The Centers for Medicare & Medicaid Services
LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD AND EVALUATION (CARE) DATA SET (LCDS) MANUAL

Version 5.3 Change Table

CMS Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Contacts

For further information regarding the LTCH QRP, please visit the CMS LTCH QRP Web site: https://www.cms.gov/medicare/quality/long-term-care-hospital

Questions regarding information presented in this manual should be directed to LTCHQualityQuestions@cms.hhs.gov

LCDS 5.3 Item Set

Below is a list of changes to the LCDS V5.3

Section	Item #	Added/Removed	Item Description
CH3 Section A	A0800	Removed	Gender
CH3 Section A	A0810	Added	Sex
CH3 Section A	A1250	Removed	Transportation
CH3 Section A	A1255	Added	Transportation
CH3 Section O	O0350	Removed from the Expired Assessment	Patient's COVID-19 Vaccination Is Up to Date

Note: Guidance has been added to the Manual pages for all the new items listed above.

All Sections

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
0.1	All sections	--	Where applicable, the manual is edited for the following: formatting, grammar, stylistic edits, improved clarity, updated dates, updated references, updated resources, updated web links, reorganized information, updated version number from 5.1 to 5.3.	--
0.2	All sections	Version 5.1, Effective October 1, 2024	Version 5.3, Effective October 1, 2026	Updated version number and effective date in the footer.
0.3	All sections	The ARD for an admission record is at most the third calendar day of the patient's stay.	The ARD for an admission record is **at most** the ~~third~~ fourth calendar day of the patient's stay.	Updated the Assessment Reference Date for the admission assessment from a 3-day assessment window to a 4-day assessment window (admission date plus 3 calendar days).
0.4	All Sections	Health care	healthcare	Updated all occurrences of health care to healthcare.

Chapter 1

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
1.1	Chapter 1, Page 1-2	(2) Use of the LCDS to collect and submit standardized patient assessment data with respect to the following categories as specified in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act: • Functional status. • Cognitive function. • Special services, treatments, and interventions. • Medical conditions and comorbidities. • Impairments. • Social determinants of health (SDOH).	(2) Use of the LCDS to collect and submit standardized patient assessment data with respect to the following categories as specified in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act: • Functional status. • Cognitive function. • Special services, treatments, and interventions. • Medical conditions and comorbidities. • Impairments. • ~~Social determinants of health (SDOH).~~	Removal of SDOH based on FY26 IPPS/LTCH PPS Final Rule.

Chapter 2

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
2.1	Chapter 2, Page 2-2	The -3900 edit (warning) is in place as a helpful reminder to staff completing the assessment that the item is required and not completing the item may result in a 2 percent reduction to the LTCH’s applicable fiscal year Annual Payment Update (APU).	The -3900 ~~edit (warning) is~~, -4014, and 3954 edits (warnings) are in place as a helpful reminder to staff completing the assessment that the item is required and not completing the item may result in a 2 percent reduction to the LTCH’s applicable fiscal year Annual Payment Update (APU).	Updating list of warnings for required items.

Chapter 3, Overview

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.0.1	Chapter 3, Overview, Page 3-5	**3.3 Coding Conventions** Several standard conventions should be used when completing the LCDS: • The standard assessment period for the LCDS 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. o Example: A patient is admitted to the LTCH on October 1, 2023 at 7:00 p.m. On October 2, 2023, 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, 2023, at 6:00 p.m. The assessment period for the patient's admission assessment will be the day of admission (October 1, 2023) through the ARD (which can be no later than October 3, 2023, at 11:59 p.m.), even though the patient was not in the LTCH during part of the assessment period	**3.3 Coding Conventions** Several standard conventions should be used when completing the LCDS: The standard assessment period for the LCDS ~~begins **2 calendar days** prior to~~ differs for the ~~Assessment Reference Date (ARD)~~Admission and ~~ends on the ARD, for a total assessment period of 3 days ,~~Discharge Assessments unless otherwise stated~~.~~: • The assessment period for the Admission assessment begins **3 calendar days** prior to the ARD and ends on the ARD for a total assessment period of 4 days after admission. o Note: Although the ARD for the admission assessment may occur no later than the fourth calendar day of the LTCH stay (the day of admission plus three calendar days), this does not change the timeframe for completing Item O0150 (Spontaneous Breathing Trial). Item O0150 must still be completed by Day 2 of the LTCH stay (the day of admission plus one calendar day).	Updated the Assessment Reference Date for the admission assessment from a 3-day assessment window to a 4-day assessment window (admission date plus 3 calendar days) *This update continues through the remainder of the LCDS V5.3 Guidance Manual.

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
			• The assessment period for the Discharge assessment begins **2 calendar days** prior to the discharge date and ends on the discharge date for a total assessment period of 3 days before discharge. • 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. o Example: A patient is admitted to the LTCH on October 1, 2023 at 7:00 p.m. On October 2, 2023, 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, 2023, at 6:00 p.m. The assessment period for the patient's admission assessment will be the day of admission (October 1, 2023) through the ARD (which can be no later than October ~~3~~4, 2023, at 11:59 p.m.), even though the patient was not in the LTCH during part of the assessment period.	

Chapter 3, Section A

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.A.1	Chapter 3, Section A, Page A-16	**A0800. Gender** *1- Male; 2- Female* **Item Rationale** • Records the gender of the patient for identification purposes. • Allows records for the same patient to be matched in iQIES. **Coding Instructions** Enter the one-digit code that corresponds to the patient's gender. • **Code 1,** if patient is male. • **Code 2,** if patient is female.	[Removed]	Removal of item A0800. Gender
3.A.2	Chapter 3, Section A, Page A-16	--	**A0810. Sex** *1- Male; 2- Female* **Item Rationale** • Records the sex of the patient for identification purposes. • Allow records for the same patient to be matched in iQIES. **Coding Instructions** • **Code 1,** if patient is male. • **Code 2,** if patient is female.	Addition of item A0810. Sex and coding instructions

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.A.3	Chapter 3, Section A, Page A-18	**Item Rationale** • The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity. • The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards. • Collection of ethnicity data is an important step in improving quality of care and health outcomes. • Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute care settings. • These categories are NOT used to determine eligibility for participation in any Federal program.	**Item Rationale** • ~~The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity.~~ • ~~The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.~~ • ~~Collection of ethnicity data is an important step in improving quality of care and health outcomes.~~ • Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple ~~post-acute care settings~~ healthcare settings and is an important step in improving quality of care and health outcomes. • These categories are NOT used to determine eligibility for participation in any Federal program.	Revisions to item rationale and steps for assessment for A1005. Ethnicity

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.A.4	Chapter 3, Section A, Page A-20	**Item Rationale** • The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including race. • The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards. • Collection of race data is an important step in improving quality of care and health outcomes. • Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute care settings. • These categories are NOT used to determine eligibility for participation in any Federal program.	**Item Rationale** • ~~The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including race.~~ • ~~The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.~~ • ~~Collection of race data is an important step in improving quality of care and health outcomes.~~ • Standardizing self-reported data collection for race allows for the equal comparison of data across multiple healthcare settings and is an important step in improving quality of care and health outcomes. ~~post-acute care settings.~~ These categories are NOT used to determine eligibility for participation in any Federal program.	Revisions to item rationale and steps for assessment for A1010. Race

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
		Steps for Assessment 1. Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race. • Individuals may be more comfortable if this and the subsequent question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their ethnic background."	**Steps for Assessment** 1. Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race. • ~~Individuals may be more comfortable if this and the subsequent question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their ethnic background."~~	
3.A.5	Chapter 3, Section A, Page A-27-28	**A1250. Transportation** **Item Rationale** • Access to transportation for ongoing health care and medication access needs is essential to effective care management. • Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.	[Removed]	Removal of item A1250. Transportation

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
		Steps for Assessment 1. Ask the patient: • "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?" • "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?" 2. Patients should be offered the option of selecting more than one yes designation, if applicable. 3. If the patient **is unable to respond**, a proxy response may be used. 4. If neither the patient nor a proxy is able to provide a response to this item, medical record documentation may be used. 5. If the patient **declines to respond**, do not code based on proxy input or medical record documentation.		

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
		Coding Instructions *Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.* • **Code A,** if the patient indicates that lack of transportation has kept the patient from medical appointments or from getting medications. • **Code B,** if the patient indicates that lack of transportation has kept the patient from non-medical meetings, appointments, work, or from getting things that the patient needs. • **Code C,** if the patient indicates that a lack of transportation has not kept the patient from medical appointments, getting medications, non-medical meetings, appointments, work, or getting things that the patient needs.		

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
		• **Code X, Patient unable to respond,** if the patient was unable to respond. o In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X, Patient unable to respond. o If the patient was unable to respond and no other resources (proxy or medical record documentation) provided the necessary information, Code X, Patient unable to respond, only. • **Code Y, Patient declines to respond,** if the patient declines to respond. o In the cases where the patient declines to respond, Code Y, Patient declines to respond, only. o If the patient declines to respond do not code based on proxy input or medical record documentation to complete this item.		

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
		Coding Tips • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative. **Example** 1. A patient is admitted with multiple sclerosis. The patient is confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No proxy with related information is available, but the patient's medical record indicates that the patient's caregiver uses their car to transport the patient wherever the patient needs to go. **Coding:** A1250, Transportation would be **coded as Code C, No and Code X, Patient unable to respond**. **Rationale:** If neither the patient nor a proxy is able to provide a response but the medical record documentation can provide the necessary information, code both the information in the medical record and X, Patient unable to respond.		

<table>
<tr><th>Edit #</th><th>Chapter, Section, Page</th><th>LCDS Manual Version 5.1 – Effective October 1, 2024</th><th>LCDS Manual Version 5.3 – Effective October 1, 2026</th><th>Description of Change</th></tr>
<tr><td>3.A.6</td><td>Chapter 3, Section A, Page A-26</td><td>--</td><td><h3>A1255. Transportation</h3><h4>Item Rationale</h4>
Access to transportation for ongoing healthcare and medication access needs, particularly for those with chronic diseases, is essential to successful care management.
Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.
<h4>Steps for Assessment</h4>
Ask the patient:
“In the past 12 months, has lack of reliable transportation kept you from medical appointments, meeting, work, or from getting things needed for daily living?”
Ask the patient to select the response that most closely corresponds to the patient’s transportation status from the list in A1255.
If the patient declines to respond, code 7, Patient declines to respond, and do not code based on proxy input or medical record documentation.
If the patient is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.</td><td>Addition of item A1255. Transportation item rationale, steps for assessment, coding instructions, and examples.</td></tr>
</table>

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
			5. Only use medical record documentation to code A1255, Transportation if the patient is unable to respond and no family member, significant other, and /or guardian/legally authorized representative provides a response to this item. **Coding Instructions** *Complete based on assessments that occur within the 4-day admission assessment time period or the 3-day discharge assessment time period.* o **Code 0, Yes,** if the patient indicates that in the past 12 months, a lack of reliable transportation has kept them from medical appointments, meetings, work, or from getting things needed for daily living. o **Code 1, No,** if the patient indicates that in the past 12 months, a lack of reliable transportation has not kept them from medical appointments, meetings, work, or from getting things needed for daily living.	

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
			Code 7, Patient declines to respond, if the patient declines to respond. - If the patient **declines to respond** do not code based on other resources (family, significant other, or legally authorized representative, or medical records). **Code 8, Patient is unable to respond,** if the patient was unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information. **Coding Tips** - If the patient is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical records, select the response that applies.	

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
			Examples 1. The patient is admitted with multiple sclerosis. The patient is confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No family, significant other, or legally authorized representative with information about transportation is available, but the patient's medical record indicates that in the past 12 months, the patient's caregiver used their car to transport the patient wherever the patient needed to go. **Coding:** A1255, Transportation would be **coded as Code 1, No.** **Rationale:** Neither the patient nor their family, significant other, or legally authorized representative was able to provide a response, but the medical record documentation provided the necessary information regarding transportation. 2. The patient indicates that in the last 12 months, they have not had reliable transportation, which has occasionally kept them from attending medical appointments. **Coding:** A1255, Transportation would be **coded as Code 0, Yes.** **Rationale:** The patient reported they have not had access to reliable transportation in the last 12 months, which has kept them from medical appointments, meetings, work or from getting things needed for daily living.	

Chapter 3, Section D

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.D.1	Chapter 3, Section D, Page D-5	D0150. Patient Mood Interview (PHQ-2 to 9) **Coding Tips** • Attempt to conduct the interview with ALL patients. • If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank**, then end the PHQ-2 and leave D0160, Total Severity Score blank. • If Column 1 equals 0, enter 0 in Column 2. • If Column 1 equals 9 or dash (-), leave Column 2 blank. • If no assessment is conducted for Patient Mood, then in each row D0150A through D0150I, enter a dash (-) in Column 1, leave Column 2 blank, and code 99 for D0160, Total Severity Score.	D0150. Patient Mood Interview (PHQ-2 to 9) **Coding Tips** • Attempt to conduct the interview with ALL patients. • If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank**, then end the PHQ-2 and leave D0160, Total Severity Score blank. • If Column 1 equals 0, enter 0 in Column 2. • If Column 1 equals 9 or dash (-), leave Column 2 blank. • If no assessment is conducted for Patient Mood, then in each row D0150A through D0150I, enter a dash (-) in Column 1, leave Column 2 blank, and code 99 for D0160, Total Severity Score. • In the rare situation that the patient cannot provide a frequency, following a yes response to a symptom in Column 1, enter a dash in Column 2. CMS expects a dash response to be rare.	Updates to coding tips for D0150. Patient Mood Interview (PHQ-2 to 9)

Chapter 3, Section GG

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.GG.1	Chapter 3, Section GG, Page GG-10	**Coding tips for coding the patient's usual performance** • When coding the patient's usual performance, use the 6-point scale or one of the four "activity not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted. • 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 during the assessment period. • An activity can be completed independently with or without devices. If the patient uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent. • Code based on patient's performance. Do not record the staff's assessment of the patient's potential capability to perform the activity.	**Coding tips for coding the patient's usual performance** • When coding the patient's usual performance, use the 6-point scale or one of the four "activity not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted. • 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 during the assessment period. • An activity can be completed independently with or without devices. If the patient uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent. • Code based on patient's performance. Do not record the staff's assessment of the patient's potential capability to perform the activity.	Added language to GG0130. Self-Care and GG0170. Mobility that is part of the Code 01 definition.

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
		• 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.	• 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. • If two or more helpers are required to assist the patient to complete an activity, code as 01, Dependent.	

Chapter 3, Section J

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.J.1	Chapter 3 Section J Page J-9	**DEFINITION** **FALL** • Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (e.g., a patient pushes another patient). • An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall.	**DEFINITION** **FALL** • Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. ~~Falls are not a result of an overwhelming external force (e.g., a patient pushes another patient).~~ • An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person.-However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered an intercepted fall. ○ An exception would be if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance during balance training, it would be reported as both a fall and a major injury in J1800 - Any Falls Since Admission and J1900 – Number of Falls Since Admission.	Updated definition to reflect updates to guidance.

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.J.2	Chapter 3 Section J Page J-10	2. A patient is participating in balance training during a therapy session. The therapist is intentionally challenging the patient's balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides steadying/contact guard assistance to allow the patient to maintain standing. **Coding**: J1800, any falls since admission would be coded 0, no. **Rationale**: the patient's balance was intentionally being challenged, so a loss of balance is anticipated by the physical therapist. When assistance is provided to a patient to allow them to maintain standing during an anticipated loss of balance, this is not considered a fall or "intercepted fall."	2. A patient is participating in balance training during a therapy session. The therapist is intentionally challenging the patient's balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides steadying/contact guard assistance to allow the patient to maintain standing. **Coding**: J1800, any falls since admission would be coded 0, no. **Rationale**: the patient's balance was intentionally being challenged, so a loss of balance is anticipated by the physical therapist. ~~When assistance is provided to a patient to allow them to maintain standing during an anticipated loss of balance, this is not considered a fall or "intercepted fall."~~ When the patient experiences an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training, unless there was a fall or "intercepted" fall that resulted in a major injury, it would not be coded as a fall in J1800.	Revised to reflect updates to guidance.

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.J.3	Chapter 3 Section J Page J-12	**Coding Tips** • For item J1900, include all falls that occurred since the time of admission. This would include any falls that occurred outside of the LTCH facility during a program interruption. • Facilities are encouraged to utilize accurate and/or new information regarding fall-related injuries as information becomes known. For example, injuries can present themselves later than the time of the fall. The facility may not learn of the level of injury until after the LCDS assessment is completed or the patient has left the facility (e.g., because the patient was transported to an emergency room and admitted to an inpatient facility post-fall). Errors should be corrected following the facility's correction policy and in accordance with guidance from Chapter 4: Submission and Correction of the LTCH Care Data Set (LCDS) Assessment Records in this manual.	**Coding Tips** • For item J1900, include all falls that occurred since the time of admission. This would include any falls that occurred outside of the LTCH facility during a program interruption. • Fractures confirmed to be pathologic (vs traumatic) are not to be considered a major injury resulting from a fall. • Facilities are encouraged to utilize accurate and/or new information regarding fall-related injuries as information becomes known. For example, injuries can present themselves later than the time of the fall. The facility may not learn of the level of injury until after the LCDS assessment is completed or the patient has left the facility (e.g., because the patient was transported to an emergency room and admitted to an inpatient facility post-fall). Errors should be corrected following the facility's correction policy and in accordance with guidance from Chapter 4: Submission and Correction of the LTCH Care Data Set (LCDS) Assessment Records in this manual.	Coding Tips revised to reflect updates to guidance.

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.J.4	Chapter 3 Section J Page J-12	**DEFINITIONS** **NO INJURY** No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall. **INJURY (EXCEPT MAJOR)** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain. **MAJOR INJURY** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma.	**DEFINITIONS** ~~**NO INJURY**~~ ~~No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.~~ **INJURY (EXCEPT MAJOR)** Includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain. **MAJOR INJURY** Includes, but is not limited to, traumatic bone fractures, joint dislocations/~~,~~ subluxations, internal organ injuries, amputations, traumatic spinal cord injuries, head injuries, and crush injuries ~~closed head injuries with altered consciousness, and subdural hematoma.~~	Revised the definitions to reflect updates to guidance.

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.J.5	Chapter 3 Section J Page J-13	**Examples** -	4. The therapist had a patient, who has Parkinson's disease, stand on one foot during their therapy session to intentionally challenge the patient's balance. Despite safety precautions, including contact guard assistance and safety mats, the patient fell while standing on one foot and landed on their left side. Due to pain and swelling in their left wrist, the physician ordered a left wrist x-ray for the patient. The x-ray confirmed a distal radius fracture (non-displaced) of the left wrist. **Coding**: J1800 would be **coded 1, Yes** and J1900C would be **coded 1, One**. **Rationale:** Despite safety precautions in place the patient sustained a radius fracture, a major injury, during a therapeutic intervention with physical therapy where their balance was being intentionally challenged. This is being considered a fall as there was a major injury even though the fall and major injury occurred when the patient's balance was being intentionally challenged.	Added to reflect updates to guidance.

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.J.6	Chapter 3 Section J Page J-13	**Examples** -	**Differentiating from Traumatic vs Pathological Fractures** 5. A patient with osteoporosis falls, resulting in a right hip fracture. The physician confirms that the fracture is a result of the patient's bone disease and not a result of the fall. **Coding**: J1800 would be **coded 1, Yes** and J1900C would be **coded 0, None**. **Rationale:** The physician determined that the fracture was a pathological fracture and was a result of osteoporosis. Because it is not considered a traumatic fracture it would not be considered a major injury. 6. A patient with osteoporosis falls, resulting in a right hip fracture. The physician confirms that the fracture is a result of the patient's fall and not due to the patient's history of osteoporosis. **Coding**: J1800 would be **coded 1, Yes** and J1900C would be **coded 1, One**. **Rationale:** Because the physician determined that the fracture was a result of the fall it would be considered a traumatic fracture and therefore would be considered a major injury.	Added to reflect updates to guidance.

Chapter 3, Section M

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.M.1	Chapter 3, Section M, Page M-7	**Step 3: Determine “Present on Admission”** --	8. If a pressure ulcer/injury was unstageable on admission and then becomes unstageable for another reason, it should be considered “present on admission” at the new unstageable status. For example, if a patient is admitted with a deep tissue injury, but later the injury opens, the wound bed is covered with slough, and the wound is still unstageable, this wound would still be considered “present on admission.”	Updates to Step 3: Determine “Present on Admission”

Chapter 3, Section O

<table>
<tr><th>Edit #</th><th>Chapter, Section, Page</th><th>LCDS Manual Version 5.1 – Effective October 1, 2024</th><th>LCDS Manual Version 5.3 – Effective October 1, 2026</th><th>Description of Change</th></tr>
<tr><td>3.O.1</td><td>Chapter 3, Section O, Page O-21</td><td>Coding Instructions
Code 0, No, patient is not up to date if the patient does not meet the CDC’s definition of “up to date.”
This includes patients who have not received one or more recommended COVID-19 vaccine doses for any reason including medical, religious, or other qualified exemptions.
This includes patients for whom vaccination status cannot be determined.
Code 1, Yes, patient is up to date if the patient meets the CDC’s definition of “up to date.”
A dash (-) is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence.</td><td>Coding Instructions
Complete only if A0250 = 10 Planned Discharge or 11 Unplanned Discharge.
Code 0, No, patient is not up to date if the patient does not meet the CDC’s definition of “up to date.”
This includes patients who have not received one or more recommended COVID-19 vaccine doses for any reason including medical, religious, or other qualified exemptions.
This includes patients for whom vaccination status cannot be determined.
Code 1, Yes, patient is up to date if the patient meets the CDC’s definition of “up to date.”
A dash (-) is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence.</td><td>Adding language to show the removal of item O0350: Patient’s COVID-19 Vaccination Is Up to Date from the Expired Assessment</td></tr>
</table>

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.O.2	Chapter 3, Section O, Page O-21	**DEFINITION** **UP TO DATE WITH COVID-19 VACCINES** For the definition of "up to date," providers should refer to the CDC webpage, "Stay Up to Date with Vaccines," at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.	~~**DEFINITION**~~ ~~**UP TO DATE WITH COVID-19 VACCINES**~~ ~~For the definition of "up to date," providers should refer to the CDC webpage, "Stay Up to Date with Vaccines," at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.~~	Removal of the definition of "Up to date with COVID-19 Vaccines."

Chapter 3, Supplement

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.S.1	Chapter 3 Supplement, Page S-11	• The following rules explain how to compute the score that is placed in item D0160. These rules consider the “number of missing items in Column 2” which is the number of items in Column 2 that are blank (or skipped). An item in Column 2 could be blank if the corresponding item in Column 1 was equal to 9, No response, or a dash (symptom not assessed). • If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values. • If any of the items in Column 2 are blank (or skipped), then omit their values when computing the sum.	• The following rules explain how to compute the score that is placed in item D0160. These rules consider the “number of missing items in Column 2” which is the number of items in Column 2 that are blank (or skipped) or dashed. An item in Column 2 could be blank if the corresponding item in Column 1 was equal to 9, No response, or a dash (symptom not assessed). • If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values. • If any of the items in Column 2 are blank (or skipped) or dashed, then omit their values when computing the sum.	Updates to Patient Mood Interview Scoring
3.S.2	Chapter 3 Supplement, Page S-12	In this example, all of the items in Column 2 have non-missing values (i.e., none of the values are blank). Therefore, the value of D0160 is equal to the simple sum of the values in Column 2, which is 14.	In this example, all of the items in Column 2 have non-missing values (i.e., none of the values are blank or dashed). Therefore, the value of D0160 is equal to the simple sum of the values in Column 2, which is 14.	Updates to Patient Mood Interview Example

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
3.S.3	Chapter 3 Supplement, Page S-13	In this example, one of the items in Column 2 (D0150C2) has a missing value (it is blank) and the other eight items have non-missing values. D0160 is computed as follows: 1. Compute the sum of the eight items with non-missing values. This sum is 11. 2. Multiply this sum by 1.125. In the example, 11 x 1.125 = 12.375. 3. Round the result to the nearest integer. In the example, 12.375 rounds to 12. 4. Place the rounded result in D0160.	In this example, one of the items in Column 2 (D0150C2) has a missing value (it is ~~blank~~ dashed) and the other eight items have non-missing values. D0160 is computed as follows: 1. Compute the sum of the eight items with non-missing, non-dashed values. This sum is 11. 2. Multiply this sum by 1.125. In the example, 11 x 1.125 = 12.375. 3. Round the result to the nearest integer. In the example, 12.375 rounds to 12. 4. Place the rounded result in D0160.	Updates to Patient Mood Interview Example

Chapter 4

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
4.1	Chapter 4, Page 4-8	**Note:** Specific user roles within iQIES will allow the provider to inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.	**Note:** Specific user roles within iQIES will allow the provider to inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record ~~using the iQIES user tool~~ are reflected in their provider software system.	Removing language related to the user tool.
4.2	Chapter 4. Page 4-8	4.7 Special Manual Record Deletion Request A special Manual Record Deletion Request is only necessary when there has been an error in a record that has been accepted into iQIES 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.	4.7 Special Manual Record Deletion Request A special Manual Record Deletion Request is only necessary when there has been an error in a record that has been accepted into iQIES 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.	Updated the language to include the electronic process.

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
		If an iQIES record has the wrong state code or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in iQIES. The record must be resubmitted with the correct STATE_CD and/or FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record. In the event that this error has occurred, the provider must contact the iQIES Help Desk at iQIES@cms.hhs.gov or 1-800-339-9313 to obtain the LTCH CARE Manual Assessment Deletion Request form. The provider is responsible for completing the form. The provider must submit the completed form to the iQIES Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The iQIES Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the iQIES Help Desk will work through the request with the provider.	If an iQIES record has the wrong state code or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in iQIES. The record must be resubmitted with the correct STATE_CD and/or FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record. In the event that this error has occurred, the provider ~~must contact the~~ will need to create and submit a change request within iQIES~~ Help Desk at~~ iQIES@cms.hhs.gov~~ or 1-800-339-9313 to obtain the~~. Directions on how to submit an LTCH CARE Manual Assessment Deletion Request ~~form. The provider is responsible~~ can be found in the CMS iQIES Assessment Management for ~~completing the form. The provider must submit the completed form to the iQIES Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The iQIES Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the~~Assessment Submitter manual ~~deletion request, the iQIES Help Desk will work through the request with the provider.~~(available on the following website: https://qtso.cms.gov/software/iqies/reference-manuals).	

Appendix A

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
A.1	Appendix A, Page A-4	**Fall** Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. A fall is not a result of an overwhelming external force (e.g., a patient pushes another patient). An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall.	**Fall** Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. ~~A fall is not a result of an overwhelming external force (e.g., a patient pushes another patient).~~ An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall. An exception would be if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance during balance training, it would be reported as both a fall and a major injury in J1800 - Any Falls Since Admission and J1900 – Number of Falls Since Admission.	Update to the definition of a fall
A.2	Appendix A, Page A-6	**Injury (except Major)** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.	**Injury (except Major)** Includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.	Update to definition of Injury (except Major)

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
A.3	Appendix A, Page A-7	**Major Injury** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.	**Major Injury** Includes, but is not limited to, traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, traumatic spinal cord injuries, ~~closed~~ head injuries, and crush injuries. ~~with altered consciousness, subdural hematoma.~~	Update to definition of Major Injury
A.4	Appendix A, Page A-12	Common Acronyms SAMS, Secure Access Management Services	Common Acronyms ~~SAMS, Secure Access Management Services~~	Removal of definition of SAMS

Appendix B

Edit #	Chapter, Section, Page	LCDS Manual Version 5.1 – Effective October 1, 2024	LCDS Manual Version 5.3 – Effective October 1, 2026	Description of Change
B.1	Appendix B, Page B-1	Internet Quality Improvement and Evaluation System (iQIES), Data Submission and Data Validation Email: iqies@cms.hhs.gov Phone: 1-800-339-9313 Examples of issues this resource can help you with: • Accessing iQIES (username and password) • Submission/validation reports • Accessing Provider and Quality Reporting Program reports • Accessing reports in iQIES • Validation utility tool (VUT) (vendor tool to ensure software meets CMS requirements and will pass iQIES system edits) • Technical questions that are related to LCDS data specifications	Internet Quality Improvement and Evaluation System (iQIES), Data Submission and Data Validation Email: iqies@cms.hhs.gov Phone: 1-800-339-9313 Examples of issues this resource can help you with: • Accessing iQIES (username and password) • Submission/validation reports • Accessing Provider and Quality Reporting Program reports and files • ~~Accessing reports in iQIES~~ • Validation utility tool (VUT) (vendor tool to ensure software meets CMS requirements and will pass iQIES system edits) • Technical questions that are related to LCDS data specifications	Condensed these bullets to more generally cover automatically distributed reports and files.