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

Archived Quarterly Q&As

Consolidated June 2022 to December 2023

Introduction

The Centers for Medicare & Medicaid Services (CMS) has archived questions from Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation Data Set (LCDS) Quarterly Q&As, in light of the release of the CMS LCDS 5.0 and 5.1 Manuals, effective October 1, 2022 and October 1, 2024. These Q&As have been archived due to inclusion of guidance in the manual, retiring of guidance, and where items are no longer included in the LCDS.

The latest version of the LCDS Quarterly Q&As can be found on the LCDS and LTCH QRP Manual webpage:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual

Consolidated Table of Contents

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Responses contained in this document may be superseded by guidance published by CMS at a later date.

Admission Items: General Questions

Question 1: If a patient is admitted to a Long-Term Care Hospital (LTCH) on Monday but has to be transferred back to the acute care hospital the next day (Tuesday) and then returns to the LTCH on Thursday, we know that this is considered a program interruption. Can we use assessment information from Tuesday morning's functional assessments (the day the patient returned to the acute care hospital) to code the admission items?

Answer 1: If the patient has a program interruption, the assessment data gathered on the discharge date (the day the patient is admitted to Acute Care from the LTCH) may be used to code the admission items.

At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance.

Added: September 2020

Archived: June 2022

Question 2: In the latest Q&A release, there was a question that spoke to a decline with a patient within the assessment window with instructions to not update the assessment with such. The example given was related to dysphagia following an ER stay. I am questioning now if we can identify other "updates" within the 3-day admission assessment time period.

Answer 2: Each LCDS item should be considered individually, and coded based on the guidance provided for that item.

Unless otherwise specified in item guidance, information collected by the assessing clinician during the time period for the specified assessment type may be used to inform LCDS coding.

Note that item guidance does specify special rules for coding pressure ulcer/injury and GG items at admission. To support consistency of data collection related to pressure ulcers and GG function data across all post-acute care (PAC) providers, cross-setting guidance directs coding for pressure ulcers/injuries to be based on the "first skin assessment" and GG self-care and mobility items should be based on a functional assessment that occurs at or soon after the patient's admission, and reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

Added: June 2021

Archived: June 2022

Section A: Administrative Information

A1005, A1010, A1110, A1250

Question 2: In Section A: Administrative Information a few of the items state that a proxy can be used. Who would be considered a proxy? Can it be a caregiver, family member, friend or can it only be the Power of Attorney (POA), or health care representative?

Answer 2: For the items in section A that reference use of a proxy, based on item-specific guidance and the patient's unique circumstances, use facility policy to determine who is an appropriate proxy. This can include but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.

Added: December 2022

Archived: March 2024

A2122, A2124

Question 1: Can CMS provide a definition of a "Health Information Exchange" organization for the purposes of coding A2122 - Route of Current Reconciled Medication List Transmission to Subsequent Provider and A2124 - Route of Current Reconciled Medication List Transmission to Patient?

Answer 1: A Health Information Exchange (HIE) is an organization used by provider facilities to electronically exchange patients' health information, including medical records, current reconciled medication lists, etc.

Added: March 2023

Archived: March 2024

Section C: Cognitive Patterns

Brief Interview for Mental Status (BIMS) C0100, C0200, C0300, C0400, C0500

Question 2: Please clarify when C0500 - BIMS Summary Score should be coded as 99 - Unable to complete interview versus coded with a dash. The guidance manual says to code 99 if any of the BIMS items are coded with a "-" dash. However, the technical data specifications say if all BIMS items (C0200-C0400) are coded with a dash then C0500 must be dashed.

Answer 2: If some, but not all, of the BIMS items (C0200-C0400) are coded with a dash then C0500 - BIMS Summary Score should be coded as 99 - Unable to complete interview.

If all of the BIMS items are coded with a dash then C0500 - BIMS Summary Score must also be coded with a dash.

Added: December 2022

Archived: March 2024

C1310

Question 2: How is "baseline" defined for C1310A - Acute Onset Mental Status Change at discharge?

Answer 2: The intent of C1310 - Signs and Symptoms of Delirium is to identify any signs or symptoms of acute mental status changes as compared to the patient's baseline status.

As stated in the Coding Instructions for C1310A - Acute Onset Mental Status Change, code 1 - Yes, if patient has an alteration in mental status observed in the assessment period or in the cognitive assessment (e.g., BIMS) that represents an acute change from baseline.

Examples of acute mental status changes:

- A patient who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
- A patient who is normally quiet and content suddenly becomes restless or noisy.
- A patient who is usually able to find their way around their living environment begins to get lost.

At discharge, compare the patient's current mental status to their baseline mental status (prior to the discharge assessment time period).

Added: December 2022

Archived: March 2024

Section D: Mood

D0150

Question 1: Please clarify when the entire Patient Mood Interview should be completed for D0150 - Patient Mood Interview (PHQ-2 to 9). The instruction in the LCDS Guidance Manual Section D-Errata appears to conflict with the language in the D0150 item.

Answer 1: At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance. Related to the Patient Mood Interview, please disregard the statement in the LCDS item that states "If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview." This statement is outdated due to refinements in LCDS guidance.

Please use the instructions found in the Steps for Assessment for D0150 in the LCDS Guidance Manual Section D-Errata, which reflects the most recent guidance. As stated in the errata, whether or not further evaluation of a patient's mood is needed depends on the patient's responses to the PHQ-2 (D0150A and D0150B). If **both** D0150A1 and D0150B1 are coded 9, OR, **both** D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise continue. For all other scenarios proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9 and complete D0160, Total Severity Score.

Added: June 2023

Archived: March 2024

Section GG: Functional Abilities and Goals

GG0110

Question 1: Should a transport chair be considered a "wheelchair" for GG0110 - Prior Device Use?

Answer 1: The intent of GG0110 - Prior Device Use is to indicate which devices and aids were used by the patient prior to the current illness, exacerbation, or injury. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how prior device use applies for each individual patient.

CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use.

Added: December 2020

Archived: June 2022

GG0130, GG0170

Question 1: For section GG what is the definition of "therapeutic intervention"?

Answer 1: At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff. "Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding.

Please note that the term "prior to the benefit of services" replaces the term "therapeutic intervention" for the GG activities.

At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance.

Added: September 2020

Archived: June 2022

Question 2: Establishing a goal is required for at least one self-care or mobility activity in section GG. Can the GG goals be changed once established during the first 3 days if the patient's status changes?

Answer 2: The GG Self-care and Mobility Discharge Goals are used in the calculation of the Process Measure - Percentage of Patients with an Admission and Discharge Function Assessment and a Care Plan that Addresses Function. The measure reports, in part, that discharge goals were established, and does not take into consideration whether or not the goals were met. Once a goal is established, there is no need to update it if circumstances change or additional information becomes available either within or after the 3-day assessment time period.

Added: September 2020

Archived: June 2022

Question 3: The LTCH CARE Data Set (LCDS) manual for section GG clarifies that a Code 03-Partial/moderate assistance indicates the helper is required to provide less than half the effort and a Code 02-Substantial/maximal assistance indicates the helper is required to provide more than half the effort. If a helper is required to provide exactly half the effort, how would the item be coded?

Answer 3: In the situation described, the helper and patient each are providing exactly half of the effort to complete a GG activity. If the patient performs half of the effort, code the item 03-Partial/moderate assistance.

Added: September 2020

Archived: June 2022

Question 4: On day 2, during an evaluation, the physical therapist feels the patient is unable to complete an activity such as sit to stand without providing therapy services; for example: skilled instruction on safe body mechanics for transfers or proper technique to maintain weight bearing restrictions. Is it appropriate to code 88 as the admission assessment of baseline functional status prior to benefiting from therapy services? PT initiates treatment by providing a walker, instructing in its use, and offering cues for proper technique. The patient performed sit to stand transfers with moderate assistance the rest of the day 2 and day 3.

Answer 4: At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

For the admission assessment, the patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, prior to the benefit of services provided by your facility/staff.

Introducing a new device should not automatically be considered as "providing a service." Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility/staff.

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

In your scenario, if even with assistance the patient was unable to perform the sit to stand activity prior to the benefit of services and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities, use the appropriate "activity not attempted" code.

Added: September 2020

Archived: June 2022

Question 6: How would you code the following scenario for GG activities: Two people are present when a patient is performing an activity; one person is assisting the patient and the second person is standing by for safety/assist as needed but when the activity is completed the second person was not needed. Would you code the activity as Code 01 - Dependent due to having the second person present just in case, or code based on the type and amount of assistance provided by the one person only?

Answer 6: For the GG self-care and mobility activities Code 01 - Dependent is when a helper is required to do all the effort and the patient does none of the effort to complete the activity, or the assistance of two or more helpers is required for the patient to complete the activity.

If the role of the second helper is to provide standby assistance, then the presence of two helpers meets the definition of Code 01 - Dependent. This would be true even if the second helper was there for supervision/standby assist and did not end up needing to provide hands-on assistance.

Added: March 2021

Archived: June 2022

GG0130A

Question 1: How would the following scenario for GG0130A - Eating be coded: A patient was admitted and on day 1 required only setup assistance for eating. On day 2 the patient was transferred to an acute care hospital and returned on day 3 with an overall decline in status and was made NPO due to dysphagia. Would we code 05 - Setup or clean-up assistance based on initial ability or 88 - Not attempted due to medical conditions or safety concerns because this is the new baseline following the decline?

Answer 1: The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

At admission, the performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

In the scenario provided, use Code 05 - Setup or clean-up assistance for GG0130A - Eating if this represents the patient's baseline status.

Only use an "activity not attempted" code if the patient was not able to complete the activity prior to the benefit of services and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.

Added: December 2020

Archived: June 2022

Question 2: How would you code GG0130A - Eating for a patient who has been on tube feeding for years but is able to drink water independently?

Answer 2: The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient. For a patient taking only fluids by mouth, the item may be coded based on ability to bring liquid to mouth, once the drink is placed in front of the patient.

When coding activities in Section GG, clinicians should code based on the patient's baseline ability during the 3-day assessment period. Allow the patient to perform the activity as independently as possible, as long as the patient is safe, regardless of the food consistency and regardless of how the patient performed the activity prior to the current illness, exacerbation, or injury.

In the scenario, if the patient is independently taking liquids by mouth, code 06 - Independent.

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Archived: June 2022

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

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

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

Added: June 2022

Archived: March 2024

GG0130B

Question 1: A helper gathers and sets out the patient's oral hygiene items. The patient is able to brush their teeth with steadying assist from a helper while standing at the sink. What is the code for oral hygiene?

Answer 1: The intent of GG0130B - Oral hygiene is to determine the patient's ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

When coding activities in Section GG, clinicians should code based on the type and amount of assistance required to complete the activity, allowing the patient to perform the activity as independently as possible, as long as they are safe.

In your scenario, if the patient standing at the sink requiring steadying assistance to brush their teeth represents the patient performing the activity as independently as possible, then code 04-Supervision or touching assistance for GG0130B - Oral hygiene.

Added: September 2020

Archived: June 2022

GG0130C

Question 1: A patient used a bedpan for both bowel and bladder and was able to lift and lower her hospital gown (no brief or underwear were stated to be present), and the patient was not able to perform any of her own perineal hygiene for bowel or bladder. How is Toileting hygiene coded?

Answer 1: The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes before and after voiding or having a bowel movement.

In your scenario, code GG0130C - Toileting hygiene based on the type and amount of assistance required to complete the ENTIRE activity, including toileting hygiene and adjusting any clothing relevant to the individual patient (in this case lifting and lowering the hospital gown). If, in the assessing clinician's clinical judgment, the patient required a helper to provide less than half the effort, then code 03-Partial/moderate assistance; or if the patient required the helper to provide more than half the effort code 02-Substantial/maximal assistance.

Added: September 2020

Archived: June 2022

Question 2: If a patient is admitted to an LTCH with a Foley catheter and does not have a bowel movement during the 3-day assessment period how should GG0130C - Toileting hygiene be coded? Would it be Code 88 - Not attempted due to medical conditions or safety concerns or can the nurse code the activity based on how much assistance the patient requires to manage the Foley bag?

Answer 2: The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

The toileting hygiene activity can be assessed and coded regardless of the patient's need to void or have a bowel movement.

If a patient has a Foley catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site. It does not include management of the equipment.

If the patient has an indwelling urinary catheter and has bowel movements, code the toileting hygiene item based on the type and amount of assistance needed by the patient before and after moving his or her bowels. This may necessarily include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.

If a patient manages an ostomy, include wiping the opening of the ostomy or colostomy bag but not managing equipment for GG0130C - Toileting hygiene.

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Question 3: How should GG0130C - Toileting hygiene be coded if a patient requires different types and amount of assistance after voiding versus after having a bowel movement?

Answer 3: The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

When the patient requires different levels of assistance to perform toileting hygiene after voiding vs. after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity. This is true even in scenarios where GG0130C - Toileting hygiene is not completed entirely during one clinical observation.

Added: June 2021

Archived: June 2022

Question 5: Should the assessment for GG0130C - Toileting hygiene include the patient's ability to maintain perineal hygiene and adjust clothing during episodes of both continence and incontinence?

Answer 5: The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

For some patients, this may include assessing the type and amount of assistance needed to complete clothing management and hygiene tasks after episodes of incontinence as well.

Added: September 2023

Archived: March 2024

GG0170C

Question 1: How do we code lying to sitting on side of bed for a bilateral amputee not wearing their prosthetics, since the definition states "with feet on floor"?

Answer 1: If the patient with a unilateral (or bilateral) lower extremity amputation does not have or is not wearing a prosthesis (or prostheses), use clinical judgment to determine if the patient completes the activity (Lying to sitting on side of bed without back support). Code the activity based upon the type and amount of assistance the patient requires to safely complete the activity.

Added: September 2020

Archived: June 2022

GG0170F

Question 1: If a patient gets up off the side of the bed, walks to the bathroom, and then sits down on the toilet, is the effort necessary to lift up off the bed considered for coding GG0170F - Toilet transfer?

Answer 1: The intent of GG0170F - Toilet transfer is to assess the patient's ability to get on and off a toilet (with or without a raised toilet seat) or commode once the patient is at the toilet or commode.

In the scenario described, the effort necessary to lift up off the bed does not count toward the toilet transfer in GG0170F - Toilet transfer.

Added: September 2020

Archived: June 2022

Question 2: A patient completes a toilet transfer requiring only supervision. As he was ambulating with contact guard assistance back to his bed he lost his balance and required assistance to steady himself. Would the contact guard assist and assistance to steady himself be considered in determining the performance code for GG0170F - Toilet transfer?

Answer 2: The intent of GG0170F - Toilet transfer is to assess the patient's ability to get on and off a toilet (with or without a raised toilet seat) or commode once the patient is at the toilet or commode.

In the scenario described, the assistance provided while ambulating to or from the toilet should not be considered when coding the GG0170F - Toilet transfer activity.

Added: December 2020

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GG0170I, GG0170J, GG0170K

Question 3: At discharge, if it is not recommended that a patient ambulate when they return home because it is not functional for them or if a discharge goal was not selected for an activity, should the GG walking activities still be assessed and coded with a performance code or should an "activity not attempted" code be used?

Answer 3: Assessment of the GG self-care and mobility items is based on the patient's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking may be assessed for a patient who did/does/will use a wheelchair as their primary mode of mobility).

At discharge, code based on the patient's ability to complete each activity regardless of whether a goal was established for that activity at admission.

If the patient is able to complete a walking activity with the assistance of one or two people, code based on the type and amount of assistance required even if walking is not being recommended or used as a functional mode of mobility.

If based on the guidance stated above, you are unable to determine the patient's discharge ability in conjunction with all current discharge assessment findings or the patient is not able to complete a walking activity safely even with the assistance of two people, code using the appropriate "activity not attempted" code.

Added: June 2021

Archived: June 2022

GG0170I

Question 2: How would you code a situation where the patient walks part of the distance, say 4 feet, and then the helper carries them the remaining distance to get to the 10 feet needed for GG0170I - Walk 10 feet? Would this be a Code 02-Substantial/maximal assistance because the helper is carrying the patient the majority of the distance? We understand that with the wheelchair activities a helper can complete the distance needed by pushing the patient in the wheelchair. Is this also true for the walking items?

Answer 2: The intent of the walking item GG0170I - Walk 10 feet is to assess the type and amount of assistance a patient requires to ambulate 10 feet once in a standing position.

Since a helper cannot complete a walking activity for a patient, the walking activities cannot be considered completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance.

In your scenario, where the patient participates in walking 4 feet and then requires the helper to carry them for further distances, the activity walking 10 feet (GG0170I) is not considered completed. If the stated distance of 10 feet was not walked by the patient, with or without some

level of assistance, GG0170I would be coded with one of the "activity not attempted" codes, for example 88-Not attempted due to the medical condition or safety concerns.

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

Added: September 2020

Archived: June 2022

GG0170J

Question 1: When assessing GG0170J - Walk 50 feet with two turns, can the two turns be combined, or should they be completed at different times during the 50 feet?

Answer 1: The intent of GG0170J - Walk 50 feet with two turns is to assess the patient's ability to ambulate 50 feet with two turns once in a standing position.

The turns included in GG0170J are 90-degree turns. The turns may occur at any time during the 50-foot distance.

Added: September 2023

Archived: March 2024

GG0170M, GG0170N, GG0170O

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

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

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

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

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Archived: March 2024

GG0170N, GG0170O

Question 1: When assessing the GG activities for 4 and 12 steps, the patient is able to navigate 4 and 12 steps by bumping up and down them with supervision. However, he needs assist getting seated on the step, and again to come to standing once completed with the steps. Is the assist required to sit on the step or to come to standing considered when coding these two stair items?

Answer 1: The intent of Section GG stair activities is to assess the patient's ability to go up and down 1 step/curb, 4 steps, and 12 steps. Clinicians should code based on the type and amount of assistance required for the patient to complete the stair activities as independently and safely as possible. Do not consider the stand-to-sit or sit-to-stand transfer when coding any of the step activities.

Added: December 2022

Archived: March 2024

Question 2: The Guidance Manual discusses how a patient is permitted to take a seated rest break between ascending and descending 4 or 12 steps. Can a patient take a seated rest break at any time while completing the activity? For example, they start ascending 12 steps but after 5 steps need to stop and rest before completing the remaining 7 steps?

Answer 2: Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up and down stairs, by any safe means, occurs sequentially, the patient may take a rest break between ascending and descending the 4 steps or 12 steps.

While a patient may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means without taking more than a brief rest break in order to consider the stair activity completed.

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Archived: March 2024

GG0170Q

Question 1: We have a question regarding the appropriate scoring for an LTCH patient who does not use a wheelchair during the admission assessment, but then begins to use a wheelchair later during the LTCH stay. Our system software will not allow us to upload goals after the 3-day admission assessment has ended. When a patient does begin using a wheelchair later in the stay, would it be appropriate to go back to the initial wheelchair assessment on the LCDS and change GG0170Q to "YES" and add the corresponding goals even though they were established after the admission assessment has ended?

Answer 1: The intent of GG0170Q - Does the patient use a wheelchair and/or scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. Only code

0-No if, at the time of the assessment, the patient does not use a wheelchair or scooter under any condition.

If, at the time of admission, GG0170Q is answered "No" correctly, and following the admission assessment period the patient begins to utilize a wheelchair, there is no need to update the admission performance and/or discharge goals for GG0170 activities on the admission LCDS. The gateway wheelchair item (GG0170Q1 and GG0170Q3) might not be coded the same on the admission and discharge assessments.

If, at the time of admission, GG0170Q was answered incorrectly then corrections to the admission LCDS should be made following Federal, State, and facility policy guidelines.

Added: September 2020

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Question 2: If a patient utilizes a wheelchair for mobility and is able to wheel 50 feet with 2 turns but is unable to wheel 150 feet (code 07, 09, 10, 88), how should we code items GG0170S/SS1? There is not a skip pattern if one of the "activity not attempted" codes are used for GG0170S, and the guidance on the LCDS states for GG0170SS1 to "Indicate the type of wheelchair or scooter used." Selecting one or the other does not feel logical but using a dash [-] impacts compliance with the LTCH QRP.

Answer 2: You are correct that there is no skip pattern for GG0170S/SS1 unless GG0170Q1 is answered "no." However, for the wheelchair items, a helper can assist the patient to complete the activity or make turns if required. Therefore, if the patient is unable to wheel the entire distance with or without assistance the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required to complete the entire activity.

If, in your scenario, the patient was unable to complete the 150 feet themselves, GG0170S - Wheel 150 feet could still be coded with a performance code based on the type and amount of assistance required to complete the entire activity. Then GG0170SS1 could indicate the type of wheelchair used.

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GG0170R, GG0170S

Question 1: Regarding Section GG Wheelchair Items, does the activity of wheeling 50 feet with 2 turns need to be done independent of the activity of wheeling 150 feet?

Also the manual states the coding is based on an assessment completed before therapeutic intervention. Patients who had not used a wheelchair previously may not be able to complete both wheelchair activities. Would an "activity not attempted" code be used?

Answer 1: The intent of GG0170R - Wheel 50 feet with two turns is to assess the patient's ability, once seated in wheelchair/scooter, to wheel at least 50 feet and make two turns.

The intent of GG0170S - Wheel 150 feet is to assess the patient's ability, once seated in a wheelchair/scooter, to wheel at least 150 feet in a corridor or similar space.

Use clinical judgment to determine how the actual patient assessment of wheelchair mobility is conducted. If a clinician chooses to combine the assessment of multiple wheelchair activities, use clinical judgment to determine the type and amount of assistance needed for each individual activity.

At Admission, the performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

The patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely. The item would then be coded based on the type and amount of assistance required, prior to the benefit of services provided by your facility staff.

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

Introducing a new device should not automatically be considered as "providing a service". Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility.

Added: December 2020

Archived: June 2022

GG0170R

Question 1: When assessing GG0170R - Wheel 50 feet with two turns, can the two turns be combined, or should they be completed at different times during the 50 feet?

Answer 1: The intent of GG0170R - Wheel 50 feet with two turns is to assess the patient's ability, once seated in wheelchair/scooter, to wheel at least 50 feet and make two turns.

The turns included in GG0170R are 90-degree turns. The turns may occur at any time during the 50-foot distance.

Added: September 2023

Archived: March 2024

GG0170S

Question 1: A patient was able to propel his wheelchair for 100 feet with moderate assistance. He was unable to go farther and the therapist pushed the wheelchair the rest of the way to the gym, which was a total of 150 feet. What score would you give this patient for GG0170S - Wheel 150 feet?

Answer 1: The intent of GG0170S - Wheel 150 feet is to assess the patient's ability, once seated in a wheelchair/scooter, to wheel at least 150 feet. If the patient is unable to complete the entire distance required for this activity, the assessing clinician can assist the patient to complete the activity, and code this item based on the type and amount of assistance required to complete the entire activity.

In your example, the patient completed wheeling 100 feet of the 150 feet with moderate assistance and required the helper to complete the remaining distance. Use clinical judgment to determine if the patient required the helper to provide less than half the effort (then code 03-Partial/moderate assistance) or if the patient required the helper to provide more than half the effort (then code 02-Substantial/maximal assistance).

Added: September 2020

Archived: June 2022

Section H: Bladder and Bowel

H0350

Question 1: Please clarify the use of the code 4 - Always incontinent for H0350 - Bladder Continence. The coding instructions state that this code is used if during the 3-day assessment period the patient had no continent voids. What if during the 3-day assessment period the patient has no continent episodes because the patient was catheterized during some portion of the 3-day assessment period?

Answer 1: The intent of H0350 - Bladder Continence is to gather information on bladder continence. Code 4 - Always Incontinent is applicable when the patient had no continent voids and did not require the use of any type of catheter at any time during the 3-day assessment period.

Added: December 2020

Archived: June 2022

Question 2: How would the following scenarios for H0350 - Bladder Continence be coded?

Scenario 1

Day 1: One intermittent catheterization, no other bladder episodes
Day 2: Foley was placed, no other bladder episodes
Day 3: Foley remained in place the entire day

Would this scenario be coded as 9 - Not applicable because the patient had a Foley in place for 2 of the 3 days or as 0 - Always Continent because there were no episodes of incontinence in between intermittent catheterization; even though there were no continent episodes either?

Scenario 2

Day 1: Intermittent catheterizations, no bladder episodes in between catheterizations
Day 2: Intermittent catheterizations, no bladder episodes in between catheterizations
Day 3: Intermittent catheterizations, no bladder episodes in between catheterizations

Answer 2: The intent of H0350 - Bladder Continence is to gather information on bladder continence. Incontinence refers to the 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.

In both scenarios, if intermittent catheterization is used to empty the bladder and there are no episodes of incontinence between catheterizations, H0350 - Bladder Continence is coded 0 - Always continent (no documented incontinence). Code 09 - Not applicable would not apply for either scenario as the patient did not have a catheter in place for the entire 3-day assessment period.

Added: December 2020

Archived: June 2022

H0400

Question 1: If a patient only has one bowel movement during the admission assessment period, and that bowel movement is incontinent, how would H0400 be coded? With the current verbiage in the LCDS manual, it meets the definition of two scores; Code 3 (because all bowel episodes were incontinent) and Code 1 (because the patient only had one bowel movement).

Answer 1: The intent of H0400 - Bowel Continence is to gather information on the frequency of bowel continence during the 3-day assessment period. Code 1-Occasionally incontinent should only be selected if during the 3-day assessment period the patient was incontinent for bowel movement once. This includes incontinence of any amount of stool at any time. Code 3-Always incontinent is selected if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).

If a patient has only one bowel movement that was incontinent during the 3-day assessment period, and there were no episodes of continent bowel movements, then code 3-Always incontinent.

Added: September 2020

Archived: June 2022

Section J: Health Conditions

J0520

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

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

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

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

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

Added: September 2022

Archived: March 2024

J1800, J1900

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

Answer 1: J1800 and J1900 include all falls that occurred since the time of admission. This would include any falls that occurred outside of the LTCH facility during a program interruption.

Added: September 2022

Archived: March 2024

J1900

Question 1: If a patient falls while a patient of an LTCH but the level of injury related to the fall is not known until after the patient has been sent to the acute-care hospital for treatment should J1900 - Number of Falls Since Admission be coded based on information known at

the time the patient left the LTCH or coded using additional information from the acute-care hospital?

Answer 1: The intent of J1900 - Number of Falls Since Admission is to determine the number of falls that occurred since admission and code the level of fall-related injury for each. For item J1900, include all falls that occurred since the time of admission. This would include any falls that occurred during a program interruption.

An injury related to a fall is defined as 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. A major injury is defined as bone fractures, joint dislocation, closed head injuries with altered consciousness, and subdural hematoma. If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

Facilities are encouraged to utilize accurate and/or new information regarding fall-related injuries as information becomes known. Errors should be corrected following the facility's correction policy and in accordance with guidance from Chapter 4: SUBMISSION AND CORRECTION OF THE LTCH CARE DATA SET (LCDS) ASSESSMENT RECORDS in the LCDS Manual. For example, injuries can present themselves later than the time of the fall. The facility may not learn of the level of injury until after the LCDS assessment is completed or the patient has left the facility (e.g., because the patient was transported to ER and admitted to an inpatient facility post-fall).

Added: June 2023

Archived: March 2024

Section K: Swallowing/Nutritional Status

K0200

Question 1: How should height be reported for item K0200A - Height for a patient with bilateral lower extremity amputations? Should their current height or their height prior to amputation be reported?

Answer 1: Item K0200A - Height records the most recent height of measurement for the patient. Measure the patient's height in accordance with the facility's policies and procedures, which should reflect current standards of practice (shoes off, etc.).

When reporting height for a patient with bilateral lower extremity amputations, measure and record the patient's current height (i.e., height after bilateral amputations).

Added: December 2020

Archived: June 2022

Question 2: When entering a patient's height and weight on admission for item K0200 do the height and weight need to be measured while a patient is in the Long-Term Care Hospital? Can they be estimated per facility policies and procedures or can they be reported based on a height and weight obtained from documentation from another facility?

Answer 2: The intent of item K0200 - Height and Weight is to record the patient's most recent height since admission and record the patient's weight based on the most recent measure in the last 3 days. Only enter a height and weight that have been directly measured by your facility staff. Do not enter a height or weight that is self-reported or derived from documentation from another provider setting.

Added: March 2021

Archived: June 2022

K0520

Question 1: When coding K0520 - Nutritional Approaches should we only consider those nutritional approaches that the patient actually receives at admission and discharge or just those that are included on the plan of care? When coding K0520 at discharge should we only indicate those nutritional approaches that the patient will continue to receive after the patient is discharged?

Admission

K0520. Nutritional Approaches Check all of the following nutritional approaches that apply on admission.	
	1. On Admission Check all that apply ↓
A. Parenteral/IV feeding	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐
Z. None of the above	☐

Discharge

K0520. Nutritional Approaches		
4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days 5. At Discharge Check all of the nutritional approaches that were being received at discharge	4. Last 7 Days Check all that apply ↓	5. At Discharge Check all that apply ↓
A. Parenteral/IV feeding	☐	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. None of the above	☐	☐

Answer 1: The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

At admission check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day admission assessment time period, even if not used during the 3-day admission assessment time period.

At discharge for column 4 - Last 7 days, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the last 7 days, even if not used in the last 7 days. At discharge for column 5 - At Discharge, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, even if not used during the 3-day discharge assessment time period. At discharge, K0520 does not report on nutritional approaches that are expected to occur after discharge.

Added: December 2022; Edited: June 2023

Archived: March 2024

Question 2: For K0520A - Nutritional Approaches; Parenteral/IV feeding, is Parenteral/IV feeding coded when there is just a documented need for hydration or does the documented need to be for both hydration and nutrition?

Answer 2: The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

IV fluids can be coded in K0520A if the additional fluid intake reflects a specifically documented need for nutrition and/or hydration.

Added: December 2022

Archived: March 2024

Question 6: Should K0520B - Nutritional Approaches; Feeding Tube be checked if there is a feeding tube present, but it is not being utilized for nutritional/hydration purposes? Can K0520B be checked if the feeding tube is just used to deliver medications?

Admission

K0520. Nutritional Approaches Check all of the following nutritional approaches that apply on admission.	
	1. On Admission Check all that apply ↓
A. Parenteral/IV feeding	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐
Z. None of the above	☐

Discharge

K0520. Nutritional Approaches		
4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days 5. At Discharge Check all of the nutritional approaches that were being received at discharge	4. Last 7 Days Check all that apply ↓	5. At Discharge Check all that apply ↓
A. Parenteral/IV feeding	☐	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. None of the above	☐	☐

Answer 6: The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

If a feeding tube is in place but there are no scheduled or PRN orders to provide nutrition or hydration via the feeding tube on the current care/treatment plan, do not code K0520B - Feeding Tube.

At admission check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day admission assessment time period, even if not used during the 3-day admission assessment time period.

At discharge for column 4 - Last 7 days, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the last 7 days, even if not used in the last 7 days. At discharge for column 5 - At Discharge, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, even if not used during the 3-day discharge assessment time period.

Added: June 2023

Archived: March 2024

Section M: Skin Conditions

M0210, M0300

Question 1: How would the following scenario be coded: A patient is admitted to a facility with one deep tissue injury (DTI) on the sacrum. A second DTI develops during the stay. A week after admission the patient is discharged emergently and does not return to the facility. Upon completion of the discharge assessment it is determined that there was no skin assessment completed during the 3-day discharge window but one was completed 3 days prior to discharge. How would M0210 - Unhealed Pressure Ulcers/Injuries and M0300 – Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage be coded?

Answer 1: In the scenario described it appears that the stages of the two pressure ulcers/injuries are known from 3 days prior to discharge but a full skin assessment has not been completed within the 3-day assessment period. If using this information in conjunction with all current discharge assessment findings you are able to determine the appropriate stage of the pressure ulcers/injuries, then code Section M based on this information. If there is no information available enter a dash (-) for M0210 - Unhealed Pressure Ulcers/Injuries and M0300 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.

Added: March 2021

Archived: June 2022

M0300

Question 1: I am seeking guidance on how to complete the LCDS accurately in this scenario. Patient is admitted with an Unstageable - Deep Tissue Injury on his right heel. On Discharge, the nurse's assessment of the patient right heel was that DTI had become Unstageable - due to the presence of eschar. How do we code M0300 at Discharge?

Answer 1: For each pressure ulcer/injury observed at Discharge, consider current and historical levels of tissue involvement. Discharge coding for the scenario described is dependent upon the clinical progression of the wound during the LTCH stay.

If the DTI noted at admission does not evolve to be numerically stageable and becomes unstageable due to eschar or slough at the time of Discharge, code at Discharge as follows:

M0300F1. Unstageable - Slough and/or eschar = 1

M0300F2. Unstageable - Slough and/or eschar = 1

M0300G1. Unstageable - Deep tissue injury = 0

M0300G2. Unstageable - Deep tissue injury = skip

However, any pressure ulcer/injury that is observed to be unstageable due to slough and/or eschar at the time of Discharge, but was previously numerically stageable, is considered new, and not coded as present at admission on the Discharge assessment.

Added: September 2020

Archived: June 2022

Question 2: Is a pressure ulcer that was present when the first skin assessment was completed then healed during the stay and reopened at the same stage or less during the same stay, considered "present on admission" when completing the discharge assessment?

Answer 2: If a patient has a pressure ulcer that was documented on admission, and at discharge is documented at the same stage, it would be considered as "present on admission." This guidance is true even if during the stay the original pressure ulcer healed and reopened.

In addition to coding the pressure ulcer as "present on admission," a previously closed pressure ulcer that opens again should be reported at its worst stage.

Added: December 2020

Archived: June 2022

Question 3: A patient is admitted Monday evening by the admissions nurse and no pressure ulcers/injuries are documented at that time. The next day the wound nurse assesses the patient's spinal incision and notices a stage 2 pressure ulcer on coccyx. Is this pressure ulcer considered "present on admission" or facility acquired?

Answer 3: The intent of the items in Section M - Skin Conditions is to document the presence, appearance, and change of pressure ulcers/injuries.

The first skin assessment was conducted on Monday and no pressure ulcer was identified. Then during a subsequent skin assessment a pressure ulcer was identified. In this case the pressure ulcer would not be reported at admission or considered "present on admission".

The pressure ulcer items should be coded based on findings from the first skin assessment that is conducted on or after, and as close to the admission as possible.

Added: December 2020

Archived: June 2022

Question 4: I am looking for clarification in regard to coding of a wound. A patient is admitted with a Deep Tissue Injury (DTI). During the stay the DTI opens, and at discharge presents as two distinct openings, each appearing as a stage 3 pressure ulcer. For the discharge LCDS should the wound be coded as one DTI - "present on admission" or as two stage 3 pressure ulcers - also "present on admission"?

Answer 4: If at discharge the patient has two stage 3 pressure ulcers, code M0300C1 - Number of Stage 3 pressure ulcers as 2. Assuming no other pressure ulcers/injuries are present at discharge, M0300G1 - Unstageable Pressure Injuries Presenting as Deep Tissue Injury = 0.

If both stage 3 pressure ulcers present at discharge evolved from the DTI that was present at admission they would be considered "present on admission" and M0300C2 - Number of these Stage 3 pressure ulcers that were present upon admission = 2. This is because they were both numerically staged as a stage 3 when first numerically stageable.

Added: September 2021

Archived: June 2022

Question 5: I have a question about the current guidance that states: If a pressure ulcer/injury is surgically closed with a flap or graft, it should be considered a surgical wound and not a pressure ulcer/injury. If the flap or graft fails, it should still be considered a surgical wound until healed.

Is this in reference to ANY point in time that the flap/graft fails? For example, if the area of flap/graft has been 100% re-epithelized greater than 30 days and patient subsequently develops a wound due to pressure at the site of the original flap/graft, would it be still considered failed surgical site or would it be considered a pressure ulcer/injury?

Answer 5: If a pressure ulcer was closed with a skin graft, the surgical wound healed, and another wound forms in the same anatomical location due to pressure, then this would be considered a pressure ulcer/injury. Note it should be staged at the highest stage the pressure ulcer/injury was prior to closure, unless currently presenting at a higher stage or unstageable.

Added: December 2021

Archived: June 2022

Section N: Medications

N0415

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

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

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

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

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

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

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

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

Added: September 2022

Archived: March 2024

Question 2: When determining if a medication should be included in one of the 6 high-risk drug classes collected in the new item N0415 - High-Risk Drug Classes: Use and Indication, which drug classification system should be used?

Is there a specific drug classification system that should be used, or can facilities use any authoritative source even if a system describes the drug classes using terminology that differs from the exact drug classes reported in the item?

Answer 2: N0415 - High-Risk Drug Classes: Use and Indication identifies if the patient is taking any prescribed medication in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Code medications according to the medication's therapeutic category and/or pharmacological classification.

CMS does not specify a source for identifying the therapeutic category and/or pharmacological classification.

Added: December 2022

Archived: March 2024

Question 4: Our facility has a standard order set for all patients that includes PRN antiemetics including prochlorperazine, which is classified in the classification reference we use as an antipsychotic. The majority of our patients do not end up needing/receiving this PRN medication.

Guidance from the September LCDS Quarterly Q&As states to "consider a medication that is included in the patient's prescribed drug regimen even if it is not taken during the 3-day assessment period."

Does this mean our facility should be checking N0415A - High Risk Drug Classes; Antipsychotics for every patient with this standing order?

Answer 4: Some facilities utilize standing orders or a standing order set, providing a specific PRN order for all patients. If a medication is included on the patient's prescribed drug regimen due to facility policy (and not due to patient-specific need), it would only be considered for N0415 - High-Risk Drug Classes: Use and Indication, if the patient received it during the 3-day assessment time period.

Added: March 2023

Archived: March 2024

Question 6: If an anticoagulant is used to flush a PICC line that has become blocked with clotted blood, should that anticoagulant be considered when coding N0415 - High-Risk Drug Classes: Use and Indication?

Answer 6: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Do not include flushes to keep an IV access port patent.

Added: March 2023

Archived: March 2024

Question 7: For N0415 - High-Risk Drug Classes: Use and Indication can you provide an example of a combination drug that would be in more than one of the listed high-risk drug classes?

Answer 7: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Combination medications should be coded in all categories/pharmacologic classes that constitute the combination, regardless of why the medication is being used. For example, Percodan is a combination medication (oxycodone and aspirin) classified as both an opioid and an antiplatelet. Therefore, for both N0415H - Opioid and N0415I – Antiplatelet, *Column 1 – Is Taking* would be coded, regardless of why the medication is being used.

Added: March 2023

Archived: March 2024

Question 8: Please provide guidance on the following scenario. A patient is admitted to an LTCH and then, during the 3-day assessment time period, goes to the Emergency Department (ED) and recieves a one-time dose of a medication that is classified as a high-risk medication for N0415 - High-Risk Drug Classes: Use and Indication. If the admission assessment was not completed until after the patient returned from the ED should the medication that was received in the ED be considered when coding N0415?

Answer 8: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Code any medication that is used by any route in any setting (e.g., at an LTCH, in a hospital emergency room, at physician office or clinic) while a patient of the LTCH that is also part of a patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment period.

Added: June 2023

Archived: March 2024

Section O: Special Treatments, Procedures, and Programs

O0110

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

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

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

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

Added: September 2022

Archived: March 2024

Question 4: Regarding coding O0110, the LCDSD V5.0 Manual in the Coding Tips for O0110 - Non-Invasive Mechanical Ventilator states "*If a ventilator is being used as a substitute for BiPAP/CPAP, code here (and do not check O0110G2 or O0110G3).*" However, if O0110G1 - Non-Invasive Mechanical Ventilator is marked then per the technical data specifications O0110G2 - BiPAP and/or O0110G3 - CPAP must also be marked. Please advise.

Answer 4: The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

If a patient's current care includes non-invasive mechanical ventilation, code O0110G1 - Non-Invasive Mechanical Ventilator. Code O0110G2 - BiPAP if the non-invasive mechanical ventilator support was BiPAP. Code O0110G3 - CPAP if the non-invasive mechanical ventilator support was CPAP.

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.

Please disregard the portion of the statement in the manual that reads "*(and do not check O0110G2 or O0110G3).*"

Added: December 2022

Archived: March 2024

Question 6: Would an AV fistula be reported in O0110O1 - IV Access?

Answer 6: 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, and no other treatments, procedures, or programs listed in O0110 apply to the patient then code O0110Z - None of the above.

Added: March 2023

Archived: March 2024

Question 8: Our facility utilizes a standing order set for all patients that allows the use of supplemental oxygen if certain conditions are met. Does this mean that we should be selecting Oxygen Therapy for all patients when coding O0110 - Special Treatments, Procedures, and Programs?

Answer 8: Some facilities utilize standing orders or a standing order set, providing a specific PRN 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 3-day assessment time period.

Added: March 2023

Archived: March 2024

Question 10: The guidance for O0110H1 - IV Medications includes an exclusion for Dextrose 50% and Lactated Ringers, stating that these are not considered medications. There are also references to the National Drug Code Directory and Orange Book with guidance to use those references to determine what is considered a medication.

When reviewing those references, both Dextrose 50% and Lactated Ringers are listed as medications. Should these be excluded from consideration when coding O0110H1? Should any solution that includes dextrose be excluded from consideration? Are these references the only resources we should use to determine what is and what isn't a medication?

Answer 10: At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases use the most recent guidance. This Q&A represents the most recent guidance.

Please disregard the statement from the Guidance Manual that states: “Dextrose 50% and/or Lactated Ringers given IV are not considered medications and should not be included here.”

As stated in the Coding Instructions for O0110H1 - IV Medications, “Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item.”

Please note the following exclusions:

“Do not include flushes to keep an IV access port patent, or IV fluids without medication here. Subcutaneous pumps are not included in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy.”

Specifically, for O0110H1 do include IV fluids with medications added, unless otherwise excluded in guidance.

The National Drug Code Directory and Orange Book are examples of resources that could be used. CMS does not specify a source that must be used for determining what is and what is not considered a medication for O0110.

Added: March 2023

Archived: March 2024