APPENDIX A: GLOSSARY AND COMMON ACRONYMS

Glossary

Term	Definition
Active Disease Diagnosis	Physician-documented diagnosis (or a nurse practitioner-, physician assistant-, or clinical nurse specialist-documented diagnosis if allowable under state licensure laws) at the time of assessment.
Admission and Discharge Reporting	LTCH CARE Data Set assessments that include a select number of items from the LTCH CARE Data Set used to gather important quality data for LTCH patients at transition points, such as when they enter or leave a LTCH. Admission/Discharge reporting includes Admission, Discharge, and Expired assessments.
Admission Date	The date a person enters the LTCH and is admitted as a patient. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the first day of admission.
Assessment Period	A specified period of time over which a specific aspect of patient assessment, or his/her condition or status, is captured by the LTCH CARE Data Set assessment. The assessment period ends on the ARD
Assessment Reference Date (ARD)	The end point of the assessment period for the LTCH CARE Data Set assessments.
Assessment Submission	The electronic submission of the LTCH CARE Data Set data to the QIES ASAP System. The data are required to be in formats that conform to standard record layouts and data dictionaries, and pass standardized edits as defined by CMS. ***Chapter 4*** of this manual and the LTCH CARE Data Submission Specifications on the CMS LTCH Technical Information Web page (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html) provide detailed information.
Assessment Submission and Processing (ASAP) System	The CMS system that receives submissions of LTCH CARE Data Set assessment records, validates records for accuracy and appropriateness, and stores validated records in the ASAP database.
Body Mass Index (BMI)	Number calculated from a person's weight and height. BMI is a reliable indicator of body fat and is used as a screening tool to identify possible weight problems for adults.

Term	Definition
Browser	A program that allows access to the Internet or a private intranet site. A browser with 128-bit encryption is necessary to access the CMS intranet to submit data or retrieve reports.
Centers for Medicare & Medicaid Services (CMS)	CMS is the Federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs.
CMS Certification Number (CCN)	This is the hospital's identification number and is linked to its Medicare provider agreement. The CCN is used for CMS certification, submitting and reviewing the hospital's cost reports, and assessment-related activities.
Code of Federal Regulations (CFR)	A codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government.
Comatose (Coma)	Pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he or she may or may not open his or her eyes, does not speak, and does not move his or her extremities on command or in response to noxious stimuli (e.g., pain).
Community Residential Setting	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 noninstitutional community residential settings that provide the following types of services: home health, homemaker/personal care, or meals.
Constipation	A condition of more than short duration where someone has fewer than three bowel movements a week or stools that are usually hard, dry, and difficult and/or painful to eliminate.
Continence	Any void into a commode, urinal, or bedpan that occurs voluntarily or as a result of prompted toileting, assisted toileting, or scheduled toileting.
Discharge Assessment	An assessment required on patient discharge. Discharge Assessments include LTCH CARE Data Set Planned or Unplanned Discharge Assessments (Item A0250 = 10 or 11, respectively). These assessments include clinical items for quality monitoring as well as discharge tracking information. Refer to Section 2.4 for additional information on situations requiring these assessments.

Term	Definition
Discharge Date	The date a patient leaves the LTCH. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual Date of Discharge on the LTCH CARE Data Set Planned or Unplanned Discharge Assessments or the Date of Death (A0270) on the LTCH CARE Data Set Expired Assessment. If a discharge is delayed, the Discharge Date is the day the patient actually leaves the LTCH.
Epithelial Tissue	New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.
Eschar	Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Eschar tissue is usually firmly adherent to the base of the wound and often the sides/edges of the wound.
Expired Assessment	The assessment that is completed when a patient dies in the LTCH, or dies during an interrupted stay at another hospital/facility of fewer than 3 calendar days.
Facility Identification Number (ID)	The facility identification number is assigned to each LTCH by the Quality Improvement Evaluation System (QIES) ASAP system. The FAC_ID must be placed in the individual LTCH CARE Data Set and tracking form records. This normally is completed as a function within the facility's LTCH CARE Data Set data entry software.
Fatal File Error	An error in the LTCH submission file format that causes the entire file to be rejected; therefore, the individual assessment records in the submission file are not validated or stored in the ASAP database. The Submitter Final Validation Report identifies Fatal File Error(s). The LTCH must contact its software support to resolve the problem with the submission file. Once the submission file problem is resolved, the submission file and associated LTCH CARE Data Set Assessment records must be resubmitted.
Fatal Record Error	An error in an LTCH CARE Data Set assessment record that results in the assessment record being rejected. The Final Validation Report lists the assessment records that were rejected. The LTCH must correct error(s) on each assessment record that was rejected and resubmit.
Fecal Impaction	A mass of dry, hard stool that can develop in the rectum due to chronic constipation. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction or obstruction.

Term	Definition
Federal Register	The official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents. It is a publication of the National Archives and Records Administration, and is available by subscription and online.
Final Validation Report	A report generated after the successful submission of LTCH CARE Data Set assessment record files. This report lists all of the patients for whom assessments have been submitted in a particular submission batch, and displays all errors and/or warnings that occurred during the validation process. Each individual record is listed on the FVR as "accepted" or "rejected." Accepted records are added to the ASAP database. Rejected records are not added to the ASAP database and must be corrected and resubmitted.
Fluctuance	The texture of wound tissue indicative of underlying unexposed fluid.
Granulation Tissue	Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Federal law that gives the Department of Health and Human Services (DHHS) the authority to mandate regulations that govern privacy, security, and electronic transactions standards for health care information.
Home Health Agency	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
Hospice	A program for terminally ill persons. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.
Hospital Emergency Department	An organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.
ID/DD Facility	An institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are intellectually disabled (ID) or who have developmental disabilities (DD).

Term	Definition
Inactivation	A type of correction allowed under the LTCH CARE Data Set Correction Policy. When an erroneous record has been accepted into the ASAP database, an inactivation request is required. This removes the erroneous record from the active file to an archive (history file). A new record to replace the removed record must be completed and submitted to the QIES ASAP system.
Inpatient Rehabilitation Facility (IRF) or Unit	A rehabilitation hospital, or a distinct rehabilitation unit of a hospital, that provides an intensive rehabilitation program to inpatients.
International Classification of Diseases–Clinical Modification (ICD-CM)	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. ICD-10-CM will replace ICD-9-CM (diagnoses) on October 1, 2014.
Item Set	LTCH CARE Data Set items that are active on a particular assessment type.
Legal Name	Patient's name as it appears on the Medicare card. If the patient is not enrolled in the Medicare program, the patient's name as it appears on a Medicaid card or other government-issued document is used.
Long-Term Care Facility	An institution that is engaged primarily in providing medical and nonmedical care to people who have a chronic illness or disability. These facilities provide care to people who cannot be cared for at home or in the community. Long-term care facilities provide a wide range of personal care and health services for individuals who cannot take care of themselves because of physical, emotional, or mental health issues. The provision of nonskilled care and related services for residents in long-term care can include, but is not limited to, supportive services such as dressing, bathing, using the bathroom, diabetes monitoring, and medication administration.
Long-Term Care Hospital	An acute-care hospital that provides treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Term	Definition
Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set	A core set of data elements, including common definitions and coding categories that form the foundation of the required assessment for all patients treated in hospitals that are certified to participate in Medicare and designated as LTCHs certified to participate in Medicare. This core set of data elements is used to collect data to inform the quality measures required by the LTCH Quality Reporting Program.
LTCH Assessment Submission Entry and Reporting	A free, Java-based application that provides an option for facilities to collect and maintain facility, patient, and LTCH CARE Data Set Assessment information for subsequent submission to the appropriate national data repository.
LTCH CARE Data Set Assessment Scheduling	The process of setting the ARD as well as calculating the last possible day for completion and day of submission to the QIES ASAP system.
LTCH CARE Data Set Assessment Submission	Assessment Submission refers to electronic submission of the LTCH CARE Data Set Assessment data to the QIES ASAP System. The data are required to be in formats that conform to standard record layouts and data dictionaries, and pass standardized edits as defined by CMS and/or the State.
LTCH CARE Data Set Assessment Timing	Assessment Timing refers to when assessments must be conducted. Assessment timing is *not* the same for all assessment types.
LTCH CARE Data Set Completion Date	The date all required information has been collected and recorded for a particular assessment and staff have signed and dated that the assessment is complete. This date should represent the date the completion of the assessment record has been verified by the individual authorized to do so. This individual signs and dates Item Z0500. The Completion Date (date in Z0500B) can be **on** or **after** the ARD but **not before** the ARD; and should be no later than the Assessment Reference Date (A0210) + 5 calendar days. Completion date can be ***equal*** to the ARD, or no greater than 5 days later; however, it ***cannot*** be a date that is earlier than the ARD. In the event that a Completion date is entered for a date prior to the ARD, the record will be rejected. This is a CMS recommended timeline. Please refer to Chapter 4 for quarterly submission deadlines.

Term	Definition
LTCH CARE Data Set Submission Date	The date on which the completed LTCH CARE Data Set Admission, Discharge, or Expired Assessment is submitted to the QIES ASAP system. The Submission Date should be **on** or **after** the ARD but **not before** the ARD, and no later than the Completion Date (Z0500B) + 7 calendar days. The Submission Date can be on or after the Completion Date. The Submission Date can be *equal* to the Completion Date, or no greater than 7 days later; however, it ***cannot*** be a date that is earlier than the Completion Date. In the event that a Submission Date is entered for a date prior to the ARD, or the Completion Date, the record will be rejected. This is a CMS recommended timeline. Please refer to Chapter 4 for quarterly submission deadlines.
Medicaid	A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.
Medicare	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 Number (or Comparable Railroad Insurance Number)	An identifier assigned to an individual for participation in a national health insurance program. The Medicare Health Insurance identifier may differ from the patient's SSN, and may contain both letters and numbers. For example, many patients receive Medicare benefits based on a spouse's Medicare eligibility. This number may also be referred to as the Health Insurance Claim (HIC) number.
Modification	A type of correction allowed under the LTCH CARE Data Set Correction Policy. A modification is required when an LTCH CARE Data Set record has been accepted by the ASAP database, but the information in the record contains errors. The modification will correct the record in the ASAP database.

Term	Definition
Monitoring	The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison with baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a goal. Monitoring can detect any improvements, complications, or adverse consequences of the condition or of the treatments; and support decisions about adding, modifying, continuing, or discontinuing, any interventions.
National Provider Identifier (NPI)	A unique Federal number that identifies providers of health care services. The NPI applies to the LTCH and all of its patients.
Necrotic Tissue	Dead or devitalized tissue categorized as eschar or slough. Necrotic tissue is usually firmly adherent to the base of the wound and often the sides/edges of the wound.
Nonblanchable	Reddened areas of tissue that do not turn white or pale after pressed firmly with a finger or device
Non-Removable Dressing/Device	A dressing or device such as a primary surgical dressing that cannot be removed, an orthopedic device, or a cast.
On Admission	As close to the actual time of admission as possible.
Persistent Vegetative State	PVS is an enduring situation in which an individual has failed to demonstrate meaningful cortical function but can sustain basic body functions supported by noncortical brain activity.
Planned Discharge	A discharge where the patient is nonemergently, medically released from care at the LTCH because of some reason arranged for in advance.
Pressure Ulcer	Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
Program Interruption	Refers to an interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per contractual agreement for services (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 one begins on the day of transfer, regardless of hour of transfer. For such an interruption, the LTCH should not complete and submit an LTCH CARE Data Set Discharge record (planned or unplanned).
Program Interruption Start Date	The start date of the program interruption is the day the patient leaves the LTCH. It is considered calendar day 1.

Term	Definition
Program Interruption End Date	The end date of the program interruption is the day the patient returns to the LTCH. An absence from the LTCH is considered a program interruption when the program interruption end date is no later than calendar day 3 of the patient's absence.
Prospective Payment System	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups [DRGs] for inpatient hospital services).
Psychiatric Hospital	An institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients.
Quality Improvement and Evaluation System	The umbrella system that encompasses collection and reporting of LTCH CARE Data Set assessment data, as well as data for other providers such as SNFs, IRFs, and home health agencies.
Quality Measure	Tools that help measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.
Short-Stay Acute Care Hospital	A hospital that has contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.
Skilled Nursing Facility (SNF)	A nursing facility with the staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category includes swing bed hospitals, which are generally small, rural hospitals or critical access hospitals (CAH) participating in Medicare that have CMS approval to provide post-hospital SNF care and meet certain requirements.
Slough Tissue	Nonviable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.
Social Security Number (SSN)	A tracking number assigned to an individual by the U.S. Federal Government for taxation, benefits, and identification purposes.
Stage 1 Pressure Ulcer	An observable, pressure-related alteration of intact skin, whose indicators as compared with an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Term	Definition
Stage 2 Pressure Ulcer	Partial-thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister.
Stage 3 Pressure Ulcer	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 or tunneling.
Stage 4 Pressure Ulcer	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.
State Medicaid Provider Number	Medicaid Provider Number established by a State.
Submission Confirmation Page	The initial feedback generated by the ASAP system after an LTCH CARE Data Set data file is electronically submitted. This page acknowledges receipt of the submission file, but does not examine the file for any warnings and/or errors. Warnings and/or errors are provided on the Final Validation Report.
Suspected Deep Tissue Injury	Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared with adjacent tissue.
System of Records	Standards for collection and processing of personal information as defined by the Privacy Act of 1974.
Tunneling	A passage way of tissue destruction under skin surface that has an opening at the skin level from the edge of the wound.
Undermining	The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

Term	Definition
Unplanned Discharge	• A transfer of the patient to be admitted to another hospital/facility, that results in the patient's absence from the LTCH (for longer than 3 days, including the date of transfer); or • A transfer of the patient to an emergency department of another hospital in order to either stabilize a condition or determine whether an acute-care admission is required based on emergency department evaluation, which results in the patient's absence from the LTCH for greater than 3 days; or • When a patient unexpectedly leaves the LTCH against medical advice; or • When a patient unexpectedly decides to go home or to another setting (such as when the patient decides to complete treatment in an alternate setting). • Does not include planned transfers to an acute-care inpatient hospital for admission for a planned intervention, treatment, or procedure, unless the patient was originally expected to return to the LTCH within 3 calendar days, but does not because of some unforeseen circumstance.
Worsening in Pressure Ulcer Status	Pressure ulcer "worsening" is defined as 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 the stage 1, and increasing in severity to stage 4) on a discharge assessment as compared with the admission assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

Common Acronyms

Acronym	Definition
ADLs	Activities of Daily Living
ARD	Assessment Reference Date
ASAP	Assessment Submission and Processing
BMI	Body mass index
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
FAC_ID	Facility ID (for LTCH CARE Data submission)
FR	Final Rule
FVR	Final Validation Report (for LTCH CARE Data submission)
FY	Fiscal Year
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD	International Classification of Diseases
ICD-CM	International Classification of Diseases, Clinical Modification
IRF	Inpatient Rehabilitation Facility or Unit
ISC	Item Set Code
LASER	LTCH Assessment Submission Entry and Reporting
LTCH	Long-Term Care Hospital
LTCH CARE Data Set	Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set
LTCHQR Program	Long-Term Care Hospital Quality Reporting Program
NPI	National Provider Identifier
OMB	Office of Management and Budget
PPS	Prospective Payment System
PVS	Persistent Vegetative State
QIES	Quality Improvement and Evaluation System
QM	Quality Measure
SNF	Skilled Nursing Facility
SOR	Systems of Records