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

This chapter provides item-by-item coding instructions for long-term care hospital (LTCH) staff members to complete each section of the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set. The goal of this chapter is to provide LTCH staff with the rationale and guidance necessary to accurately complete each item of the LTCH CARE Data Set.

## 3.1 Using This Chapter

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

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

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

Additional layout characteristics to note include the following:

- Important terms are defined in a box next to the item throughout *The Centers for Medicare & Medicaid Services Long-Term Care Hospital Quality Reporting Program Manual*. These and other definitions of interest are also included in ***Appendix A***: ***Glossary and Common Acronyms***.
- When an item needs to be completed only in certain situations (e.g., only at admission), the item's coding instructions note this information in italics.

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

**Table 3-1**
**LTCH CARE Data Set Sections**

| Section | Title | Intent |
|---|---|---|
| A | Administrative Information | This section obtains key information that uniquely identifies each patient, the LTCH in which he or she receives health care services, and the reason(s) for assessment. |
| B | Hearing, Speech, and Vision | This section includes B0100. Comatose, BB0700. Expression of Ideas and Wants, and BB0800. Understanding Verbal and Non-Verbal Content. The intent of these items is to document the patient's ability to understand and communicate with others. |
| C | Cognitive Patterns | This section includes C1610. Signs and Symptoms of Delirium (from CAM©). The intent of this item is to determine the patient's attention, orientation, and ability to register and recall new information. |
| GG | Functional Status: Functional Abilities and Goals | This section includes GG0100. Prior Functioning: Everyday Activities, GG0110. Prior Device Use, GG0130. Self-Care, and GG0170, Mobility. This section assesses the patient's need for assistance with functional activities. |
| H | Bladder and Bowel | This section includes H0350. Bladder Continence and H0400. Bowel Continence. |
| I | Active Diagnoses | The items in this section are intended to indicate the presence of select diagnoses that influence a patient's functional outcomes, ventilator liberation outcomes, or a patient's risk for the development or worsening of pressure ulcers/injuries. |
| J | Health Conditions | This section includes J1800. Any Falls Since Admission and J1900. Number of Falls Since Admission. These items are intended to code any falls since admission in addition to any injury caused by falls. |
| K | Swallowing/ Nutritional Status | This section includes K0200A. Height and K0200B. Weight. These items assess the patient's body mass index (BMI) using the patient's height and weight. |
| M | Skin Conditions | The items in this section document the presence, appearance, and change of pressure ulcers/injuries. |
| 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. |
| O | Special Treatments, Procedures, and Programs | This section includes O0100. Special Treatments, Procedures, and Programs and O0250. Influenza Vaccine. The intent of the items in this section is to identify any special treatments, procedures, and programs that the patient received during the stay, including spontaneous breathing trial (SBT) for ventilator liberation, IV vasoactive medication, and influenza vaccination status. O0150. Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar or Continuous Positive Airway Pressure [CPAP] Breathing Trial) by Day 2 of the LTCH Stay and O0200. Ventilator Liberation Rate have been added to assess ventilator weaning processes and outcomes. |
| Z | Assessment Administration | The items in this section provide signatures of individuals completing the LTCH CARE Data Set and signature of individual verifying LTCH CARE Data Set assessment completion for a patient record. |

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

1. **Read this manual. It is essential.**
   - *The Centers for Medicare & Medicaid Services Long-Term Care Hospital Quality Reporting Program Manual* is your *primary* source of information for completing the LTCH CARE Data Set.
   - Familiarize yourself with how this manual is organized.
   - Use the information in this chapter correctly to increase the accuracy of your facility's LTCH CARE Data Set patient assessment records.
   - Be certain that you understand the intent and rationale for coding items on the LTCH CARE Data Set.
   - LTCHs should also become familiar with the content of ***Chapters 1, 2, 4***, and ***5***. These chapters provide the framework and supporting information for data collected and submitted using the LTCH CARE Data Set for the LTCH Quality Reporting Program (QRP).
   - For updates, check the LTCH QRP Web site regularly at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html.
   - If you require further assistance (e.g., clarifications, questions, or issues), submit your inquiry to the appropriate Centers for Medicare & Medicaid (CMS) LTCH CARE Data Set contact listed in ***Appendix B*** or to the LTCH Quality Questions Help Desk at LTCHQualityQuestions@cms.hhs.gov.
2. **Review the LTCH CARE Data Set.**
   - Notice how the sections are organized and where information should be recorded.
   - Work through one section at a time.
   - Examine the item wording and response categories as provided on the LTCH CARE Data Set. For definitions and coding instructions for each item, refer to the appropriate ***Chapter 3*** section.
3. **Complete a thorough review of Chapter 3.**
   - Review procedural instructions, timeframes, and general coding conventions.
   - Become familiar with each item's intent, rationale, and steps for assessment.
   - Become familiar with the item itself and with its coding choices and responses, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item.
   - Consider completing a paper version of the LTCH CARE Data Set as a test case for a patient at your facility by entering the appropriate codes on the LTCH CARE Data Set. Make a note of where your understanding could benefit from additional information, training, and use of the varying skill sets of the staff at your facility. Be sure to explore all resources available to you.

- Read through the instructions that apply to each section as you are completing this test case. Work through the manual and the LTCH CARE Data Set one section at a time until you are comfortable coding items. Make sure you understand the information in each before proceeding to the next section.
- Review the test case once it is completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code Skin Conditions items?
- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.
- Would you now complete any items on your initial test case differently?

4. **Use the information in this chapter.**
   - Where clarification is needed, review the intent, rationale, and specific coding instructions for each item in question.

## 3.3 Coding Conventions

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

- The standard assessment period for the LTCH CARE Data Set begins **2 calendar days** prior to the Assessment Reference Date (ARD) and ends on the ARD, for a total assessment period of 3 days, unless otherwise stated.
- If the patient leaves the LTCH during the assessment period, the assessment period will include the stay at another hospital/facility, provided the patient returns to the LTCH within 3 calendar days.
  - Example: A patient is admitted to the LTCH on October 1, 2014, at 7:00 p.m. On October 2, 2014, at 8:00 a.m., the patient is transferred to a short-term acute-care hospital. The patient returns to the LTCH on October 4, 2014, at 6:00 p.m. The assessment period for the patient's admission assessment will be the day of admission (October 1, 2014) through the ARD (which can be no later than October 3, 2014, at 11:59 p.m.), even though the patient was not in the LTCH during part of the assessment period.
- In a few instances, coding one item will govern whether coding is necessary for one or more additional items. This is called a *skip pattern*. The instructions direct the assessor to skip over the next item (or several items) and go on to another area of the item set. When you encounter a skip pattern, leave the item blank, and move on to the next item as directed.
  - Example: On a Planned Discharge assessment, if item **M0210, Unhealed Pressure Ulcers/Injuries** is **coded as 0, No** (the patient does not have one or more unhealed pressure ulcers/injuries), the admission assessment form directs the assessor to skip to **N2005, Medication Intervention**. In this case, the intervening items (M0300A through M0300G) would not be coded (i.e., left blank) because a skip pattern is created. If M0210 is **coded as 1, Yes** (the patient has one or more unhealed pressure

ulcers/injuries), then the assessor would continue to code the next LTCH CARE Data Set item, **M0300A**.

- When coding instructions direct the assessor to "check all that apply," use a check mark to indicate which condition(s) are met (e.g., **A1000, Race/Ethnicity**, boxes A–F). If none of the conditions are met, these boxes remain blank. Be aware that a "check all that apply" item may have a checkbox for "Other," indicating that none of the other options apply.
- Use a numeric response (a number or preassigned value) in blank boxes (e.g., **A0800, Gender**).
- Each response box should contain only one character (numeric or alphabet). For example, you should enter only the number 2 in a box, not 02, or .2.

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

| 1 | 0 | - | 0 | 1 | - | 2 | 0 | 1 | 2 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

- Several LTCH CARE Data Set items allow a dash (–) value to be entered and submitted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. CMS allows the use of a dash for some items, so as we do not want to force providers to provide data to which they do not have access, because we want data to be as accurate as possible. CMS realizes that the use of a dash is sometimes necessary, but LTCHs should limit the use of the dash to only those items for which they were unable to obtain assessment data, or for items that were intentionally left unanswered by the LTCH. When a provider enters a dash for an item that is necessary to calculate the quality measure, a warning will be issued that states the use of a dash may subject the LTCH to a 2 percentage point reduction to their applicable annual payment update (APU). Please note that we issue this warning as a courtesy and reminder that a given item is required to help ensure that providers have entered the default response of a dash intentionally.
  - A dash value indicates that an item was not assessed or that no information is available to complete the item.
  - Some items may be completed with a dash. For example, item **A1000, Race/Ethnicity,** may be completed with a dash if ethnicity is unknown.
  - A few items where a dash value is not allowed include identification items in Section A (e.g., **A0250, Reasons for Assessment** and **A0210, Assessment Reference Date**).
  - To determine whether a specific item allows a dash value, refer to the LTCH CARE Data Submission Specifications and associated errata files, at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html.
  - Please also refer to ***Appendix D*** of this LTCH QRP Manual for more information regarding the overview of data elements used for reporting assessment-based quality measures for the LTCH CARE Data Set.

- When the term *physician* is used in this manual, it should be interpreted as including providers such as nurse practitioners, physician assistants, and clinical nurse specialists, if allowable under State licensure laws.
- The word *significant* is used several times throughout the manual. The term may have different connotations depending on the circumstances in which it is used. For the LTCH CARE Data Set, the term *significant*, when discussing clinical, medical, or laboratory findings, refers to supporting evidence that is considered when selecting or coding a diagnosis, and therefore reflects clinical judgment. When the term is used to refer to relationships between people, as in "significant other," it means a person, such as a family member or a close friend who is important or influential in the life of the patient.
- When completing the LTCH CARE Data Set, some items require a count or measurement; however, there are instances in which the actual results of the count or measurement are greater than the number of available boxes—for example, number of pressure ulcers/injuries. In these cases, maximize the count or measurement by placing a "9" in each box. The correct number should be documented in the patient's medical record.
  - Example: If a patient has 10 Stage 2 pressure ulcers, the LTCH would enter 9 in **M0300B1, Number of Stage 2 pressure ulcers**. The LTCH should document 10 Stage 2 pressure ulcers in the patient's medical record.