

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

O0110. Special Treatments, Procedures, and Programs

Intent: The intent of this item is to identify any special treatments, procedures, and programs that apply to the patient.

Admission

O0110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
	a. On Admission Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>
Respiratory Therapies	
C1. Oxygen Therapy	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>
D3. As Needed	<input type="checkbox"/>
E1. Tracheostomy care	<input type="checkbox"/>
G1. Non-Invasive Mechanical Ventilator	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>
Other	
H1. IV Medications	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>
H4. Anticoagulation	<input type="checkbox"/>
H10. Other	<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>
J1. Dialysis	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>
O1. IV Access	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>
O3. Midline	<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>
None of the Above	
Z1. None of the above	<input type="checkbox"/>

Planned/Unplanned Discharge

00110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply at discharge.	
	c. At Discharge Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>
Respiratory Therapies	
C1. Oxygen Therapy	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>
D3. As Needed	<input type="checkbox"/>
E1. Tracheostomy care	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>
G1. Non-Invasive Mechanical Ventilator	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>
Other	
H1. IV Medications	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>
H4. Anticoagulation	<input type="checkbox"/>
H10. Other	<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>
J1. Dialysis	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>
O1. IV Access	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>
O3. Midline	<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>
None of the Above	
Z1. None of the above	<input type="checkbox"/>

Item Rationale

- The treatments, procedures, and programs listed in O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

Steps for Assessment for Admission

1. Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs are part of the patient's current care/treatment plan during the 4-day admission assessment time period.
2. Check each type of treatment, procedure, or program that applies.

Coding Instructions for Admission

Complete only if A0250 = 01 Admission.

Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 4-day admission assessment time period. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply on admission, **check Z1, None of the above.**

Steps for Assessment for Discharge

1. Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs are part of the patient's current care/treatment plan during the 3-day discharge assessment time period. Do not consider what is expected to occur after discharge.
2. Check each type of treatment, procedure, or program that applies.

Coding Instructions for Discharge

Complete only if A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.

Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply on discharge, **check O0110Z1, None of the above.**

Coding Tips

- Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan. Include treatments, procedures, and programs performed by others and those the patient performed themselves 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).

- Do not check services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as intravenous (IV) medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
- Some facilities utilize standing orders or a standing order set, providing a specific PRN (as needed) order for their patients. If a standing order for treatment is included on the patient's current care/treatment plan due to facility policy (and not due to patient-specific need), it would only be considered for O0110, Special Treatments, Procedures, and Programs, if the patient received it during the assessment time period.

- **O0110A1, Chemotherapy**

Code any type of chemotherapy medication administered as an antineoplastic for cancer treatment given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment. For example, megestrol acetate is classified as an antineoplastic medication. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item, as the patient is not receiving the medication for chemotherapy purposes in this situation. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the LCDS. IVs, IV medication, and blood transfusions administered during chemotherapy are not recorded under items K0520A (Parenteral/IV feeding), O0110H1 (IV Medications), or O0110I1 (Transfusions).

- **O0110A2, IV**

Check if chemotherapy was administered intravenously.

- **O0110A3, Oral**

Check if chemotherapy was administered orally (e.g., pills, capsules, or liquids the patient swallows). This sub-element also applies if the chemotherapy is administered through a feeding tube/percutaneous endoscopic gastrostomy (PEG) (i.e., enterally).

- **O0110A10, Other**

Check if chemotherapy was given in a way other than intravenously or orally (e.g., intramuscular, intraventricular/intrathecal, intraperitoneal, or topical routes).

- **O0110B1, Radiation**

Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

- **O0110C1, Oxygen Therapy**

Code continuous or intermittent oxygen administered via mask, cannula, etc., that is part of the patient's current care/treatment plan regardless of reason for its use. Code oxygen used in bi-level positive airway pressure/continuous positive airway pressure (BiPAP/CPAP) here. Do **not** code hyperbaric oxygen for wound therapy in this item. This item may be coded if the patient places or removes their own oxygen mask or cannula.

- **00110C2, Continuous**

Check if oxygen therapy was continuously delivered for greater than/equal to 14 hours per day.

- **00110C3, Intermittent**

Check if oxygen therapy was intermittent (i.e., not delivered continuously for at least 14 hours per day).

- **00110C4, High-concentration**

Check if oxygen therapy was provided via a high-concentration delivery system. A high-concentration oxygen delivery system is one that delivers oxygen at a concentration that exceeds an FiO₂ of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow rate of 4 liters per minute).

A high-concentration delivery system can include either high- or low-flow systems (e.g., simple face masks, partial and non-rebreather masks, face tents, venturi masks, aerosol masks, high-flow cannula or masks).

These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO₂ of these systems exceeds 40%.

Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO₂ of greater than 40%.

- **00110D1, Suctioning**

Code only tracheal and/or nasopharyngeal suctioning in this item. Do not include oral suctioning here. This item may also be checked if the patient performs their own tracheal and/or nasopharyngeal suctioning.

- **00110D2, Scheduled**

Check if suctioning was scheduled. Scheduled suctioning is performed when the patient is assessed to clinically benefit from regular interventions, such as every hour or once per shift. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of facility-based clinical standards, protocols, and guidelines.

- **00110D3, As Needed**

Check if suctioning was performed on an as-needed basis, as opposed to regular scheduled intervals, such as when secretions become so prominent that gurgling or choking is noted, or a sudden desaturation occurs from a mucus plug.

- **00110E1, Tracheostomy care**

Code cleansing of the tracheostomy and/or cannula in this item. This item may also be checked if the patient performs their own tracheostomy care or receives assistance.

- **00110F1, Invasive Mechanical Ventilator (ventilator or respirator)**

Complete only if A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.

Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge.

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the patient who is or who may become (such as during weaning attempts) **unable to support their own respiration** in this item. During invasive mechanical ventilation, the patient's breathing is controlled by the ventilator. Patients receiving closed-system ventilation include those receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A patient who has been weaned off or is currently being weaned off a respirator or ventilator during the assessment period should also be included here. Do not check this item when the ventilator is used only as a substitute for BiPAP or CPAP.

- **00110G1, Non-Invasive Mechanical Ventilator**

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support their own spontaneous respiration** by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that “breathe” for the individual. If a ventilator is being used as a substitute for BiPAP/CPAP, code here. This item may be checked if the patient places or removes their own BiPAP/CPAP mask/device or if the staff applies it for the patient.

- **00110G2, BiPAP**

Check if the non-invasive mechanical ventilator support was BiPAP.

- **00110G3, CPAP**

Check if the non-invasive mechanical ventilator support was CPAP.

- **00110H1, IV Medications**

Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Include IV fluids with medications added, unless otherwise excluded in guidance. Do **not** include flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be checked here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** included in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.

- **00110H2, Vasoactive medications**

Check when at least one of the IV medications was a vasoactive medication.

- **00110H3, Antibiotics**

Check when at least one of the IV medications was an antibiotic.

- **00110H4, Anticoagulation**

Check when at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.

- **00110H10, Other**

Check when at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).

- **00110I1, Transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products) that are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- **00110J1, Dialysis**

Code peritoneal or renal dialysis which occurs at the LTCH or at another facility, record treatments of hemofiltration, slow continuous ultrafiltration (SCUF), continuous arteriovenous hemofiltration (CAVH), and continuous ambulatory peritoneal dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0520A (Parenteral/IV feeding), O0110H1 (IV Medications), or O0110I1 (Transfusions). This item may also be checked if the patient performs their own dialysis.

- **00110J2, Hemodialysis**

Check when the dialysis was hemodialysis. In hemodialysis the patient's blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood.

- **00110J3, Peritoneal dialysis**

Check when the dialysis was peritoneal dialysis. In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) serves as a filter to remove the waste products and excess fluid from the blood.

- **00110O1, IV Access**

Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, IV fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure. An AV fistula does not meet the definition of IV access for O0110O1. If there is not a current IV access in place at the time of assessment do not code IV access for O0110O1, even if a treatment which would require an IV access is part of the patient's current care/treatment plan.

- **00110O2, Peripheral**

Check when IV access was peripheral access (catheter is placed in a peripheral vein) and remains peripheral.

- **00110O3, Midline**

Check when IV access was midline access. Midline catheters are inserted into the antecubital (or other upper arm) vein and do not reach all the way to a central vein such as the superior vena cava.

- **00110O4, Central (e.g., PICC, tunneled, port)**

Check when IV access was centrally located (e.g., peripherally inserted central catheter [PICC], tunneled, port).

- **00110Z1, None of the above**

Check if none of the above treatments, procedures, or programs apply.

Examples

1. The patient's referral information indicates that they were discharged from an acute care facility following inpatient stay for bacterial pneumonia that required placement of a tracheostomy. On admission, the patient requires intermittent oxygen. Their suctioning needs are PRN. The patient has, however, had intermittent desaturations due to mucus plugging that have required use of a tracheostomy mask at an FiO₂ of greater than 40% intermittently. The patient has orders for 1 more week of IV antibiotics, which are being delivered via a PICC line.

Coding: Check boxes **O0110C1** (Oxygen Therapy), **O0110C3** (Intermittent), and **O0110C4** (High-concentration), **O0100D1** (Suctioning) and **O0110D3** (As Needed), **O0110E1** (Tracheostomy Care), **O0110H1** (IV Medications) and **O0110H3** (Antibiotics), and **O0110O1** (IV Access) and **O0110O4** (Central).

Rationale: The patient is receiving intermittent oxygen, high-concentration oxygen delivery, as-needed suctioning, tracheostomy care, and IV antibiotics via a PICC line on admission.

2. The patient has advanced prostate cancer and is receiving radiation and an oral chemotherapy medication to treat their prostate cancer. The patient is being admitted today, following an inpatient stay for an acute pulmonary embolism. Their discharge orders include enoxaparin subcutaneously for continued anticoagulation. The patient does not have orders for IV medications but still has a port in place.

Coding: Check boxes **O0110A1** (Chemotherapy), **O0110A3** (Oral), and **O0110B1** (Radiation), and **O0110O1** (IV Access) and **O0110O4** (Central).

Rationale: O0110H4 (Anticoagulation) is not checked because enoxaparin is administered subcutaneously, not intravenously. Even though the patient's port is not being accessed currently, they still have one and therefore O0110O1 (IV Access) and O0110O4 (Central) should be checked. The patient is also receiving oral chemotherapy and radiation so O0110A1 (Chemotherapy) and O0110A3 (Oral), and O0110B1 (Radiation) should be selected.

3. The patient has multiple myeloma and was discharged from an acute admission after a pathologic vertebral fracture with significant pain. On admission to the LTCH, referral documentation and physician orders include palliative radiation, lenalidomide, and notes that frequent transfusions are required. The patient has a port for pamidronate infusions due to hypercalcemia.

Coding: Check boxes **O0110A1** (Chemotherapy), **O0110A3** (Oral), and **O0110B1** (Radiation), **O0110I1** (Transfusions), **O0110H1** (IV Medications) and **O0110H10** (Other) and **O0110O1** (IV Access) and **O0110O4** (Central).

Rationale: The patient is receiving oral chemotherapy (lenalidomide), radiation, transfusions, an IV medication (pamidronate), which falls under "other" IV medications, and has a port. The transfusions are not noted to be occurring only with chemotherapy, and as such should be coded separately.

4. The patient has sleep apnea and requires a CPAP device to be worn when sleeping. The staff set up the humidifier element of the CPAP and the patient puts on the CPAP mask prior to falling asleep.

Coding: Check boxes **O0110G1** (Non-Invasive Mechanical Ventilator) and **O0110G3** (CPAP).

Rationale: The patient is able to breathe on their own and wears the CPAP mask when sleeping to manage their sleep apnea.

00150. Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar Trial (TCT) or Continuous Positive Airway Pressure (CPAP) Breathing Trial) by Day 2 of the LTCH Stay

00150. Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar Trial (TCT) or Continuous Positive Airway Pressure (CPAP) Breathing Trial) by Day 2 of the LTCH Stay (Note: Day 2 = Date of Admission to the LTCH (Day 1) + 1 calendar day)	
Enter Code <input type="checkbox"/>	A. Invasive Mechanical Ventilation Support upon Admission to the LTCH 0. No, not on invasive mechanical ventilation support upon admission → Skip to Z0400, Signature of Persons Completing the Assessment 1. Yes, on invasive mechanical ventilation support upon admission → Continue to 00150A2, Ventilator Weaning Status
Enter Code <input type="checkbox"/>	A2. Ventilator Weaning Status 0. No, determined to be non-weaning upon admission → Skip to Z0400, Signature of Persons Completing the Assessment 1. Yes, determined to be weaning upon admission → Continue to 00150B, Assessed for readiness for SBT by day 2 of LTCH stay
Enter Code <input type="checkbox"/>	B. Assessed for readiness for SBT by day 2 of the LTCH stay 0. No → Skip to Z0400, Signature of Persons Completing the Assessment 1. Yes → Continue to 00150C, Deemed medically ready for SBT by day 2 of the LTCH stay
Enter Code <input type="checkbox"/>	C. Deemed medically ready for SBT by day 2 of the LTCH stay 0. No → Continue to 00150D, Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay? 1. Yes → Continue to 00150E, If the patient was deemed medically ready for SBT, was SBT performed by day 2 of the LTCH stay?
Enter Code <input type="checkbox"/>	D. Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay? 0. No → Skip to Z0400, Signature of Persons Completing the Assessment 1. Yes → Skip to Z0400, Signature of Persons Completing the Assessment
Enter Code <input type="checkbox"/>	E. If the patient was deemed medically ready for SBT, was SBT performed by day 2 of the LTCH stay? 0. No 1. Yes

Item Rationale

- These data elements document the use of invasive mechanical ventilation support upon admission to the LTCH and the implementation of an SBT by day 2 of the LTCH stay.
- These data elements document the facility's implementation of evidence-based weaning guidelines that occurred as early as is beneficial to the patient during the LTCH patient stay when the patient is assessed as a candidate for weaning upon admission.

Coding Instructions

Complete only if A0250 = 01 Admission.

Complete by day 2 of the LTCH stay (day of admission to the LTCH plus one calendar day).

00150A. Invasive Mechanical Ventilation Support upon Admission to the LTCH

- Code 0, No, not on invasive mechanical ventilation support upon admission**, if the patient was **not** on invasive mechanical ventilation support upon admission to the LTCH. If coded No, not on invasive mechanical ventilation support upon admission, end data collection for 00150. Skip to Z0400, Signature of Persons Completing the Assessment.

- **Code 1, Yes, on invasive mechanical ventilation support upon admission,** if the patient was on invasive mechanical ventilation support upon admission to the LTCH. Continue to O0150A2, Ventilator Weaning Status.

O0150A2. Ventilator Weaning Status

- **Code 0, No, determined to be non-weaning upon admission,** if the patient has any type of electrical or pneumatic closed-system mechanical ventilator support device that delivers oxygen to a patient who is unable to support their own respiration and for whom weaning attempts are **not** expected or anticipated at the time of admission (e.g., patients who are chronically ventilated in the community or at a facility, or who have progressive neuromuscular disease, such as amyotrophic lateral sclerosis, or irreversible neurological injury or disease or dysfunction, such as high C-2 spinal cord injury). Patients receiving closed-system ventilation include patients receiving ventilation via a tracheostomy and patients with an endotracheal tube (e.g., nasally or orally intubated). Documentation in support of this item should be recorded and dated by day 2 of the LTCH stay, where day 1 is the day of admission. If coded 0, No, determined to be non-weaning upon admission, end data collection for O0150. Skip to Z0400, Signature of Persons Completing the Assessment.
- **Code 1, Yes, determined to be weaning upon admission,** if the patient has any type of electrical or pneumatic closed-system mechanical ventilation device that delivers oxygen to a patient who is unable to support their own respiration and for whom weaning attempts **are** expected or anticipated at the time of admission. Patients receiving closed-system ventilation include patients receiving ventilation via a tracheostomy and patients with an endotracheal tube (e.g., nasally or orally intubated). Documentation in support of this item should be recorded and dated by day 2 of the LTCH stay, where day 1 is the day of admission. Continue to O0150B, Assessed for readiness for SBT by day 2 of the LTCH stay.

Complete O0150B-O0150E only if O0150A = 1, Yes, on invasive mechanical ventilation support upon admission and O0150A2 = 1, Yes, determined to be weaning upon admission.

O0150B. Assessed for readiness for SBT by day 2 of the LTCH stay

- **Code 0, No,** if the patient was **not** assessed for readiness for SBT by day 2 of the LTCH stay. If coded No, end data collection for O0150. Skip to Z0400, Signature of Persons Completing the Assessment.
- **Code 1, Yes,** if the patient was assessed for readiness for SBT by day 2 of the LTCH stay. If coded Yes, continue to item O0150C, Deemed medically ready for SBT by day 2 of the LTCH stay.

O0150C. Deemed medically ready for SBT by day 2 of the LTCH stay

- **Code 0, No,** if the patient was **not** deemed medically ready for SBT by day 2 of the LTCH stay. If coded No, continue to item O0150D, Is there documentation of reason(s)

in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?

- **Code 1, Yes,** if the patient was deemed medically ready for SBT by day 2 of the LTCH stay. If coded Yes, continue to item O0150E, If the patient was deemed medically ready for SBT, was SBT performed by day 2 of the LTCH stay?

O0150D. Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?

- **Code 0, No,** if there is no documentation of reason(s) that the patient was deemed medically unready for SBT by day 2 of the LTCH stay. Skip to Z0400, Signature of Persons Completing the Assessment.
- **Code 1, Yes,** if there is documentation that the patient was deemed medically unready for SBT by day 2 of the LTCH stay. Skip to Z0400, Signature of Persons Completing the Assessment.

O0150E. If the patient was deemed medically ready for SBT, was SBT performed by day 2 of the LTCH stay?

- **Code 0, No,** if an SBT was not performed by day 2 of the LTCH stay.
- **Code 1, Yes,** if an SBT was performed by day 2 of the LTCH stay.

Coding Tips

- Day 1 of the LTCH stay is the day of admission to the LTCH.
- Day 2 of the LTCH stay is defined as the second day of the patient's LTCH stay. In other words, it is the day of admission to the LTCH plus one calendar day.
- If O0150A is marked "No, not on invasive mechanical ventilation support upon admission" or O0150A2 is marked "No, determined to be non-weaning upon admission," then completion of items O0150B through O0150E is not required for the patient.
- If O0150A is marked "Yes, on invasive mechanical ventilation support upon admission" and O0150A2 is marked "Yes, determined to be weaning upon admission," then proceed to O0150B.
- If O0150B is marked "No," then O0150C through O0150E are not required for the patient. Skip to Z0400, Signature of Persons Completing the Assessment. If O0150B is marked "Yes," then proceed to O0150C.
- The purpose of O0150D is to identify whether the reason(s) that the patient is deemed medically unready for SBT by day 2 of the LTCH stay is documented by the LTCH by the end of day 2 of the LTCH stay. The specific reason(s) are not required in the assessment.

- For O0150D, documentation in the medical record indicates explicit physician, registered nurse (RN), or respiratory therapist (RT) documentation of the reason that a patient was not deemed medically ready for SBT by day 2 of the LTCH stay.
- Only one item, either O0150D or O0150E, should be coded. The response to O0150C determines which one of these items is coded on each patient's assessment.

Examples

1. **Invasive Mechanical Ventilation Support upon Admission to the LTCH:** A patient with a history of heart failure was admitted to the acute care hospital to undergo a surgical implant of a left ventricular assist device (LVAD). After the surgery, the patient spent several days in the intensive care unit (ICU) and received mechanical ventilation for 3 days. The patient was liberated from the ventilator successfully while in the ICU. The patient was transferred to the cardiac step-down unit where they developed pneumonia. The patient began a course of antibiotic therapy and is now being admitted to the LTCH. Their LTCH stay will include the completion of the antibiotic treatment, and daily physical and occupational therapy to increase the patient's strength. The patient will complete their LVAD training prior to discharge to home.

Coding: O0150A would be coded **0, No, not on invasive mechanical ventilation support upon admission.**

Rationale: The patient is not on invasive mechanical ventilation upon admission to the LTCH.

2. **Invasive Mechanical Ventilation Support upon Admission to the LTCH:** A patient is being discharged from the acute care hospital after an acute episode of respiratory failure secondary to pneumonia. The patient is diagnosed with cystic fibrosis and has had recurrent respiratory infections over the course of 6 months. The patient was intubated in the emergency department and transferred to the ICU, where they were treated for the pneumonia. After several failed attempts to wean and extubate, the patient underwent surgery for placement of a tracheostomy tube. They remain fully ventilated and are being transferred to the LTCH for weaning. The patient is admitted to the ventilator weaning unit where they are anticipated to liberate from mechanical ventilation; this is recorded in their discharge summary as well as in their care plan upon admission to the LTCH.

Coding: O0150A would be coded **1, Yes, on invasive mechanical ventilation support upon admission** and O0150A2 would be coded **1, Yes, determined to be weaning upon admission.**

Rationale: The patient is on invasive mechanical ventilation upon admission to the LTCH, and it was documented in their care plan that they are anticipated to liberate from mechanical ventilation.

3. **Invasive Mechanical Ventilation Support upon Admission to the LTCH:** The patient is admitted to the LTCH after receiving treatment at an acute care facility secondary to a myasthenic crisis. While in the emergency department, the patient was placed on a mechanical ventilator to manage their elevated partial pressure of carbon dioxide (PaCO₂) levels. The patient has a tracheostomy tube in place from a prior admission to an acute care facility due to recurrent aspiration pneumonia. During this stay in the ICU, the patient had

several failed attempts to liberate from mechanical ventilation. Given the patient's history of myasthenia gravis and their recurrent aspiration pneumonias with subsequent need for tracheostomy tube, they are unlikely to fully liberate from mechanical ventilation. The patient's discharge summary indicates that they are expected to require nocturnal ventilation on discharge from the LTCH.

Coding: O0150A would be coded **1, Yes, on invasive mechanical ventilation support upon admission** and O0150A2 would be coded **0, No, determined to be non-weaning upon admission**.

Rationale: The patient is on invasive mechanical ventilation upon admission to the LTCH; however, they are unlikely to fully liberate from mechanical ventilation due to their condition.

4. **Assessed for readiness for SBT by day 2 of the LTCH stay:** A patient is transferred to the ventilator unit at the LTCH for weaning and physical therapy to increase their endurance. The patient is approximately 6 weeks status post a bone marrow transplant and is deconditioned due to chronic shortness of breath that does not allow them to perform most activities of daily living (ADLs) independently. The patient's current admission to the acute care facility was due to acute respiratory distress; they were admitted to the ICU with a diagnosis of idiopathic pneumonia syndrome. During the ICU stay, the patient suffered several failed attempts to liberate from mechanical ventilation.

On admission to the LTCH the patient was receiving full mechanical ventilation through a tracheostomy tube. There is documentation in their admission summary and their LTCH care plan that they are anticipated to liberate from mechanical ventilation. The LTCH physician orders the weaning protocol that requires assessment for SBT by day 2 of the LTCH stay. The patient is expected to wean from mechanical ventilation. They were not assessed on day 2 of their LTCH stay due to a clinical change in their condition. The patient's assessment for readiness for SBT occurred on day 4 of the LTCH stay due to 48 hours of severe nausea, vomiting, and diarrhea, which temporarily increased their shortness of breath and exacerbated their deconditioned status. Due to the patient's high respiratory rate and a decrease in blood pressure, they did not meet criteria for assessment for SBT.

Coding: O0150B would be coded **0, No**, the patient was not assessed for SBT by day 2 of the LTCH stay.

Rationale: The patient was assessed for readiness for SBT on day 4 of the LTCH stay due to a clinical change in their condition that did not allow them to be assessed by day 2 of the LTCH stay.

5. **Assessed for readiness for SBT by day 2 of the LTCH stay:** A patient with cystic fibrosis was discharged from the ICU to the ventilator weaning unit at the LTCH. They were admitted to the ventilator weaning unit yesterday afternoon. Their night was stable, they were comfortable on the new ventilator, and they are eager to begin their weaning trials. The patient's care plan includes weaning trials and assessment for SBT on day 2 of their LTCH stay. The patient was assessed for SBT trial on the day after their admission to the LTCH, which is day 2 of the LTCH stay.

The LTCH uses evidence-based criteria to assess a patient's readiness to perform the SBT. The patient's assessment included but was not limited to the following: their pneumonia is

resolving, their gas exchange is adequate on positive end-expiratory pressure (PEEP) of 5 centimeters of water (cmH₂O) and fraction of inspired oxygen (FiO₂) of 40%, they are hemodynamically stable, they have a rapid shallow breathing index (RSBI) < 105, and they have the capacity to breathe spontaneously.

Coding: O0150B would be coded **1, Yes**, the patient was assessed for SBT by day 2 of the LTCH stay.

Rationale: The patient was assessed for SBT trial on the day after their admission to the LTCH, which is day 2 of the LTCH stay.

6. **Deemed medically ready for SBT by day 2 of the LTCH stay:** The patient is admitted to the LTCH with a diagnosis of hypercarbic hypoxemic respiratory failure secondary to a chronic obstructive pulmonary disease (COPD) exacerbation brought on by flu-like symptoms. While the patient was in the ICU, they required intubation and mechanical ventilation. The patient was extubated twice and was placed on non-invasive ventilation (NIV) immediately following both extubations. Both attempts at NIV led to elevated PaCO₂ levels and respiratory distress, which required re-intubation and ventilation. After the second failed attempt to liberate the patient from mechanical ventilation, they underwent a procedure to insert a tracheostomy tube. The patient has been stable in the ICU and transferred to the LTCH early this morning. The acute care referral and the attending physician notes from the ICU state that the patient is expected to wean off mechanical ventilation.

The patient was assessed for readiness for SBT on the day they were admitted to the LTCH. The patient did not pass their SBT assessment. The patient's assessment included evidence-based guidelines to assess their readiness to perform SBT. It was noted in the medical record by the RT that the patient had significant auto PEEP levels and breath stacking. The physician ordered the patient's applied PEEP to be increased to a level above the acceptable high range for readiness to perform SBT.

Coding: O0150C would be coded **0, No**, the patient was not deemed medically ready for SBT by day 2 of the LTCH stay.

Rationale: The patient did not pass their SBT assessment.

7. **Deemed medically ready for SBT by day 2 of the LTCH stay:** A patient with cystic fibrosis was discharged from the ICU yesterday and admitted to the ventilator weaning unit at the LTCH. They had a stable first night and transitioned from the ICU ventilator to the LTCH ventilator without issue. The patient understands that they passed the SBT criteria and are medically stable and ready to transition to spontaneous breathing via a trach mask. The RN and RT coordinated the trial for SBT to begin when the patient is finished with routine morning care.

Coding: O0150C would be coded **1, Yes**, the patient was deemed medically ready for SBT by day 2 of the LTCH stay.

Rationale: The patient passed the SBT criteria and is medically stable and ready to transition to spontaneous breathing via a trach mask.

8. **Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?:** The patient is admitted to the LTCH from the ICU at the acute care facility. The patient suffered a cervical spine,

C4/C5, injury following a diving accident. They were intubated at the scene and transferred to the acute care facility and surgical ICU. The patient is status post cervical spine surgery. Their course in the ICU was stable, but they did require bedside surgery for a percutaneous tracheostomy after a failed trial to extubate. The patient was eventually liberated from mechanical ventilation while in the ICU. From the ICU, they were transferred to the surgical floor with a tracheostomy tube in place receiving oxygen and humidification. While on the surgical floor, the patient was found unresponsive with agonal breathing and hypoxemia in the setting of secretions plugging their trach tube. The patient was placed back on mechanical ventilation in the ICU. The patient is now admitted to the LTCH ventilator weaning unit. It is documented in the patient's discharge summary that they are anticipated to liberate from mechanical ventilation prior to discharge from the LTCH. The discharge summary also states that due to the patient's inability to manage their secretions, they may not be a candidate for tracheostomy decannulation. It is also documented in the patient's admission care plan that they are expected to liberate from mechanical ventilation prior to discharge from the LTCH.

The patient was deemed medically unready for SBT when assessed on the day after admission to the LTCH. There is no documentation in the medical record why the patient was medically unready for SBT by day 2 of the LTCH stay.

Coding: O0150D would be coded **0**, No, there is no documentation in the medical record that indicates that the patient was deemed medically unready for SBT by day 2 of the LTCH stay.

Rationale: There is no documentation in the medical record stating why the patient was medically unready for SBT by day 2 of the LTCH stay.

9. **Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?:** The patient is admitted to the LTCH with a diagnosis of hypercarbic hypoxemic respiratory failure secondary to a COPD exacerbation brought on by flu-like symptoms. While the patient was in the ICU, they required intubation and mechanical ventilation. The patient was extubated twice and was placed on NIV. Both attempts at NIV led to elevated PaCO₂ levels, which led to the patient being re-intubated and placed on mechanical ventilation. After the second failed attempt to liberate the patient, they underwent a procedure to insert a tracheostomy tube. The patient was admitted to the LTCH yesterday and is expected to wean off mechanical ventilation as documented in their admission care plan.

The patient was assessed for readiness for SBT on the day of their admission to the LTCH. The patient did not pass the SBT assessment. The patient's assessment included evidence-based guidelines to assess their readiness to perform SBT. It was noted in the medical record by the RT that patient had significant auto PEEP levels and breath stacking. The physician ordered the patient's applied PEEP to be increased to a level above the acceptable high range for readiness to perform SBT. The treatment plan is to increase the patient's bronchodilator treatments and to stop their steroid taper. The physician order and the documentation of breath stacking and significant auto PEEP are documented in the medical chart.

Coding: O0150D would be coded **1**, Yes, there is documentation in the medical record that indicates that the patient was deemed medically unready for SBT by day 2 of the LTCH stay.

Rationale: There is documentation in the medical chart on why the patient was medically unready for SBT by day 2 of the LTCH stay.

10. **SBT performed by day 2 of the LTCH stay:** A patient is admitted to the LTCH with a diagnosis of non-small cell lung cancer. After a successful pneumonectomy procedure, the patient was transferred to the surgical ICU. While in the ICU, they required high levels of oxygen to maintain normal oxygen saturations. They eventually required intubation and ventilation for respiratory distress. The patient's course was then complicated by the development of acute respiratory distress syndrome (ARDS). The patient was treated for ARDS and slowly improved over the course of 2 weeks; during this 2-week period they underwent a procedure to place a tracheostomy tube. Yesterday the patient was discharged to the LTCH, where they were admitted to the ventilator weaning unit. It is documented in the patient's care plan that they are expected or anticipated to liberate from mechanical ventilation prior to discharge.

The patient was assessed on the day of admission and determined to be medically ready for SBT. However, due to inconsistent communication among the healthcare team, the patient did not perform the SBT until the third day of the LTCH stay.

Coding: O0150E would be **coded 0, No**, if an SBT was not performed by day 2 of the LTCH stay.

Rationale: The patient did not perform the SBT until day 3 of the LTCH stay.

11. **SBT performed by day 2 of the LTCH stay:** A patient with cystic fibrosis was discharged from the ICU yesterday and admitted to the ventilator weaning unit at the LTCH. They were assessed for readiness for the SBT on the morning of their second day at the LTCH. They passed the criteria for the SBT and were deemed medically ready to perform the SBT. The patient completed their morning routine and was placed on the SBT using a trach mask. The patient tolerated the tracheostomy mask wean for 45 minutes.

Coding: O0150E would be **coded 1, Yes**, if an SBT was performed by day 2 of the LTCH stay.

Rationale: The patient performed SBT on day 2 of the LTCH stay.

O0200. Ventilator Liberation Rate

O0200. Ventilator Liberation Rate (Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge)	
Enter Code <input type="text"/>	A. Invasive Mechanical Ventilator: Liberation Status at Discharge 0. Not fully liberated at discharge (i.e., patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge) 1. Fully liberated at discharge (i.e., patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge) 9. Not applicable (code only if the patient was not on invasive mechanical ventilator support upon admission [O0150A = 0] or the patient was determined to be non-weaning upon admission [O0150A2 = 0])

Item Rationale

- To determine the facility's rate of discontinuation of invasive mechanical ventilation, known as weaning or liberation, which is associated with improved patient health outcomes.

Coding Instructions

*Complete only if A0250 = 10 Planned Discharge or 11 Unplanned Discharge.
 Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge.*

O0200A. Invasive Mechanical Ventilator: Liberation Status at Discharge

- Code 0, Not fully liberated at discharge**, if the patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge.
- Code 1, Fully liberated at discharge**, if the patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge.
- Code 9, Not applicable**, if this item does not apply. This code only applies if the patient was not on invasive mechanical ventilation support on admission (O0150A = 0) or the patient was determined to be non-weaning upon admission (O0150A2 = 0).

Coding Tips

- For patients to be considered fully liberated, patients should not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge and upon discharge.

Examples

- Invasive Mechanical Ventilator: Liberation Status at Discharge:** The patient was admitted to the LTCH with a diagnosis of hypercarbic hypoxemic respiratory failure secondary to a COPD exacerbation. While the patient was in the ICU, they underwent two attempts to wean fully from the ventilator and had two unsuccessful trials of BiPAP post

extubation. The patient was admitted to the LTCH with the expectation of fully liberating from invasive mechanical ventilation.

Despite several attempts to wean the patient from the ventilator they were unable to maintain normal PaCO₂ levels for greater than a few hours. The patient remained fully ventilated until the time they were discharged to the acute care facility with sepsis.

Coding: O0200A would be **coded 0, Not fully liberated at discharge** from mechanical ventilation.

Rationale: The patient was not fully liberated from mechanical ventilation at discharge.

2. **Invasive Mechanical Ventilator: Liberation Status at Discharge:** A patient is being discharged from the LTCH to a skilled nursing facility. The patient was admitted to the ventilator weaning unit after their ICU stay at an acute care hospital. The patient is diagnosed with cystic fibrosis complicated by multiple, recurrent respiratory infections and had a tracheostomy tube placed while at the acute care hospital after they failed several attempts to liberate from mechanical ventilation. While at the LTCH, the patient successfully liberated from mechanical ventilation. The patient will be discharged to a skilled nursing facility for tracheal decannulation, and they have not required invasive mechanical ventilation for at least 2 consecutive calendar days immediately prior to this discharge.

Coding: O0200A would be **coded 1, Fully liberated at discharge**.

Rationale: The patient did not require invasive mechanical ventilation for at least 2 consecutive calendar days immediately prior to discharge and was fully liberated at discharge.

3. **Invasive Mechanical Ventilator: Liberation Status at Discharge:** The patient was diagnosed several years ago with amyotrophic lateral sclerosis and has been managing their respiratory system adequately using a non-invasive ventilator. Over the past 2 months it has become increasingly difficult for the patient to maintain ventilation using a non-invasive ventilator in the home without developing pneumonia and atelectasis. The patient was recently admitted to the ICU at an acute care hospital for elective surgery to receive a tracheostomy tube and subsequently be placed on full invasive mechanical ventilation. After the patient's 3-day stay in the ICU, they were stable on appropriate ventilator settings and transferred to the LTCH to prepare their family and caretakers to care for the patient's needs in the home setting.

Coding: O0200A would be **coded 9, Not applicable** since this patient was admitted as non-weaning upon admission.

Rationale: The patient is on invasive mechanical ventilation but was determined to be non-weaning on admission due to their condition.

O0350. Patient's COVID-19 Vaccination Is Up to Date

O0350. Patient's COVID-19 vaccination is up to date.	
Enter Code	0. No, patient is not up to date 1. Yes, patient is up to date

Item Rationale

- The intent of this item is to report if a patient is up to date with their COVID-19 vaccine status.
- Age is the strongest risk factor for severe coronavirus disease 2019 (COVID-19) outcomes. In 2020, persons aged 65 years or older accounted for 81% of United States (U.S.) COVID-19-related deaths.
- Severe illness caused by COVID-19 means that the person with COVID-19 may require hospitalization, intensive care, ventilator support for breathing, or may even die.
- A strong infection prevention and control program (IPCP) is vital to protect both patients and healthcare personnel (HCP).
- Remaining up to date with all recommended COVID-19 vaccine doses is critical to protect both staff and patients from SARS-CoV-2 infection.
- COVID-19 vaccines currently approved or authorized by the U.S. Food and Drug Administration (FDA) are effective in reducing the risk of serious outcomes of COVID-19, including severe disease, hospitalization, and death.
- Efforts to increase the number of people in the U.S. who are up to date with their COVID-19 vaccines remain an important strategy to preventing illnesses, hospitalizations, and deaths from COVID-19.
- A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. Serious problems from COVID-19 vaccine are very rare. More information about potential side effects of the COVID-19 vaccine, precautions, and contraindications can be found on the Centers for Disease Control and Prevention (CDC) webpage “Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States” at <https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications>.

Guidelines for Assessment

- Vaccination status may be determined based on information from any available source.
- Review the patient’s medical record or documentation of COVID-19 vaccination and/or interview the patient, family, or other caregivers or healthcare providers to determine whether the patient is up to date with their COVID-19 vaccine.
- If the patient is **not up to date**, and the facility has the vaccine available, ask the patient if they would like to receive the COVID-19 vaccine.

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. Coding Tips

- If there is conflicting information regarding a patient's vaccination status, use clinical judgment to determine if the patient is up to date with their COVID-19 vaccine based on information from any available source.
- Current COVID-19 vaccine recommendations are available on the CDC webpage "Staying Up to Date with COVID-19 Vaccines" at <https://www.cdc.gov/covid/vaccines/stay-up-to-date.html>