

# LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 2.01

## PATIENT ASSESSMENT FORM - PLANNED DISCHARGE

### Section A Administrative Information

#### A0050. Type of Record

Enter Code

1. **Add new assessment/record**
2. **Modify existing record**
3. **Inactivate existing record**

#### A0100. Facility Provider Numbers. Enter Code in boxes provided.

**A. National Provider Identifier (NPI):**
**B. CMS Certification Number (CCN):**
**C. State Medicaid Provider Number:**

#### A0200. Type of Provider

Enter Code

3. **Long-Term Care Hospital**

#### A0210. Assessment Reference Date

Observation end date:

— —

Month      Day      Year

#### A0220. Admission Date

— —

Month      Day      Year

#### A0250. Reason for Assessment

Enter Code

01. **Admission**
10. **Planned discharge**
11. **Unplanned discharge**
12. **Expired**

#### A0270. Discharge Date

— —

Month      Day      Year

|                  |                                   |
|------------------|-----------------------------------|
| <b>Section A</b> | <b>Administrative Information</b> |
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|--|
| <b>Patient Demographic Information</b> |
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|                                     |
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| <b>A0500. Legal Name of Patient</b> |
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**A. First name:**

**B. Middle initial:**

**C. Last name:**

**D. Suffix:**

|  |
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| <b>A0600. Social Security and Medicare Numbers</b> |
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**A. Social Security Number:**

— — —

**B. Medicare number** (or comparable railroad insurance number):

|                  |                                   |
|------------------|-----------------------------------|
| <b>Section A</b> | <b>Administrative Information</b> |
|------------------|-----------------------------------|

**A0700. Medicaid Number** - Enter "+" if pending, "N" if not a Medicaid recipient

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**A0800. Gender**

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| Enter Code<br><div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div> | 1. <b>Male</b><br>2. <b>Female</b> |
|--|------------------------------------|

**A0900. Birth Date**

|  |       |   |     |  |      |  |  |  |  |  |
|--|-------|---|-----|--|------|--|--|--|--|--|
|  | —     | — |     |  |      |  |  |  |  |  |
|  | Month |   | Day |  | Year |  |  |  |  |  |

**A1000. Race/Ethnicity**

|                               |   |
|-------------------------------|---|
| ↓ <b>Check all that apply</b> |   |
| <input type="checkbox"/>      | <b>A. American Indian or Alaska Native</b>          |
| <input type="checkbox"/>      | <b>B. Asian</b>                                     |
| <input type="checkbox"/>      | <b>C. Black or African American</b>                 |
| <input type="checkbox"/>      | <b>D. Hispanic or Latino</b>                        |
| <input type="checkbox"/>      | <b>E. Native Hawaiian or Other Pacific Islander</b> |
| <input type="checkbox"/>      | <b>F. White</b>                                     |

**A1400. Payer Information**

|                               |   |
|-------------------------------|---|
| ↓ <b>Check all that apply</b> |   |
| <input type="checkbox"/>      | <b>A. Medicare</b> (traditional fee-for-service)            |
| <input type="checkbox"/>      | <b>B. Medicare</b> (managed care/Part C/Medicare Advantage) |
| <input type="checkbox"/>      | <b>C. Medicaid</b> (traditional fee-for-service)            |
| <input type="checkbox"/>      | <b>D. Medicaid</b> (managed care)                           |
| <input type="checkbox"/>      | <b>E. Workers' compensation</b>                             |
| <input type="checkbox"/>      | <b>F. Title programs</b> (e.g., Title III, V, or XX)        |
| <input type="checkbox"/>      | <b>G. Other government</b> (e.g., TRICARE, VA, etc.)        |
| <input type="checkbox"/>      | <b>H. Private insurance/Medigap</b>                         |
| <input type="checkbox"/>      | <b>I. Private managed care</b>                              |
| <input type="checkbox"/>      | <b>J. Self-pay</b>  |
| <input type="checkbox"/>      | <b>K. No payor source</b>                                   |
| <input type="checkbox"/>      | <b>X. Unknown</b>   |
| <input type="checkbox"/>      | <b>Y. Other</b>   |

Section A

Administrative Information

A2110. Discharge Location

Enter Code

01. **Community residential setting** (e.g., private home/apt., board/care, assisted living, group home, adult foster care)  
02. **Long-term care facility**  
03. **Skilled nursing facility** (SNF)  
04. **Hospital emergency department**  
05. **Short-stay acute hospital** (IPPS)  
06. **Long-term care hospital** (LTCH)  
07. **Inpatient rehabilitation facility or unit** (IRF)  
08. **Psychiatric hospital or unit**  
09. **ID/DD facility**  
10. **Hospice**  
12. **Discharged Against Medical Advice**  
98. **Other**

A2500. Program Interruption(s)

Enter Code

**Program Interruptions**  
0. **No** → *Skip to M0210, Unhealed Pressure Ulcer(s)*  
1. **Yes** → *Continue to A2510, Number of Program Interruptions During This Stay in This Facility*

A2510. Number of Program Interruptions During This Stay in This Facility

Enter Number

**Number of Program Interruptions During This Stay in This Facility.** *Code only if A2500 is equal to 1.*

A2520. Program Interruption Dates. *Code only if A2510 is greater than or equal to 01.*

A1. Most Recent Interruption Start Date

—

—

—

Month

Day

Year

A2. Most Recent Interruption End Date

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—

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Month

Day

Year

B1. Second Most Recent Interruption Start Date. *Code only if A2510 is greater than 01.*

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—

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Month

Day

Year

B2. Second Most Recent Interruption End Date. *Code only if A2510 is greater than 01.*

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—

—

Month

Day

Year

C1. Third Most Recent Interruption Start Date. *Code only if A2510 is greater than 02.*

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—

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Month

Day

Year

C2. Third Most Recent Interruption End Date. *Code only if A2510 is greater than 02.*

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Month

Day

Year

|                  |                        |
|------------------|------------------------|
| <b>Section M</b> | <b>Skin Conditions</b> |
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Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

**M0210. Unhealed Pressure Ulcer(s)**

|   |  |
|---|--|
| Enter Code<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <b>Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?</b><br>0. <b>No</b> → <i>Skip to O0250, Influenza Vaccine</i><br>1. <b>Yes</b> → <i>Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage</i> |
|---|--|

**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage**

|   |   |
|---|---|
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <b>A. Number of Stage 1 pressure ulcers</b><br><b>Stage 1:</b> Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues                                    |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister<br><br>1. <b>Number of Stage 2 pressure ulcers</b> - If 0 → <i>Skip to M0300C, Stage 3</i>  |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | 2. <b>Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission  |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <b>C. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling<br><br>1. <b>Number of Stage 3 pressure ulcers</b> - If 0 → <i>Skip to M0300D, Stage 4</i> |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | 2. <b>Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission  |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling<br><br>1. <b>Number of Stage 4 pressure ulcers</b> - If 0 → <i>Skip to M0300E, Unstageable: Nonremovable dressing</i>               |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | 2. <b>Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission  |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <b>E. Unstageable - Nonremovable dressing:</b> Known but not stageable due to nonremovable dressing/device<br><br>1. <b>Number of unstageable pressure ulcers due to nonremovable dressing/device</b> - If 0 → <i>Skip to M0300F, Unstageable: Slough and/or eschar</i>   |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | 2. <b>Number of <u>these</u> unstageable pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission  |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | <b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar<br><br>1. <b>Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b> - If 0 → <i>Skip to M0300G, Unstageable: Deep tissue injury</i>                          |
| Enter Number<br><div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div> | 2. <b>Number of <u>these</u> unstageable pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission  |

**M0300 continued on next page**

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| <b>Section M</b> | <b>Skin Conditions</b> |
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| <b>M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued</b> |
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|   |   |
|---|---|
| Enter Number<br><input style="width: 40px; height: 20px;" type="text"/> | <b>G. Unstageable - Deep tissue injury:</b> Suspected deep tissue injury in evolution   |
| Enter Number<br><input style="width: 40px; height: 20px;" type="text"/> | 1. <b>Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</b> - If 0 → <i>Skip to M0800, Worsening in Pressure Ulcer Status Since Prior Assessment</i> |
| Enter Number<br><input style="width: 40px; height: 20px;" type="text"/> | 2. <b>Number of <u>these</u> unstageable pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission                                      |

|   |
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| <b>M0800. Worsening in Pressure Ulcer Status Since Prior Assessment</b> |
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Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment.  
 If no current pressure ulcer at a given stage, enter 0

|   |                   |
|---|-------------------|
| Enter Number<br><input style="width: 40px; height: 20px;" type="text"/> | <b>A. Stage 2</b> |
| Enter Number<br><input style="width: 40px; height: 20px;" type="text"/> | <b>B. Stage 3</b> |
| Enter Number<br><input style="width: 40px; height: 20px;" type="text"/> | <b>C. Stage 4</b> |

| Section O  |  | Special Treatments, Procedures, and Programs |  |
|--|--|--|--|
| <b>O0250. Influenza Vaccine - Refer to current version of LTCHQR Program Manual for current influenza season and reporting period.</b> |  |  |  |
| <div>Enter Code</div> <div></div>  | <b>A.</b> Did the <b>patient receive the influenza vaccine in this facility</b> for this year's influenza <u>vaccination</u> season?<br>0. <b>No</b> → <i>Skip to O0250C, If influenza vaccine not received, state reason</i><br>1. <b>Yes</b> → <i>Continue to O0250B, Date influenza vaccine received</i>  |  |  |
|  | <b>B.</b> Date influenza vaccine received → <i>Complete date and skip to Z0400, Signature of Persons Completing the Assessment</i><br><br><div> <div>—</div> <div>—</div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>  |  |  |
| <div>Enter Code</div> <div></div>  | <b>C. If influenza vaccine not received, state reason:</b><br>1. <b>Patient not in this facility during this year's influenza vaccination season</b><br>2. <b>Received outside of this facility</b><br>3. <b>Not eligible</b> - medical contraindication<br>4. <b>Offered and declined</b><br>5. <b>Not offered</b><br>6. <b>Inability to obtain influenza vaccine</b> due to a declared shortage<br>9. <b>None of the above</b> |  |  |

Section Z

Assessment Administration

Z0400. Signature of Persons Completing the Assessment

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that submitting false information may subject my organization to a 2% reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

| Signature | Title | Sections | Date Section Completed |
|-----------|-------|----------|------------------------|
| A.        |       |          |                        |
| B.        |       |          |                        |
| C.        |       |          |                        |
| D.        |       |          |                        |
| E.        |       |          |                        |
| F.        |       |          |                        |
| G.        |       |          |                        |
| H.        |       |          |                        |
| I.        |       |          |                        |
| J.        |       |          |                        |
| K.        |       |          |                        |
| L.        |       |          |                        |

Z0500. Signature of Person Verifying Assessment Completion

A. Signature:

B. LTCH CARE Data Set Completion Date:

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MonthDayYear



### **PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1163**. The time required to complete this information collection is estimated to average **16 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.