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

Frequently Asked Questions with Answers

Current as of May 2017
This version replaces all previous versions.

LTCH CARE Data Set Frequently Asked Questions with Answers

#	Question	Answer
Section A. Administrative Information		
1.	There are LTCH facilities with multiple buildings or sites working under the same CCN that often have different NPIs for each building – meaning, a single CCN can encompass multiple NPIs. Which NPI would be appropriate to enter for A0100A on the LTCH CARE Data Set: the NPI belonging to the "main facility" under the CCN (where that can be determined) or the NPI for the patient's location?	The National Provider Identifier (NPI) refers to the number used on your LTCH claims. LTCHs should use the NPI for the patient's location. The NPI is not the same number as the facility ID number. Additional information can be found in Chapter 3, Section A, of the LTCH QRP Manual V 3.0 available in the Downloads section at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html.
2.	Regarding program interruptions, is there a minimum amount of time required to be considered an interrupted stay or does this apply only to overnight stays? Is it still considered an "interruption" if the referenced absence is due to reasons other than "for services unavailable at LTCH" such as absence without leave, a scheduled visit to their doctor, or trial home visit?	For the LTCH QRP, a program interruption refers to an interruption in a patient's care provided by an LTCH because the patient is transferred to another hospital/facility per agreement for medical services not provided at the LTCH (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 time of transfer. For such an interruption, the LTCH should not complete and submit an LTCH CARE Data Set Discharge record (planned or unplanned).
3.	Would specialist appointments, performed outside the LTCH, be considered an interrupted stay?	Yes, specialist appointments performed outside of the LTCH would be considered an interrupted stay. Such an interruption must not exceed 3 calendar days, whereby day 1 begins on the day of transfer, regardless of the time of transfer. For such an interruption, the LTCH should not complete and submit an LTCH CARE Data Set Discharge record (planned or unplanned).
4.	If a patient was transferred out of the LTCH and does not return by day 3 and instead returns on day 4, will I need to complete an LTCH CARE Data Set Unplanned Discharge assessment and mark the interruption dates?	This is not considered an interrupted stay because the patient transferred out of the LTCH and did not return by day 3. You will need to complete an LTCH CARE Data Set Unplanned Discharge assessment for this patient but you should not mark the interruption dates of this transfer.
5.	If a patient is transferred to another facility for only few hours but the stay extends beyond midnight before returning to the LTCH, is this considered an interrupted stay?	Yes, on the patient's discharge assessment, you should indicate that there was a program interruption. Because the patient returned to the LTCH after midnight, you would enter the start date (date in which the patient transferred to another facility) and the end date (date in which the patient returned to the LTCH).

#	Question	Answer
Section B. Hearing, Speech, and Vision		
6.	Will the data collected in Section B, Hearing, Speech, and Vision be risk adjusted?	These items are used to calculate the quality measure, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), which is a process measure and is not risk adjusted. These items are also risk adjustors for the quality measure, LTCH Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632).
7.	How do you code Section B, item BB0800, and Section C for patients who are on a ventilator and are receiving sedation medication?	If a patient is diagnosed with a communication impairment or is using a ventilator, the patient should be offered the use of alternative communication devices to assess the patient's function. Evidence of acute changes in mental status is not only observational, but can also be found in the medical record, and/or from family or staff over the 3-day assessment period. Available information may indicate the patient's baseline status or an acute mental status change that occurred within the first 3 days of the LTCH stay. You would answer the questions in this section based on all the information that was gathered. The LTCH CARE Data Set V 3.00 Section B item B0100 asks if the patient has been diagnosed as comatose or in a persistent vegetative state with no discernable consciousness. If the answer to this item is 1, Yes, then the clinician is to skip over the remaining Section B items and skip Section C, Cognitive Patterns, which includes all items in C1610. Signs and Symptoms of Delirium.
Section C. Cognitive Patterns		
8.	For Section C item C1610A, is there evidence of an acute change in mental status from the patient's baseline? How is the patient's baseline defined? Does assessing the acute change in the patient's mental status only include observation of the 3-day assessment period, or does it include the patient's baseline status prior to admission?	Using your example of a patient with a TBI, the baseline is the cognitive status of the patient after the TBI occurred. The clinician should compare the patient's baseline mental status after the TBI with the observed change(s) in behavior. Information about the patient's baseline mental status may be obtained from the transferring facility's documentation or from the patient's family or caregiver.

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	Our LTCH treats patients with traumatic brain injury (TBI) and so should we consider their cognitive patterns prior to the TBI as their baseline mental status?	
9.	If a patient is lethargic or has an altered mental status and is unable to provide their medical history, I'm coding the item as unknown for prior level of function. What should I put in the prior device use (manual wheelchair, motorized wheelchair, Hoyer lift) if the patient is not able to coherently state information and the family is not available?	In this scenario, the LTCH should attempt to reference information provided by the previous medical setting prior to or during the patient's transition to the LTCH. If the patient is non-communicative, and has no family that can speak on their behalf, you would code Z, None of the above. In the absence of information, you would default to say no device.
Section GG. Functional Abilities and Goals		
10.	Can information obtained through an interview from a certified nursing assistant be used to complete Section GG or does it have to be documented in the medical record?	Information about a patient's functional status provided by a certified nursing assistant and obtained by interview may be considered by the clinician coding Section GG items. Please note that information on the LTCH CARE Data Set must be consistent with information documented in the patient's medical record. Procedures for documentation of functional status in the medical record should follow facility policies, and patient assessments are to be completed in compliance with facility, State, and Federal requirements.
11.	If the patient had multiple admissions to different hospitals and post-acute care settings spanning several months, do we still use the patient's prior level of function prior to the first admission?	If the patient experienced a medical event or an injury, such as a stroke or brain injury, and received care in multiple acute and post-acute settings as part of the episode of care, the patient's prior functioning would be based on the time immediately before the stroke or brain injury.
12.	If a patient, who is paralyzed, is unable to perform the activity prior to admission, is GG0100B coded 01, Dependent, or 09, Not applicable?	If the person used a wheelchair and did not walk immediately prior to the current illness/injury, code GG0100B, Prior Functioning: Everyday Activities, Indoor Mobility (Ambulation) as 09, Not Applicable. For this item, code 09 indicates that the activity was not applicable to the patient prior to the current illness, injury, or exacerbation. If the patient used a device prior to the current illness/injury/exacerbation, indicate the type of device in item GG0110, Prior Device Use. For example,

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		check the wheelchair item as a device in GG0110, Prior Device Use, if the person used a wheelchair. This is a risk adjustor for the function outcome measure and so it is important to document wheelchair use for item GG0110, Prior Device Use, when applicable.
13.	How do you code the function items if the patient's function varies and it varies between two levels? What is the definition of “most usual” and how is it determined?	If the patient performs an activity, such as walking 50 feet with 2 turns more than once during the assessment period and the patient’s performance varies, Section GG should be coded based on the patient’s “usual performance” which is the patient’s usual activity/performance, not the most independent or most dependent performance during the assessment period. Documentation in the medical record is used to support assessment coding of Section GG items. Data entered on the LTCH CARE Data Set should be consistent with the clinical assessment documentation in the patient’s medical record.
14.	If a patient has an inconsistent level of function (inconsistent meaning sometimes the patient feels that she wants to walk one day and on another day refuses to walk due to fatigue), what would be the appropriate functional level under GG on the discharge assessment?	For this patient, code the walking items based on the distance the patient walked and the amount of assistance the patient required when she walked each distance. The patient does not need to walk each day or multiple times to be coded on the walking items, but walking must occur at least once during the 3-day assessment period. If the patient walks 10 feet, but not more than 20 feet due to endurance and fatigue problems, code item GG0170I, Walk 10 feet, based on the amount of assistance required by a helper. For this patient, items GG0170J, Walk 50 feet with 2 turns, and GG0170K, Walk 150 feet, would be coded as 88, Not attempted due to medical condition or safety concerns.
15.	If a patient requires two helpers to complete an activity, is the patient's function coded as 01, Dependent?	If a patient requires the assistance of two helpers to complete an activity, then code the patient’s functional status on that activity as 01, Dependent. If the patient attempts any portion of the activity and still requires two helpers, the patient’s level of function is still coded as 01, Dependent, because two helpers were needed to complete the activity.
16.	Does the use of an assistive device, for example, a slide board, affect the coding of the activity as the LTCH QRP Manual indicates that activities may be completed with or without assistive device(s)?	The guidance about the use of assistive devices indicates that a patient’s score would not be lowered due to the patient’s use of an assistive device. The scores are determined based on the need for assistance from one or more helpers.

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		If the patient uses an assistive device that they can retrieve and use independently, the use of the device would not be considered when coding the activity. If the patient needs assistance in retrieving or using the assistive device, then the assistance would be considered in coding the activity. If the helper retrieves the device, and the patient does not need any other assistance, code 05, Setup or clean-up assistance. If the patient needs assistance in using the assistive device to perform the activity, then code the activity per the amount of assistance that was needed.
17.	Are you able to provide examples of "clean-up" assistance for the self-care coding option 05, Setup or clean-up assistance?	The following are examples that illustrate the helper providing "clean-up" assistance that would be coded as 05, Setup or clean-up assistance: • Oral hygiene: The certified nursing assistant returns to gather the toothbrush and rinse cup and dispose of the waste after Mrs. C finishes brushing her teeth, which she does without help. • Wash upper body: The certified nursing assistant returns to Mr. G's room after he completes washing his upper body without assistance. The certified nursing assistant collects and removes the washbasin, washcloth, and towel that Mr. G used to wash his upper body.
18.	For item GG0130A, Eating, would tube feedings or total parenteral nutrition (TPN) be considered code 09, Not applicable?	If the patient eats by mouth, code item GG0130A, Eating, based on the type and amount of assistance required from a helper. The patient may be eating by mouth even though she receives liquids or nutrition via tube feedings. If the patient is unable to eat by mouth due to a new medical condition, and relies solely on nutrition and liquids through tube feedings or TPN, code GG0130A, Eating, as 88, Not attempted due to medical condition or safety concerns. If the patient is unable to eat by mouth and has relied on tube feedings or TPN for liquids and nutrition prior to the current illness, injury or exacerbation, code GG0130A, Eating, as 09, Not applicable.
19.	If a patient is fed through a percutaneous endoscopic gastrostomy (PEG) tube is it appropriate to put in Not Applicable for the feeding section?	Eating is coded based on eating by mouth. If the use of the PEG tube is new with this episode of care code 88, Not attempted due to medical or safety concerns. If the patient did not eat by mouth prior to the current illness, injury, or exacerbation code 09, Not applicable.

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20.	Is item GG0130D, Wash upper body, part of the quality measure, NQF #2631?	The item GG0130D, Wash upper body, is included in the quality measure, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), and thus this item must be coded as part of the LTCH QRP requirements. The LTCH QRP adopted the quality measure, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), in the FY 2015 IPPS/LTCH PPS Final Rule (79 FR 50291 through 50298). A cross-setting application of the quality measure, 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) was adopted in the FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49739 through 49747).
21.	Is coding a discharge goal required?	A minimum of one discharge goal is required for at least one of the self-care or mobility items on the LTCH CARE Data Set as part of the LTCH QRP requirements. Even though only one discharge goal is required, the facility may choose to code more than one discharge goal for a patient.
22.	Can you use/code the discharge goals as their prior level of function?	Yes, if the patient is expected to return to her prior level of functioning, and the clinician and patient have determined that the code reflects this intended discharge goal. The discharge goal may be based on the patient's prior level of function as well as other factors considered to determine the discharge goal.
23.	What is the best method for identifying function goals? For example, where you expect the most progress?	Licensed clinicians can establish a patient's discharge goal(s) at the time of admission based on discussions with the patient and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the patient's care plan. A minimum of one self-care or mobility discharge goal must be coded per patient stay on the LTCH CARE Data Set. Even though only one discharge goal is required, the facility may choose to code more than one discharge goal for a patient.

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		Goals may be determined based on the patient's admission functional status, prior functioning, medical conditions/comorbidities, discussions with the patient and family, and the clinician's consideration of expected treatments, and patient motivation to improve.
24.	If a function goal is not established for a particular task, is that discharge goal item left blank?	If you do not code all of the function goals, code a "-" (dash) for any self-care or mobility goal that you do not report. Goals should be established as part of the patient's care plan and the clinician reports at least one discharge goal for one of the self-care (GG0130) or mobility (GG0170) items.
25.	My patient ambulates independently on admission. Do I need to have a function discharge goal for this patient? My patient is only able to walk 50 feet with assistance at discharge. How do I code GG0170K, Walk 150 feet?	Discharge goals should be established as part of the patient's care plan. Document at least one discharge goal for one of the items in Section GG0130 or GG0170 to meet the requirements of the LTCH QRP. If a patient is independent with daily activities then code 06, Independent, for all self-care and mobility items as the goal for these activities indicates the patient is expected to maintain her independence. For the patient who walks 50 feet, but not 150 feet, code the patient's usual performance for item GG0170J, Walk 50 feet with two turns. For item GG0170K, Walk 150 feet, use code 88 to indicate this activity was not completed due to medical condition or safety concerns.
26.	How do you clinically assess walking items GG0170I, GG0170J, and GG0170K? All 3 items separately? Or is it considered one progressive episode?	The clinician is to assess each walking item individually. Each item has specific activity components or tasks that assess the level of function. Item GG0170I assesses the ability to walk at least 10 feet. Item GG0170J assesses the ability to walk 50 feet and make 2 turns. Item GG0170K assesses the ability to walk 150 feet. The clinician should assess the patient's performance specific to each item. For example, the patient may be able to walk 10 feet without assistance, but may need some assistance to walk further or make turns. Each activity should be assessed by observing the amount of assistance required from the helper.

#	Question	Answer
27.	How do you clinically assess GG0170Q1, Does the patient use a wheelchair/scooter? Separately or as one progressive episode?	The clinician is to assess each wheelchair item individually. Each item has specific activity components or tasks that assess the level of function. Item GG0170R assesses the ability to wheel 50 feet with two turns. Item GG0170S assesses the ability to wheel 150 feet. The clinician should assess the patient's performance specific to each item. For example, the patient may be able to wheel 150 feet without assistance, but may need some assistance to wheel 50 feet with two turns. Each activity should be assessed by observing the amount of assistance required from the helper.
28.	If the wheelchair activity was not attempted, is it still required to code GG0170RR1 and GG0170SS1, "Indicate the type of wheelchair/scooter used?" How would you indicate the type of wheelchair/scooter used?	If the patient does not use a wheelchair or scooter (GG0170Q1/GG0170Q3 Does the patient use a wheelchair/scooter? code = 0), then the wheelchair items are skipped, and you will not be able to enter codes for the wheelchair items. However, if the patient uses a wheelchair, but did not attempt using the wheelchair, code the reason the activity was not attempted. After coding Items GG0170R, Wheel 50 feet with two turns and GG0170S, Wheel 150 feet, indicate the type of wheelchair/scooter the patient used. Coding of these items is required even if GG0170R and GG0170S have been coded 07 or 88. The clinician should code the items based upon the customary type of wheelchair (manual or motorized) the patient would use. For example, if the patient refused to use the wheelchair (code 07), indicate the type of wheelchair the patient would have used.
29.	In Section GG, should the walking or wheelchair mobility items be left blank if they are skipped on the assessment or should we code 09, Not applicable? For instance, if a patient is walking on admission and not using a wheelchair, should items GG0170R & GG0170S be left blank?	Items GG0170H, Does the patient walk? and GG0170Q, Does the patient use a wheelchair? are gateway questions. If the patient does not walk and a walking goal is not clinically indicated (code 0), then the walking performance items are skipped and the computer application will not allow codes to be entered for the walking items. If the patient does not use a wheelchair or scooter (code 0), then the wheelchair items are skipped, and the computer application will not allow scores to be entered for the wheelchair items.

#	Question	Answer
	Section H. Bowel & Bladder	
30.	How do we code if the patient has stress incontinence usually and during the assessment period patient had bladder incontinence daily?	If the patient is incontinent daily during the admission assessment period, item H0350 Bladder Continence is to be coded 03. Incontinent daily. Stress incontinence is coded if the patient has only stress incontinence. Stress incontinence refers to episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
31.	For Section H item H0350, how is stress incontinence distinguished from incontinence? How can this distinction be determined in a non-verbal patient?	H0350 would be coded as 1, Stress incontinence only, if during the 3-day assessment period the patient has episodes of incontinence only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise. H0350 would be coded as 3, Incontinent daily, if during the 3-day assessment period the patient was incontinent of urine at least once a day. Although stress incontinence may occur daily, it only occurs with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise. Staff observations would be helpful in distinguishing incontinence from stress incontinence in non-verbal patients.
	Section I. Active Diagnoses	
32.	For Section I, there are several comorbidities and co-existing conditions listed and we need to check all that apply. If the patient's medical condition includes one of those listed in Section I, for example amyotrophic lateral sclerosis (ALS) or peripheral vascular disease (PVD), how do we code the first item I0050?	You would indicate the patient's primary medical condition category in I0050. The patient's primary medical condition is one of the four categories (1. Acute onset respiratory condition, 2. Chronic respiratory condition, 3. Acute onset and chronic respiratory conditions, 4. Chronic cardiac condition) or code as 5. Other medical condition and indicate the ICD code. For example, if the condition is ALS, then code 5. Other medical condition, enter the ICD code for ALS, and check I5450, Amyotrophic Lateral Sclerosis, in the comorbidities and co- existing conditions.
	Section J. Medical Conditions	
33.	What is the definition of an "intercepted fall"? How does this relate to the definition of a "fall"?	An intercepted fall occurs when the patient would have fallen if she had not caught him/herself or had not been intercepted by another person. This is still considered a fall. The definition of a fall is "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)."

#	Question	Answer
Section M. Skin Conditions		
34.	Are pressure ulcers that are identified during the admission Assessment Reference Date (ARD) considered to be hospital-acquired if identified during the initial assessment?	Pressure ulcers that are found during the timeframe of the admission assessment are considered as present on admission. However, if a pressure ulcer develops after that, they would be considered as not present on admission.
35.	Our wound nurse assesses newly admitted patients on day two of the hospitalization. Is it acceptable to use this information to stage pressure ulcers on admission?	Clinical assessments performed on patients in the LTCH should be completed according to accepted clinical practice and comply with facility policy and State and Federal regulations. The general standard of practice for newly admitted patients is that patient clinical admission assessments are completed beginning as close to the actual time of admission as possible, and usually within 24 hours. So, if your facility requires the wound nurse to complete that assessment within a timeframe that coincides with accepted clinical standards and as enumerated in your facility policy, then that is acceptable and the LTCH CARE Data Set would be coded based on that assessment. Information related to this question can be found Section M of the LTCH QRP Manual.
36.	Is this a true statement: A wound is considered worsened only if worsened numerically (by depth)? In this scenario, would any unstageable wound be considered a new pressure ulcer? Would a Stage 3 wound that becomes covered by slough be coded as unstageable and the Stage 3 wound would no longer be coded in M0300C?	The definition of worsened is a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1–4 (using the staging assessment determinations assigned to each stage; starting at Stage 1, and increasing in severity to Stage 4) on a Discharge assessment as compared to the Admission assessment. So, if a stage 3 pressure ulcer reported in M0300C becomes covered by slough and/or eschar by discharge it would be reported on M0300F, unstageable due to slough and/or eschar, on discharge and not in M0300C.
37.	If a pressure ulcer is assessed as a Stage 3 on admission, but by discharge has improved and now has the characteristics of a Stage 2, how would it be staged at discharge?	Due to the tissue loss associated with a Stage 3 pressure ulcer, it will never have characteristics of a Stage 2 ulcer as the tissues lost are not replaced by the same type of tissue. Stage 3 pressure ulcers fill using granulation tissue which would not be seen in a Stage 2 pressure ulcer. Reverse staging is not clinically correct for this reason. Therefore, a Stage 3 pressure ulcer remains a Stage 3 pressure ulcer until it is completely covered with epithelial tissue (i.e. is healed) or worsens to a deeper stage. The LTCH would code the Admission assessment to indicate that a Stage 3 pressure ulcer was present on admission (M0300C1 = 1, M0300C2 = 1). At discharge, because the Stage 3 pressure ulcer has neither healed nor increased in numerical stage, the LTCH

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		would code the Discharge assessment to indicate that a Stage 3 was present on admission and present at discharge (M0300C1 = 1, M0300C2 = 1).
38.	Can you please provide guidance with the following scenario: On admission (day 1) the nurse performing the admission assessment charts that the patient has a wound on the sacrum (gives a short description but no stage) and a wound on the right heel (gives a short description but no stage). The next day (day 2), the wound care nurse completes the wound care assessment. The wound care nurse charts that there is a pressure wound on the sacrum- stage 3, a pressure wound on the right heel stage- 2, a pressure wound on the right elbow stage 3 (not charted by the admission nurse). Is the right elbow pressure ulcer considered present on admission since it was charted within the first 3 days or is it considered new because it was not in the initial skin assessment completed by the admission nurse?	For the LTCH QRP, the right elbow pressure ulcer would not be considered present on admission. The admission skin assessment should be completed by the ARD, which includes the date of admission and the two following calendar days. The 3-day assessment period used in the LTCH CARE Data Set is not intended to replace the timeframe required for clinical Admission assessments as established by accepted standards of practice, facility policy, and State and Federal regulations. Therefore, the LTCH CARE Data Set Admission assessment sections that include patient assessment should be consistent with the initial clinical assessment (e.g., the assessment of skin conditions that are present on admission are based on the skin assessment that is completed in conjunction with the admission assessment). So, if a patient that is clinically assessed upon admission has a pressure ulcer identified and staged, that initial clinical assessment is what should be used to assist in coding the LTCH CARE Data Set Admission assessment pressure ulcer items. If a new pressure ulcer is identified after the initial skin assessment but within the 3-day LTCH assessment period, it should not be documented as present on admission. Rather, the initial skin assessment should be documented on the LTCH CARE Data Set Admission assessment. Therefore, in this scenario the sacral wound and the right heel wound (and any additional pressure ulcers identified on the initial skin assessment) should both be reported as present on admission in the LTCH CARE Data Set Admission assessment. Any subsequent identified pressure ulcers are not considered present on admission and should be reported on the LTCH CARE Data Set Discharge assessment as new or worsened.
39.	Are device-related pressure ulcers to be captured on LTCH CARE Data Set? Most of the pressure ulcers that we have had to code as worsening or newly developed are due to devices such as nasal cannulas, CPAP or buck traction devices. So, to clarify, should we not include these pressure ulcers in the LTCH CARE Data Set when coding the discharge assessment?	All types of skin pressure injuries should be included when completing your assessment. For the purposes of coding, determine that the skin lesion being assessed is *primarily* related to pressure and that other conditions have been ruled out. If pressure is *not the primary cause*, **do not code under Section M**. As stated in the LTCH QRP Manual, “Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, oxygen tubing, endotracheal tubes, urinary catheters,

#	Question	Answer
		mucosal ulcers in the oral cavity, etc.) should not be coded on the LTCH CARE Data Set." (Chapter 3, Section M, page M-3) The definition related to coding "unstageable due to non-removeable dressing/device" items in Section M of the LTCH QRP Manual states that it includes a primary surgical dressing that cannot be removed, an orthopedic device, or a cast. It does not include endotracheal tubes, tracheostomy ties, elastic wraps, splints, oxygen tubing, CPAP, and the like. It is important to ensure that you are using the appropriate size medical device, and the skin is assessed and protected in high- risk areas like the bridge of the nose or over the ears.
Section O. Special Treatments, Procedures, and Programs		
40.	What is the influenza vaccination season for LTCH CARE Data Set items O0250A, O0250B, and O0250C for the quality measure Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)? How should I code items O0250A, O0250B, and O0250C during the period from April 1st to September 30th each year (i.e., outside of the influenza vaccination season)?	The *influenza vaccination season* is defined as beginning October 1st or when the influenza vaccine becomes available (whichever comes first) through March 31st of the following year. The *influenza season* is defined as beginning July 1st through June 30th of the following year. Patients who were in the LTCH for one or more days during the influenza vaccination season are included in the quality measure. As finalized in the FY 2017 IPPS/LTCH PPS final rule (https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf), beginning October 1, 2016, LTCHs are required to code the influenza vaccine items year-round. This includes assessments completed outside the influenza vaccination season, which is between April 1st and September 30th. Vaccines received 'for the current influenza vaccination season' include all vaccines received during the influenza season, including those received before or after the influenza vaccination season. For example, vaccines received in September or received in April of the following year should be coded as follows:

#	Question	Answer
		O0250A: Code 0 (No) or 1 (Yes) depending on whether the patient received the influenza vaccine in this facility for the current influenza vaccination season. Code 1 (Yes) for any vaccine received during the current influenza season, even if outside the influenza vaccination season. If 1, skip to O0250B to record the date the vaccine was received, regardless of whether received during or outside the influenza vaccination season. If 0, skip to O0250C, and state reason influenza vaccine was not received as follows: • If there is documentation of a contraindication, Code 3, Not eligible - medical contraindication. • If there is no documentation of any of the following: staff offering the vaccine, contraindication, refusal of the vaccine, then Code 9, None of the above listed reasons describe why the influenza vaccine was not administered. LTCHs should no longer code any of the influenza vaccine items with a dash, including those assessments completed outside the influenza vaccination season.
41.	How should the influenza vaccine items be coded when a patient stay overlaps influenza seasons?	The discharge assessments should code immunization status according to the patient's stay relative to the vaccination season as of the date of admission and date of discharge. If a stay overlaps influenza seasons (e.g., admitted in March 2016 and discharged October 2016) then the discharge assessment should be coded according to the most recent influenza season. In this scenario, the patient may have been immunized in the previous influenza season (e.g., March 2016) and the admission assessment would reflect this vaccination. The discharge assessment, however, would not code the previous vaccination. The discharge assessment would be coded according to the vaccination status for the most recent influenza season, which began July 1, 2016.

#	Question	Answer
42.	For item O0250C, when would code 6 “inability to obtain influenza vaccine due to a declared shortage” be used? Who declares the shortage?	Code 6 should be used for item O0250C when the influenza vaccination was not administered to the patient due to a declared national vaccine shortage. The vaccine shortage can be declared by the CDC and State Public Health Officers. We refer you to the following CDC Web page for information regarding shortages of the influenza vaccines: https://www.cdc.gov/vaccines/hcp/clinical-resources/shortages.html.
43.	If the patient does not receive a vaccine in the facility and the item is coded either “not offered” (choice 5) or “none of the above” (choice 9) because the patient cannot cognitively respond appropriately to questions or for a different reason is that considered “not assessed” and count against a facility’s compliance?	In your example, the patient has been assessed and item O0250A would be coded 0, No, because the patient did not receive the influenza vaccine during the influenza vaccination season; O0250B would be skipped; and O0250C would be coded 9, None of the above. This coding would not count against a facility’s compliance.
44.	How should the influenza vaccine items be coded on the Admission Assessment if unable to obtain the patient's history or there is no evidence that the patient was previously vaccinated?	To determine whether the patient has received the influenza vaccination in the LTCH for this year’s influenza season, you should first review the patient’s medical record. If the patient’s influenza vaccination status is unknown, you should ask the patient if she received the vaccine outside of the facility for this year’s influenza vaccination season. If the patient cannot answer, you should consult with the patient’s responsible party, legal guardian, or primary care physician as to whether the patient received the influenza vaccination for this year’s influenza vaccination season. If the vaccination status still cannot be determined, please refer to the standards of clinical practice to determine whether the patient should receive the influenza vaccination and proceed to code item O0250A.
Section Z. Assessment Administration		
45.	Should the signature sections (Section Z) be filed and held at the LTCH and, if so, how long should they be kept?	The signature items from the LTCH CARE Data Set assessment records (i.e. Z0400 and Z0500A) are not transmitted to CMS in LTCH submission files. CMS, however, will receive the submission date (Z0500B). CMS strongly suggests that you retain what you submit to CMS, in addition to the signatures in Section Z, according to your facility, State, and Federal regulations and requirements. Facilities that have or require use of electronic health records should comply with any additional requirements they may have.

#	Question	Answer
46.	If only one person completes the entire assessment, does each section completed require the signature e.g., A, B, GG etc. or would noting A-O be acceptable?	Item Z0400 should be signed by the individual(s) completing the assessment to acknowledge that the assessment was completed according to the standards of the LTCH QRP and facility compliance standards and that the information was recorded as accurately as possible. The purpose of this section is for the LTCH to identify the person responsible for completing that section of the LTCH CARE Data Set and to acknowledge that the assessment is complete and accurate for payment and quality reporting purposes. When completing the information for Z0400, any staff member who has completed a section should identify which specific section(s) she completed on the form, even if it's the entire assessment, in the box labeled "Sections". Further, please note that CMS will not be receiving the signatures from LTCH CARE Data Set, Section Z items Z0400 and Z0500. CMS receives the submission date. We suggest that you retain what you submit to CMS, including Section Z, according to your facility, State and Federal regulations and requirements. Facilities should comply with their requirements pertaining to electronic signatures, should they require them. Item Z0500 involves the signature of the person verifying that the LTCH CARE Data Set assessment is complete and should be signed and dated when the assessment is submitted. The purpose of this item is to identify the person responsible for ensuring a complete and timely submission of the LTCH CARE Data Set assessment.