Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation Data Set (LCDS) Quarterly Q&As

September 2022

Consolidated September 2020 to September 2022

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Introduction

The Centers for Medicare & Medicaid Services (CMS) is publishing the Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation Data Set (LCDS) Quarterly Q&As so that all LTCH providers have the clarifications to existing guidance. Through inquiries to the LTCH Post-Acute Care (PAC) Quality Reporting Program (QRP) Help Desk, CMS identifies the opportunity to clarify or refine guidance.

CMS has updated the Quarterly Q&A document in light of the release of the CMS LCDS 5.0 Manual on April 1, 2022, effective October 1, 2022. CMS has archived Q&As reflected in the LCDS 5.0 Manual, and where items are not included in the LCDS 5.0.

The archived Q&As can be found in the LTCH Quality Reporting Archives here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/-LTCH-Quality-Reporting-Archives

New Q&As Added in September 2022

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This document is intended to provide guidance on LCDS questions that were received by CMS help desks.
Responses contained in this document may be superseded by guidance published by CMS at a later date.

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Admission Items: General Questions

Question 1: Archived June 2022

Question 2: Archived June 2022

[NEW] Question 3: Several of the new items have a copyright. Does a facility need to get permission to include the items in the LTCH medical record for data collection?

Answer 3: The LCDS includes a few copyright items such as D0150 - Patient Mood Interview (PHQ-2 to 9). CMS has obtained permission to use these items in the LCDS V5.0. Your facility has permission to use these items within the LCDS assessment only.

Added: September 2022

[NEW] Question 4: Can information collected prior to admission to an LTCH be used when completing items such as A1005 - Ethnicity, A1010 - Race, A1110 - Language, A1250 - Transportation, B1300 - Health Literacy, and D0700 - Social Isolation? Our EMR is able to pull this information directly into the LCDS from the information collected during the preadmission screening.

Answer 4: If information used to complete the LCDS is gathered prior to the patient's admission this information should be verified, and coded following applicable coding guidance, during an assessment that occurs during the 3-day admission assessment time period.

A facility's software should not answer or generate the LCDS responses for the assessing clinician.

Please note that based on coding guidance, the medical record should not be used as the data source for coding Health Literacy and Social Isolation. Also note that the medical record should not be used as the data source for coding Ethnicity, Race, Language, and Transportation unless the patient and proxy are unable to respond during the admission or discharge assessment time periods.

Added: September 2022

Section A: Administrative Information

A1250

[NEW] Question 1: Please provide an example of where the codes for A1250 - Transportation change from admission to discharge.

Answer 1: The intent of A1250 - Transportation is to identify if a lack of transportation has kept the patient from medical appointments, meetings, work, or from getting things needed for daily living over the past 6 to 12 months. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how this item applies for each individual patient at both the admission and discharge time points.

It is possible that the admission and discharge coding are the same.

Added: September 2022

Section B: Hearing and Vision

B0200, B1000

[NEW] Question 1: For B0200 - Hearing and B1000 - Vision what if aids (glasses, hearing aids, etc.) are unavailable to patient at the time of assessment? For example, if the patient reports they can read newspaper headlines with their glasses on but they do not have their glasses and are unable to read that size print when provided upon assessment, what should be coded?

Answer 1: The intent of B0200 - Hearing is to assess the patient's ability to hear (with hearing aid or hearing appliances if normally used).

The intent of B1000 - Vision is to assess the patient's ability to see in adequate light (with glasses or other visual appliances).

The patient may not have their normal hearing appliances or visual aids available to them during the 3-day admission assessment period. In addition to observation, ask about hearing/vision function by interviewing the patient, family, caregivers, direct care staff, specialists, etc., and review the clinical record or other available documentation to determine the most accurate response for B0200 and B1000.

Added: September 2022

B1300

[NEW] Question 1: Please provide an example of where the codes for B1300 - Health Literacy change from admission to discharge.

Answer 1: The intent of B1300 - Health Literacy is to identify how often the patient needs to have someone help them when they read instructions, pamphlets, or other written material from their doctor or pharmacy. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how this item applies for each individual patient at both the admission and discharge time points.

It is possible that the admission and discharge coding are the same.

Added: September 2022

Section GG: Functional Abilities and Goals

GG0100, GG0110

Question 1: We have questions regarding prior level of functioning and prior device use. A patient is admitted to our facility for rehab, has a medical issue, and is discharged to an acute care hospital for a week. When the patient returns to our facility, would the prior level of functioning reported in GG0100B - Prior Functioning: Indoor Mobility reflect the patient's ambulation status prior to the original admission (which is the reason we are still treating the patient) or is the prior level of functioning based on what the patient was doing during the hospital stay? Would this also apply to GG0110 - Prior Device Use?

Answer 1: The intent of GG0100B - Prior Functioning: Indoor Mobility is to report the patient's need for assistance with walking from room to room, with or without a device such as a cane, crutch, or walker, prior to the current illness, exacerbation, or injury. The intent of GG0110 - Prior Device Use is to indicate which devices and aids were used by the patient prior to the current illness, exacerbation, or injury. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how prior functioning and prior device use apply for each individual patient.

In responding to GG0100 - Prior Functioning: Everyday Activities, the activities should be reported based on the patient's usual ability prior to the current illness, exacerbation, or injury. This is the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is most recent, that initiated this episode of care. Clinicians should use clinical judgment within these parameters in determining the time frame that is considered "prior to the current illness, exacerbation, or injury."

The same approach should be used in determining Prior Device Use for GG0110.

Added: September 2020

GG0110

Question 1: Archived June 2022

GG0130, GG0170

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Archived June 2022

Question 4: Archived June 2022

Question 5: We understand that if a patient initially refuses to attempt an activity during the assessment period, but later agrees to perform the activity, the code that represents the patient's actual performance supersedes the refusal code (07). What if on day 1 or day 2 a safety or medical issue prevents the patient from attempting an activity, but on day 3, after benefiting from therapeutic intervention, the patient can now perform the activity? Which code should be reported on the LCDS: Code 88 - Not attempted due to medical condition or safety concerns, or one of the performance codes, 01-06?

Answer 5: At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff. *"Prior to the benefit of services"* means prior to provision of any care by your facility staff that would result in more independent coding.

Use of an "activity not attempted" code should occur only after determining that the activity is not completed prior to the benefit of services, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.

If this is the case in your scenario code 88- Not attempted due to medical condition or safety concerns even if the patient's status changes and the patient is able to complete the activity on a later day during the assessment period.

Added: September 2020

Question 6: Archived June 2022

Question 7: How should the following situation be coded for the GG0130 - Self-Care and GG0170 - Mobility items? On discharge a patient was nonadherent with spinal precautions. The patient was able to demonstrate completing functional tasks independently with good balance and strength, and was cognitively intact. By the patient's report, they were choosing not to routinely adhere to spinal precautions in her day-to-day activities, although they were aware of the precautions and risks. Should the GG activities be coded based on the patient's ability, which is independent, or based on the fact that they knowingly break their precautions?

Answer 7: The GG activities focus on the patient's ability to complete the activities as independently as possible as long as they are safe; willingness and nonadherence are not the focus of the coding.

If, in your scenario, you have assessed the patient being able to independently complete the GG activities safely, code 06 - Independent.

Added: June 2021

Question 8: For GG0130 - Self-Care and GG0170 - Mobility, it is our facility's policy that a patient always have a staff member present during walking or toileting activities. Is it possible for the GG activity to be assessed and coded 06 - Independent, for situations where a staff member is required to be present per facility policy, but is not required to assist or supervise the patient in any way?

Answer 8: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe.

If a helper is present (only due to facility policy) code the activity based on the type and amount of assistance the patient requires to complete the activity as independently as possible, as long as they are safe. If no assistance/supervision/set-up is required, then code 06 - Independent.

Added: September 2021

Question 9: When determining the appropriate performance code at admission for the GG self-care and mobility activities there are times when the score on day 1 differs from the scores on days 2 and 3. For example:

- **On Day 1 when attempting to perform a sit to stand transfer, even with assist from the therapist the patient is unable to complete the transfer due to pain. The therapist scores GG0170D - Sit to stand as a Code 88 - Not attempted due to medical condition or safety concerns in day 1 notes. On day 2, per therapy notes the patient was able to complete the sit to stand transfer with assistance of two people. Which code would I use? Code 88 - Not attempted due to medical condition or safety concerns or Code 01 - Dependent?**
- **On Day 1 there is no mention of sit to stand noted in documentation. On day 2 documentation reports that the patient requires partial/moderate assistance of 1 (Code 03) and later that day the therapy note shows that the patient required the assistance of two people to stand. How would this scenario be coded? Does any source take priority? Do I look at all three days and select usual performance from all sources?**

Answer 9: At Admission, the self-care or mobility performance code is to be based on a functional assessment that occurs at or soon after the patient's admission, and reflects the patient's baseline ability to complete the activity prior to the benefit of services provided by your facility staff.

"Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding.

When the baseline function code differs from the usual performance during the assessment period, report the baseline function code.

If in your first scenario, the patient being unable to complete the sit to stand activity due to medical conditions or safety concerns represents their baseline ability, then code 88 - Not attempted due to medical condition or safety concerns.

In your second scenario, as in all admission scenarios, select the code that represents the patient's baseline ability to complete the activity as independently as possible as long as they are safe, prior to the benefit of services provided by your facility staff.

Added: December 2021

[NEW] Question 10: The guidance for GG0130 and GG0170 states "the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely, not based on the availability of such assistance." Can you provide an example of "not based on the availability of such assistance"?

Answer 10: When assessing and coding GG activities, allow the patient to perform the activity as independently as possible, as long as they are safe. Select the code based on the type and amount of assistance required to complete the activity, not based on the availability of assistance.

For example, a patient requires a physical therapist to provide assistance to ambulate 10 feet safely. However, when the therapist is not available, the patient is unable to ambulate 10 feet safely. The walking activity would be coded based on the type and amount of assistance required (assistance to walking 10 feet), even though a physical therapist may not always be available to provide the needed assistance.

Added: September 2022

GG0130A

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: A patient is independent with self-feeding, but requires encouragement for adequate intake. Would the encouragement to increase food and/or fluid intake be considered when scoring GG0130A - Eating?

Answer 3: The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient. The adequacy of the patient's nutrition or hydration is not considered for GG0130A - Eating.

When coding activities in Section GG, clinicians should code based on the type and amount of assistance required allowing the patient to perform the activity as independently as possible, as long as they are safe. If the patient is able to meet the intent of the activity with no assistance (physical, verbal/nonverbal cueing, setup/clean-up) then code 06 - Independent.

Added: June 2022

GG0130B

Question 1: Archived June 2022

GG0130C

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Archived June 2022

Question 4: I understand that if a helper provides setup before toileting hygiene or clean-up after, and the patient completes the activity of toileting hygiene without additional assistance, the correct code is 05 - Setup or clean-up assistance.

What would the correct code be if a helper provided assistance (contact guard or touching assistance) to the patient as the patient gathered their incontinence products but then the patient completed the toileting hygiene activity without further assistance?

Answer 4: The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

It is not the type of assistance that is provided that determines the 05 - Setup or clean-up assistance code but rather when (related to the completion of the activity) the needed assistance is provided.

If the assistance provided is necessary only before or after the activity is completed, and no assistance is needed during the completion of the activity, select Code 05 - Setup or clean-up assistance.

Added: December 2021

GG0170

Question 1: If a patient is dependent for all GG bed mobility activities would it be acceptable to code the patient as dependent for all other GG mobility activities even if those activities were not specifically assessed?

Answer 1: At Admission, the mobility performance code is to reflect the patient's baseline ability to complete the activity, and is based on observation of activities, to the extent possible. Clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient and/or family, assessment of similar activities, collaboration with other facility staff, and other relevant strategies to complete all GG items.

Each LCDS item should be considered individually and coded based on the guidance provided for that item.

It is important to determine whether the appropriate code for each GG activity is a performance code (including 01 - Dependent) vs. an "activity not attempted" code.

It is also important to note that a helper cannot complete the walking activities for a patient. The walking activities cannot be considered completed without some level of patient participation that allows patient ambulation to occur the entire stated distance. For instance, if even with assistance a patient was not able to participate in walking a distance of 10 feet, an "activity not attempted" code (rather than 01 - Dependent) would be selected.

Added: December 2020

GG0170C

Question 1: Archived June 2022

GG0170E

Question 1: We understand that verbal cueing during a task should fall under the score of 04-Supervision or touching assistance. Our question is can a verbal cue provided prior to the task be considered set up as long as no further cues were provided during the actual task?

A specific example we just encountered was during the "chair/bed to chair transfer" activity. The therapist cued the patient prior to the activity where to place their hand for stability (in a novel environment), and then the patient completed all of the activity safely and without further cues or assistance. Is this Code 05-Setup or Code 04-Supervision?

Answer 1: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe. At admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity prior to benefit of services provided by your facility/staff. This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code, and coding based on the type and amount of assistance required.

Communicating the activity request (e.g., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity ("Push down on the grab bar," etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.

In the scenarios described, assuming the verbal cues were only provided prior to the benefit of services and were required, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues would be considered 05-Setup.

Added: September 2020

Question 2: We have a patient who at discharge requires max assistance to perform a transfer, so is coded as 02 - Substantial/maximal assistance for GG0170E - Chair/bed-to-chair transfer. This maximal assist transfer will not be safe for the patient and elderly family to attempt once at home, so two family members will be using a Hoyer lift to transfer the patient from bed to chair. At discharge, would the correct code for GG0170E be 02 - Substantial/maximal assistance, based on the patient's performance in the facility; or would the correct code be 01 - Dependent, because that is what the patient's "usual" status will be at home?

Answer 2: The intent of GG0170E - Chair/bed-to-chair transfer is to assess the patient's ability to transfer to and from a bed to a chair (or wheelchair).

When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe.

If the patient performed the activity during the discharge assessment period, code based on that assessment. Use the GG 6-point scale codes to identify the patient's usual performance on the discharge assessment.

If in your scenario, at discharge, when allowed to complete the activity as independently as possible, the patient was able to safely complete the transfer activity with max assist, then code 02 - Substantial/maximal assistance.

Added: December 2020

GG0170F

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: In the recent September Quarterly Q&A publication, it indicates that "assessment of similar activities" is acceptable for coding the LCDS. Please provide clarification on if the following scenarios would be acceptable simulations for the GG0170F - Toilet transfer activity in situations where a patient does not need to use the toilet during an assessment:

1. **An Occupational Therapist (OT) takes the patient to the toilet and simulates a toileting experience, with patient pulling down pants and transferring onto the toilet and then back to the chair.**
2. **Using the functional performance of the patient's Chair/bed-to-chair transfer performance code to code toilet transfer.**
3. **Using the functional performance of the patient's ability to transfer on and off a bedside commode in the therapy gym to code toilet transfer.**

Answer 3: The intent of GG0170F - Toilet transfer is to assess the patient's ability to get on and off a toilet or commode. Do not consider or include GG0130C - Toileting hygiene item tasks (managing clothing, undergarments, or perineal hygiene) when coding the toilet transfer item. The toilet transfer activity can be assessed and coded regardless of the patient's need to void or have a bowel movement in conjunction with the toilet transfer assessment.

Use clinical judgment to determine if each situation described adequately represents the patient's ability to transfer on and off the toilet or commode. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the activity.

In each scenario, if the patient was not able to transfer on/off the toilet or commode and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities, use the appropriate "activity not attempted" code.

Added: December 2020

GG0170I, GG0170J, GG0170K

Question 1: Many of our patients with a stroke ambulate with PT along a railing mounted in the hall. We understand that walking/transferring in the parallel bars would not be used to code the GG activities. Could coding be based on the patient walking in the hallway if using a railing as a support?

Answer 1: The intent of the walking items (GG0170I, GG0170J, GG0170K) is to assess the patient's ability to ambulate once in a standing position.

As noted in your question, you would not code self-care and mobility activities with use of a device that is restricted to patient use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems). Note that while a patient may use a hallway railing during therapy sessions, its use would not be restricted to therapy sessions only and therefore does not meet the definition described above.

CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Other than the exceptions listed above, clinical assessments may include any device or equipment (including a hallway railing) that the patient can use to allow them to safely complete the activity as independently as possible.

Added September 2020

Question 2: If a patient requires a therapist to provide steadying assistance/contact guard assist and manage an oxygen tank while the patient is ambulating how would the walking activities be coded?

Answer 2: The intent of the GG0170 walking items is to assess the patient's ability once standing to safely walk the stated distances and circumstances in each item.

If the helper is required to manage the oxygen tank and/or oxygen tubing and/or provide steadying assistance/contact guard, to allow the patient to complete an activity safely, then code 04 - Supervision or touching assistance.

Added: March 2021

Question 3: Archived June 2022

GG0170I

Question 1: Can you give some clarification regarding scoring a performance with the help of a second person (if this second person is helping push an oxygen tank, IV pole, or wheelchair following the patient) because the first helper is physically assisting the patient during the walking activity? Both helpers are needed to complete the activity safely. The IRF-PAI manual says "if two or more helpers are required to assist the patient to complete the activity, code as 01, Dependent."

Answer 1: The intent of the GG0170 walking items is to assess the patient's ability once standing to safely walk the stated distances and circumstances in each item.

You are correct that if a patient requires the assistance of two helpers to complete an activity (one to provide support to the patient and a second to manage the necessary equipment to allow the safe walk), Code 01 - Dependent is the appropriate code.

If a single helper only manages the oxygen tank or the IV pole and otherwise the patient needs no assistance to safely complete the walking activity, code the walking activity as 04 – Supervision or touching assistance. This is because the helper is required to be present during the activity for the patient to complete the activity safely.

Added: September 2020

Question 2: Archived June 2022

GG0170M, GG0170N, GG0170O

Question 1: What is specifically assessed when a patient uses a stair lift to ascend/descend stairs? Should the GG activities be coded based on the type and amount of assistance required to get on and off the stair lift? Or is it the type and amount of assistance required to use the stair lift itself?

Answer 1: The intent of Section GG stair activities is to assess the patient's ability to go up and down 1 step/curb, 4 steps, and 12 steps. Clinicians should code based on the type and amount of assistance required for the patient to complete the stair activities as independently and safely as possible.

Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (including cane, walker, railing, or stair lift) and with or without some level of assistance. Going up and down stairs by any safe means includes the patient walking up and down stairs on their feet or bumping/scooting up and down stairs on their buttocks.

When using a stair lift to ascend/descend stairs code based on the type and amount of assistance the patient requires to ascend/descend stairs once seated.

Added: June 2022

GG0170Q

Question 1: Archived June 2022

Question 2: Archived June 2022

GG0170R, GG0170S

Question 1: Archived June 2022

GG0170S

Question 1: Archived June 2022

Section H: Bladder and Bowel

H0350

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Please provide clarification on how the following scenario would be coded for H0350 – Bladder Continence on Admission?

Day One: Admitted with Indwelling catheter

Day Two: Indwelling removed, 1 incontinent episode, 2 Continent

Day Three: 1 incontinent episode, 2 Continent

Answer 3: The intent of H0350 - Bladder Continence is to gather information on bladder continence. If the use of a catheter is intermittent (e.g., the indwelling catheter is in use during part of the 3-day assessment period, but not used for the entire 3-day assessment period), code continence level based on when catheter is not in use during the 3-day assessment period.

If the incontinent episodes during the 3 days occur only with stress, then code 1 – Stress Incontinence Only. If a patient is incontinent 1 or 2 times or incontinent any number of times on one or two days, but at least one full day with no incontinent episodes, then code 2 – Incontinent Less than Daily.

Added: June 2022

H0400

Question 1: Archived June 2022

Section J: Falls

J0520

[NEW] Question 1: The rehab therapy definition in J0520 - Pain Interference with Therapy Activities in the guidance manual states:

Rehab Therapy - special healthcare service or programs that help a person regain physical, mental, and or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, PT, OT, SLP, and cardiac and pulmonary therapies

Based on the term "regain," would maintenance therapy not be considered a rehab therapy for the item J0520 - Pain Interference with Therapy Activities?

Answer 1: Rehabilitation Therapy includes, but is not limited to, special healthcare service or programs that help a person regain physical, mental, and or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, any services provided by PT, OT, SLP, and cardiac and pulmonary therapies

Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present, regardless of the rehab focus or goal(s).

Added: September 2022

J1800, J1900

[NEW] Question 1: Is a fall that occurred at an acute care hospital during a program interruption considered when coding J1800 - Any Falls Since Admission and J1900 - Number of Falls Since Admission on the discharge LCDS?

Answer 1: J1800 and 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.

Added: September 2022

Section K: Swallowing/Nutritional Status

K0200

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: If a patient's height and/or weight was not measured within the 3-day admission assessment period for K0200 is it okay to use a height and/or weight that was measured day 5?

Answer 3: In order to be compliant, the admission assessment must be completed by the end of the 3-day assessment period (i.e., midnight of the third calendar day). If a patient's height and/or weight cannot be measured during the 3-day assessment period enter a dash (–) to indicate "no information" for K0200A - Height and/or K0200B - Weight. CMS expects dash use to be a rare occurrence.

Added: June 2021

Section M: Skin Conditions

M0210, M0300

Question 1: Archived June 2022

M0300

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Archived June 2022

Question 4: Archived June 2022

Question 5: Archived June 2022

Section N: Medications

N0415

[NEW] Question 1: If a medication is ordered at admission but not taken within the first 3 days of the LTCH stay (e.g., PRN orders), does this medication get considered for N0415 – High Risk Drug Classes: Use and Indication?

Additionally, is there guidance on how specific the indication documented needs to be? Can the generic use of the medication included on a pharmacy pamphlet suffice?

If a medication is ordered for the patient to take once they return home, should that medication be considered when coding N0415 at discharge?

Answer 1: The intent of N0415 – High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any medications in specified drug classes and whether the patient-specific indication was noted for taking the prescribed medications.

When coding N0415, determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). If Column 1 is checked (patient is taking a medication in drug classification), review patient documentation to determine if there is a documentated **patient-specific** indication for all medications in the drug class (Column 2).

When coding N0415, consider a medication that is included in the patient's prescribed drug regimen even if it is not taken during the 3-day assessment period.

Review patient documentation to determine if there is a patient-specific indication noted for all medications in the drug class.

At Discharge, N0415 considers medications included in the patient's prescribed drug regimen at discharge, and not what is expected to occur after discharge.

Added: September 2022

N2005

Question 1: Can the response for N2005 - Medication Intervention be determined at any time during the discharge window (day of discharge and 2 calendar days preceding the day of discharge) or does this item need to be completed on the day of discharge?

Answer 1: The intent of N2005 - Medication Intervention is to indicate if the facility contacted and completed physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission.

In order to report on all potential clinically significant medication issues, N2005 should be completed at the time of discharge.

Added: September 2021

Section O: Special Treatments, Procedures, and Programs

O0110

[NEW] Question 1: We have a question regarding O0110 - Special Treatments, Procedures, and Programs. Are treatments, procedures, and/or programs that the patient was receiving only on the day of admission and only on discharge considered? For the discharge assessment, must we also consider what the patient has ordered to receive after discharge (e.g., Chemotherapy or radiation scheduled to begin after discharge)?

Answer 1: The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

Check all treatments, programs, and procedures that are part of the patient's current care/treatment plan during the 3-day admission (or 3-day discharge) assessment time period. Include treatments, programs, and procedures performed by others and those the patient performed themself independently or after setup by facility staff or family/caregivers. Check treatments, procedures, and programs that are performed in the care setting, or in other settings (e.g., dialysis performed in a dialysis center).

At discharge O0110 considers special treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, and not what is expected to occur after discharge.

Added: September 2022

[NEW] Question 2: For O0110C - Special Treatments, Procedures, and Programs; Oxygen therapy: If the oxygen is ordered PRN, is that considered intermittent because it is ordered PRN or only if the patient uses it PRN during the 3-day assesment period?

Additionally, the guidance manual specifically states "delivered to relieve hypoxia". If there is no documentation of hypoxia but the patient reported shortness of breath and the oxygen was used, can oxygen still be marked?

Answer 2: The intent of O0110 - Special Treatments, Procedures, and Programs identifies if any of the listed special treatments, procedures, and programs apply to the patient.

O0110 should be completed based on an assessment that occurs within the 3-day admission assessment period or the 3-day discharge assessment period.

Check all treatments, programs, and procedures that are part of the current care/treatment plan during the 3-day admission assessment or the 3-day discharge assessment period.

If the oxygen is part of the patient's current care/treatment plan regardless of reason for its use, O0110C1 - Oxygen therapy should be checked. Regardless of whether the oxygen is ordered continuously or intermittently, apply the LCDS specific definitions in determining whether oxygen

is coded as continuous (delivered for greater than/equal to 14 hours per day) or intermittent (oxygen was not delivered continuously for at least 14 hours per day).

Added: September 2022

[NEW] Question 3: For Special Treatments, Procedures, and Programs: Non-Invasive Mechanical Ventilator O0110G2 - BiPAP and O0110G3 - CPAP, are these only selected if the BiPAP/CPAP was used during the assessment window? Sometimes a treatment may be ordered and available but the patient will refuse to wear it.

Answer 3: If the BiPAP or CPAP is part of the patient's current care/treatment plan, then mark O0110G1 - Non-Invasive Mechanical Ventilator and O0110G2 or O0110G3 - CPAP.

Added: September 2022