

## APPENDIX A: GLOSSARY AND COMMON ACRONYMS

### Appendix A: Glossary and Common Acronyms

Term	Definition
<b>Active Diagnoses</b>	Diagnoses (conditions or diseases) that have a direct relationship to the patient's current functional, cognitive, mood, or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
<b>Activities of Daily Living (ADLs)</b>	Activities performed as part of a person's daily routine such as self-care, bathing, dressing, eating, and toileting.
<b>Activity</b>	The performance of a task or action by an individual (definition from the World Health Organization's International Classification of Functioning, Disability and Health [ICF]).
<b>Activity Limitation</b>	A restriction or lack of ability to perform an activity in the manner or within a range considered normal for a person of the same age, culture, and education.
<b>Admission Date</b>	The date a person enters the LTCH and is admitted as a patient. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the first day of admission.
<b>Ambulation</b>	Self-mobilization along a surface on foot, step by step so that one foot is always in contact with the ground. Ambulation may include walking short or long distances and walking on different surfaces as specified in the assessment item. Movement from place to place, which usually includes walking.
<b>Assessment Period</b>	The 4-day assessment period for the admission assessment includes the day of admission and the 3 days following the day of admission, ending at 11:59 pm. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge.
<b>Assessment Reference Date (ARD)</b>	The end-point of the assessment period for the LCDS assessment record.
<b>Assessment Submission</b>	The electronic submission of the LCDS data to iQIES. The data are required to be in formats that conform to standard record layouts and data dictionaries, and pass standardized edits as defined by CMS. Chapter 4 of this manual and the LCDS Data Submission Specifications on the CMS LTCH Quality Reporting Technical Information webpage ( <a href="https://www.cms.gov/medicare/quality/long-term-care-hospital/lrch-quality-reporting-technical-information">https://www.cms.gov/medicare/quality/long-term-care-hospital/lrch-quality-reporting-technical-information</a> ) provide detailed information.
<b>Assessment Time Frame</b>	Refers to when assessments must be conducted. The assessment time frame is <i>not</i> the same for all assessment types and is illustrated in Table 2-1 and Table 2-2 in Chapter 2 of this manual.
<b>Board and Care, Assisted Living, Group Home</b>	A non-institutional community residential setting that includes homemaker/personal care services or meal services.
<b>Body Mass Index (BMI)</b>	Number calculated from a person's weight and height. BMI is a reliable indicator of body fat and is used as an indicator to identify possible weight problems for adults.

Term	Definition
<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>	The Federal agency that administers the Medicare, Medicaid, and the Child Health Insurance Program (CHIP).
<b>CMS Certification Number (CCN)</b>	Replaces the term “Medicare/Medicaid Provider Number” in survey, certification, and assessment-related activities.
<b>Comatose (Coma)</b>	Pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; the person does not open their eyes, does not speak, and does not move their extremities on command or in response to noxious stimuli (e.g., pain).
<b>Completion Date</b>	The date all required information has been collected and recorded for a particular assessment and staff have signed and dated that the assessment is complete. This date should represent the date the completion of the assessment record has been verified by the individual authorized to do so.
<b>Confusion Assessment Method (CAM)</b>	An instrument that screens for overall cognitive impairment as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments.
<b>Constipation</b>	A condition of more than short duration where someone has fewer than three bowel movements a week or stools that are usually hard, dry, and difficult and/or painful to eliminate.
<b>Contact with Physician (or Physician-Designee)</b>	Communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue, AND a response from the physician (or physician-designee) to convey prescribed/ recommended actions in response to the medication issue. Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status. Communication can be directly to/from the physician (or physician-designee), or indirectly through physician’s office staff on behalf of the physician (or physician-designee), in accordance with the legal scope of practice.
<b>Continence</b>	Any void into a commode, urinal, or bedpan that occurs voluntarily or as a result of prompted toileting, assisted toileting, or scheduled toileting.

Term	Definition
<b>Critical Access Hospital (CAH)</b>	<p>CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoPs) as well as a separate payment method.</p> <p>The following providers may be eligible to become CAHs:</p> <ul style="list-style-type: none"> <li>• Currently participating Medicare hospitals;</li> <li>• Hospitals that ceased operations on or after November 29, 1989; or</li> <li>• Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.</li> </ul> <p>A Medicare-participating hospital must meet the following criteria to be designated by CMS as a CAH:</p> <ul style="list-style-type: none"> <li>• Be located in a State that has established a State Medicare Rural Hospital Flexibility Program;</li> <li>• Be designated by the State as a CAH;</li> <li>• Be located in a rural area or an area that is treated as rural;</li> <li>• Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified as a CAH based on State designation as a "necessary provider" of healthcare services to residents in the area;</li> <li>• Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services;</li> <li>• Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units);</li> <li>• Demonstrate compliance with the CAH CoPs found at 42 CFR Part 485 subpart F; and</li> <li>• Furnish 24-hour emergency care services 7 days a week.</li> </ul> <p>A CAH may also be granted "swing-bed" approval to provide post-hospital Skilled Nursing Facility-level care in its inpatient beds.</p> <p>In addition to the 25 inpatient CAH beds, a CAH may also operate a psychiatric and/or a rehabilitation distinct part unit of up to 10 beds each. These units must comply with the Hospital Conditions of Participation.</p>
<b>Deep Tissue Injury (DTI)</b>	Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler compared with adjacent tissue.
<b>Delirium</b>	A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations.
<b>Discharge Assessment</b>	An assessment required on patient discharge. Discharge Assessments include LCDS Planned Discharge or Unplanned Discharge Assessments (Item A0250 = 10 or 11, respectively). These assessments include clinical items for quality monitoring as well as discharge tracking information.
<b>Discharge Date</b>	The date a patient leaves the LTCH. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual Date of Discharge on the LCDS Planned or Unplanned Discharge Assessments or the Date of Death (A0270) on the LCDS Expired Assessment. If a discharge is delayed, the Discharge Date is the day the patient actually leaves the LTCH.

Term	Definition
<b>Disorganized Thinking</b>	Evidenced by rambling, irrelevant, and/or incoherent speech.
<b>Drug Regimen Review</b>	The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using, and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
<b>Electronic Health Record (EHR)/ Electronic Medical Record (EMR)</b>	An electronic health record (EHR), sometimes referred to as an electronic medical record (EMR), is an electronic version of a patient's medical history that is maintained by the provider over time. This may include key clinical data relevant to that person's care under a particular provider, including demographics, progress notes, medical conditions, diagnoses, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. <a href="https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-are-electronic-health-records-ehrs">https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-are-electronic-health-records-ehrs</a>
<b>Epithelial Tissue</b>	New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.
<b>Eschar Tissue</b>	Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scablike. Eschar tissue is usually firmly adherent to the base of the wound and often the sides/edges of the wound.
<b>Expired Assessment</b>	The assessment that is completed when a patient dies in the LTCH, or dies during an interrupted stay of fewer than 3 calendar days at another hospital/facility.
<b>Facility Identification Number (FAC ID)</b>	The number that is assigned to each LTCH by iQIES. The FAC ID must be placed in the individual LCDS and tracking form records. This normally is completed as a function within the facility's LCDS data entry software.
<b>Fall</b>	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. An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themselves 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.
<b>Fatal File Error</b>	An error in the LCDS submission file format that causes the entire file to be rejected; therefore, the individual assessment records in the submission file are not validated or stored in the iQIES. The Submitter Final Validation Report identifies Fatal File Error(s). The LTCH must contact its software support to resolve the problem with the submission file. Once the submission file problem is resolved, the submission file and associated LCDS assessment records must be resubmitted.

Term	Definition
<b>Fatal Record Error</b>	An error in an LCDS assessment record that results in the assessment record being rejected. The Final Validation Report lists the assessment records that were rejected. The LTCH must correct error(s) on each assessment record that was rejected, and resubmit.
<b>Fecal Impaction</b>	A mass of dry, hard stool that can develop in the rectum due to chronic constipation. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction or obstruction.
<b>Federal Register</b>	The official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential documents. It is a publication of the National Archives and Records Administration, and is available by subscription and online.
<b>Final Validation Report (FVR)</b>	A report generated after the successful submission of LCDS assessment record files. This report lists all of the patients for whom assessments have been submitted in a particular submission batch and displays all errors and/or warnings that occurred during the validation process. Each individual record is listed on the FVR as “accepted” or “rejected.” Accepted records are added to the iQIES database. Rejected records are not added to the iQIES database and must be corrected and resubmitted.
<b>Fluctuance</b>	The texture of wound tissue indicative of underlying unexposed fluid.
<b>Fluctuating Course</b>	Disease symptoms that tend to come and go or increase and decrease in severity.
<b>Fluctuation</b>	Refers to a behavior that tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of an interview/ discussion or the assessment period. Fluctuating behavior may be noted by staff or family or documented in the medical record.
<b>Granulation Tissue</b>	Red tissue with “cobblestone” or bumpy appearance; bleeds easily when injured.
<b>Health Information Exchange (HIE)</b>	Health Information Exchange (HIE) allows healthcare professionals and patients to appropriately access and securely share a patient’s medical information electronically. There are many healthcare delivery scenarios driving the technology behind the different forms of HIE available today including directed exchange, query-based exchange, and consumer-mediated exchange.
<b>Health Insurance Portability and Accountability Act of 1996 (HIPAA)</b>	Federal law that gives the Department of Health and Human Services (DHHS) the authority to mandate regulations that govern privacy, security, and electronic transaction standards for healthcare information.
<b>Home Health Agency</b>	A Medicare-certified organization that provides home care services, such as skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
<b>Hospice</b>	A program for terminally ill persons. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient’s family or caregiver.
<b>Hospital Emergency Department</b>	An organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.
<b>Impairment</b>	Any loss or abnormality of psychological, physiological, or anatomical structure or function.

Term	Definition
<b>Inactivation</b>	A type of correction allowed under the LCDS Correction Policy. When an erroneous record has been accepted into the iQIES database, an inactivation request is required. This removes the erroneous record from the active file to an archive (history file). A new record to replace the removed record must be completed and submitted to iQIES.
<b>Inattention</b>	Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated, or darting attention).
<b>Incontinence</b>	Involuntary loss of urine, when there is a loss of control of the evacuation of urine from the bladder, regardless of whether clothing or linens are soiled.
<b>Injury (except major)</b>	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.
<b>Injury Related to a Fall</b>	Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.
<b>Inpatient Psychiatric Facility</b>	For the purposes of coding item A2105, this code should be used when a patient is admitted from/transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.
<b>Inpatient Rehabilitation Facility (IRF) or Unit</b>	A rehabilitation hospital, or a distinct rehabilitation unit of a hospital, that provides an intensive rehabilitation program to inpatients.
<b>Intellectually Disabled/ Developmentally Disabled (ID/DD) Facility</b>	An institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals with intellectual disabilities (ID) or developmental disabilities (DD).
<b>International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM)</b>	Official system of assigning codes to diagnoses associated with hospital utilization in the United States. The ICD-10-CM contains a numerical list of the disease code numbers in tabular form and an alphabetical index to the disease entries.
<b>Interoperable/ Interoperability</b>	<p>“Interoperability,” with respect to health information technology, means health information technology that: “(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; (B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and (C) does not constitute information blocking as defined in section 3022(a).”</p> <p>Section 4003 of the 21st Century Cures Act, available at: <a href="https://www.healthit.gov/topic/interoperability">https://www.healthit.gov/topic/interoperability</a></p>



Term	Definition
<b>Interrupted Stay</b>	A stay by a patient who is discharged from the LTCH and returns to the same LTCH within 3 consecutive calendar days. Since Medicare treats this situation as one combined LTCH stay, the LTCH would not need to repeat all of the required documentation when the patient returns to the LTCH after the interruption. However, it is expected that the LTCH update the information in the patient's medical record to make sure that it is current (i.e., update the patient's condition, comorbidities, goals, plan of care, etc.). If the patient returns to the LTCH in 4 or more consecutive days (i.e., it is not considered an interrupted stay), then all of the required documentation must be completed as with any "new" LTCH patient.
<b>Item Set</b>	LCDS items that are included on a particular assessment type. The item set for a particular LCDS is determined by the reason for assessment item (A0250).
<b>Legal Name</b>	Patient's name as it appears on the Medicare card. If the patient is not enrolled in the Medicare program, the patient's name as it appears on a Medicaid card or other government-issued document is used.
<b>Length of Stay (LOS)</b>	The number of days a patient spends in the LTCH. The day of discharge is not counted in the length-of-stay calculation. Length of stay does not include the interrupted stay days. It includes all days that the patient is in the LTCH for the midnight census.
<b>Long-Term Care Facility</b>	An institution that is engaged primarily in providing medical and nonmedical care to people who have a chronic illness or disability. These facilities provide care to people who cannot be cared for at home or in the community. Long-term care facilities provide a wide range of personal care and health services for individuals who cannot take care of themselves because of physical, emotional, or mental health issues. The provision of nonskilled care and related services for residents in long-term care can include, but is not limited to, supportive services such as dressing, bathing, using the bathroom, diabetes monitoring, and medication administration.
<b>Long-Term Care Hospital (LTCH)</b>	A facility certified as a hospital and designated as a long-term care hospital under the Medicare program (as denoted by the last four digits of its six-digit CMS Certification Number [CCN] in the range of 2000–2299).
<b>Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS)</b>	A core set of data elements, including common definitions and coding categories that form the foundation of the required assessment for all patients treated in hospitals that are certified to participate in Medicare and designated as LTCHs. This core set of data elements is used to collect data to satisfy the requirements of the LTCH QRP.
<b>Major Injury</b>	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.
<b>Major Surgery</b>	Generally, for the purposes of the LCDS, major surgery refers to a procedure that meets all the following criteria: (1) the patient was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the LCDS, and (2) the surgery carried some degree of risk to the patient's life or the potential for severe disability.
<b>Medicaid</b>	A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.

Term	Definition
<b>Medicare</b>	<p>A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities.</p> <ul style="list-style-type: none"> <li>• Medicare Part A: The part of Medicare that covers inpatient hospital services and services furnished by other institutional healthcare providers, such as nursing facilities, home health agencies, and hospices.</li> <li>• Medicare Part B: The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services.</li> <li>• Medicare Part C (Medicare Advantage): Plans that are offered by private companies approved by Medicare.</li> </ul>
<b>Medicare Beneficiary Identifier (MBI)</b>	<p>A randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously used SSN-based Medicare HIC Number (HICN). Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.</p>
<b>Medication Follow-Up</b>	<p>The process of contacting a physician (or physician-designee) to communicate the identified medication issue and addressing all physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day at the latest.</p>
<b>Modification</b>	<p>A type of correction allowed under the LCDS Correction Policy. A modification is required when an LCDS record has been accepted by iQIES, but the information in the record contains errors. The modification will correct the record in iQIES.</p>
<b>Motorized Wheelchair/ Scooter</b>	<p>Battery-powered vehicles that are used for home or community self-mobilization. Motorized wheelchairs provide more trunk and extremity support than a motorized scooter, which may be smaller than a motorized wheelchair. These motorized vehicles can be used in the home or outdoors. Adaptations for controlling the speed and steering direction of the vehicle with hand, arm, foot, head, or mouth controls can be designed and implemented.</p>
<b>National Provider Identifier (NPI)</b>	<p>A unique Federal number that identifies providers of healthcare services. The NPI applies to the LTCH and all of its patients.</p>
<b>Necrotic Tissue</b>	<p>Dead or devitalized tissue categorized as eschar or slough. Necrotic tissue is usually firmly adherent to the base of the wound and often the sides/edges of the wound.</p>
<b>No Injury</b>	<p>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 a fall.</p>
<b>Non-blanchable</b>	<p>Reddened areas of tissue that do not turn white or pale after pressed firmly with a finger or device.</p>
<b>Non-removable Dressing/Device</b>	<p>A dressing or device such as a primary surgical dressing that cannot be removed, per physician's order, an orthopedic device, or a cast.</p>
<b>Nurse Monitoring</b>	<p>Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management).</p>
<b>On Admission</b>	<p>As close to the actual time of admission as possible.</p>
<b>Orthosis</b>	<p>An appliance (device) applied over a portion of a limb or the trunk and used to support or immobilize body parts, correct or prevent deformity, or assist or restore function. Anti-embolic (and other) stockings, abdominal binders, and elastic wraps are examples of orthoses.</p>



Term	Definition
<b>Outlier</b>	Observation outside a certain range differing widely from the rest of the data.
<b>Participation</b>	An individual's involvement in life situations in relation to health conditions, body functions and structures, and activities and contextual factors (definition from the World Health Organization's International Classification of Functioning, Disability and Health [ICF]).
<b>Persistent Vegetative State (PVS)</b>	Sometimes patients who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.
<b>Planned Discharge</b>	A discharge where the patient is non-emergently, medically released from care at the LTCH, for longer than 3 days, for some reason arranged for in advance.
<b>Portal (e.g., patient or provider portal)</b>	A secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, providers and patients can view health information such as current medications, recent doctor visits, and discharge summaries. Office of the National Coordinator, What is a patient portal? <a href="https://www.healthit.gov/fag/what-patient-portal">https://www.healthit.gov/fag/what-patient-portal</a>
<b>Potential (or Actual) Clinically Significant Medication Issue</b>	A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.
<b>Pressure Ulcer/Injury</b>	Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.
<b>Private Home or Apartment</b>	Non-institutional community residential settings that include any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities and independent housing for the elderly.
<b>Prospective Payment System</b>	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups [DRGs] for inpatient hospital services).
<b>Prosthesis</b>	A device that replaces a body part.
<b>Qualified Clinician</b>	A healthcare professional practicing within their scope of practice and consistent with Federal, State, and local law and regulations.
<b>Quality Measure</b>	Tool that helps measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare. These goals include effective, safe, efficient, patient-centered, and timely care.
<b>Short-Term General Hospital</b>	A hospital that has contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.

Term	Definition
<b>Skilled Nursing Facility (SNF)</b>	A Medicare-certified nursing facility with the staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category includes swing-bed hospitals, which are generally small, rural hospitals or critical access hospitals (CAHs) participating in Medicare that have CMS approval to provide post-hospital SNF care and meet certain requirements.
<b>Slough Tissue</b>	Nonviable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.
<b>Social Security Number (SSN)</b>	A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.
<b>Stage 1 Pressure Injury</b>	An observable, pressure-related alteration of intact skin whose indicators, as compared with an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues.
<b>Stage 2 Pressure Ulcer</b>	Partial-thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.
<b>Stage 3 Pressure Ulcer</b>	Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.
<b>Stage 4 Pressure Ulcer</b>	Full-thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
<b>State Medicaid Provider Number</b>	Medicaid Provider Number established by a State.
<b>Stress Incontinence</b>	Episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
<b>Submission Confirmation Page</b>	The initial feedback generated by the iQIES system after an LCDS data file is electronically submitted. This page acknowledges receipt of the submission file but does not examine the file for any warnings and/or errors. Warnings and/or errors are provided on the Final Validation Report.
<b>Submission Date</b>	The date on which the completed LCDS Admission, Planned Discharge, Unplanned Discharge, or Expired Assessment is submitted to iQIES.
<b>Tunneling</b>	A passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.
<b>Undermining</b>	The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

Term	Definition
<b>Unplanned Discharge</b>	An unplanned transfer of the patient to be admitted to another hospital/facility that results in the patient's absence from the LTCH for longer than 3 calendar days (including the date of transfer) or the patient's discharge from the LTCH; or a transfer of the patient to an emergency department of another hospital to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation, which results in the patient's absence from the LTCH for longer than 3 calendar days; or when a patient unexpectedly decides to go home or to another hospital/facility (e.g., patient prefers to complete treatment in an alternate setting).
<b>Unstageable Pressure Ulcer/Injury</b>	Visualization of the wound bed is necessary for accurate numerical staging. If the extent of soft tissue damage cannot be visualized or palpated in the wound bed, that pressure ulcer/injury should be classified as unstageable. For example, pressure ulcers/injuries may be unstageable due to eschar or slough or non-removable dressing/device.
<b>Usual Performance</b>	A patient's functional status can be impacted by the environment or situations encountered at the facility. Observing the patient's interactions with others in different locations and circumstances is important for a comprehensive understanding of the patient's functional status. If the patient's functional status varies, record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance.
<b>Worsening in Pressure Ulcer/Injury Status</b>	Pressure ulcer/injury "worsening" is defined as a pressure ulcer/injury that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1–4 (using the staging assessment determinations assigned to each stage, starting at stage 1, and increasing in severity to stage 4) on a discharge assessment as compared with the admission assessment. To denote the absence of a pressure ulcer/injury or that there is no skin breakdown or evidence of damage, indicate that there are zero pressure ulcers/injuries.

## Common Acronyms

Acronym	Definition
ADLs	Activities of Daily Living
APU	Annual Payment Update
ARD	Assessment Reference Date
BMI	Body Mass Index
CAH	Critical Access Hospital
CAM	Confusion Assessment Method
CCN	CMS Certification Number
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DTI	Deep Tissue Injury
EHR/EMR	Electronic Health Record/Electronic Medical Record
FVR	Final Validation Report
FY	Fiscal Year
HHA	Home Health Agency
HICN	Health Insurance Claim Number
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
ICD	International Classification of Diseases
ICD-CM	International Classification of Diseases—Clinical Modification
IPPS	Inpatient Prospective Payment System
iQIES	Internet Quality Improvement and Evaluation System
IPF	Inpatient Psychiatric Facility
IRF	Inpatient Rehabilitation Facility or Unit
LCDS	Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set
LOS	Length of Stay
LTCH	Long-Term Care Hospital
LTCH QRP	Long-Term Care Hospital Quality Reporting Program
MBI	Medicare Beneficiary Identifier
NHSN	National Healthcare Safety Network
NPI	National Provider Identifier
OMB	Office of Management and Budget
PPS	Prospective Payment System
PVS	Persistent Vegetative State
QTSO	QIES Technical Support Office
RRB	Railroad Retirement Board

Acronym	Definition
SNF	Skilled Nursing Facility
SSN	Social Security Number