GG0170N, GG0170O Coding Tips** • If, at the time of the assessment, the patient is unable to complete the activity due to a physician prescribed restriction (for instance, no stair climbing for 2 weeks), but could perform this activity prior to the current illness, exacerbation, or injury, code 88, Not attempted due to medical condition or safety concern.	**GG170M, GG0170N, GG0170O Coding Tips** • If, at the time of the assessment, the patient is unable to complete the activity due to a physician prescribed restriction of no stair climbing, they may be able to complete the stair activities safely by some other means (e.g., stair lift, bumping/scooting on their buttocks). If so, code based on the type and amount of assistance required to complete the activity. If, at the time of assessment, a patient is unable to complete the stair activities because of a physician-prescribed bedrest, code the stair activity using the appropriate "activity not attempted" code.	Revised for clarity.

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3.GG.15	Chapter 3 Section GG Page GG-46	**GG0170Q, Example #1** **Does the patient use a wheelchair and/or scooter?** On admission, the patient wheels themself using a manual wheelchair but with difficulty due to their severe osteoarthritis and COPD. **Coding:** GG0170Q1, Does the patient use a wheelchair and/or scooter? would be **coded 1, Yes**. The admission performance codes for wheelchair items GG0170R, Wheel 50 feet with two turns and GG0170S, Wheel 150 feet are coded; in addition, the type of wheelchair the patient uses for GG0170RR1 and RR3 is indicated as **code 1, Manual**. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded. **Rationale:** The patient currently uses a wheelchair. Coding both items and coding the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.	**GG0170Q, Example #1** **Does the patient use a wheelchair and/or scooter?** On admission, the patient wheels themself using a manual wheelchair but with difficulty due to their severe osteoarthritis and COPD. **Coding:** GG0170Q1, Does the patient use a wheelchair and/or scooter? would be **coded 1, Yes**. The admission performance codes for wheelchair items GG0170R, Wheel 50 feet with two turns and GG0170S, Wheel 150 feet are coded; in addition, the type of wheelchair the patient uses for GG0170RR1 and RR3 is indicated as **code 1, Manual**. **Rationale:** The patient currently uses a wheelchair. Coding both items and coding the type of wheelchair (manual) is indicated.	Example revised to reflect removal discharge goals.

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3.GG.16	Chapter 3 Section GG Page GG-46	**GG0170R, GG0170RR Coding Tips** • The turns included in the items GG0170R, Wheel 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.	**GG0170R, GG0170RR Coding Tips** • The turns included in the items GG0170R, Wheel 50 feet with two turns are 90 degree turns. The turns may occur at any time during the 50-foot distance. 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.	Revised to reflect updates to guidance.

Chapter 3, Section J

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3.J.1	Chapter 3 Section J Page J-1	**SECTION J: HEALTH CONDITIONS** **Intent:** The intent of the items in this section is to assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities.	**SECTION J: HEALTH CONDITIONS** **Removed**	Removed Section Intent.
3.J.2	Chapter 3 Section J Page J-1	**J0510-J0530. Pain Interview** **Did not exist**	**J0510-J0530. Pain Interview** **Intent:** The intent of the items in this section is to assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities.	Added Item Intent.
3.J.3	Chapter 3 Section J Page J-3	**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.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
3.J.4	Chapter 3 Section J Page J-5	**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.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.

Chapter 3, Section J				
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3.J.5	Chapter 3 Section J Page J-5	**Definition Box** **Rehabilitation Therapy** Special healthcare service or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.	**Definition Box** **Rehabilitation Therapy** Includes, but is not limited to, special healthcare service or programs that help a person regain physical, mental, and or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, any services provided by PT, OT, SLP, and cardiac and pulmonary therapies.	Revised to reflect updates to guidance.
3.J.6	Chapter 3 Section J Page J-6	**Coding Tips** • Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient carrying out a prescribed therapy program without staff present.	**Coding Tips** • Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present, regardless of the rehab focus or goal(s).	Revised to reflect updates to guidance.
3.J.7	Chapter 3 Section J Page J-7	**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.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
3.J.8	Chapter 3 Section J Page J-9	**Coding Tips** **Did not exist**	**Coding Tips** • Include all falls that occurred since the time of admission. This would include any falls that occurred outside of the LTCH facility during a program interruption.	Added coding tip to reflect updates to guidance.

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3.J.9	Chapter 3 Section J Page J-12	**Coding Tips** **Did not exist**	**Coding Tips** • For item J1900, include all falls that occurred since the time of admission. This would include any falls that occurred outside of the LTCH facility during a program interruption. • Facilities are encouraged to utilize accurate and/or new information regarding fall-related injuries as information becomes known. For example, injuries can present themselves later than the time of the fall. The facility may not learn of the level of injury until after the LCDS assessment is completed or the patient has left the facility (e.g., because the patient was transported to ER and admitted to an inpatient facility post-fall). Errors should be corrected following the facility's correction policy and in accordance with guidance from Chapter 4: SUBMISSION AND CORRECTION OF THE LTCH CARE DATA SET (LCDS) ASSESSMENT RECORDS in the LCDS Manual.	Added coding tip to reflect updates to guidance.

Chapter 3, Section K

Chapter 3, Section K				
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3.K.1	Chapter 3 Section K Page K-4	**Coding Instructions for Admission** Check all that apply on admission. If none apply, check K0250Z, None of the above.	Coding Instructions for Admission Check all that are part of the patient's current care/treatment plan during the 3-day admission assessment time period, even if not used during the 3-day admission assessment time period. If none apply, check **K0520Z**, None of the above.	Revised to reflect updates to guidance.
3.K.2	Chapter 3 Section K Page K-4	**Steps for Assessment for Discharge** 1. Review the medical record to determine if any of the listed nutritional approaches were received in the last 7 days (Column 1) and at discharge (Column 2).	**Steps for Assessment for Discharge** 1. Review the medical record to determine if any of the listed nutritional approaches were part of the current care/treatment plan in the last 7 days (Column 4) and at discharge (Column 5).	Revised to reflect updates to guidance.
3.K.3	Chapter 3 Section K Page K-4	**Definition Box** **Feeding Tube** Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.	**Definition Box** **Feeding Tube** Presence of any type of tube that can deliver food/nutritional substances/fluids directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.	Revised to reflect updates to guidance.

Chapter 3, Section K				
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3.K.4	Chapter 3 Section K Page K-5	**Coding Instructions for Discharge** Check all nutritional approaches that were received in the last 7 days and at discharge. If none apply, check K0520Z, None of the above.	**Coding Instructions for Discharge** Check all of nutritional approaches that were part of the patient's current care/treatment plan during the last 7 days, even if not used in the last 7 days and check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, even if not used during the 3-day discharge assessment time period. If none apply, check **K0520Z**, None of the above.	Revised to reflect updates to guidance.
3.K.5	Chapter 3 Section K Page K-5	**Coding Tips for Discharge** **Did not exist**	**Coding Tips for Discharge** • At discharge, K0520 does not report on nutritional approaches that are expected to occur after discharge.	Added coding tips to reflect updates to guidance.
3.K.6	Chapter 3 Section K Page K-5	**K0520A Coding Tips** IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration.	**K0520A Coding Tips** ○ IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and/or hydration.	Revised to reflect updates to guidance.
3.K.7	Chapter 3 Section K Page K-6	**K0250B, Feeding Tube (e.g., nasogastric or abdominal [PEG])** **Coding Tips** **Did not exist**	**K0250B, Feeding Tube (e.g., nasogastric or abdominal [PEG])** **Coding Tips** • If a feeding tube is in place but there are no scheduled or PRN orders to provide nutrition or hydration via the feeding tube on the current care/treatment plan, do not code K0520B - Feeding Tube.	Added coding tip to reflect updates to guidance.

Chapter 3, Section M

Chapter 3, Section M				
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3.M.1	Chapter 3 Section M Page M-3	**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 the last skin assessment in the 3-day assessment period at discharge)	**Code 0, No,** if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day admission 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 admission assessment period (or the last skin assessment in the 3-day assessment period at discharge)	Added "admission" to improve clarity.

Chapter 3, Section N

Chapter 3, Section N				
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3.N.1	Chapter 3 Section N Page N-1	**Section N: Medications** **Intent:** The intent of the High-Risk Drug Classes items in this section is to record whether the patient is taking any medications in specified drug classes and whether the indication was noted for taking the prescribed medications.	**Section N: Medications** **Removed**	Removed Section Intent.
3.N.2	Chapter 3 Section N Page N-1	**N0415: High-Risk Drug Classes: Use and Indication** **Did not exist**	**N0415: High-Risk Drug Classes: Use and Indication** **Intent:** The intent of the High-Risk Drug Classes items in this section is to record whether the patient is taking any medications in specified drug classes and whether the patient-specific indication was noted for the prescribed medications.	Added Item intent.
3.N.3	Chapter 3 Section N Page N-1	**Definition Box** **Did not exist**	**Definition Box** **INDICATIONS** The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the patient's condition and therapeutic goals.	Added new definition for clarity in guidance.

Chapter 3, Section N				
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3.N.4	Chapter 3 Section N Page N-2	**Steps for Assessment** Complete on admission and discharge. 1. Determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). 2. If Column 1 is checked (patient is taking medication in drug classification), review patient documentation to determine if there is a documented indication noted for all medications in the drug class (Column 2).	**Steps for Assessment** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period. 1. Determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). Include all medications that are part of a patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment time period. 2. If Column 1 is checked (patient is taking medication in drug classification), review patient documentation to determine if there is a documented patient-specific indication noted for all medications in the drug class (Column 2).	Revised to reflect updates to guidance.
3.N.5	Chapter 3 Section N Page N-2 through N-3	**Coding Tips** • Code medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication. • Include any of these medications used by any route (e.g., PO, IM, transdermal, or IV) in any setting (e.g., at LTCH, in a hospital emergency room, at physician office or clinic) while a patient of the setting.	**Coding Tips** • Code medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it. • Include any of these medications used by any route in any setting (e.g., at LTCH, in a hospital emergency room, at physician office or clinic) while a patient of the setting that is also part of a patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment time period.	Revised to reflect updates to guidance.

3.N.5 (cont.)	Chapter 3 Section N Page N-2 through N-3	**Coding Tips** • Code medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication. • Include any of these medications used by any route (e.g., PO, IM, transdermal, or IV) in any setting (e.g., at LTCH, in a hospital emergency room, at physician office or clinic) while a patient of the setting. • Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly **only** if they are taken at admission/discharge. • A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the LCDS, and are only counted if the patch is attached to the skin during admission or discharge assessment period. • Combination medications should be coded in all categories/drug classes that constitute the combination. For example, if the patient receives a single tablet that combines an antipsychotic and an antidepressant, then both antipsychotic and antidepressant categories should be coded.	**Coding Tips** • Code medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it. • Include any of these medications used by any route in any setting (e.g., at LTCH, in a hospital emergency room, at physician office or clinic) while a patient of the setting that is also part of a patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment time period. • Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly **only** if they are part of the patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment time period. • A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the LCDS, and are counted if they are part of the patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment time period. • Combination medications should be coded in all categories/drug classes that constitute the combination. For example, if the patient receives a single tablet that combines an opioid and an antiplatelet, then both opioid and antiplatelet categories should be coded, regardless of why the medication is being used.	Revised to reflect updates to guidance.

Chapter 3, Section N				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.N.6	Chapter 3 Section N Page N-2 through N-4	**Coding Tips** **Did not exist**	**Coding Tips** • Some facilities utilize standing orders or a standing order set, providing a specific PRN order for all patients. If a medication is included on the patient's prescribed drug regimen due to facility policy (and not due to patient-specific need), it would only be considered for N0415 - High-Risk Drug Classes: Use and Indication if the patient received it during the 3-day assessment time period. • Do not include flushes to keep an IV access patent in N0415E, Anticoagulant. • CMS does not provide an exhaustive list of examples for determining the source for the documented patient-specific indication. • CMS does not specify a source for identifying the therapeutic category and/or pharmacological classification. • At Discharge, N0415 considers medications included in the patient's prescribed drug regimen at discharge, and not what is expected to occur after discharge.	Added new coding tips to reflect updates to guidance.
3.N.7	Chapter 3 Section N Page N-3	**Coding Tips** • Code a medication even if it was taken only once during the assessment period.	**Coding Tips** **Removed**	Removed a coding tip.
3.N.8	Chapter 3 Section N Page N-7	**Coding Instructions** **Did not exist**	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period	Added coding instructions for clarity.

Chapter 3, Section N				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.N.9	Chapter 3 Section N Page N-10	**Steps for Assessment** This item is completed if one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).	**Steps for Assessment** This item is completed if A0250 = Admission and one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).	Revised to reflect updates to guidance.
3.N.10	Chapter 3 Section N Page N-11	**Coding Instructions** Complete only if A0250 = Admission; and if N2001 Drug Regimen Review was coded 1. Yes – Issues found during review.	**Coding Instructions** **Removed**	Removed coding instruction due to redundancy.

Chapter 3, Section O

Chapter 3, Section O				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.O.1	Chapter 3 Section O Page O-1	**Section O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS** **Intent:** The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient.	**Section O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS** **Removed**	Removed Section intent.
3.O.2	Chapter 3 Section O Page O-1	**O0110: Special Treatment, Procedures, and Programs** **Did not exist**	**O0110: Special Treatment, Procedures, and Programs** Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient.	Added item intent.
3.O.3	Chapter 3 Section O Page O-4	**Steps for Assessment** **1.** Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs apply on admission.	**Steps for Assessment** 1. Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs are part of the patient's current care/treatment plan during the 3-day admission assessment time period.	Revised to reflect updates to guidance.
3.O.4	Chapter 3 Section O Page O-4	**Coding Instructions** Check all treatments, procedures, and programs that apply on admission. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply on admission, **check Z1, None of the above**.	**Coding Instructions** Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day admission assessment time period. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply on admission, **check Z1, None of the above.**	Revised to reflect updates to guidance.

Chapter 3, Section O				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.O.5	Chapter 3 Section O Page O-4	**Steps for Assessment for Discharge** **1.** Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs apply at discharge.	**Steps for Assessment for Discharge** 1. Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs are part of the patient's current care/treatment plan during 3-day discharge assessment time period. Do not consider what is expected to occur after discharge.	Revised to reflect updates to guidance.
3.O.6	Chapter 3 Section O Page O-4	**Coding Instructions for Discharge** Check all treatments, procedures, and programs that apply at discharge. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply at discharge, **check Z1, None of the above**.	**Coding Instructions for Discharge** Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply on discharge, **check Z1, None of the above.**	Revised to reflect updates to guidance.
3.O.7	Chapter 3 Section O Page O-5	**Coding Tips** **Did not exist**	**Coding Tips** • Some facilities utilize standing orders or a standing order set, providing a specific PRN order for their patients. If a standing order for treatment is included on the patient's current care/treatment plan due to facility policy (and not due to patient-specific need), it would only be considered for O0110 - Special Treatments, Procedures, and Programs, if the patient received it during the 3-day assessment time period.	Added new coding tip to reflect updates to guidance.

Chapter 3, Section O				
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3.O.8	Chapter 3 Section O Page O-5	**O0100A3, Oral** **O0100A10, Other**	**O0110A3, Oral** **O0110A10, Other**	Corrected item number.
3.O.9	Chapter 3 Section O Page O-6	**O0110C1, Oxygen Therapy** Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a patient to relieve hypoxia in this item.	**O0110C1, Oxygen Therapy** Code continuous or intermittent oxygen administered via mask, cannula, etc., that is part of the patient's current care/treatment plan regardless of reason for its use.	Revised to reflect updates to guidance.
3.O.10	Chapter 3 Section O Page O-7	**O0110G1, Non-Invasive Mechanical Ventilator** Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support their own spontaneous respiration** by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that "breathe" for the individual. If a ventilator is being used as a substitute for BiPAP/CPAP, code here (and do not check O0110G2 or O0110G3).	**O0110G1, Non-Invasive Mechanical Ventilator** Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support their own spontaneous respiration** by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that "breathe" for the individual. If a ventilator is being used as a substitute for BiPAP/CPAP, code here.	Revised to reflect updates to guidance.

Chapter 3, Section O				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.O.11	Chapter 3 Section O Page O-7	**O0110H1, IV Medications** Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** include flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be checked here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** included in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.	**O0110H1, IV Medications** Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Include IV fluids with medications added, unless otherwise excluded in guidance. Do **not** include flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be checked here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** included in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.	Revised to reflect updates to guidance.
3.O.12	Chapter 3 Section O Page O-7	**O0110H1, IV Medications** Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be included here. To determine what products are considered medications or for more information consult the FDA website: The Orange Book, http://www.accessdata.fda.gov/scripts/cder/ob/ The National Drug Code Directory, http://www.fda.gov/drugs/informationondrugs/ucm142438.htm	**O0110H1, IV Medications** **Removed**	Removed coding tip to reflect updated guidance.

Chapter 3, Section O				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.O.13	Chapter 3 Section O Page O-8	**O0110O1, IV Access** Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure.	**O0110O1, IV Access** Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure. An AV fistula does not meet the definition of IV Access for O0110O1. If there is not a current IV access in place at the time of assessment do not code IV access for O0110O1, even if a treatment which would require an IV access is part of the patient's current care/treatment plan.	Revised to reflect updates to guidance.
3.O.14	Chapter 3 Section O Page O-9	**Example #1** 1. The patient's referral information indicates that they were discharged from an acute care facility following inpatient stay for bacterial pneumonia that required placement of a tracheostomy. On admission, the patient requires intermittent oxygen. Their suctioning needs vary but are decreasing. The patient has, however, had intermittent desaturations due to mucus plugging that have required use of a tracheostomy mask at an FiO2 of greater than 40% intermittently. The patient has orders for 1 more week of IV antibiotics, which are being delivered via a PICC line.	**Example #1** 1. The patient's referral information indicates that they were discharged from an acute care facility following inpatient stay for bacterial pneumonia that required placement of a tracheostomy. On admission, the patient requires intermittent oxygen. Their suctioning needs are PRN. The patient has, however, had intermittent desaturations due to mucus plugging that have required use of a tracheostomy mask at an FiO2 of greater than 40% intermittently. The patient has orders for 1 more week of IV antibiotics, which are being delivered via a PICC line.	Revised for clarity.

Chapter 3, BIMS Supplement

Chapter 3, Supplement				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
3.S.1	Chapter 3 Supplement Page S-3	C0500C, Able to recall "bed" should be written as "a piece of furniture".	C0400C, Able to recall "bed" should be written as "a piece of furniture."	Corrected item number.
3.S.2	Chapter 3 Supplement Page S-3	There are several BIMS sections that require direct interview of the patient as the primary source of information (e.g., mood, pain).	**Removed**	Removed language.

Chapter 4

Chapter 4				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
4.1	Chapter 4 Page 4-4	Detailed information on the validation of fatal and warning messages is available in Section 5 of the LTCH Submission User's Guide	Detailed information on the validation of fatal and warning messages is available in Section 5 of the *LTCH Error Message User Guide*	Updated name of guide.

Appendix A

Appendix A				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
A.1	Appendix A Page A-1	**Term: Activities of daily living (ADLs)** **Did not exist**	**Term: Activities of daily living (ADLs)** **Definition:** Activities performed as part of a person's daily routine such as self-care, bathing, dressing, eating, and toileting.	Added new term and definition.
A.2	Appendix A Page A-1	**Term: Activity** **Did not exist**	**Term: Activity** **Definition:** The performance of a task or action by an individual (definition from the World Health Organization's International Classification of Functioning, Disability and Health [ICF]).	Added new term and definition.
A.3	Appendix A Page A-1	**Term: Activity limitation** **Did not exist**	**Term: Activity limitation** **Definition:** A restriction or lack of ability to perform an activity in the manner or within a range considered normal for a person of the same age, culture, and education.	Added new term and definition.
A.4	Appendix A Page A-1	**Term: Assessment Period** **Definition:** A specified period of time over which a specific aspect of patient assessment, or the patient's condition or status, is captured by the LCDS assessment. The assessment period ends on the ARD.	**Term: Assessment Period** **Definition:** 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. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge.	Updated definition for conciseness.

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A.5	Appendix A Page A-3	**Term: Community Residential Setting** **Definition:** A private home, apartment, board and care, assisted living facility, group home, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community whether owned by the patient or another person, retirement communities, or independent housing for the elderly. Also included in this category are noninstitutionalized community residential settings that provide the following types of services: home health, homemaker/personal care, or meals.	**Removed**	Removed term and its definition.

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A.6	Appendix A Page A-7	**Term: Fall** **Definition:** Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. A fall is not a result of an overwhelming external force (e.g., a patient pushes another patient). 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.	**Term: Fall** **Definition:** Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. A fall is not a result of an overwhelming external force (e.g., a patient pushes another patient). 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.	Added additional information in the definition of the term.
A.7	Appendix A Page A-7	**Term: Health Information Exchange (HIE)** **Did not exist**	**Term: Health Information Exchange (HIE)** **Definition:** Health Information Exchange (HIE) allows health care professionals and patients to appropriately access and securely share a patient's medical information electronically. There are many health care delivery scenarios driving the technology behind the different forms of HIE available today including directed exchange, query-based exchange, and consumer-mediated exchange.	Added new term and definition.

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A.8	Appendix A Page A-7	**Term: Home Health Agency** **Definition:** An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.	**Term: Home Health Agency** **Definition:** A Medicare-certified organization that provides home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.	Updated definition.
A.9	Appendix A Page A-8	**Term: Impairment** **Did not exist**	**Term: Impairment** **Definition:** Any loss or abnormality of psychological, physiological, or anatomical structure or function.	Added new term and definition.
A.10	Appendix A Page A-8	**Term: Inpatient Psychiatric Facility** **Did not exist**	**Term: Inpatient Psychiatric Facility** **Definition:** For the purposes of coding item A2105, this code should be used when a patient is admitted from/transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.	Added new term and definition.
A.11	Appendix A Page A-8	**Term: International Classification of Diseases–Clinical Modification (ICD–CM)** **Definition:** Official system of assigning codes to diagnoses associated with hospital utilization in the United States. The ICD-CM contains a numerical list of the disease code numbers in tabular form, an alphabetical index to the disease entries.	**Term: International Classification of Diseases–, 10th Edition, Clinical Management (ICD-10)** **Definition:** Official system of assigning codes to diagnoses associated with hospital utilization in the United States. The ICD-CM contains an alpha/ numerical list of the disease code numbers in tabular form, an alphabetical index to the disease entries.	Updated term and definition.

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A.12	Appendix A Page A-8	**Term: Interoperable/Interoperability** Interoperability, with respect to health information technology, means such health information technology that: "(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; (B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and (C) does not constitute information blocking as defined in section 3022(a)."	**Term: Interoperable/Interoperability** **Definition:** "Interoperability," with respect to health information technology, means such health information technology that: "(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; (B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and (C) does not constitute information blocking as defined in section 3022(a)." Section 4003 of the 21st Century Cures Act, available at: https://www.healthit.gov/topic/interoperability	Added resource.

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A.13	Appendix A Page A-9	**Term: Interrupted Stay** **Did not exist**	**Term: Interrupted Stay** **Definition:** A stay by a patient who is discharged from the LTCH and returns to the same LTCH within 3 consecutive calendar days. Since Medicare treats this situation as one combined LTCH stay, the LTCH would not need to repeat all of the required documentation when the patient returns to the LTCH after the interruption. However, it is expected that the LTCH update the information in the patient's medical record to make sure that it is current (i.e., update the patient's condition, comorbidities, goals, plan of care, etc.). If the patient returns to the LTCH in 4 or more consecutive days (i.e., it is not considered an interrupted stay), then all of the required documentation must be completed as with any "new" LTCH patient.	Added new term and definition.
A.14	Appendix A Page A-9	**Did not exist**	**Term: Length of stay (LOS)** **Definition:** The number of days a patient spends in the LTCH. The day of discharge is not counted in the length-of-stay calculation. Length of stay does not include the interrupted stay days. It includes all days that the patient is in the LTCH for the midnight census.	Added new term and definition.

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A.15	Appendix A Page A-10	**Term: Major surgery** **Did not exist**	**Term: Major surgery** **Definition:** Generally, for the purposes of the LCDS, major surgery refers to a procedure that meets all the following criteria: (1) the patient was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the LCDS, and (2) the surgery carried some degree of risk to the patient's life or the potential for severe disability.	Added new term and definition.
A.16	Appendix A Page A-10	**Term: Medicare** **Definition:** A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities. Medicare Part A: The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, home health agencies, and hospices. Medicare Part B: The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services.	**Term: Medicare** **Definition: (…)** A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities. • Medicare Part A: The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, home health agencies, and hospices. • Medicare Part B: The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services. • Medicare Part C (Medicare Advantage): Plans that are offered by private companies approved by Medicare.	Added additional plan to the definition.

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A.17	Appendix A Page A-10	**Term: Medicare Number (or Comparable Railroad Insurance Number)** **Definition:** An identifier assigned to an individual for participation in a national health insurance program. The Medicare number may contain both letters and numbers.	**Term: Medicare Beneficiary Identifier (MBI)** **Definition:** The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.	Updated term name and definition.
A.18	Appendix A Page A-10	**Term: Non-removable Dressing/Device** **Definition:** A dressing or device such as a primary surgical dressing that cannot be removed, an orthopedic device, or a cast.	**Term: Non-removable Dressing/Device** **Definition:** A dressing or device such as a primary surgical dressing that cannot be removed, per physician's order, an orthopedic device, or a cast.	Updated definition.
A.19	Appendix A Page A-10	**Term: Orthosis** **Did not exist**	**Term: Orthosis** **Definition:** An appliance (device) applied over a portion of a limb or the trunk and used to support or immobilize body parts, correct or prevent deformity, or assist or restore function. Anti-embolic (and other) stockings, abdominal binders, and elastic wraps are examples of orthoses.	Added new term and definition.
A.20	Appendix A Page A-10	**Term: Outlier** **Did not exist**	**Term: Outlier** **Definition:** Observation outside a certain range differing widely from the rest of the data.	Added new term and definition.

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A.21	Appendix A Page A-10	**Term: Participation** **Did not exist**	**Term: Participation** **Definition:** An individual's involvement in life situations in relation to health conditions, body functions and structures, and activities and contextual factors (definition from the World Health Organization's ICF).	Added new term and definition.
A.22	Appendix A Page A-10	**Term: Portal (e.g., patient or provider portal)** **Did not exist**	**Term: Portal (e.g., patient or provider portal)** **Definition: (…)** Office of the National Coordinator, What is a patient portal? Available from https://www.healthit.gov/faq/what-patient-portal	Added reference.
A.23	Appendix A Page A-10	**Term: Program Interruption** **Definition:** An interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per agreement for medical services (e.g., when the patient requires a higher level of care and is transferred to an acute-care hospital). Such an interruption must not exceed 3 calendar days, whereby day 1 begins on the day of transfer, regardless of the hour of transfer. For such an interruption, the LTCH should not complete and submit an LCDS Discharge Assessment (planned or unplanned).	**Removed**	Removed term and its definition.
A.24	Appendix A Page A-10	**Term: Prosthesis** **Did not exist**	**Term: Prosthesis** **Definition:** A device that replaces a body part.	Added new term and definition.

Appendix A				
Edit #	**Chapter, Section, Page**	**LCDS Manual Version 5.0 – Effective October 1, 2022**	**LCDS Manual Version 5.1 – Effective October 1, 2024**	**Description of Change**
A.25	Appendix A Page A-10	**Term: Psychiatric Hospital** **Definition:** An institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients.	**Removed**	Removed term and its definition.
A.26	Appendix A Page A-10	**Term: Qualified Clinicians** **Did not exist**	**Term: Qualified Clinicians** **Definition:** A healthcare professional practicing within their scope of practice and consistent with Federal, State, and local law and regulations.	Added new term and definition.
A.26	Appendix A Page A-10	**Term: Short Stay Acute Care Hospital**	**Term: Short-Term General Hospital**	Updated term's name.
A.27	Appendix A Page A-10	**Term: Skilled Nursing Facility (SNF)** **Definition:** A nursing facility with…	**Term: Skilled Nursing Facility (SNF)** **Definition: A Medicare-certified nursing facility with…**	Added language for accuracy.
A.28	Appendix A Page A-10	**Did not exist**	**Common Acronyms** **ADLS** **CAM** **DTI** **EHR/EMR** **FVR** **HIE** **IPF** **LOS** **PPS** **PVS** ~~**QIES**~~	Added and removed acronyms.