Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
1.	All sections	N/A	N/A	Formatting, grammar and stylistic edits have been made throughout the manual, where applicable
Cover Page				
2.	Cover Page	Revised, November 2017	Revised, May 2018	Updated date
Chapter 1				
3.	Chapter 1, Page 1-2	The items on the LTCH CARE Data Set that are necessary to calculate the quality measures can be found in Appendix D of this LTCH QRP Manual.	The items on the LTCH CARE Data Set that are necessary to calculate the quality measures and the items that are specified as standardized patient assessment data elements can be found in Appendix D of this LTCH QRP Manual.	Updated sentence to include information related to standardized patient assessment data elements
Chapter 3, Intro				
4.	Chapter 3, Intro, Page 3-2	**Did not exist**	Section N: Medications The items in this section document whether LTCH providers conducted a drug regimen review upon the patient admission, and whether clinically significant medication issues were addressed in a timely manner when identified throughout the patient stay.	Added row to table to include Section N: Medications
Chapter 3, Section A				
5.	Chapter 3, Section A, Page A-1 to A-3	A **Modification Request** is used when an LTCH CARE Data Set Assessment Record has been previously submitted and accepted in the QIES ASAP system, but the information in the record contains inaccurate data item values. The process for completing a Modification Request entails the completion of a corrected record, which will replace the previous erroneous record in the QIES ASAP system. The data item values that are submitted in the corrected record should contain accurate data item values for **all** items (not just those that were previously inaccurate). There are exceptions to which data item values on an LTCH CARE Data Set Assessment Record can be corrected with a Modification Request. These exceptions are listed below:	A **Modification Request** (A0050 = 2) is used when an LTCH CARE Data Set assessment record is accepted into the QIES ASAP system, but the information in the record contains clinical or non-key demographic errors. The **Modification Request** (A0050 = 2) record is used to correct most LTCH CARE Data Set assessment record items that are erroneous. However, there are items that **cannot be corrected** with a Modification Request; rather, the erroneous record must be inactivated with an Inactivation Request record and a new LTCH CARE Data Set assessment record submitted to the QIES ASAP system.	Updated formatting and language to align with similar guidance in Chapter 4

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
5. (cont)		• A0210: Assessment Reference Date (ARD) • A0220 Admission Date (on an Admission record A0250 = 01) • A0250: Reason for Assessment • A0270: Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12) • Any patient identifier (i.e., First name, Last name, Social Security Number (SSN), Gender, Birth Date) found to be inaccurate. In order to correct the above data item values, the Inactivation Request process must be followed. An **Inactivation Request** is used when an LTCH CARE Data Set Assessment Record has been previously submitted and accepted in the QIES ASAP system but: • The corresponding event did not occur (e.g., a Discharge LTCH CARE Data Set Assessment Record was submitted, but the patient was not discharged), • The following data item values are inaccurate: - A0210: Assessment Reference Date (ARD) - A0220 Admission Date (on an Admission record A0250 = 01) - A0250: Reason for Assessment - A0270: Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12) - Any patient identifier (i.e., First name, Last name, Social Security Number (SSN), Gender, Birth Date) found to be inaccurate. The Inactivation Request record should include the following data item values from the LTCH CARE Data Set Assessment Record that is being inactivated. Any of the following items	These items **cannot** be corrected with a Modification Request: Record Event Identifiers • A0210: Assessment Reference Date (ARD) • A0220: Admission Date (on an Admission record A0250 = 01) • A0250: Reason for Assessment • A0270: Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12) Patient Identifiers • A0500A: First name • A0500C: Last name • A0600A: Social Security Number (SSN) • A0800: Gender • A0900: Birth Date Note: To make corrections to a record event identifier and/or patient identifier you must complete an **Inactivation Request** record for the incorrect record and create a new record with the correct information. When an error is discovered (except for those items listed in the preceding bullets) in an LTCH CARE Data Set assessment record, the provider must submit a Modification Request (A0050 = 2) to the QIES ASAP system. When completing a Modification Request record, the Modification Request record should contain correct values for all items (not just the values previously in error). This means if A0050 is coded as 2, the LTCH staff should proceed to A0100, Facility Provider Numbers, and complete all items in all other LTCH CARE Data Set assessment record sections. For more information on Modification Requests, please refer to Chapter 4. An **Inactivation Request** (A0050 = 3) should be used when a record has been accepted into the QIES ASAP system, but the corresponding event did not occur, for example, an LTCH CARE	

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5. (cont)		that were submitted as part of the original record *must also* be submitted as part of this inactivation request and values for each item must match across the original record and the inactivation request record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record. A0050: Type of Record • A0200: Type of Provider • A0210: Assessment Reference Date • A0220: Admission Date (on an Admission record A0250 = 01) • A0250: Reason for Assessment • A0270: Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12) • A0500A: First name • A0500C: Last name • A0600A: Social Security Number • A0800: Gender • A0900: Birth Date An Inactivation Request, unlike a Modification Request, does not replace the erroneous record with a corrected record. It allows for the archiving of the erroneous record from the QIES ASAP database. Neither the Modification Request nor the Inactivation Request processes *completely* removes the prior erroneous record from the QIES ASAP database. Rather, in each instance, the erroneous record is archived in a history file so that it will not be used for quality reporting purposes. New or corrected LTCH CARE Data Set records that are completed and submitted under the Modification or Inactivation Request processes will replace the erroneous records and thus will be used for	Data Set Discharge Assessment Record was submitted for a patient but there was no actual discharge. This request should also be used when one or more event identifiers and/or patient identifiers are found to be in error. An Inactivation Request (A0050 = 3) **must** be completed when any of the following items are inaccurate: Record Event Identifiers • A0210: Assessment Reference Date (ARD) • A0220: Admission Date (on an Admission record A0250 = 01) • A0250: Reason for Assessment • A0270: Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12) Patient Identifiers • A0500A: First name • A0500C: Last name • A0600A: Social Security Number (SSN) • A0800: Gender • A0900: Birth Date Note: Any item in the previous list that was submitted as part of the original record must also be submitted as part of the Inactivation Request, and values for each item must match in the erroneous record and the inactivation record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record. If an ARD (A0210), Admission Date (A0220), Reason for Assessment (A0250), or Discharge Date (A0270) is incorrect, or if one or more patient identifiers are found to be in error, the provider must inactivate the erroneous record in the QIES ASAP system, complete and submit a new LTCH CARE Data Set assessment record with the event and patient identifiers, and	

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5. (cont)		quality reporting purposes. There is only one instance in which it is necessary to delete a record permanently and not retain any information about the record in the QIES ASAP database, which is when the record was submitted for the wrong facility. Only in this instance is it necessary to complete a **Manual Deletion Request** to ensure that the patient record is not associated with an incorrect facility and does not appear on the reports of the incorrect facility. Manual Deletion Requests must come from the LTCH to CMS so that all traces of this record will be manually and permanently deleted from the QIES ASAP database. A new record must then be submitted to the QIES ASAP system for the correct facility. The policy and procedures for a Manual Deletion Request are provided in ***Chapter 4*** of this manual.	ensure that the clinical information is accurate. For more information on Inactivation Requests, please refer to Chapter 4. A special **Manual Record Deletion Request** is only necessary when there has been an error in a record that has been accepted into the QIES ASAP system that cannot be corrected with an automated Modification or Inactivation Request. There are only two items to which this applies. A **Manual Record Deletion Request** must be performed when the record has the wrong state code and/or facility ID in the control items STATE_CD and FAC_ID. Control items are items created by the file submission software. These error(s) most likely occurred at the time of software development, or when initializing the software, and not during the entry of the provider's administrative or patient's data.	
Chapter 3, Section B				
6.	Chapter 3, Section B, Page B-4	4. Mr. B had a stroke several weeks ago and has a diagnosis of expressive aphasia. The certified nursing assistant asks Mr. B if he needs help with bathing. He looks at the certified nursing assistant and smiles, but does not respond verbally. The certified nursing assistant reports to the nurse that she has not been able to determine Mr. B's preferences and needs with any of his activities of daily living since he was admitted the day before. The nurse interacts with Mr. B and determines he rarely expresses himself. The nurse plans to collaborate with the speech language pathologist, other care team members, and Mr. B to increase Mr. B's ability to express himself.	4. Mr. B had a stroke several weeks ago and has a diagnosis of expressive aphasia. The certified nursing assistant asks Mr. B if he needs help with bathing. He looks at the certified nursing assistant and smiles, but does not respond verbally. The certified nursing assistant reports to the nurse that she has not been able to determine Mr. B's preferences and needs with any of his activities of daily living since he was admitted the day before. The nurse offered alternative means of communication with no response from the patient. The nurse interacts with Mr. B and determines he rarely expresses himself. The nurse plans to collaborate with the speech language pathologist, other care team members, and Mr. B to increase Mr. B's ability to express himself.	Added clarification to coding scenario 4 that the nurse offered alternative means of communication with no response from the patient
7.	Chapter 3, Section B, Page B-7	**Rationale:** Mrs. K has used her electronic device to respond to questions in the LTCH and demonstrated her understanding through the accuracy of her replies.	**Rationale:** Mrs. K has used her electronic communication device to respond to questions in the LTCH and demonstrated her understanding through the accuracy of her replies.	Added the word "communication" in the rationale for coding example 6 for clarity

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Chapter 3, Section GG				
8.	Chapter 3, Section GG, Page GG-1	*Steps for Assessment* 1. Interview patient or family or review patient's medical records describing patient's prior functioning with everyday activities.	*Steps for Assessment* 1. Ask the patient or family member, or review the patient's medical record, for details describing the patient's prior functioning with everyday activities.	Revised in GG0100 for clarity
9.	Chapter 3, Section GG, Page GG-1	*Coding Instructions* • Code 1, Dependent, if the helper completed the activities for the patient.	*Coding Instructions* • Code 1, Dependent, if the helper completed the activities for the patient, or the assistance of two or more helpers was required for the patient to complete the activities.	Added language in GG0100 for clarity
10.	Chapter 3, Section GG, Page GG-2	*Coding Tips* • If the clinician does not attempt to gather this information, he or she should enter a dash (–) for this item. The Centers for Medicare & Medicaid Services (CMS) expects dash use to be a rare occurrence. An example of appropriate use of a dash is if a patient is admitted to and discharged from the long-term care hospital (LTCH) before the facility has completed the patient/family interview and no medical records are available for the clinician to review.	**Removed**	Removed to avoid duplication
11.	Chapter 3, Section GG, Page GG-2	*Item Rationale* • Knowledge of the patient's use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.	*Item Rationale* • Knowledge of the patient's routine use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.	Added the word "routine" for clarity
12.	Chapter 3, Section GG, Page GG-2	*Steps for Assessment* 1. Interview patient or family or review the patient's medical record describing the patient's use of prior devices and aids.	*Steps for Assessment* 1. Ask the patient or family member, or review the patient's medical record, for details describing the patient's use of prior devices and aids.	Revised in GG0110 for clarity

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13.	Chapter 3, Section GG, Page GG-4	*Steps for Assessment* 1. Licensed clinicians may assess the patient's performance based on direct observation as well as reports from patient's self-report, clinicians, care staff, or family during the 3-day assessment period. We anticipate that a multidisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.	*Steps for Assessment* 1. Assess the patient's self-care performance based on direct observation, as well as the patient's self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.	Revised in GG0130 for clarity. Note that we have revised this text at every mention for alignment.
14.	Chapter 3, Section GG, Page GG-4	*Steps for Assessment* 5. If the patient's self-care performance varies during the assessment period, report the patient's usual status, **not** the patient's most independent performance and **not** the patient's most dependent episode.	**Removed**	Removed to avoid duplication. This text is already included in the "usual status" section.
15.	Chapter 3, Section GG, Page GG-4	***Assessment period:*** The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. Clinicians should code the patient's admission functional status based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The assessment should occur prior to the start of therapy services to capture the patient's true admission baseline status. This is because therapy interventions can affect the patient's functional status; the score should reflect the patient's status prior to any benefit from therapy. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.	***Assessment period:*** The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. Clinicians should code the patient's admission functional status based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The admission functional assessment, when possible, should occur prior to the patient benefiting from treatment interventions in order to determine the patient's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.	Updated text for clarity

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16.	Chapter 3, Section GG, Page GG-4	*Usual status*	*Usual performance*	Revised for clarity
17.	Chapter 3, Section GG, Page GG-5	*Coding Tips*	*Admission and Discharge Performance Coding Tips*	Revised section title for clarity
18.	Chapter 3, Section GG, Page GG-5 to GG-6	**Did not exist**	***General coding tips:*** • When reviewing the patient's medical record, interviewing staff, and observing the patient, be familiar with the definition for each activity. For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food and liquid to the mouth and swallow food and liquid once the meal is placed in front of the patient.	New coding tip
19.	Chapter 3, Section GG, Page GG-7	***General coding tips:*** • A patient's functional status can be impacted by the environment or situations encountered at the facility. Observing the patient's interactions with others in different locations and circumstances is important for a comprehensive understanding of the patient's functional status. If the patient's functional status varies, record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance.	**Removed**	Removed to avoid duplication. This text is already included in the "usual status" section.
20.	Chapter 3, Section GG, Page GG-6	**Did not exist**	***General coding tips:*** • If two or more helpers are required to assist the patient in completing the activity, code as 01, Dependent.	Added to align with coding tips for GG0170

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21.	Chapter 3, Section GG, Page GG-6	***General coding tips:*** • A dash (–) indicates "No information." CMS expects dash use to be a rare occurrence. Use of dashes for items necessary to calculate quality measures may result in a 2% payment reduction to the LTCH's annual payment update (APU). Do not use a dash if the reason that the item was not assessed was because the patient refused (code 07), the item is not applicable (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to medical condition or safety concerns (code 88).	***General coding tips:*** • A dash (–) indicates "No information." CMS expects dash use to be a rare occurrence.	Revised for brevity
22.	Chapter 3, Section GG, Page GG-6	***General coding tips:*** • The self-care items are not included on the Unplanned Discharge Assessment or the Expired Assessment.	**Removed**	Removed to avoid duplication. This text is already included in the "Coding tip for patients with incomplete stays due to an unplanned discharge" section.
23.	Chapter 3, Section GG, Page GG-6	***Coding tips for coding the patient's usual performance:*** • On the admission assessment, code the patient's usual performance using the 6-point scale, or code the reason an activity was not attempted, as well as the patient's discharge goal(s) using the 6-point scale.	***Coding tips for coding the patient's usual performance:*** • When coding the patient's usual performance and the patient's discharge goal(s), use the 6-point scale, or one of the four "activity was not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted.	Revised for clarity
24.	Chapter 3, Section GG, Page GG-7	***Coding tips for coding the patient's usual performance:*** • On the discharge assessment, code the patient's usual performance using the 6-point scale or code the reason an activity was not attempted.	**Removed**	Removed to avoid duplication

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25.	Chapter 3, Section GG, Page GG-7	***Coding tips for coding the patient's usual performance:*** • We anticipate that a multidisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period. Licensed clinicians may assess the patient's performance based on direct observation, input from patient self-report, care staff, patient's family, and the medical record during the 3-day assessment period.	***Coding tips for coding the patient's usual performance:*** • Assess the patient's self-care performance based on direct observation, as well as the patient self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.	Revised for clarity
26.	Chapter 3, Section GG, Page GG-7	**Did not exist**	***Coding tips for coding the patient's usual performance:*** • If the patient performs the activity more than once during the assessment period and the patient's performance varies, coding in Section GG should be based on the patient's "usual performance," which is identified as the patient's usual activity/performance for any of the Self-Care activities, not the most independent or dependent performance over the assessment period. Therefore, if the patient's Self-Care performance varies during the assessment period, report the patient's usual performance, **not** the patient's most independent performance and **not** the patient's most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the patient's usual performance.	New coding tip
27.	Chapter 3, Section GG, Page GG-7	*Specific activity coding tips:*	*Examples and Specific Coding Tips for Admission Performance or Discharge Performance* Note: The following are coding examples and coding tips for each Self-Care item. Some examples describe a single observation of the patient completing the activity; other examples describe a summary of several observations of the patient completing an activity across different times of the day and different days.	Revised section title for clarity. Also revised the formatting of the section so coding tips appear first, then coding examples for any given item.

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28.	Chapter 3, Section GG, Page GG-11	**Did not exist**	*Coding Tips for GG0130C, Toileting hygiene* • Toileting hygiene includes the tasks of managing undergarments, clothing and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the patient does not usually use undergarments, then assess the patient's need for assistance to manage lower-body clothing and perineal hygiene. • Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal. If the patient completes a bowel toileting program in bed, code the item Toileting hygiene based on the patient's need for assistance for managing clothing and perineal cleansing. • If the patient has an indwelling urinary catheter and has bowel movements, code the Toileting hygiene item based on the amount of assistance needed by the patient when moving his or her bowels.	New coding tips
29.	Chapter 3, Section GG, Page GG-15	**Did not exist**	*Discharge Goal: Coding Tips* • Discharge Goal(s) is (are) coded with each Admission assessment.	New coding tip
30.	Chapter 3, Section GG, Page GG-19	*Steps for Assessment* 1. Licensed clinicians may assess the patient's performance based on direct observation as well as reports from patient's self-report, clinicians, care staff, or family during the 3-day assessment period. We anticipate that a multidisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.	*Steps for Assessment* 1. Assess the patient's mobility performance based on direct observation, as well as the patient's self-report, and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.	Revised in GG0170 for clarity. Note that we have revised this text at every mention for alignment.
31.	Chapter 3, Section GG, Page GG-19	*Steps for Assessment* 5. If the patient's mobility performance varies during the assessment period, report the patient's usual status, not the patient's most independent performance and not the patient's most dependent episode.	**Removed**	Removed to avoid duplication. This text is already included in the "usual status" section

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32.	Chapter 3, Section GG, Page GG-19 to GG-20	***Assessment period:*** The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. Clinicians should code the patient's admission functional status based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The assessment should occur prior to the start of therapy services to capture the patient's true admission baseline status. This is because therapy interventions can affect the patient's functional status; the score should reflect the patient's status prior to any benefit from therapy. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.	***Assessment period:*** The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. Clinicians should code the patient's admission functional status, based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The admission functional assessment, when possible, should occur prior to the patient benefiting from treatment interventions in order to determine the patient's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.	Updated text for clarity
33.	Chapter 3, Section GG, Page GG-19	*Usual status*	*Usual performance*	Revised for clarity
34.	Chapter 3, Section GG, Page GG-21	*Coding Tips*	*Admission and Discharge Performance Coding Tips*	Revised section title for clarity
35.	Chapter 3, Section GG, Page GG-21	**Did not exist**	***General coding tips:*** • When reviewing the patient's medical record, interviewing staff, and observing the patient, be familiar with the definition for each activity. For example, when assessing Roll left and right (item GG0170A), determine the level of assistance required to roll from lying on the back to the left side and right side and then return to lying on the back.	New coding tip

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36.	Chapter 3, Section GG, Page GG-21	***General coding tips:*** • A patient's functional status can be impacted by the environment or situations encountered at the facility. Observing the patient's interactions with others in different locations and circumstances is important for a comprehensive understanding of the patient's functional status. If the patient's functional status varies, record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance.	**Removed**	Removed to avoid duplication. This text is already included in the "usual status" section.
37.	Chapter 3, Section GG, Page GG-21	***General coding tips:*** • A dash (–) indicates "No information." CMS expects dash use to be a rare occurrence. Use of dashes for items necessary to calculate quality measures may result in a 2% payment reduction to the LTCH's annual payment update (APU). Do not use a dash if the reason that the item was not assessed was because the patient refused (code 07), the item is not applicable (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to medical condition or safety concerns (code 88).	***General coding tips:*** • A dash (–) indicates "No information." CMS expects dash use to be a rare occurrence.	Revised for brevity
38.	Chapter 3, Section GG, Page GG-22	***General coding tips:*** • The mobility items are not included on the Unplanned Discharge Assessment or the Expired Assessment.	**Removed**	Removed to avoid duplication. This text is already included in the "Coding tip for patients with incomplete stays due to an unplanned discharge" section

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39.	Chapter 3, Section GG, Page GG-22	***Coding tips for coding the patient's usual performance:*** • On the admission assessment, code the patient's usual performance using the 6-point scale, or code the reason an activity was not attempted, as well as the patient's discharge goal(s) using the 6-point scale. Instructions about coding discharge goals are provided below.	***Coding tips for coding the patient's usual performance:*** • When coding the patient's usual performance and the patient's discharge goal(s), use the 6-point scale, or one of the four "activity was not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted.	Revised for clarity
40.	Chapter 3, Section GG, Page GG-22	***Coding tips for coding the patient's usual performance:*** • On the discharge assessment, code the patient's usual performance using the 6-point scale or code the reason an activity was not attempted.	**Removed**	Removed to avoid duplication
41.	Chapter 3, Section GG, Page GG-22	***Coding tips for coding the patient's usual performance:*** • We anticipate that a multidisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period. Licensed clinicians may assess the patient's performance based on direct observation, input from patient self-report, care staff, patient's family, and the medical record during the 3-day assessment period.	***Coding tips for coding the patient's usual performance:*** • Assess the patient's mobility performance based on direct observation, as well as the patient self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period.	Revised for clarity
42.	Chapter 3, Section GG, Page GG-22	**Did not exist**	***Coding tips for coding the patient's usual performance:*** • If the patient performs the activity more than once during the assessment period and the patient's performance varies, coding in Section GG should be based on the patient's "usual performance," which is identified as the patient's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the patient's Mobility performance varies during the assessment period, report the patient's usual performance, **not** the patient's most independent performance and **not** the patient's most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the patient's usual performance.	New coding tip

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43.	Chapter 3, Section GG, Page GG-22	*Specific activity coding tips:*	*Examples and Specific Coding Tips for Admission Performance or Discharge Performance* Note: The following are coding examples and coding tips for each Mobility item. Some examples describe a single observation of the patient completing the activity; other examples describe a summary of several observations of the patient completing an activity across different times of the day and different days.	Revised section title for clarity. Also revised the formatting of the section so coding tips appear first, then coding examples for any given item.
44.	Chapter 3, Section GG, Page GG-43	*Discharge Goal: Coding Tips* • For the LTCH QRP, a minimum of one self-care or mobility goal must be coded. Code the patient's discharge goal(s) using the 6-point scale. Use of activity not attempted codes (07, 09, 10, or 88) is permissible to code discharge goal(s). The use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance does not affect APU determination. • Licensed clinicians can establish a patient's discharge goal(s) at the time of admission based on the patient's prior medical condition, admission assessment self-care and mobility status, discussions with the patient and family, professional judgment, the profession's practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan. Goals should be established as part of the patient's care plan. One goal must be coded for either self-care or mobility. • If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a discharge goal may be coded using the 6-point scale if the patient is expected to be able to perform the activity by discharge.	*Discharge Goal: Coding Tips* • Discharge Goal(s) is (are) coded with each Admission assessment. • A minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to code more than one self-care or mobility discharge goal. Code the patient's discharge goal(s) using the 6-point scale. Use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination. • Licensed clinicians can establish a patient's discharge goal(s) at the time of admission based on the patient's prior medical condition, admission assessment self-care and mobility status, discussions with the patient and family, professional judgment, the professional's standard of practice, expected treatments, the patient's motivation to improve, anticipated length of stay, and the patient's discharge plan. Goals should be established as part of the patient's care plan. • If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a discharge goal may be entered using the 6-point scale if the patient is expected to be able to perform the activity by discharge.	Moved to end of section and made some revisions for clarity. Also, the first bullet is new.

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44. (cont)		• If the patient is in the LTCH for less than 3 calendar days, code a minimum of one self-care or mobility goal per patient stay in the Self-Care and/or Mobility Discharge Goal boxes of the LTCH CARE Data Set. Code at least one goal to the best of your ability based on the predicted plan of care for the patient.	• If the patient is in the LTCH for less than 3 calendar days, for Self-Care and Mobility Discharge Goals, a minimum of one self-care or mobility goal must be coded per patient stay on the LTCH CARE Data Set. Code at least one goal to the best of your ability based on the predicted plan of care for the patient.	
45.	Chapter 3, Section GG, Page GG-23	**Did not exist**	*Coding Tip for GG0170A, Roll left and right* • If the clinician determines the patient's medical condition does not allow for the patient to complete all tasks of the activity (roll left, roll right, roll to back) for the entire 3-day assessment period then code Roll left to right as 88, Not attempted due to medical condition or safety concerns. This can include patient refused due to intolerable pain for any tasks required of the activity.	New coding tip. Also included in coding tips for GG0170B and GG0170C.
46.	Chapter 3, Section GG, Page GG-23	**Rationale:** The nurse provides more than half of the effort for the patient to complete the activity of roll left and right.	**Rationale:** The nurse provides more than half of the effort needed for the patient to complete the activity of rolling left and right. This is because the nurse provided physical assistance to move Mr. R's body weight to turn onto his right side. The nurse provided the same assistance when Mr. R turned to his left side and when he returned to his back. Mr. R was able to return to lying on his back from his right side by himself.	Added text to rationale for GG0170A example 1 for clarity.

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47.	Chapter 3, Section GG, Page GG-25	**Did not exist**	*Coding Tips for GG0170C, Lying to sitting on side of bed* • The activity includes patient transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support. The patient's ability to perform each of the tasks within this activity and how much support the patient requires to complete the tasks within this activity is assessed. • For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for a particular patient. • If the patient's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment is required to accommodate foot placement on the floor. • Back support refers to an object or person providing support for the patient's back. • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.	New coding tips
48.	Chapter 3, Section GG, Page GG-26	**Did not exist**	*Coding Tip for GG0170D, Sit to stand* • If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer, and the patient is not able to complete Sit to stand due to medical condition or safety issues, then GG0170D, Sit to stand would be coded 88, Not attempted due to medical condition or safety issues. However, if the patient did not attempt to perform sit to stand during the assessment and did not perform this activity prior to the current illness, exacerbation, or injury, then use code 09, Not applicable. • If a sit to stand lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.	New coding tips

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49.	Chapter 3, Section GG, Page GG-27 to GG-28	**Did not exist**	*Coding Tips for GG0170E, Chair/bed-to-chair transfer* • Item GG0170E, Chair/bed-to-chair transfer, begins with the patient sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying and GG0170C, Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E. • If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the patient assists with any part of the chair/bed-to-chair transfer. • If a patient performs a stand pivot transfer due to inability to fully stand upon rising and instead rises to a squat, then pivots, turns and sits, this style of chair/bed-to-chair transfer is acceptable and should be coded based upon the amount of assistance required to perform this style of transfer.	New coding tips
50.	Chapter 3, Section GG, Page GG-29	**Did not exist**	*Coding Tips for GG0170F, Toilet transfer* • Toilet transfer includes the patient's ability to get on and off a toilet (with or without a raised toilet seat), or bedside commode. Do not consider or include GG0130C, Toileting hygiene item tasks (managing clothing, undergarments, or perineal hygiene) when assessing the Toilet transfer item. Transferring on and off a bedpan is **not** included in Toilet transfer. • If the patient usually needs a helper to position/set-up the bedside commode before and/or after the patient's bed to commode transfers (place at an accessible angle/location next to the bed) and the patient does not need helper assistance during Toilet transfers, then use code 05, Setup or clean-up assistance.	New coding tips

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51.	Chapter 3, Section GG, Page GG-30	**Rationale:** The helper provides less than half the effort to complete the activity.	**Rationale:** The helper provides less than half the effort to complete the activity. The assistance provided to the patient was physical support or weight bearing assistance.	Added text to rationale for GG0170F example 5 for clarity.
52.	Chapter 3, Section GG, Page GG-32	**4. Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. The therapy assistant secures Mr. O's arms onto the platform walker's arm supports to manage the tremors. The therapy assistant guides and steadies the shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last 5 feet of the 10-foot walk. Overall, the assistant provides less than half of the effort. **Coding:** GG0170I, Walk 10 feet, would be coded 03, Partial/moderate assistance. **Rationale:** The helper provides less than half the effort for the patient to complete the activity, Walk 10 feet.	**4. Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. The therapy assistant guides and steadies the shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last 5 feet of the 10-foot walk. Overall, the assistant provides less than half of the effort. **Coding:** GG0170I, Walk 10 feet, would be coded 03, Partial/moderate assistance. **Rationale:** The helper provides less than half the effort required for the patient to complete the activity, Walk 10 feet. While the helper guided and steadied the walker during the walk, Mr. O supported his own body weight with his arms and legs and propelled his legs forward for 8 of the 10 feet. The helper only supported part of Mr. O's weight 2 of the 10 feet, thus Mr. O did more than half the effort.	Removed sentence in coding scenario 4. Also, added text to rationale for clarity.
53.	Chapter 3, Section GG, Page GG-33	**Rationale:** The helper provides more than half of the effort for the patient to complete the activity of Walk 50 feet with two turns.	**Rationale:** The helper provides more than half of the effort for the patient to complete the activity of Walk 50 feet with two turns. Assistance with rising from a seated position to standing is not considered when coding this walking item.	Added text to rationale for GG0170J example 6 for clarity.

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54.	Chapter 3, Section GG, Page GG-34	**Did not exist**	*Coding Tips for Wheelchair Items* • The intent of the wheelchair mobility items is to assess the ability of patients who are learning how to self-mobilize using a wheelchair or those who used a wheelchair prior to admission. Use clinical judgment to determine whether a patient's use of a wheelchair is for self-mobilization as a result of the patient's medical condition or safety, or used for convenience. • Do not code wheelchair mobility if the patient uses a wheelchair only when transported between locations within the facility for staff convenience (e.g. because the patient walks slowly). Only code wheelchair mobility based on an assessment of the patient's ability to mobilize in the wheelchair. • If the patient walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the patient use a wheelchair/scooter? — as 0, No, and skip all remaining wheelchair questions. • Admission assessment for wheelchair items should be coded for patients who used a wheelchair prior to admission or are expected to use a wheelchair during their stay in the LTCH, even if the patient is also expected to ambulate during the stay or by discharge. - The responses for gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the Admission and Discharge assessments.	New coding tips

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54. (cont)			• The turns included in the items GG0170R (wheeling 50 feet with 2 turns) are 90 degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level.	
55.	Chapter 3, Section GG, Page GG-35	**Did not exist**	1. **Does the patient use a wheelchair/scooter?** On admission, Mr. T wheels himself using a manual wheelchair, but with difficulty due to his severe osteoarthritis and COPD. Item GG0170Q1, Does the patient use a wheelchair/scooter? will be coded 1, Yes. **Coding:** GG0170Q1, Does the patient use a wheelchair/scooter? would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the type of wheelchair Mr. T uses for GG0170RR1 and RR2 is indicated as code 1, Manual. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded. **Rationale:** The patient currently uses a wheelchair. Coding all and coding the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.	New example
56.	Chapter 3, Section GG, Page GG-38 to GG-37	**Examples for Unplanned Discharge**	**Examples for Unplanned Discharge**	Revised coding and rationale for all examples under this section to reflect Unplanned Discharge assessment coding

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Chapter 3, Section I				
57.	Chapter 3, Section I, Page I-8	2. Mrs. I underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The nurse practitioner's progress note documents peripheral vascular disease and left below the knee amputation. **Coding:** I0900, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), and I4100, Major Lower Limb Amputation, would be checked. **Rationale:** These would both be considered active diagnoses because the nurse practitioner's note documents the peripheral vascular disease diagnosis, with peripheral pulse monitoring and recent below the knee amputation, with dressing changes and wound status monitoring.	2. Mrs. I underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the incision site and monitoring for wound healing. In addition, assessment of circulation, sensation, and motion is ordered. The nurse practitioner's progress note documents peripheral vascular disease and left below the knee amputation. **Coding**: I0900, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), and I4100, Major Lower Limb Amputation, would be checked. **Rationale**: These would both be considered active diagnoses because the nurse practitioner's note documents the peripheral vascular disease diagnosis, with peripheral pulse monitoring and recent below the knee amputation, with dressing changes and wound status monitoring.	Updated active diagnoses in coding scenario 2
Chapter 3, Section M				
58.	Chapter 3, Section M, Page M-2	*Item Rationale* • For the LTCH CARE Data Set assessment, the initial (at admission) numerical staging of pressure ulcers/injuries and the initial numerical staging of ulcers/injuries after debridement, or a DTI that evolves to an open ulcer, should be coded in terms of what is assessed (i.e., seen and palpated, such as visible tissue, palpable bone) as close to admission as possible.	*Item Rationale* • For the LTCH CARE Data Set assessment, the initial (at admission) numerical staging of pressure ulcers/injuries and the initial numerical staging of ulcers/injuries after debridement, or a DTI that declares itself, should be coded in terms of what is assessed (i.e., seen and palpated, such as visible tissue, palpable bone) as close to admission as possible.	Revised "evolves to an open ulcer" to "declares itself"
59.	Chapter 3, Section M, Page M-2	*Steps for Assessment* • Key areas for pressure ulcer/injury development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries.	*Steps for Assessment* • Key areas for pressure ulcer/injury development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony prominences, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries.	Revised "deformities" to "prominences"

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60.	Chapter 3, Section M, Page M-3	**Did not exist**	*Steps for Assessment* • For any pressure ulcers/injuries identified, measure and record the stage of the ulcer/injury based on the extent of damage to the skin and/or underlying soft tissue.	Added for clarity
61.	Chapter 3, Section M, Page M-3	*Steps for Assessment* • For any pressure ulcers/injuries identified, the wound bed should be carefully cleansed and/or irrigated prior to staging so that the extent of tissue damage can be visualized or palpated. This will ensure more accurate pressure ulcer/injury staging. Measure the length, width, and depth of the ulcer and record the stage of the ulcer/injury based on the extent of damage to the skin and/or underlying soft tissue.	**Removed**	Removed to avoid duplication
62.	Chapter 3, Section M, Page M-3	*Coding Tips for M0210* • If two or more pressure ulcers/injuries were present on admission and merge into a single pressure ulcer/injury by discharge, the resulting pressure ulcer/injury is reported as one single pressure ulcer at the appropriate stage on the LTCH CARE Data Set.	*Coding Tips for M0210* • If two or more pressure ulcers/injuries were observed at the time of admission and merge into a single pressure ulcer/injury by discharge, the resulting pressure ulcer/injury is reported as one single pressure ulcer/injury at the appropriate stage on the LTCH CARE Data Set.	Revised "present on admission" to "observed at the time of admission" for clarity.
63.	Chapter 3, Section M, Page M-4	**DEFINITIONS** **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. **ESCHAR TISSUE** Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.	**DEFINITIONS** **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 at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound. **GRANULATION TISSUE** Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.	Included definitions for Epithelial Tissue and Granulation Tissue. Definitions for Slough Tissue and Eschar Tissue moved to section M0300D.

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64.	Chapter 3, Section M, Page M-4	For each pressure ulcer/injury identified, determine the deepest anatomical stage, i.e., the extent of damage to the skin and/or soft tissue, and assign the appropriate pressure ulcer/injury stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.	For each pressure ulcer/injury, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.	Simplified language
65.	Chapter 3, Section M, Page M-4	Step 1: Determine Deepest Anatomical Stage 2. Ulcer/injury staging should be based on the extent of damage to the skin and/or soft tissue that is visible or palpable in and around the ulcer/injury. To ensure the visualization of these tissues, it is important that the ulcer/injury be carefully cleansed and/or irrigated. If after careful cleansing and/or irrigation of the pressure ulcer/injury the pressure ulcer's/injury's tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable (see Step 2, below).	Step 1: Determine Deepest Anatomical Stage 2. Ulcer/injury staging should be based on the extent of damage to the skin and/or soft tissue that is visible or palpable in and around the ulcer/injury. If a pressure ulcer/injury's, tissues are obscured such that the extent of soft tissue damage cannot be observed or palpated, it is considered unstageable (see Step 2, below).	Simplified language
66.	Chapter 3, Section M, Page M-4	**Did not exist**	Step 1: Determine Deepest Anatomical Stage 4. Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.	Added for clarification

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67.	Chapter 3, Section M, Page M-4 to M-5	**Did not exist**	Step 1: Determine Deepest Anatomical Stage 5. Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse or backstaging would have permitted identification of this pressure ulcer as a stage 3, then a stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. LTCHs can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e. depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.	Added for clarification
68.	Chapter 3, Section M, Page M-5	Step 2: Identify Unstageable Pressure Ulcers/Injuries 1. Visualization of the wound bed is necessary for accurate staging. Therefore, ensure that the ulcer/injury is carefully cleansed and/or irrigated prior to staging so that the extent of tissue damage can be visualized or palpated. This will ensure more accurate pressure ulcer/injury staging.	Step 2: Identify Unstageable Pressure Ulcers/Injuries 1. Visualization of the wound bed is necessary for accurate staging.	Simplified language
69.	Chapter 3, Section M, Page M- 5	**Did not exist**	Step 2: Identify Unstageable Pressure Ulcers/Injuries 2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.	Added language for clarification

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70.	Chapter 3, Section M, Page M- 5	Step 2: Identify Unstageable Pressure Ulcers/Injuries 3. If the wound bed is only partially covered by eschar or slough, and the extent of soft tissue damage can be visualized or palpated, the ulcer/injury should be numerically staged and should not be coded as unstageable.	Step 2: Identify Unstageable Pressure Ulcers/Injuries 3. If the wound bed is only partially covered by eschar or slough, and the extent of soft tissue damage can be visualized or palpated, the ulcer/injury should be numerically staged and do not code as unstageable.	Revised for clarity
71.	Chapter 3, Section M, Page M-5	Step 3: Determine "Present on Admission" Any pressure ulcer/injury identified and coded on the admission assessment is assumed to be "present on admission," per the definition of "on admission." For each pressure ulcer/injury identified and coded in items M0300B1-G1 on discharge, (Planned or Unplanned), determine whether that the pressure ulcer/injury was present at the time of admission and not acquired while the patient was in the care of the LTCH at that stage. Consider current and historical levels of tissue involvement. to accurately code the present on admission items (M0300B2-G2) on discharge.	Step 3: Determine "Present on Admission" For each pressure ulcer/injury, determine whether the pressure ulcer/injury was present at the time of admission and not acquired while the patient was in the care of the LTCH. Consider current and historical levels of tissue involvement.	Simplified language
72.	Chapter 3, Section M, Page M-5	Step 3: Determine "Present on Admission" 2. Review for location and stage of pressure ulcers/injuries at the time of admission.	Step 3: Determine "Present on Admission" 2. Review for location and stage of pressure ulcers/injuries at the time of admission. If the pressure ulcer/injury was observed at the time of admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer/injury is coded at the initial stage on the Admission assessment, and the higher stage should not be coded on the Admission assessment.	Added language for clarification

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73.	Chapter 3, Section M, Page M-6	Step 3: Determine "Present on Admission" • If the pressure ulcer/injury that is assessed on discharge was present on admission at the same stage it is on discharge, then the pressure ulcer/injury is, and would be coded as, present on admission in items M0300B2-G2 on the Discharge assessment. If the pressure ulcer/injury that is assessed on discharge was not present on admission at the same stage it is on discharge, then the pressure ulcer/injury is not present on admission and would be coded as 0 in items M0300B2-G2 on the Discharge assessment.	**Removed**	Removed to avoid duplication
74.	Chapter 3, Section M, Page M-6	Step 3: Determine "Present on Admission" • If on admission a pressure ulcer/injury was unstageable, but becomes and remains numerically stageable later in the patient's stay, it **should be considered and coded as present on admission on the Discharge assessment at the stage at which it first becomes numerically stageable**. However, if that same pressure ulcer/injury subsequently **increases** in numerical stage, it would be coded at that higher stage and **should not be considered nor coded as present on admission on the Discharge assessment.** In this instance, the discharge present on admission item for that higher numerical stage would be coded as 0.	Step 3: Determine "Present on Admission" • If on admission a pressure ulcer/injury was unstageable, but becomes and remains numerically stageable later in the patient's stay, it **should be coded as present on admission on the Discharge assessment at the stage at which it first becomes numerically stageable**. However, if that same pressure ulcer/injury subsequently **increases** in numerical stage, it would be coded at that higher stage and **should not be coded as present on admission on the Discharge assessment.**	Revised for clarity

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
75.	Chapter 3, Section M, Page M-6	Step 3: Determine "Present on Admission" • If on admission a pressure ulcer/injury was numerically stageable, but becomes and remains unstageable by discharge, it would be coded in the appropriate unstageable item (M0300E1-G1) on the Discharge assessment. Since the pressure ulcer/injury that is assessed on discharge was not present on admission at the same stage it is on discharge, the unstageable pressure ulcer/injury is neither considered nor coded as present on admission on the Discharge assessment. In this instance, the discharge present on admission item for the unstageable pressure ulcer/injury would be coded as 0.	**Removed**	Moved and revised under M0300E and M0300F Coding Tips
76.	Chapter 3, Section M, Page M-6	Step 3: Determine "Present on Admission" • If a patient is discharged to another facility/hospital and a current pressure ulcer/injury increases in numerical stage during a patient visit/stay longer than 3 calendar days at the other hospital/facility **it is coded at the higher stage and should be coded as present on admission.**	Step 3: Determine "Present on Admission" • If a patient is discharged to another facility/hospital for longer than 3 calendar days and subsequently returns to the LTCH, and a current pressure ulcer increases in numerical stage, **it is coded at the higher stage on the patient's new Admission assessment for the second LTCH stay.**	Simplified and revised to improve clarity

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
77.	Chapter 3, Section M, Page M-6	Step 3: Determine "Present on Admission" • If a pressure ulcer/injury is documented as healed during the stay, but **prior to discharge** a pressure ulcer/injury is identified at the same anatomical location as the previously documented healed ulcer, the facility staff, including the physician, should determine if the previous ulcer/injury reopened, or if it is a new pressure ulcer/injury. If it is determined that the previous ulcer/injury has reopened, it should not be considered as healed and should be staged at its previously identified highest numerical stage until it is fully healed. If the reopened pressure ulcer/injury was originally present on admission and has not worsened, it would still be considered present on admission. However, if the reopened pressure ulcer/injury has worsened (i.e., the current stage of the reopened pressure ulcer is a higher numerical stage than it was before it was considered healed), it must be coded at its new higher numerical stage and would no longer be considered present on admission. If the reopened pressure ulcer/injury does not heal before discharge, the facility must code the status of the pressure ulcer on the Discharge assessment according to the instructions in Section M. If it is determined that the pressure ulcer/injury is a new pressure ulcer/injury, and does not heal before discharge, it should be staged and coded on the Discharge assessment according to the instructions in Section M as would be done for any new pressure ulcer/injury that develops during the stay.	**Removed**	Removed to align coding guidance across PAC settings
78.	Chapter 3, Section M, Page M-7	*Steps for Assessment* 1. Perform a full-body (head to toe) skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	*Steps for Assessment* 1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	Simplified language in M0300A

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
79.	Chapter 3, Section M, Page M-7	*Steps for Assessment* 3. Use more than one descriptor to determine the difference between Stage 1 and DTIs as relying on only one is inadequate (see definition for DTI on page M-25). The descriptors are similar for these two types of ulcers (e.g., temperature [warmth or coolness], tissue consistency [firm or boggy]).	*Steps for Assessment* 3. Reliance on only one descriptor is inadequate to determine the staging of the pressure injury between Stage 1 and DTIs (see definition for DTI on page M-27). The descriptors are similar for these two types of injuries (e.g., temperature [warmth or coolness], tissue consistency [firm or boggy]).	Revised for clarity in M0300A
80.	Chapter 3, Section M, Page M-7	*Coding Instructions for M0300A* • Enter 0, if no Stage 1 pressure injuries are present.	*Coding Instructions for M0300A* • Enter 0, if no Stage 1 pressure injuries are currently present.	Added the word "currently" in M0300A
81.	Chapter 3, Section M, Page M-8	*Item Rationale* • Most Stage 2 pressure ulcers should heal in a reasonable timeframe.	*Item Rationale* • Most Stage 2 pressure ulcers should heal in a reasonable timeframe (e.g., 60 days).	Added timeframe for clarity in M0300B
82.	Chapter 3, Section M, Page M-8	**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.	**DEFINITION** **STAGE 2 PRESSURE ULCER** Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.	Added "or bruising" for clarification
83.	Chapter 3, Section M, Page M-8	*Steps for Assessment* 1. Perform a full-body (head to toe) skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	*Steps for Assessment* 1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	Simplified language in M0300B
84.	Chapter 3, Section M, Page M-8	**Did not exist**	*Steps for Assessment* 5. When completing the discharge assessment, identify the number of these pressure ulcers that were present on admission.	Added step for clarification in M0300B
85.	Chapter 3, Section M, Page M-9	**Did not exist**	*Coding Tips* • Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.	Added language for clarification in M0300B

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
86.	Chapter 3, Section M, Page M-10	*Steps for Assessment* 1. Perform a full-body (head to toe) skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	*Steps for Assessment* 1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	Simplified language in M0300C
87.	Chapter 3, Section M, Page M-10	**Did not exist**	*Steps for Assessment* 4. When completing the discharge assessment, identify the number of these pressure ulcers that were present on admission.	Added step for clarification in M0300C
88.	Chapter 3, Section M, Page M-10	**DEFINITION** **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	**DEFINITION** **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 (see definition of undermining and tunneling on page M-17).	Added page reference to definition for undermining and tunneling
89.	Chapter 3, Section M, Page M-10	**Did not exist**	*Coding Tips* • Do *not* code skin tears, tape burns, moisture-associated skin damage, or excoriation here.	New coding tip added

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
90.	Chapter 3, Section M, Page M-11	**Rationale:** On the Admission assessment, the Stage 2 pressure ulcer was present on admission and is therefore coded as 1 in M0300B1 on the Admission assessment. On the Discharge assessment, the designation of present on admission in M0300B2 requires that the pressure ulcer be at the same location and not have increased in numerical stage. The (Stage 2) pressure ulcer increased in numerical stage (to Stage 3) after admission. So, M0300B1 would be coded as 0 on the Discharge assessment, and M0300B2 would be skipped because there is no Stage 2 pressure ulcer on discharge. M0300C1 would have been coded as 0 on the Admission assessment because there were no Stage 3 pressure ulcers present on admission. However, on the Discharge assessment, M0300C1 would be coded as 1, and M0300C2 would be coded as 0 because the Stage 3 pressure ulcer that is present on discharge was not a Stage 3 pressure ulcer on admission.	**Rationale:** On the Admission assessment, the Stage 2 pressure ulcer was present on admission and is therefore coded as 1 in M0300B1. On the Discharge assessment, the designation of present on admission in M0300B2 requires that the pressure ulcer be at the same location and not have increased in numerical stage. The (Stage 2) pressure ulcer increased in numerical stage (to Stage 3) after admission. So, M0300B1 would be coded as 0 on the Discharge assessment, and M0300B2 would be skipped because there is no Stage 2 pressure ulcer on discharge. M0300C1 would have been coded as 0 on the Admission assessment because there were no Stage 3 pressure ulcers present on admission. However, on the Discharge assessment, M0300C1 would be coded as 1, and M0300C2 would be coded as 0 because the Stage 3 pressure ulcer that is present on discharge was not a Stage 3 pressure ulcer on admission.	Removed "on the Admission assessment" after M0300B1 for brevity in coding rationale of example 1
91.	Chapter 3, Section M, Page M-12	**Rationale:** Two of the pressure ulcers on the coccyx that were present on admission have merged but have remained at the same stage as they were at the time of admission (therefore, M0300B1 is coded as 3 on Admission and 1 at discharge). The third Stage 2 pressure ulcer that increased in numerical staging to a Stage 3 has developed an increased extent of tissue damage in the time since admission; therefore, on the Discharge assessment, M0300C1 is coded as 1 and M0300C2 is coded as 0.	**Rationale:** Two of the pressure ulcers on the coccyx have merged but have remained at the same stage as they were at the time of admission (therefore, M0300B1 is coded as 3 on Admission and 1 at discharge). The third Stage 2 pressure ulcer that increased in numerical staging to a Stage 3 has developed an increased extent of tissue damage in the time since admission; therefore, on the Discharge assessment, M0300C1 is coded as 1 and M0300C2 is coded as 0**.**	Removed reference to present on admission for clarity in coding rationale of example 3

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
92.	Chapter 3, Section M, Page M-13	**Rationale:** Two Stage 2 pressure ulcers developed during the first LTCH stay and are coded on discharge in M0300B1 as 2 and in M0300B2 as 0. On return from the hospital, the Stage 2 pressure ulcer on the coccyx that was present prior to the patient's transfer to a short-stay acute-care hospital is coded as 1 in M0300B1 on the patient's second admission to the LTCH. There is a new Stage 3 pressure ulcer that developed during the hospital stay; therefore, M0300C1 is coded as 1 on the patient's second admission to the LTCH. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is not coded when the patient is admitted to the LTCH for the second time.	**Rationale:** On initial admission, this patient had no pressure ulcers/injuries. Two Stage 2 pressure ulcers developed during the first LTCH stay and are coded on discharge in M0300B1 as 2 and in M0300B2 as 0. On return from the hospital, the Stage 2 pressure ulcer on the coccyx that was present prior to the patient's transfer to a short-stay acute-care hospital is coded as 1 in M0300B1 on the patient's second admission to the LTCH. There is a new Stage 3 pressure ulcer that developed during the hospital stay; therefore, M0300C1 is coded as 1 on the patient's second admission to the LTCH. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is not coded when the patient is admitted to the LTCH for the second time.	First sentence of example 4 updated to reflect no pressure ulcers identified on initial admission assessment. Also, updated coding guidance to reflect M0210 coding and skip patterns.
93.	Chapter 3, Section M, Page M-13	5. A patient arrives at the LTCH with a Stage 2 pressure ulcer. The patient is transferred to a short-stay acute-care hospital but returns to the LTCH less than 3 calendar days after leaving the LTCH. When the patient returns, upon reassessment of the ulcer, the LTCH notes that the extent of tissue damage in the Stage 2 pressure ulcer now includes loss of adipose tissue, which is now visible in the ulcer. Therefore, the ulcer is staged as a Stage 3 pressure ulcer. The patient is discharged 3 weeks later with a healing Stage 3 pressure ulcer.	5. A patient arrives at the LTCH with a Stage 2 pressure ulcer. The patient is transferred to a short-stay acute-care hospital but returns to the LTCH less than 3 calendar days after leaving the LTCH. When the patient returns, the LTCH notes that the Stage 2 pressure ulcer has worsened to a Stage 3 pressure ulcer. The patient is discharged 3 weeks later with a Stage 3 pressure ulcer.	Simplified and clarified coding scenario in example 5

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94.	Chapter 3, Section M, Page M-13	**Rationale:** Because the patient returned to the LTCH less than 3 calendar days after being transferred to a short-stay acute-care hospital, the patient's return to the LTCH is not considered a new admission; therefore, any new pressure ulcer formation increase in numerical staging that occurred at the short-stay acute-care hospital should not be coded as present on admission on the discharge assessment. The Stage 2 pressure ulcer that was present on admission was coded on the Admission assessment as 1 in M0300B1. On Discharge, the Stage 3 pressure ulcer was not present upon the patient's admission to the LTCH; therefore, M0300C1 should be coded as 1 and M0300C2 should be coded as 0 on the Discharge assessment.	**Rationale:** Because the patient returned to the LTCH less than 3 calendar days after being transferred to a short-stay acute-care hospital, the patient's return to the LTCH is not considered a new admission; therefore, any new pressure ulcer/injury formation or pressure ulcer/injury increase in numerical staging that occurred at the short-stay acute-care hospital should not be coded as present on admission on the discharge assessment. The Stage 3 pressure ulcer was not present upon the patient's admission to the LTCH; therefore, M0300C1 should be coded as 1 and M0300C2 should be coded as 0 on the Discharge assessment.	Simplified coding rationale in example 5
95.	Chapter 3, Section M, Page M-13	6. A patient develops a Stage 2 pressure ulcer while at the LTCH. The patient is transferred to a short-stay acute-care hospital because of pneumonia. The patient returns to the LTCH after 4 days. Upon return, the LTCH received documentation from the acute-care hospital and confirmed via assessment at the LTCH, that the Stage 2 ulcer, which was present prior to discharge, now has the extent of tissue loss consistent with a Stage 3 pressure ulcer. Therefore, the ulcer is staged as a Stage 3 pressure ulcer.	6. A patient develops a Stage 2 pressure ulcer while at the LTCH. The patient is transferred to a short-stay acute-care hospital because of pneumonia. The patient returns to the LTCH after 4 days and returns with a Stage 3 pressure ulcer in the same anatomical location.	Revised coding scenario in example 6 for clarity

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96.	Chapter 3, Section M, Page M-14	**Rationale:** There were no pressure ulcers identified on admission. Therefore, items M0300B1 and M0300C1 on the first Admission assessment are coded as 0. On the first Discharge assessment, M0300B1 is coded as 1, because there was one Stage 2 pressure ulcer identified on discharge. M0300B2 was coded as 0 on Discharge because the Stage 2 pressure ulcer that developed in the LTCH was not present on admission to the LTCH. When the patient returned on the second admission to the LTCH, it was noted that the Stage 2 pressure ulcer that was present prior to transfer to the short-stay acute-care hospital had tissue damage consistent with the extent of tissue loss of a Stage 3 pressure ulcer. Thus, while the patient was hospitalized at another facility that lasted longer than 3 calendar days, M0300C1 should be coded as 1 on the second Admission assessment to indicate that the Stage 3 pressure ulcer was present on the patient's second admission to the LTCH.	**Rationale:** There were no pressure ulcers identified on admission. Therefore, on the first Admission assessment, item M0210 is coded as 0 and items M0300B1 and M0300C1 are skipped. On the Discharge assessment, M0300B1 is coded as 1, because there was one Stage 2 pressure ulcer identified on discharge. M0300B2 was coded as 0 on Discharge because the Stage 2 pressure ulcer that developed in the LTCH was not present on admission to the LTCH. When the patient returned on the second admission to the LTCH, it was noted that the Stage 2 pressure ulcer that was present prior to transfer to the short-stay acute-care hospital had tissue damage consistent with the extent of tissue loss of a Stage 3 pressure ulcer. Because the patient returns to the LTCH with a Stage 3 pressure ulcer after a short stay acute-care hospitalization that lasted longer than 3 days, M0300C1 should be coded as 1 on the second Admission assessment to indicate that the Stage 3 pressure ulcer was present on the patient's second admission to the LTCH.	Updated to reflect no pressure ulcers identified on initial admission assessment in coding rationale of example 6. Also, updated coding guidance to reflect M0210 coding and skip patterns.
97.	Chapter 3, Section M, Page M-14	7. A patient enters the LTCH with a Stage 2 pressure ulcer. On day 2 of the patient's stay, the pressure ulcer is reassessed as a Stage 3 pressure ulcer due to the presence of adipose tissue. The pressure ulcer has heal not healed by the time of discharge, 2 weeks later.	7. A patient enters the LTCH with a Stage 2 pressure ulcer. On day 2 of the patient's stay, the wound is reassessed as a Stage 3 pressure ulcer due to the presence of adipose tissue. The wound does not heal by the time of discharge, 2 weeks later.	Revised coding scenario in example 7
98.	Chapter 3, Section M, Page M-14	**Rationale:** The Stage 2 pressure ulcer was present on admission, so M0300B1 is coded as 1 on the Admission assessment. Even though the LTCH identified further tissue damage in the pressure ulcer that was consistent with a Stage 3 pressure ulcer during the 3-day assessment period, it is the initial stage of the pressure ulcer that should be captured because it reflects the patient's condition at the time of admission. On the Discharge assessment, M0300C1 should be coded as 1 and M0300C2 should be coded as 0 because the Stage 3 pressure ulcer was not present, at that stage, on admission.	**Rationale:** The Stage 2 pressure ulcer was observed at the time of admission, so M0300B1 is coded as 1 on the Admission assessment. Even though the wound worsened during the 3-day assessment period, the initial stage of the pressure ulcer that should be captured because it reflects the patient's condition at the time of admission. On the Discharge assessment, M0300C1 should be coded as 1 and M0300C2 should be coded as 0 because the Stage 3 pressure ulcer was not present, at that stage, on admission.	Clarified coding rationale in example 7. Also, replaced present on admission with observed at the time of admission for clarity.

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99.	Chapter 3, Section M, Page M-15	8. A patient is admitted to an LTCH with one large Stage 3 pressure ulcer on the coccyx. At the time of discharge, there is some epithelialization in the center of the pressure ulcer.	8. A patient is admitted to an LTCH with one large Stage 3 pressure ulcer on the coccyx. At the time of discharge, there is some epithelialization across the pressure ulcer in the center, separating one side of the pressure ulcer from the other.	Revised coding scenario 8 for clarity
100.	Chapter 3, Section M, Page M-15	**Rationale:** At the time of discharge, the Stage 3 pressure ulcer on the coccyx that was present on admission has begun to show some healing at the center. Because this ulcer is healing and has not fully closed, it remains a Stage 3 pressure ulcer on discharge. It will continue to be considered a Stage 3 pressure ulcer until it heals; therefore, M0300C1 is coded as 1 and M0300C2 is coded as 1 on the Discharge assessment.	**Rationale:** At the time of discharge, the Stage 3 pressure ulcer on the coccyx that was observed at the time of admission has begun to show some healing at the center. Because this ulcer is healing and has not fully closed, it remains a Stage 3 pressure ulcer on discharge. It will continue to be considered a Stage 3 pressure ulcer until it heals; therefore, M0300C1 is coded as 1 and M0300C2 is coded as 1 on the Discharge assessment.	Revised rationale in coding example 8 to replace present on admission with observed at the time of admission for clarity
101.	Chapter 3, Section M, Page M-15	**Rationale:** Because there were nine Stage 2 pressure ulcers present on admission, M0300B1 is coded as 9 on the Admission assessment. At the time of discharge, the patient had 10 Stage 2 pressure ulcers. However, because there is space to enter only one digit in M0300B1, M0300B1 would be coded as 9 on the Discharge assessment. M0300B2 would be coded as 9 on the Discharge assessment because nine of the ten Stage 2 pressure ulcers that are present on discharge were present on admission.	**Rationale:** Because there were nine Stage 2 pressure ulcers observed at the time of admission, M0300B1 is coded as 9 on the Admission assessment. At the time of discharge, the patient had 10 Stage 2 pressure ulcers. However, because there is space to enter only one digit in M0300B1, M0300B1 would be coded as 9 on the Discharge assessment. M0300B2 would be coded as 9 on the Discharge assessment because nine of the ten Stage 2 pressure ulcers that are present on discharge were present on admission.	Revised rationale in coding example 9 to replace present on admission with observed at the time of admission for clarity
102.	Chapter 3, Section M, Page M-16	**Rationale:** The non-healing Stage 3 pressure ulcer is present on admission, so M0300C1 is coded as 1 on the Admission assessment. On the Discharge assessment, M0300C1 is coded 0 because a flap has been used to close the Stage 3 pressure ulcer. A flap used to close a pressure ulcer would essentially render the pressure ulcer as closed and would now be considered a surgical wound.	**Rationale:** The non-healing Stage 3 pressure ulcer is present on admission, so M0300C1 is coded as 1 on the Admission assessment. On the Discharge assessment, M0210 is coded 0 and M0300 items are skipped because a flap has been used to close the Stage 3 pressure ulcer. A flap used to close a pressure ulcer would essentially render the pressure ulcer as closed and would now be considered a surgical wound.	Updated coding rationale in example 10 to replace present on admission with observed at the time of admission. Also, updated coding guidance to reflect M0210 coding and skip patterns.

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103.	Chapter M, Section M, Page-17	*Steps for Assessment* 1. Perform a full-body (head to toe) skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	*Steps for Assessment* 1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	Simplified language in M0300D
104.	Chapter 3, Section M, Page M-17	**Did not exist**	*Steps for Assessment* 4. When completing the discharge assessment, identify the number of these pressure ulcers that were present on admission.	Added step for clarification in M0300D
105.	Chapter 3, Section M, Page M-19	*Steps for Assessment* 2. Determine the number of documented pressure ulcers/injury that are covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order (such as those used in negative-pressure wound therapy), an orthopedic device, or a cast. These ulcers/injuries are considered "unstageable" due to the inability to further assess the documented pressure ulcer/injury that is covered by a non-removable dressing/device.	*Steps for Assessment* 2. Determine the number of documented unstageable pressure ulcers/injuries related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order (such as those used in negative-pressure wound therapy [NPWT]), an orthopedic device, or a cast.	Simplified language in M0300E and revised for clarity regarding unstageable pressure ulcers
106.	Chapter 3, Section M, Page M-19	**Did not exist**	*Steps for Assessment* 3. When completing the discharge assessment, identify the number of these pressure ulcers/injuries that were present on admission.	Added step for clarification in M0300E

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107.	Chapter 3, Section M, Page M-19 to M-20	**Did not exist**	*Coding Tips* • If a pressure ulcer/injury that is observed on admission does not increase in numerical stage or become unstageable due to slough/eschar during the stay and then is unstageable due to non-removable dressing or device at discharge, the unstageable pressure ulcer/injury would be coded on the Discharge assessment and *would be coded as present on admission on the Discharge assessment.* This is because even though the stage of the pressure ulcer/injury is unknown at discharge, there is no documentation or indication that it increased in numerical stage during the stay. • If a pressure ulcer/injury that is observed on admission, increases in numerical stage or becomes unstageable due to slough/eschar during the stay and then becomes unstageable due to non-removable dressing or device at discharge, the unstageable pressure ulcer due to non-removable dressing or device would be coded on the Discharge assessment and *would not be coded as present on admission on the Discharge assessment.* This is because even though the stage of the pressure ulcer/injury is unknown at discharge, it increased in numerical stage during the stay and reverse staging is not permitted. • If a pressure ulcer/injury is observed upon removal of a non-removeable dressing/device and there was no available documentation that stated the pressure ulcer/injury existed under the non-removeable dressing/device at the time of admission, then the pressure ulcer is coded on the Discharge assessment at the observed stage at discharge (M0300x1 = 1) and that this pressure ulcer was not present on admission (M0300x2 = 0).	New coding tips added

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<tr><td>108.</td><td>Chapter 3, Section M, Page M-21</td><td>Did not exist</td><td>2. A patient is admitted to an LTCH with a known pressure ulcer/injury due to a non-removable dressing. Ten days after admission, the surgeon removed the dressing, and a Stage 2 pressure ulcer was identified. Two weeks later the pressure ulcer is determined to be a full thickness ulcer and is at that point Stage 3. It remained Stage 3 at the time of discharge.

Coding:
<table><tr><th>Item</th><th>Admission Assessment</th><th>Discharge Assessment</th></tr><tr><td>M0300C1, Number of Stage 3 pressure ulcers</td><td>Code as 0</td><td>Code as 1</td></tr><tr><td>M0300C2, Number of these Stage 3 pressure ulcers that were present upon admission</td><td></td><td>Code as 0</td></tr><tr><td>M0300E1, Number of Unstageable pressure ulcers/injuries due to nonremovable dressing/device</td><td>Code as 1</td><td>Code as 0</td></tr><tr><td>M0300E2, Number of Unstageable pressure ulcers/injuries due to nonremovable dressing/device that were present upon admission</td><td></td><td>Skip</td></tr></table>Rationale: This patient was admitted with an unstageable pressure ulcer/injury due to non-removable dressing or device, so on the admission assessment this pressure ulcer/injury is coded as 1 for M0300F1. The dressing was removed to reveal a Stage 2 pressure ulcer, and this is the first numerical stage. Subsequent to this first stage, the ulcer worsened to Stage 3 and remained at Stage 3 at discharge. On Discharge, M0300C1 is coded as 1 and M0300C2 is coded as 0, because this pressure ulcer was previously staged as a Stage 2, so on the discharge assessment it is not considered present on admission as a Stage 3.</td><td>New coding example added related to non-removable dressings</td></tr>
</table>

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
109.	Chapter 3, Section M, Page M-21	*Item Rationale* • Pressure ulcers/injuries may affect quality of life for patients because it may limit activity, be painful, and require time-consuming treatments and dressing changes.	*Item Rationale* • Although the wound bed cannot be visualized—hence the pressure ulcer cannot be numerically staged—the pressure ulcers/injuries may affect quality of life for patients because it may limit activity, be painful, and require time-consuming treatments and dressing changes.	Language added for clarity
110.	Chapter 3, Section M, Page M-22	*Item Rationale* • Visualization of the wound bed is necessary for accurate pressure ulcer/injury staging. Therefore, prior to staging, ensure that the ulcer is carefully cleansed and/or irrigated. If after careful cleansing and/or irrigation of the pressure ulcer/injury, the pressure ulcer's/injury's tissues remain obscured and therefore the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is unstageable.	*Item Rationale* • Visualization of the wound bed is necessary for accurate pressure numerical staging.	Simplified language in M0300F
111.	Chapter 3, Section M, Page M-22	**Did not exist**	*Steps for Assessment* 2. When completing the discharge assessment, identify the number of these pressure ulcers that were present on admission.	Added step for clarification in M0300F
112.	Chapter 3, Section M, Page M-23	*Coding Tips* • Pressure ulcers that are covered with slough and/or eschar such that the tissues within the ulcer cannot be assessed should be coded as unstageable because the extent of soft tissue damage (and therefore, the numerical stage) cannot be determined. Only when enough slough and/or eschar are removed to expose the extent of soft tissue damage involved can the numerical stage of the wound be determined.	*Coding Tips* • Pressure ulcers that are covered with slough and/or eschar and the wound bed cannot be visualized should be coded as unstageable because the extent of soft tissue damage (and therefore, the numerical stage) cannot be determined. Only when enough slough and/or eschar are removed to expose the extent of soft tissue damage involved can the numerical stage of the wound be determined.	Revised coding tip in M0300F for clarity

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
113.	Chapter 3, Section M, Page M-23 to M-24	**Did not exist**	*Coding Tips* • If a Stage 1 or 2 pressure ulcer/injury observed at the time of admission further deteriorates and eventually becomes unstageable due to slough or eschar at discharge, the unstageable pressure ulcer would be coded on the Discharge assessment and would not be considered as present on admission, so M0300F2 would be coded 0. This is because the pressure ulcer/injury that is assessed on discharge was not present on admission at the same stage it is observed at the time of discharge. • If a Stage 3 or 4 pressure ulcer observed on admission is unstageable due to slough or eschar on discharge, the unstageable pressure ulcer would be coded on the Discharge assessment and would not be coded as present on admission, so M0300F2 would be coded 0. • If a pressure ulcer becomes unstageable due to slough or eschar and is debrided sufficiently to be numerically staged *by discharge*, review the pressure ulcer history. If the pressure ulcer's stage increased numerically during the stay, it would be coded at that higher stage and **would not be considered nor coded as present on admission on the Discharge assessment**. In this instance, the discharge present on admission item for that higher numerical stage would be coded as 0 (M0300x2 = 0). • The following guidance is provided regarding pressure ulcers that were observed on admission that were numerically staged, become unstageable, are debrided, and subsequently become numerically stageable:	New coding tips added to M0300F

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
113. (cont)			- If a numerically-staged pressure ulcer that was observed on admission becomes unstageable due to slough or eschar during the stay (i.e., cannot be numerically staged), is debrided, and after debridement is able to be staged numerically, and the reassessed stage is higher than a previous numerical stage, it would be coded at that higher stage and **would not be considered nor coded as present on admission on the Discharge assessment (M0300x2 = 0)**. - If a numerically-staged pressure ulcer that was observed on admission becomes unstageable due to slough or eschar (i.e., cannot be numerically staged), is debrided, and after debridement is able to be staged numerically, and the reassessed stage at discharge is the same as the stage at admission, **it would be considered and coded as present on admission on the Discharge assessment at the stage at which it first becomes numerically stageable (M0300x1 = 1 and M0300x2 = 1)**. - If an unstageable pressure ulcer due to slough or eschar that was observed on admission is debrided and is subsequently able to be numerically staged and remains at the same stage at discharge **it would be considered and coded as present on admission on the Discharge assessment at the stage at which it first becomes numerically stageable** (M0300x1 = 1 and M0300x2 = 1). - If an unstageable pressure ulcer due to slough or eschar that was observed on admission, is debrided and is able to be numerically staged and subsequent to this numerical staging, the pressure ulcer further deteriorates and is staged at a higher numerical stage and/or is unstageable due to slough or eschar at discharge, the pressure ulcer **would not be considered nor coded as present on admission on the Discharge assessment (M0300x2 = 0).**	

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
114.	Chapter 3, Section M, Page M-24	1. A patient is admitted to the LTCH with eschar tissue identified on both the right and left heels, as well as a Stage 2 pressure ulcer to the coccyx. The patient's pressure ulcers are reassessed before discharge, and the Stage 2 coccyx pressure ulcer had healed. The left heel eschar became fluctuant, showed signs of infection, had to be debrided at the bedside, and was subsequently numerically staged as a Stage 4 pressure ulcer. The right heel eschar remained stable and dry (i.e., remained unstageable).	1. A patient is admitted to the LTCH with eschar tissue identified on both the right and left heels, as well as a Stage 2 pressure ulcer to the coccyx. The patient's pressure ulcers are reassessed before discharge, and the Stage 2 coccyx pressure ulcer had healed. The left heel eschar became fluctuant, showed signs of infection, had to be debrided at the bedside. The left heel wound was subsequently numerically staged as a Stage 4 pressure ulcer. The right heel eschar remained stable and dry (i.e., remained unstageable).	Clarified left heel wound was staged as a Stage 4 pressure ulcer in coding scenario of example 1
115.	Chapter 3, Section M, Page M-24 to M-25	**Rationale:** Both heels cannot be numerically staged at admission because the extent of tissue damage cannot be determined due to the eschar present, so M0300F1 is coded as 2 on the Admission assessment. The Stage 2 pressure ulcer on the coccyx healed, so M0300B1 is coded as 1 on the Admission assessment, and M0300B1 is coded as 0 on the Discharge assessment. The left heel eschar that was debrided is coded as a Stage 4 at discharge, so M0300D1 is coded as 1. This ulcer is coded in M0300D2 as 1, present on admission, on the Discharge assessment because the first time an unstageable ulcer can be numerically staged, it is present on admission at the stage it is first assessed. The right heel eschar remained stable and intact, so both M0300F1 and M0300F2 are coded as 1 on the Discharge assessment.	**Rationale:** Both heels cannot be numerically staged at admission because the extent of tissue damage cannot be determined due to the eschar present, so M0300F1 is coded as 2 on the Admission assessment. The Stage 2 pressure ulcer on the coccyx healed, so M0300B1 is coded as 1 on the Admission assessment, and M0300B1 is coded as 0 on the Discharge assessment. The left heel eschar that was debrided is coded as a Stage 4 at discharge, so M0300D1 is coded as 1. Since the left heel eschar was debrided, and the first time an unstageable ulcer/injury is staged, it is considered as present on admission at the stage it is initially assessed. Therefore, M0300D2 is coded as 1 on the Discharge assessment.	Simplified rationale in coding example 1 for clarity

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
116.	Chapter 3, Section M, Page M-25	**Rationale:** The two Stage 2 pressure ulcers on the heels that were present on admission have resolved, so M0300B1 is coded as 2 on the Admission assessment and M0300B1 is coded as 0 on the Discharge assessment. M0300D1 is coded as 1 on the Admission assessment, and M0300D1 is coded as 2 on the Discharge assessment because the patient has a new Stage 4 pressure ulcer in addition to the Stage 4 pressure ulcer that was present on admission. M0300D2 is coded as 1 on the Discharge assessment because only one of the two Stage 4 pressure ulcers present on discharge was present on admission to the LTCH.	**Rationale:** The two Stage 2 pressure ulcers on the heels that were observed at the time of admission have resolved, so M0300B1 is coded as 2 on the Admission assessment and M0300B1 is coded as 0 on the Discharge assessment. M0300D1 is coded as 1 on the Admission assessment, and M0300D1 is coded as 2 on the Discharge assessment because the patient has a new Stage 4 pressure ulcer in addition to the Stage 4 pressure ulcer that was present on admission. M0300D2 is coded as 1 on the Discharge assessment because only one of the two Stage 4 pressure ulcers present on discharge was present on admission to the LTCH.	Revised rationale in coding example 2 to replace present on admission with observed at the time of admission for clarity
117.	Chapter 3, Section M, Page M-25	3. A patient is admitted to an LTCH with one Stage 2 pressure ulcer on the left heel and a Stage 3 pressure ulcer on the coccyx. The patient transfers to a short-stay, acute-care hospital three times for repeat computerized tomography (CT) studies of his abdomen, and each time returns the same day. There is no documentation of pressure ulcer changes immediately after the patient returns from the acute-care hospital. The patient is reassessed before discharge to a nursing home, and the Stage 2 pressure ulcer on the left heel was assessed to have further tissue damage consistent with a Stage 4 pressure ulcer, as was the coccyx pressure ulcer. There was also a new Stage 3 pressure ulcer identified on the patient's left buttock.	3. A patient is admitted to an LTCH with one Stage 2 pressure ulcer on the left heel and a Stage 3 pressure ulcer on the coccyx. The patient is reassessed before discharge to a nursing home, and the Stage 2 pressure ulcer on the left heel is now a Stage 4 pressure ulcer, and he has a new Stage 3 on his left buttock area.	Simplified coding scenario in example 3 for clarity
118.	Chapter 3, Section M, Page M-27	*Steps for Assessment* 1. Perform a full-body (head to toe) skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	*Steps for Assessment* 1. Perform head-to-toe assessment. Conduct a full-body skin assessment focusing on bony prominences and pressure-bearing areas (e.g., sacrum, buttocks, heels, ankles).	Simplified language in M0300G
119.	Chapter 3, Section M, Page M-27	*Steps for Assessment* 2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is not the primary cause, **do not code here.**	*Steps for Assessment* 2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is not the primary cause, **do not code as a DTI.**	Revised for clarity

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
120.	Chapter 3, Section M, Page M-27	**Did not exist**	*Steps for Assessment* 7. When completing the discharge assessment, identify the number of these pressure ulcers that were present on admission.	Added step for clarification in M0300G
121.	Chapter 3, Section M, Page M-28	*Coding Tips* • When a lesion due to pressure presents with an intact blister and the surrounding or adjacent soft tissue does not have the characteristics of DTI, do not code here.	*Coding Tips* • When a lesion due to pressure presents with an intact blister and the surrounding or adjacent soft tissue does not have the characteristics of DTI, do not code here (see definition of Stage 2 pressure ulcer on page M-8).	Added page reference to definition of Stage 2 Pressure Ulcer
Chapter 3, Section N				
122.	Chapter 3, Section N, Page N-1	*Item Rationale* • Medication errors can lead to medication-related adverse reactions, emergency department visits, and re-hospitalizations.	*Item Rationale* • Medication errors can lead to medication-related adverse reactions, emergency department visits, and re-hospitalizations, and affects the patient's health, safety and quality of life.	Added more descriptive, comprehensive language
123.	Chapter 3, Section N, Page N-1 to N-2	*Steps for Assessment* 1. Complete a drug regimen review upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.	*Steps for Assessment* 1. Complete a drug regimen review upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. 2. Review the medical record documentation to determine if a drug regimen review was conducted upon admission) or close to the actual time of admission as possible, to identify any potential or actual clinically significant medication issues. • Medical record sources include medical records received from facilities where the patient received health care, the most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available. • Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the patient and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.	Added another step to Steps for Assessment and updated to include data sources/resources

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
124.	Chapter 3, Section N, Page N-1	**DEFINITIONS** **DRUG REGIMEN REVIEW** The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues. Note: The drug regimen review includes all medications, prescribed and over the counter (OTC) (including nutritional supplements, vitamins and herbals); administered by any route (for example, oral, topical, inhalant, injection, sublingual, parenteral, and by infusion). The drug regimen review also includes total parenteral nutrition (TPN); and, oxygen.	**DEFINITIONS** **DRUG REGIMEN REVIEW** The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues. Note: The drug regimen review includes all medications, prescribed and over the counter (OTC) (including nutritional supplements, vitamins and homeopathic and herbal products); administered by any route (for example, oral, topical, inhalant, injection, sublingual, parenteral, and by infusion). The drug regimen review also includes total parenteral nutrition (TPN); and, oxygen.	Revised language for clarity and alignment with SNF and IRF
125.	Chapter 3, Section N, Page N-2	**DEFINITIONS** **POTENTIAL (OR ACTUAL) CLINICALLY SIGNIFICANT MEDICATION ISSUE** A clinically significant medication issue is a potential or existing issue that, in the clinician's professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).	**DEFINITIONS** **POTENTIAL (OR ACTUAL) CLINICALLY SIGNIFICANT MEDICATION ISSUE** A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.	Revised for consistency
126.	Chapter 3, Section N, Page N-3	Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed medications, and the clinician determines this is a potential or actual clinically significant medication issue.	Patient takes multiple non-prescribed medications (OTCs, herbal and homeopathic products) that could interact with prescribed medications, and the clinician determines this is a potential or actual clinically significant medication issue.	Revised language for clarity and alignment with SNF and IRF

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
127.	Chapter 3, Section N, Page N-3	Note: The drug regimen review includes all medications, prescribed and OTC (including nutritional supplements, vitamins and herbals); administered by any route (for example, oral, topical, inhalant, injection, sublingual, parenteral, and by infusion). The drug regimen review also includes total parenteral nutrition (TPN); and, oxygen.	*Coding Tips* • A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence. • The drug regimen review includes all medications, prescribed and OTC (including nutritional supplements, vitamins and herbal and homeopathic products); administered by any route (for example, oral, topical, inhalant, injection, sublingual, parenteral, and by infusion). The drug regimen review also includes total parenteral nutrition (TPN); and, oxygen.	Revised language for clarity and alignment with SNF and IRF. Also, moved to Coding Tips.
128.	Chapter 3, Section N, Page N-3	*Data Sources/Resources for Coding the Items May Include:* • Medical record (within the electronic health record [EHR]/ electronic medical record [EMR], and/or paper medical records as transferred from the acute care hospital). • Medication list (for example, medication administration record [MAR], home medication list). • Clinical communication notes (including pharmacy, nursing, physician/physician-designee, and other applicable clinical notes). • Acute care hospital discharge summary and discharge instructions. • Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, patient and patient family/significant other).	**Removed**	Moved to Steps for Assessment

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
129.	Chapter 3, Section N, Page N-3	1. The admitting LTCH nurse reviewed and compared the acute care hospital discharge medication orders and the LTCH physician's admission medication orders for Ms. W. The nurse interviewed Ms. W, who confirmed the medications she was taking for her current medical conditions. Upon the nurse's request, the pharmacist reviewed and approved the medication orders as appropriate for the patient. As a result of this collected and communicated information, the RN determined that there were no identified potential or actual clinically significant medication issues.	1. The admitting LTCH nurse reviewed and compared the acute care hospital discharge medication orders and the LTCH physician's admission medication orders for Ms. W. The nurse interviewed Ms. W, who confirmed the medications that she was taking for her current medical conditions. The pharmacist reviewed and confirmed the medication orders as appropriate for the patient. As a result of this collected and communicated information, the RN determined that there were no identified potential or actual clinically significant medication issues.	Revised language for clarity and accuracy

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
130.	Chapter 3, Section N, Page N-3 to N-4	1. Mr. C was admitted to an LTCH after undergoing mitral valve replacement cardiac surgery. The acute care hospital discharge information indicated that Mr. C had a mechanical mitral heart valve and was to continue receiving anticoagulant medication. While completing a review and comparison of the patient's discharge healthcare records from the acute care hospital with the LTCH physician's admission medication orders, an RN noted that the admitting physician ordered the patient's anticoagulation medication to be held if the INR was below 1.0. The RN questioned the INR level listed on the admitting physician's order, based on the LTCH's established INR therapeutic parameters of (2.0-3.0) which prompted the RN to call the physician immediately to address the issue. **Coding:** N2001, Drug Regimen Review, would be coded 1, Yes - Issues found during review. **Rationale:** The admitting RN reviewed and compared the patient's discharge healthcare records from the acute care hospital with the LTCH physician's admission medication orders. The RN identified a discrepancy between the physician's ordered INR level (1.0) for this patient and the LTCH's standard therapeutic range (2.0 – 3.0. The RN considered this to be a potential clinically significant medication issue because the admitting LTCH physician's order was to hold the anticoagulation medication for an INR of 1.0, which is below the LTCH's established therapeutic INR parameters (2.0 – 3.0) which could lead to potential clotting issues.	1. Mr. C was admitted to an LTCH after undergoing mitral valve replacement cardiac surgery. The acute care hospital discharge information indicated that Mr. C had a mechanical mitral heart valve and was to continue receiving anticoagulant medication. While completing a review and comparison of the patient's discharge healthcare records from the acute care hospital with the LTCH physician's admission medication orders, an RN noted that the admitting physician ordered the patient's anticoagulation medication to be held if the INR was below 1.0. The RN questioned the INR level listed on the admitting physician's order, based on the LTCH's established INR therapeutic parameters of 2.5-3.5 which prompted the RN to call the physician immediately to address the issue. **Coding:** N2001, Drug Regimen Review, would be coded 1, Yes - Issues found during review. **Rationale:** The admitting RN reviewed and compared the patient's discharge healthcare records from the acute care hospital with the LTCH physician's admission medication orders. The RN identified a discrepancy between the physician's ordered INR level (1.0) for this patient and the LTCH's standard therapeutic range (2.5 – 3.5). The RN considered this to be a potential clinically significant medication issue because the admitting LTCH physician's order was to hold the anticoagulation medication for an INR of 1.0, which is below the LTCH's established therapeutic INR parameters (2.5 – 3.5) which could lead to potential clotting issues.	Revised for clinical accuracy

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
131.	Chapter 3, Section N, Page N-4	**DEFINITIONS** **MEDICATION FOLLOW-UP** The process of contacting a physician (or physician-designee) to communicate the identified medication issue and addressing all physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day (at the latest).	**DEFINITIONS** **MEDICATION FOLLOW-UP** The process of contacting a physician (or physician-designee) to communicate the identified medication issue and addressing all physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day at the latest.	Revised language for consistency
132.	Chapter 3, Section N, Page N-5	*Steps for Assessment* 1. Determine if the following criteria were met for all potential and actual clinically significant medication issues that were identified upon admission: • Two-way communication between the clinician(s) and the physician (or physician-designee) was completed by midnight of the next calendar day; AND • All physician (or physician-designee) prescribed/recommended actions were completed by midnight of the next calendar day.	*Steps for Assessment* 1. Complete a drug regimen review upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically signification issues. Determine if the following criteria were met for all potential and actual clinically significant medication issues that were identified during the admission drug regimen review: • Two-way communication between the clinician(s) and the physician (or physician-designee) was completed by midnight of the next calendar day; AND • All physician (or physician-designee) prescribed/recommended actions were completed by midnight of the next calendar day. Medical record sources include medical records received from facilities where the patient received health care, the most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available. Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the patient and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.	Data Sources/Resources section incorporated to align across settings

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133.	Chapter 3, Section N, Page N-6	*Data Sources/Resources for Coding the Items May Include:* • Medical record (within the electronic health record [EHR]/ electronic medical record [EMR], and/or paper medical records as transferred from the acute care hospital). • Medication list (for example, medication administration record [MAR], home medication list). • Clinical communication notes (including pharmacy, nursing, physician/physician-designee, and other applicable clinical notes). • Acute care hospital discharge summary and discharge instructions. • Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, patient and patient family/significant other).	**Removed**	Moved to Steps for Assessment section
134.	Chapter 3, Section N, Page N-6 to N-7	1. Mr. B was admitted to the LTCH with a history of pneumonia. The acute care facility medication record indicated that the patient was on a seven-day course of antibiotics and the patient had 3 remaining days of this treatment plan. The LTCH pharmacist reviewing the discharge records from the acute care facility and the LTCH admission medication orders noted that the patient had an order for an anticoagulant drug as well as the antibiotic. On the date of admission, the LTCH pharmacist contacted the LTCH physician caring for Mr. B and noted concern about a potential increase in the patient's INR with this combination of medications, which placed the patient at greater risk for bleeding. The LTCH physician provided orders for laboratory testing so that the patient's INR levels would be monitored over the next three days, starting today. However, the first INR laboratory test did not occur until after midnight of the next calendar day.	1. Mr. B was admitted to the LTCH with an active diagnosis of pneumonia and atrial fibrillation. The acute care facility medication record indicated that the patient was on a seven-day course of antibiotics and the patient had 3 remaining days of this treatment plan. The LTCH pharmacist reviewing the discharge records from the acute care facility and the LTCH admission medication orders noted that the patient had an order for an anticoagulant medication that required INR monitoring as well as the antibiotic. On the date of admission, the LTCH pharmacist contacted the LTCH physician caring for Mr. B and communicated a concern about a potential increase in the patient's INR with this combination of medications, which placed the patient at greater risk for bleeding. The LTCH physician provided orders for laboratory testing so that the patient's INR levels would be monitored over the next three days, starting that day. However, the first INR laboratory test did not occur until after midnight of the next calendar day.	Revised to align with SNF and IRF

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
135.	Chapter 3, Section N, Page N-8	*Steps for Assessment* 1. Review the patient's medical record and all available data sources and identify all potential and actual clinically significant medication issues that were identified upon admission and throughout the patient's stay. 2. Determine if the following criteria were met for all potential and actual clinically significant medication issues that were identified upon admission or at any time throughout the patient's stay (admission through discharge): • Two-way communication between the clinician(s) and the physician (or physician-designee) was completed by midnight of the next calendar day; AND • All physician (or physician-designee) prescribed/recommended actions were completed by midnight of the next calendar day.	*Steps for Assessment* 1. Review the patient's medical record and all available data sources and identify all potential and actual clinically significant medication issues that were identified upon admission and throughout the patient's stay. 2. Determine if the following criteria were met for all potential and actual clinically significant medication issues that were identified upon admission or at any time throughout the patient's stay (admission through discharge): • Two-way communication between the clinician(s) and the physician (or physician-designee) was completed by midnight of the next calendar day; AND • All physician (or physician-designee) prescribed/recommended actions were completed by midnight of the next calendar day. Medical record sources include medical records received from facilities where the patient received health care, the most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available. Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the patient and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.	Data Sources/Resources section incorporated to align with SNF and IRF
136.	Chapter 3, Section N, Page N-8	• **Code 0, No,** if all clinically significant medication issues identified at admission or at any time throughout the patient stay (admission through discharge) were not addressed **by midnight of the next calendar day.**	• **Code 0, No,** if the facility did not contact the physician (or physician-designee) and completed prescribed/recommended actions **by midnight of the next calendar day** each time clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge).	Revised for clarity and guidance

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
137.	Chapter 3, Section N, Page N-9	• **Code 1, Yes,** if all clinically significant medication issues identified at admission or at any time throughout the patient stay (admission through discharge) were addressed **by midnight of the next calendar day**.	• **Code 1, Yes,** if the facility contacted the physician (or physician-designee) and completed prescribed/recommended actions **by midnight of the next calendar day** each time clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge).	Revised for clarity and guidance
138.	Chapter 3, Section N, Page N-9	*Data Sources/Resources for Coding the Items May Include:* • Medical record (within the electronic health record [EHR]/ electronic medical record [EMR], and/or paper medical records as transferred from the acute care hospital). • Medication list (for example, medication administration record [MAR], home medication list). • Clinical communication notes (including pharmacy, nursing, physician/physician-designee, and other applicable clinical notes). • Acute care hospital discharge summary and discharge instructions. • Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, patient and patient family/significant other).	**Removed**	Moved to Steps for Assessment

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
139.	Chapter 3, Section N, Page N-10	1. At discharge from the LTCH, the discharging licensed clinician reviewed Ms. T's medical records, which included admission through her entire stay at the LTCH, and noted that a clinically significant medication issue was documented during the admission assessment. At admission, Ms. T was taking two antibiotics – an antibiotic prescribed during a recent acute care hospital stay that the LTCH physician had included in her LTCH medication orders, and a second antibiotic prescribed by the LTCH physician upon admission that is toxic to the patient's kidneys due to the patient's renal disease. Ms. T's medical records further indicated that an LTCH nurse had attempted to contact the assigned LTCH physician several times about this clinically significant medication issue. After midnight of the second calendar day, the LTCH physician communicated to the nurse via a telephone order to administer a newly-prescribed antibiotic in addition to the previously-prescribed antibiotic. The nurse implemented the physician's order. Upon further review of Ms. T's medical records, the discharging nurse determined that no additional clinically significant medication issues had been recorded throughout the remainder of Ms. T's stay. **Coding:** N2005, Medication Intervention, would be coded 0, No. *(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review. N2003, Medication Follow-up, would have been coded 0, No.)* **Rationale:** Coding of this assessment item includes all clinically significant medication issues identified at admission or at any time throughout the patient stay that were or were not communicated to the physician, with prescribed/recommended actions completed by midnight of the next calendar day. In this scenario, although no potential	1. At discharge from the LTCH, the discharging licensed clinician reviewed Ms. T's medical records, which included admission through her entire stay at the LTCH, and noted that a clinically significant medication issue was documented during the admission assessment. At admission, Ms. T was taking two antibiotics – an antibiotic prescribed during a recent acute care hospital stay that the LTCH physician had included in her LTCH medication orders, and a second antibiotic prescribed by the LTCH physician upon admission that is known for drug-induced nephrotoxicity. Ms. T has renal disease. Ms. T's medical records further indicated that an LTCH nurse had attempted to contact the assigned LTCH physician several times about this clinically significant medication issue. After midnight of the second calendar day, the LTCH physician communicated to the nurse via a telephone order to administer a newly-prescribed antibiotic in addition to the previously-prescribed antibiotic. The nurse implemented the physician's order. Upon further review of Ms. T's medical records, the discharging nurse determined that no additional clinically significant medication issues had been recorded throughout the remainder of Ms. T's stay. **Coding:** N2005, Medication Intervention, would be coded 0, No. The facility did not contact the physician (or physician-designee) and complete prescribed/recommended actions by midnight of the next calendar day each time clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge). *(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review. N2003, Medication Follow-up, would have been coded 0, No The facility did not contact the physician (or physician-designee) and complete prescribed/recommended actions by midnight of the next calendar day.)*	Revised and added language for clarity and further guidance

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	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
139. (cont)		or actual clinically significant medication issues were identified by the nurse during the remainder of the stay, notification of the medication issue identified at admission, despite repeated communication attempts by the nurse, was not addressed by the physician by midnight of the next calendar day.	**Rationale:** Coding of this assessment item includes all clinically significant medication issues identified at admission or at any time throughout the patient stay that were or were not communicated to the physician, with prescribed/recommended actions completed by midnight of the next calendar day. In this scenario, although no potential or actual clinically significant medication issues were identified by the nurse during the remainder of the stay, notification of the medication issue identified at admission, despite repeated communication attempts by the nurse, was not addressed by the physician by midnight of the next calendar day.	
140.	Chapter 3, Section N, Page N-10 to N-11	1. At discharge, the licensed clinician completing a review of Ms. K's medical records identified and noted two clinically significant medication issues during the patient's stay. The patient's record included an order to hold the medication Ms. K was receiving for deep vein thrombosis prophylaxis, and based on the patient's clinical status, the LTCH RN determined that the physician needed urgent notification. The day after the observed symptoms were identified and physician notification occurred, the LTCH physician provided an order to resume the medication, which was carried out by the nursing staff within the hour. In addition, a licensed clinician identified a clinically significant medication issue during the admission assessment period and contacted the physician on the same day. Both medication issues identified during the patient's stay were communicated and addressed by midnight of the next calendar day, and there were no additional clinically significant medication issues identified during the rest of the LTCH stay.	1. At discharge, the licensed clinician completing a review of Ms. K's medical records identified and noted two clinically significant medication issues during the patient's stay. The patient's record included an order to hold the medication Ms. K was receiving for deep vein thrombosis prophylaxis for a scheduled procedure. However, this medication had not been restarted 48 hours post-procedure and the LTCH RN determined that the physician needed urgent notification. The day after the notification occurred, the LTCH physician provided an order to resume the medication, which was carried out by the nursing staff within the hour. In addition, a licensed clinician identified a clinically significant medication issue had occurred during the admission assessment period and the physician had been contacted on the same day. Both medication issues identified during the patient's stay (admission through discharge) were communicated and addressed by midnight of the next calendar day, and there were no additional clinically significant medication issues identified during the remainder of the LTCH stay.	Revised and added language for clarity and further guidance

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Change Table Summarizing Revisions to the LTCH QRP Manual Version 4.0 – Revised May 2018 (continued)

	Chapter, Section, Page	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised November 2017	LTCH QRP Manual Version 4.0 – Effective July 1, 2018: Revised May 2018	Description of Change
140. (cont)		**Coding:** N2005, Medication Intervention, would be coded as 1, Yes. *(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review. N2003, Medication Follow-up, would have been coded 1, Yes.)* **Rationale:** While a medication error was identified as a clinically significant medication issue at admission, it was resolved by midnight of the next day. Further, the drug regimen review conducted at discharge included the entire patient stay (admission through discharge). During the patient's stay an additional clinically significant medication issue was identified. The identified clinically significant medication issues identified at admission and during the stay were communicated to the physician and resolved through completion of prescribed/recommended actions by midnight of the next calendar day.	**Coding:** N2005, Medication Intervention, would be coded as 1, Yes. The facility did contact the physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge). *(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review. N2003, Medication Follow-up, would have been coded 1, Yes. The facility contacted a physician by midnight of the next calendar day and completed prescribed recommended actions in response to the identified potential clinically significant medication issue.)* **Rationale:** While a medication issue was identified as a clinically significant medication issue at admission, it was resolved by midnight of the next day. Further, the drug regimen review conducted at discharge included the entire patient stay (admission through discharge). During the patient's stay a second clinically significant medication issue was identified. The identified clinically significant medication issues identified at admission and during the stay were communicated to the physician and resolved through completion of prescribed/recommended actions by midnight of the next calendar day.	
Chapter 3, Section O				
141.	Chapter 3, Section O, Page O-14	As of 2017, the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) continues to recommend annual influenza vaccinations for all persons aged 6 months and older in the United States.[2]	The Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) continues to recommend annual influenza vaccinations for all persons aged 6 months and older in the United States.[2]	Removed reference to year