

PRE-QUIZ: LTCH CARE Data Set v3.00 Scenarios

Section A

A0050. Type of Record

1. A patient was discharged from the LTCH but returned 2 days later. During this 2-day interval, the LTCH completed and submitted a Discharge Assessment to CMS. However, because the patient returned 2 days later, this is considered an interrupted stay. How can the original Discharge Assessment for this patient be revised?

Coding: How would you code A0050 and correct this error?

Rationale: What is your rationale?

ANSWER

Coding: A0050 would be coded as **3. Inactivate existing record.**

Rationale: In this scenario, the date of discharge needs to be changed (A0270), which is one of the four Record Event Identifiers that require an inactivation request because the patient was not discharged but rather had an interrupted stay.

Section A

A2500. Program Interruptions

2. Mrs. G is transferred from an LTCH to a short-term acute-care hospital and is gone longer than 3 calendar days. Mrs. G returned to the LTCH 8 days later.

Coding: How would you code A2500?

Rationale: What is your rationale?

ANSWER

Coding: A2500 would be coded as **0. No.**

Rationale: If a patient is transferred to another facility for a period of 3 calendar days or more (including the date of transfer), then a Discharge Assessment must be completed when the patient is transferred to the other facility and an Admission Assessment must be completed when the patient returns to the LTCH.

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Section B

B0100. Comatose

1. Mrs. F arrived at the LTCH comatose due to a traumatic brain injury. Mrs. F's medical record includes the diagnosis of persistent vegetative state.

Coding: How would you code B0100?

Rationale: What is your rationale?

ANSWER:

Coding: B0100 would be coded **1, Yes**.

Rationale: It was documented in the medical record that Mrs. F was in a persistent vegetative state since admission.

Section B

BB0700. Expression of Ideas and Wants (3-day assessment period)

2. Ms. T underwent surgery for a glioblastoma and is now admitted to the LTCH for further treatments. When she needs to go to the bathroom, she uses the call light. When the certified nursing assistant arrives, Ms. T points to the bathroom and with garbled speech says, "Go." The certified nursing assistant reports to the nurse that she often has difficulty understanding Ms. T.

Coding: How would you code BB0700?

Rationale: What is your rationale?

ANSWER:

Coding: BB0700 would be coded **2, Frequently** exhibits difficulty with expressing needs and ideas.

Rationale: Ms. T gets her point across regarding the need to go to the bathroom, but staff often have difficulty understanding Ms. T.

Section B

BB0800. Understanding Verbal Content (3-day assessment period)

3. Ms. H recently had a cancerous brain tumor removed, and it affected her ability to comprehend others. The certified nursing assistant asks Ms. H if she is ready to bathe. Ms. H nods and reaches for the wash cloth. When the certified nursing assistant tells Ms. H to be careful not to get her head bandages wet, Ms. H continues to bring the wash cloth toward her head, and she looks puzzled and asks why. The

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certified nursing assistant explains to Ms. H that she had surgery but Ms. H doesn't understand until the certified nursing assistant shows her a reflection of her head in the mirror. The nurse notes that cues or repetition are frequently required for Ms. H to understand.

Coding: How would you code BB0800?

Rationale: What is your rationale?

ANSWER:

Coding: BB0800 would be coded **2, Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.

Rationale: Ms. H understands only basic conversation and needs repetition or cues to understand.

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Section C

C1610A. Acute Onset and Fluctuating Course

1. The nurse reports that a patient who has been quiet and has short-term memory problems suddenly becomes agitated, calling out to her husband who died several years ago, removing her clothes, and being disoriented to time, person, and place.

Coding: How would you code C1610A?

Rationale: What is your rationale?

ANSWER:

Coding: C1610A – Acute Onset would be coded **1, Yes**.

Rationale: The new behaviors represent an acute change in mental status compared with the patient’s baseline status.

Section C

C1610C. Inattention

2. Mrs. T tries to answer all questions during an interaction with the clinician. Although she answers several items incorrectly and responds “I don’t know” to others, she pays attention to the clinician. The medical record and staff indicate that this is her consistent behavior during the assessment period.

Coding: How would you code C1610C?

Rationale: What is your rationale?

ANSWER:

Coding: C1610C – Inattention would be coded **0, No**.

Rationale: Mrs. T remained focused throughout the interaction, which was constant during the 3-day assessment period.

Section C

C1610D. Disorganized Thinking

3. Mr. D responds that the year is 1937 when asked to give the date. The medical record notes and staff reports indicate that Mr. D has not been oriented to time, but has

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coherent conversations. For example, staff reports he often discusses his passion for baseball.

Coding: How would you code C1610D?

Rationale: What is your rationale?

ANSWER:

Coding: C1610D – Disorganized Thinking would be coded **0, No**.

Rationale: The patient's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

Section C

C1610E1 & C1610E2. Altered Level of Consciousness

4. Mr. Q is alert and conversational and answers all questions during the discussion, although not all answers are correct. Medical record documentation and staff reports during the 3-day assessment period consistently note that the patient was alert.

Coding: How would you code C1610E1 and C1610E2?

Rationale: What is your rationale?

ANSWER:

Coding:

C1610E1 would be coded **1, Yes**, the patient was alert.

C1610E2 would be coded **0, No**, the patient is not exhibiting an altered level of consciousness.

Rationale: All evidence indicates that the patient is alert during conversations and activities.

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Section GG

GG0130A. Eating

1. Ms. S has multiple sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. After eating three-fourths of her meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

Coding: How would you code GG0130A?

Rationale: What is your rationale?

ANSWER:

Coding: GG0130A. Eating would be coded **03, Partial/moderate assistance.**

Rationale: The certified nursing assistant provides less than half the effort for the patient to complete the activity of eating.

Section GG

GG0130B. Oral Hygiene

2. Mrs. F brushes her teeth while sitting on the side of the bed. The certified nursing assistant gathers her toothbrush, toothpaste, water and an empty cup and puts them on the bedside table for her before leaving the room. Once Mrs. F is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste.

Coding: How would you code GG0130B?

Rationale: What is your rationale?

ANSWER:

Coding: GG0130B. Oral hygiene would be coded **05, Setup or clean-up assistance.**

Rationale: The helper provides setup and clean-up assistance. The patient brushes her teeth without any help.

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Section GG

GG0130C. Toileting Hygiene

3. Mrs. J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Mrs. J pulls down her underwear before sitting down on the toilet. When Mrs. J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as Mrs. J wipes her perineal area and pulls up her underwear without assistance.

Coding: How would you code GG0130C?

Rationale: What is your rationale?

ANSWER:

Coding: GG0130C. Toileting hygiene would be coded **04, Supervision or touching assistance**.

Rationale: The helper provides steadying (touching) assistance to the patient to complete toileting hygiene.

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Section GG

GG0130D. Wash Upper Body

4. Mrs. L has severe rheumatoid arthritis and peripheral vascular disease that affects her hands with joint pain, weakness, numbness, and tingling. Mrs. L uses a wash mitt to wash her upper arms and part of her chest. The certified nursing assistant helps to wash and rinse her face and part of her chest. Mrs. L rinses her arms and chest after the certified nursing assistant places a rinsed mitt on her hand. She soaks her hands in soapy water and rinses them under the faucet that is set up for her use. Mrs. L slowly dries herself with a towel.

Coding: How would you code GG0130D?

Rationale: What is your rationale?

ANSWER:

Coding: GG0130D. Wash upper body would be coded **03, Partial/moderate assistance**.

Rationale: The helper provided less than half the effort for the patient to complete the activity of washing the upper body.

Section GG

GG0170A. Roll Left and Right

5. Mr. R has a history of skin breakdown. The nurse instructs him to turn onto his right side providing step-by-step instructions to use the bedrail, bend his left leg, and then roll onto his right side. The patient attempts to roll with the use of the bedrail, but indicates he cannot do the task. The nurse then rolls him onto his right side. Next, the patient is instructed to return to lying on his back, which he successfully completes. Mr. R then requires physical assistance from the nurse to roll onto his left side and to return to lying on his back to complete the activity.

Coding: How would you code GG0170A?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170A. Roll left and right would be coded **02, Substantial/maximal assistance**.

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Rationale: The nurse provided more than half of the effort for the patient to complete the activity of roll left and right.

Section GG

GG0170B. Sit To Lying

6. Mrs. H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on her right side. The helper lifts and positions Mrs. H's right leg. Mrs. H uses her arms to position her upper body. Overall, Mrs. H performs more than half of the effort.

Coding: How would you code GG0170B?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170B. Sit to lying would be coded **03, Partial/moderate assistance**.

Rationale: A helper lifts Mrs. H's right leg and helps her position it as she moves from a seated to a lying position; Mrs. H does more than half of the effort.

Section GG

GG0170C. Lying To Sitting on Side of Bed

7. Ms. P is being treated for sepsis and has multiple infected wounds on her lower extremities. Full assistance from the certified nursing assistant is needed to move Ms. P from a lying position to sitting on the side of her bed because she usually has pain in her lower extremities upon movement.

Coding: How would you code GG0170C?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170C. Lying to sitting on side of bed would be coded **01, Dependent**.

Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the patient.

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Section GG

GG0170D. Sit To Stand

8. Mr. M has osteoarthritis and is recovering from sepsis. Mr. M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse's hand on Mr. M's trunk.

Coding: How would you code GG0170D?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170D. Sit to stand would be coded **04, Supervision or touching assistance.**

Rationale: The helper provides touching assistance only.

Section GG

GG0170E. Chair/Bed-To-Chair Transfer

9. Mr. F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and he recently underwent bilateral above-the-knee amputations. Mr. F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer Mr. F from the bed to a wheelchair. Mr. F is unable to assist in the transfer from his bed to the wheelchair.

Coding: How would you code GG0170E?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170E. Chair/bed-to-chair transfer would be coded **01, Dependent.**

Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the patient to complete an activity, code as 01, Dependent.

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Section GG

GG0170F. Toilet Transfer

10. Mrs. Y is anxious about getting up to use the bathroom. She asks the certified nursing assistant to stay with her in the bathroom as she gets on and off the toilet. The certified nursing assistant stays with her, as requested, and provides verbal encouragement and instructions (cues) to Mrs. Y.

Coding: How would you code GG0170F?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170F. Toilet transfer would be coded **04, Supervision or touching assistance.**

Rationale: The helper provides supervision/verbal cues as Mrs. Y transfers onto and off the toilet.

Section GG

GG0170H1. Does the Patient Walk?

11. Mr. Z currently does not walk, but a walking goal is clinically indicated.

Coding: How would you code GG0170H1?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170H1. Does the patient walk? would be coded **1, No**, and walking goal is clinically indicated. Discharge goal(s) for items GG0170I. Walk 10 feet, J. Walk 50 feet with two turns, and K. Walk 150 feet may be coded.

Rationale: Patient does not currently walk, so no admission performance code is entered for the walking items. However, a walking goal is clinically indicated and walking goals may be coded.

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Section GG

GG0170I. Walk 10 Feet

12. Mrs. C has Parkinson's disease and walks with a walker. The physical therapist must advance the walker for Mrs. C with each step. The physical therapist assists Mrs. C by physically initiating the stepping movement forward, advancing Mrs. C's foot during the activity of walking 10 feet. The assistance provided to Mrs. C is more than half of the effort for her to walk the 10 foot distance.

Coding: How would you code GG0170I?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170I. Walk 10 feet would be coded **02, Substantial/maximal assistance**.

Rationale: The helper provides more than half the effort as the patient completes the activity.

Section GG

GG0170J. Walk 50 Feet with Two Turns

13. Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and making two turns, her husband supports her trunk. He provides less than half the effort.

Coding: How would you code GG0170J?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170J. Walk 50 feet with two turns would be coded **03, Partial/moderate assistance**.

Rationale: The helper provides trunk support as the patient walks more than 50 feet and two turns (but not 100 feet).

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Section GG

GG0170K. Walk 150 Feet

14. Mr. R has endurance limitations due to heart failure, and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance.

Coding: How would you code GG0170K?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170K. Walk 150 feet would be coded **88, Activity not attempted due to medical or safety concerns.**

Rationale: The activity was not attempted.

Section GG

GG0170R. Wheel 50 Feet with Two Turns

15. Once seated in the manual wheelchair, Ms. R wheels about 10 feet then asks the therapist to push the wheelchair an additional 40 feet into her room and her bathroom.

Coding: How would you code GG0170R?

Rationale: What is your rationale?

ANSWER:

Coding: GG0170R. Wheel 50 feet with two turns would be coded **02, Substantial/maximal assistance.**

Rationale: The helper provides more than half the effort.

Section GG

GG0170S. Wheel 150 Feet

16. Mr. G always uses a motorized scooter to mobilize himself down the hallway and the therapist provides cues due to safety issues (to avoid running into the walls).

Coding: How would you code GG0170S?

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Rationale: What is your rationale?

ANSWER:

Coding: GG0170S. Wheel 150 feet would be coded **04, Supervision or touching assistance.**

Rationale: The helper provides verbal cues to complete the activity.

Section GG

GG0170. Unplanned Discharge

17. Mr. C was admitted to the LTCH with healing, complex, post-surgery open reduction internal fixation fractures and sepsis. However, complications during the LTCH stay arise and Mr. C is unexpectedly hospitalized, resulting in his discharge from the LTCH.

Coding: How would you code GG0170?

Rationale: What is your rationale?

ANSWER:

Coding: No function data are reported.

Rationale: The unplanned discharge assessment form will be completed and no functional status data are reported on this form due to the unexpected discharge.

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Section H

H0350. Bladder Continence

1. Mr. A has multi-infarct dementia. He was incontinent of urine twice on day 1 of the 3-day assessment period, once on day 2, and once on day 3.

Coding: How would you code H0350?

Rationale: What is your rationale?

ANSWER:

Coding: H0350 would be coded **3, Incontinent daily**.

Rationale: The patient had at least one episode of urinary incontinence every day over the 3-day assessment period.

Section H

H0400. Bowel Continence

2. Mr. G has Parkinson's disease and finds it very difficult to get to the bathroom in time to move his bowels. Mr. G made it to the bathroom and defecated in the toilet one time during the 3-day assessment period. Otherwise, he was incontinent of stool multiple times on the other 2 days during the assessment period.

Coding: How would you code H0400?

Rationale: What is your rationale?

ANSWER:

Coding: H0400 would be coded **2, Frequently incontinent**.

Rationale: The patient was incontinent of stool for multiple episodes, but had at least one continent bowel movement during the 3-day assessment period.

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Section I

I0050. Indicate the Patient's Primary Medical Condition Category

1. A patient with amyotrophic lateral sclerosis requires a ventilator to breathe. The physician's progress note documents the diagnosis of amyotrophic lateral sclerosis.

Coding: How would you code I0050?

Rationale: What is your rationale?

ANSWER:

Coding: I5450, Amyotrophic Lateral Sclerosis would be checked.

Rationale: Considered an active diagnosis because the physician progress note documents the amyotrophic lateral sclerosis diagnosis resulting in the need for ventilation.

Section I

I0050. Indicate the Patient's Primary Medical Condition Category

2. Mrs. I underwent a below the knee amputation (BKA) due to gangrene associated with peripheral vascular disease (PVD). She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The nurse practitioner's progress note documents PVD and left BKA.

Coding: How would you code I0050?

Rationale: What is your rationale?

ANSWER:

Coding: I0900, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), and I4100, Major Lower Limb Amputation, would be checked.

Rationale: Both considered active diagnoses because the nurse practitioner's note documents the peripheral vascular disease diagnosis, with peripheral pulse monitoring and recent below the knee amputation, with dressing changes and wound status monitoring.

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Section I

I0050. Indicate the Patient's Primary Medical Condition Category

3. A patient had surgical removal of a spinal cord tumor at the level of T6 and a diagnosis of complete paraplegia. The physician's progress note documents the diagnosis of malignancy and the need for further treatment with chemotherapy and radiation.

Coding: How would you code I0050?

Rationale: What is your rationale?

ANSWER:

Coding: I0101, Severe and Metastatic Cancers, and I5000, Paraplegia, would be checked.

Rationale: Both considered active diagnoses because the physician's progress note documents the diagnoses of cancer and paraplegia.

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Section J

J1800. Any Falls Since Admission

1. An incident report describes an event in which Mr. S. was walking down the hall and appeared to slip on a wet spot on the floor. He lost his balance and bumped into the wall, but was able to grab onto the handrail and steady himself.

Coding: How would you code J1800?

Rationale: What is your rationale?

ANSWER:

Coding: J1800 would be coded **1. Yes.**

Rationale: An intercepted fall is considered a fall.

Section J

J1900A. Number of Falls Since Admission

2. A nursing note states that Mrs. K slipped out of her wheelchair onto the floor during a transfer from the bed to the wheelchair. Before being assisted back into her bed, an assessment was completed that indicated no injury.

Coding: How would you code J1900A?

Rationale: What is your rationale?

ANSWER:

Coding: J1900A would be coded **1.**

Rationale: Slipping onto the floor is a fall. No injury was noted.

Section J

J1900B. Number of Falls Since Admission

3. A nurse's note describes a patient who climbed over his bedrail and fell to the floor. On examination, he had a cut over his left eye and some swelling on his arm. He was sent to the emergency room, where x-rays revealed no injury and neurological checks revealed no changes in mental status. Patient returned to the LTCH within 24 hours.

Coding: How would you code J1900B?

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Rationale: What is your rationale?

ANSWER:

Coding: J1900B would be coded **1**.

Rationale: Lacerations and swelling without fracture are classified as injury (except major).

Section J

J1900C. Number of Falls Since Admission

4. A patient fell, lacerated her head, and was sent to the emergency room, where a head CT scan revealed a subdural hematoma. Patient received treatment and returned to the LTCH after 2 days

Coding: How would you code J1900C?

Rationale: What is your rationale?

ANSWER:

Coding: J1900C would be coded **1**.

Rationale: Subdural hematoma is a major injury, and it occurred as a result of a fall.

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Section K

K0200B. Weight

1. Mrs. G has terminal breast cancer and is receiving palliative care. She is at risk for pathological fractures due to metastatic bone disease. She is pain free at rest but experiences discomfort when she moves. Daily weights are not part of her prescribed medical care and they do not affect her end of life (EOL) care.

Coding: How would you code K0200B?

Rationale: What is your rationale?

ANSWER:

Coding: K0200B would be coded (-)

Rationale: If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, use the default response of a dash (-) and document the rationale on the patient's medical record.

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Section M

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

1. A patient arrives at the LTCH on Day 1, a clinical skin assessment is completed on admission, with no pressure ulcers identified. On Day 3, while bathing the patient, a Stage 2 pressure ulcer was noted on the patient's sacrum and documented in the patient's medical record. The patient was discharged with a Stage 2 pressure ulcer 8 days later.

Coding: How would you code M0300 on the Admission and Discharge Assessments?

Rationale: What is your rationale?

ANSWER:

Coding:

- **M0300B1 is coded as 0** on the Admission Assessment.
- **M0300B1 is coded as 1** on the Discharge Assessment.
- **M0300B2 is coded as 0** on the Discharge Assessment.

Rationale: Even though the patient had a Stage 2 pressure ulcer identified on Day 3 of the LTCH stay, only those pressure ulcers that were present as close to the time of admission are coded on the Admission Assessment.

Section M

M0800. Worsening in Pressure Ulcer Status Since Admission

2. A patient is admitted to the LTCH with a Stage 2 pressure ulcer. The ulcer develops a deeper level of tissue damage, exposing muscle, and is staged as a Stage 3 pressure ulcer during the stay. The wound bed subsequently covers with slough, and is identified as an unstageable pressure ulcer. The patient discussed his discharge plan with the LTCH and decided to go home with home health services and receive wound treatment at a local wound care clinic. On discharge, the patient record notes that wound debridement was not performed on the Stage 3 pressure ulcer at the LTCH and would be performed at the wound clinic.

Coding: How would you code M0800 on the Discharge Assessments?

Rationale: What is your rationale?

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ANSWER:

Coding:

- **M0300B1 is coded as 1** on the Admission Assessment.
- **M0300B1 and M0300B2 are coded as 0** on the Discharge Assessment.
- **M0300F1 is coded as 1** on the Discharge Assessment.
- **M0300F2 is coded as 0** on the Discharge Assessment.
- **M0800E is coded as 1** on the Discharge Assessment.

Rationale: The Stage 2 pressure ulcer that was present on admission further evolved to a Stage 3 pressure ulcer during the LTCH stay and covered over with slough prior to discharge. The ulcer was not debrided prior to the patient's discharge.

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Section O

O0100. Special Treatments, Procedures, and Programs

1. Mrs. C has been unable to eat or ingest adequate nutrients since her bowel surgery. Mrs. C receives total parenteral nutrition (TPN) using a peripherally inserted central catheter (PICC line) that infuses her nutrients, 24 hours daily.

Coding: How would you code O0100?

Rationale: What is your rationale?

ANSWER:

Coding: Check box **N, Total Parenteral Nutrition.**

Rationale: Mrs. C's treatment plan includes TPN.

Section O

O0250. Influenza Vaccine

2. Mrs. T received the influenza vaccine at her doctor's office during this year's influenza vaccination season. Her doctor provided documentation of Mrs. T's receipt of the vaccine to the LTCH in order to place the documentation in Mrs. T's medical record. He also provided documentation that Mrs. T was explained the benefits and risks for the vaccine prior to administration.

Coding: How would you code O0250?

Rationale: What is your rationale?

ANSWER:

Coding:

- O0250A would be coded **0, No.**
- O0250B would be skipped.
- O0250C would be coded **2, Received outside of this facility.**

Rationale: Mrs. T received the influenza vaccine at her doctor's office during this year's influenza vaccination season.