CHAPTER 3: OVERVIEW TO THE ITEM-BY-ITEM GUIDE TO THE LTCH CARE DATA SET

The Long-Term Care Hospital (LTCH) CARE Data Set Version 3.00 contains items identified as necessary or relevant to the following quality measures: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680), Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), 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), and Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632). This chapter provides item-by-item coding instructions to the long-term care hospital (LTCH) staff members to inform the completion of each section of the LTCH CARE Data Set Version 3.00. The goal of this chapter is to provide LTCH staff with the rationale and guidance to optimize the accurate completion of each item of the LTCH CARE Data Set.

3.1 Using This Chapter

Throughout this chapter, sections of the LTCH CARE Data Set Version 3.00 are presented using a standard format for ease of review by LTCH staff. In addition, screen shots of each item are included for illustration purposes. Note: Images of the LTCH CARE Data Set are embedded in this manual. If you are using a screen reader to access the content of the manual, please refer to the LTCH CARE Data Set Version 3.00 (***Appendix C***) to review the items of the LTCH CARE Data Set Version 3.00 included in this manual.

The order of information presented for each section of the LTCH CARE Data Set is as follows:

- Intent. States the reason(s) for including this set of assessment items in the LTCH CARE Data Set Version 3.00.
- Item Display. Each assessment section provides screen shots, which display the item from the LTCH CARE Data Set Version 3.00.
- Item Rationale. Explains the purpose of documenting particular facility characteristics, patient demographics, and/or clinical or functional status.
- Steps for Assessment. Provides resources and methods for determining the correct response when coding each LTCH CARE Data Set Version 3.00 item. This information is not relevant for some sections, hence, is NOT included for these sections (for example, Section A).
- Coding Instructions. Outlines the proper method of recording each response, with explanations of individual response categories.

- Coding Tips and Special Populations. States clarifications, issues of note, and conditions to be considered when coding each LTCH CARE Data Set Version 3.00 item.
- Examples. Illustrates examples of appropriate coding for several of the LTCH CARE Data Set Version 3.00 sections/items.

Additional layout characteristics to note include the following:

- Important terms are defined in a box next to the item throughout the *CMS LTCH Quality Reporting Program Manual Version 3.0*. These and other definitions of interest are also included in ***Appendix A***: ***Glossary and Common Acronyms***.
- When an item needs to be completed only in certain situations (e.g., only at admission), the item's coding instructions note this information in italics.

Table 3-1 provides the title and intent for each section of the LTCH CARE Data Set, Version 3.00.

Table 3-1
LTCH CARE Data Set Version 3.00 sections

Section	Title	Intent
A	Administrative Information	This section obtains key information that uniquely identifies each patient, the LTCH in which he or she receives health care services, and the reason(s) for assessment.
B	Hearing, Speech, and Vision	For the April 1, 2016, release of the LTCH CARE Data Set Version 3.00, B0100. Comatose, BB0700. Expression of Ideas and Wants, and BB0800. Understanding Verbal Content are included in this section. The intent of these items is to document the patient's ability to understand and communicate with others.
C	Cognitive Patterns	For the April 1, 2016, release of the LTCH CARE Data Set Version 3.00, C1610. Signs and Symptoms of Delirium (from CAM©) is included in this section. The intent of this item is to determine the patient's attention, orientation, and ability to register and recall new information.
GG	Functional Status: Functional Abilities and Goals	For the April 1, 2016, release of the LTCH CARE Data Set Version 3.00, GG0100. Prior Functioning: Everyday Activities, GG0110. Prior Device Use, GG0130. Self-Care, and GG0170. Mobility are included in this section. This section assesses the need for assistance with functional activities.
H	Bladder and Bowel	For the April 1, 2016 release of the LTCH CARE Data Set Version 3.00, H0350. Bladder Continence and H0400. Bowel Continence are included in this section.
I	Active Diagnoses	For the April 1, 2016, release of the LTCH CARE Data Set Version 3.00, the items included in Section I are intended to indicate the presence of select diagnoses that influence a patient's functional outcomes or increase a patient's risk for the development or worsening of pressure ulcer(s).

Section	Title	Intent
J	Health Conditions	For the April 1, 2016, release of the LTCH CARE Data Set Version 3.00, J1800. Any Falls Since Admission and J1900. Number of Falls Since Admission are included in this section. These items are intended to code any falls since admission in addition to any injury caused by falls.
K	Swallowing/ Nutritional Status	For the April 1, 2016, release of the LTCH CARE Data Set Version 3.00, K0200A. Height and K0200B. Weight are included in this section. These items assess the patient's body mass index (BMI) using the patient's height and weight.
M	Skin Conditions	For the April 1, 2016, release of the LTCH CARE Data Set Version 3.00, the items in this section document the presence, appearance, and change of pressure ulcers.
O	Special Treatments, Procedures, and Programs	For the April 1, 2016, release of the LTCH CARE Data Set Version 3.00, O0100. Special Treatments, Procedures, and Programs, and O0250. Influenza Vaccine are included in this section. The intent of the items in this section is to identify any special treatments, procedures, and programs that the patient received during the stay, including the influenza vaccination status.
Z	Assessment Administration	The items in this section provide signatures of individuals completing the LTCH CARE Data Set and signature of individual verifying LTCH CARE Data Set assessment completion for a patient record.

3.2 Becoming Familiar with the LTCH CARE Data Set—Recommended Approach

1. Read this manual. It is essential.

- The *CMS LTCH Quality Reporting Program Manual* Version 3.0 is your *primary* source of information for completing the LTCH CARE Data Set.
- Familiarize yourself with how this manual is organized.
- Use the information in this chapter correctly to increase the accuracy of your facility's LTCH CARE Data Set patient assessment records.
- Be certain that you understand the intent and rationale for coding items on the LTCH CARE Data Set.
- LTCHs should also become familiar with the content of ***Chapters 1, 2, 4***, and ***5***. These chapters provide the framework and supporting information for data collected and submitted using the LTCH CARE Data Set for the LTCH Quality Reporting Program (QRP).
- For updates, check the LTCH QRP Web site regularly at http://www.cms.gov/LTCH-Quality-Reporting/.

- If you require further assistance (e.g., clarifications, questions, or issues), submit your inquiry to the appropriate CMS LTCH CARE Data Set contact listed in ***Appendix B*** or to the LTCH Quality Questions Help Desk at LTCHQualityQuestions@cms.hhs.gov**.**

2. Review the LTCH CARE Data Set.

- Notice how the sections are organized and where information should be recorded.
- Work through one section at a time.
- Examine the item wording and response categories as provided on the LTCH CARE Data Set. For definitions and coding instructions for each item, refer to the appropriate ***Chapter 3*** section.

3. Complete a thorough review of *Chapter 3.*

- Review procedural instructions, timeframes, and general coding conventions.
- Become familiar with each item's intent, rationale, and steps for assessment.
- Become familiar with the item itself and with its coding choices and responses, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item.
- Consider completing a paper version of the LTCH CARE Data Set as a test case for a patient at your facility by entering the appropriate codes on the LTCH CARE Data Set. Make a note of where your understanding could benefit from additional information, training, and use of the varying skill sets of the staff at your facility. Be sure to explore all resources available to you.
- Read through the instructions that apply to each section as you are completing this test case. Work through the manual and the LTCH CARE Data Set one section at a time until you are comfortable coding items. Make sure you understand the information in each before proceeding to the next section.
- Review the test case once it is completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code Skin Conditions items? Do you understand how to code the Influenza Vaccine items in Section O?
- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.
- Would you now complete any items on your initial test case differently?

4. Use the information in this chapter.

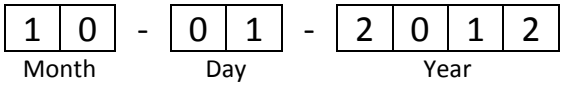
- Where clarification is needed, review the intent, rationale, and specific coding instructions for each item in question.

3.3 Coding Conventions

Several standard conventions should be used when completing the LTCH CARE Data Set:

- The standard assessment period for the LTCH CARE Data Set begins **2 calendar days** prior to the Assessment Reference Date (ARD) and ends on the ARD, for a total assessment period of 3 days, unless otherwise stated.
- If the patient leaves the LTCH during the assessment period, the assessment period will include the stay at another hospital/facility, provided the patient returns to the LTCH within 3 calendar days.
  - Example: A patient is admitted to the LTCH on October 1, 2014, at 7:00 p.m. On October 2, 2014, at 8:00 a.m., the patient is transferred to a short-term acute care hospital. The patient returns to the LTCH on October 4, 2014, at 6:00 p.m. The assessment period for the patient's admission assessment will be the day of admission (October 1, 2014) through the ARD (which can be no later than October 3, 2014, at 11:59 p.m.), even though the patient was not in the LTCH during part of the assessment period.
- In a few instances, coding on one item will govern whether coding is completed for one or more additional items. This is called a *skip pattern*. The instructions direct the assessor to skip over the next item (or several items) and go on to another area of assessment. When you encounter a skip pattern, leave the item blank and move on to the next item as directed.
  - Example: On a Planned Discharge assessment, if item **M0210, Unhealed Pressure Ulcer(s)** is **coded as 0, No** (the patient does not have one or more unhealed pressure ulcers), the admission assessment form directs the assessor to skip to **O0250, Influenza Vaccine**. In this case, the intervening items (M0300 through M0800) would not be coded (i.e., left blank) because a skip pattern is created. If M0210 is **coded as 1, Yes** (the patient has one or more unhealed pressure ulcers), then the assessor would continue to code the next LTCH CARE Data Set item, **M0300A**.
- When coding instructions instruct to "check all that apply," use a check mark to indicate which condition(s) are met (e.g., **A1000, Race/Ethnicity**, boxes A–F). If none of the conditions are met, these boxes remain blank. Be aware that a "check all that apply" item may have a checkbox for "Other," indicating that none of the other options apply.
- Use a numeric response (a number or preassigned value) in blank boxes (e.g., **A0800, Gender**).
- Each response box should contain only one character (numeric or alphabet). For example, you should enter only the number 2 in a box, not 02, or .2.

When recording month, day, and year for dates, enter two digits for the month, two digits for the day, and four digits for the year. For example, the first day of October in the year 2012 is recorded as:



- Almost all LTCH CARE Data Set Version 3.00 items allow a dash (-) value to be entered and submitted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. CMS allows the use of a dash for most items, as we do not want to force providers to provide data to which they do not have access, and we want data to be as accurate as possible. CMS realizes that the use of a dash is sometimes necessary, but LTCHs should limit the use of the dash to only those items for which they were unable to obtain assessment data, or for items that were intentionally left unanswered by the LTCH. When a provider enters a dash for an item that is considered "required," a warning will be issued that states that the use of a dash may subject the LTCH to a 2 percentage point reduction to their applicable annual payment update (APU). Please note that we issue this warning as a reminder that a given data item is required to help ensure that providers have entered the default response of a dash intentionally.
  - A dash value indicates that an item was not assessed or that no information is available to complete the item.
  - Several date items can be dash filled. For example, item **A1000, Race/Ethnicity** can be dash filled if ethnicity is unknown. Dashes must be inserted into each of the six available boxes.
  - A few items that do not allow dash values include identification items in Section A (e.g., **A0250, Reasons for Assessment** and **A0210, Assessment Reference Date**).
  - To determine whether a specific item allows a dash value, refer to the LTCH Data Submission Specifications, Version 2.00.0 and associated errata files, at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html.
- When the term *physician* is used in this manual, it should be interpreted as including providers such as nurse practitioners, physician assistants, and clinical nurse specialists, if allowable under State licensure laws.
- The word *significant* is used several times throughout the manual. The term may have different connotations depending on the circumstances in which it is used. For the LTCH CARE Data Set, the term *significant*, when discussing clinical, medical, or laboratory findings, refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment. When the term is used in discussing relationships between people, as in "significant other," it means a person, such as a family member or a close friend who is important or influential in the life of the patient.
- When completing the LTCH CARE Data Set, some items require a count or measurement; however, there are instances in which the actual results of the count or measurement are greater than the number of available boxes –d for example, number of pressure ulcers. In these cases, maximize the count or measurement by placing a "9" in each box. The correct number should be documented in the patient's medical record.
  - Example: If a patient has 10 Stage 2 pressure ulcers, the LTCH would enter 9 in **M0300B1, Number of Stage 2 pressure ulcers**. The LTCH should document 10 Stage 2 pressure ulcers in the patient's medical record.