Page Number	Item	Text as it appears in LTCHQR Program Manual V1.1 – August 2012	Revisions to Text	Description of revision(s)*
A-2	A0050	There is only once instance where it is necessary to delete a record and not retain any information about the record in the QIES ASAP database, and that is when the record was submitted for the wrong facility.	There is only one instance where it is necessary to delete a record and not retain any information about the record in the QIES ASAP database, and that is when the record was submitted for the wrong facility.	• "Once" changed to "one" • Extra space removed
A-3	A0050	For these items, an **inactivation request** is required in order for the incorrect record to be removed...	For these items, an **inactivation request** is required in order for the incorrect record to be removed...	• Extra space removed after "incorrect record"
A-8	A0250	• A transfer of the patient to be admitted to another hospital/facility, that results in the patient's absence from the LTCH for longer than 3 days (including the date of transfer); or • A transfer of the patient to an emergency department of another hospital, in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation, which results in the patient's absence from the LTCH for greater than 3 days;	• A transfer of the patient to be admitted to another hospital/facility that results in the patient's absence from the LTCH for longer than 3 days (including the date of transfer); or • A transfer of the patient to an emergency department of another hospital in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation, which results in the patient's absence from the LTCH for greater than 3 days;	• Removed commas after "hospital/facility" and "hospital"
A-15	A1100	If an interpreter is wanted or needed, request one and note in A1100B, Preferred language	If an interpreter is wanted or needed, request one and note the preferred language in A1100B, Preferred Language	• Clarified what should be noted in A1100B • Capitalized "L" in language
A-16	A1100B	An organized system of signing such as American Sign Language (ASL) can be reported as the preferred language if the patient needs or wants to communicate in this manner.	An organized system of signing, such as American Sign Language (ASL), can be reported as the preferred language if the patient needs or wants to communicate in this manner.	• Added commas after "system of signing" and "(ASL)"

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A-16	A1200	Allows understanding of the formal relationship the patient has and can be important for care and discharge planning.	Allows understanding of any formal relationship the patient may have and can be important for care and discharge planning.	• Revised wording for clarity
A-16	A1200	If neither source can report, review the medical information.	If no source can report, review the medical information.	• Revised wording for clarity
A-17	A1300D	Coding Instructions for 1300D, Lifetime Occupation(s)	Coding Instructions	• Removed item name for consistency
A-19	A1800	Code 03, Skilled nursing facility if the patient was admitted from a nursing facility with the staff and equipment for the provision of skilled nursing services skilled rehabilitative services, and/or other related health services. This category includes swing bed hospitals which are generally small, rural hospitals or critical access hospitals (CAH) participating in Medicare that has CMS approval to provide the post-hospital SNF care and meets certain requirements	Code 03, Skilled nursing facility if the patient was admitted from a nursing facility with the staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category includes swing bed hospitals, which are generally small, rural hospitals or critical access hospitals (CAH) participating in Medicare that has CMS approval to provide the post-hospital SNF care and meets certain requirements	• Added commas after “skilled nursing services” and “swing bed hospitals”
A-19	A1800	Code 07, Inpatient rehabilitation facility or unit (IRF) if the patient was admitted from a hospital or a distinct unit that provides an intensive rehabilitation program to inpatients	Code 07, Inpatient rehabilitation facility or unit (IRF) if the patient was admitted from a hospital, or a distinct unit of a hospital, that provides an intensive rehabilitation program to inpatients	• Added “of a hospital” for clarity • Added commas after both instances of “hospital”
A-24	A2100	Community residential setting (private home/apartment, board/care, assisted living, group home adult foster care)	Community residential setting (private home/apartment, board/care, assisted living, group home, adult foster care)	• Added comma after “group home”

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B-1	B0100	Sometimes patients who were comatose after an anoxic-ischemic injury (i.e. not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition.	Sometimes patients who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness, but do not evidence any purposeful behavior or cognition.	• Added comma after "i.e." • Added comma after "wakefulness"
GG-4	GG	A "She sits up without any instructions or physical help? CNA: No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed. But once I remind her to check her arm, she can do it herself.	A: "She sits up without any instructions or physical help? CNA: No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed, but once I remind her to check her arm, she can do it herself.	• Added colon after "A" • Rephrased last sentence for clarity
H-2	H0400	Code 3, **always incontinent** if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e. had no continent bowel movements).	Code 3, **always incontinent** if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).	• Added comma after "i.e."
H-2	H0400	Patients who require assistance to maintain the passage of stool via artificial initiation (e.g. manual stimulation, rectal suppositories or enema) would be considered *continent* of bowel.	Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories or enema) would be considered *continent* of bowel.	• Added comma after "e.g."

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I-1	I	Medical record sources for physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) diagnoses include, but are not limited to transfer documents, physician progress notes, recent history and physical, discharge summary, medication sheets, physician orders, consults and official diagnostic reports, diagnosis/problem list(s), and other resources as available.	Medical record sources for physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) diagnoses include, but are not limited to: transfer documents, physician progress notes, recent history and physical, discharge summary, medication sheets, physician orders, consults and official diagnostic reports, diagnosis/problem list(s), and other resources as available.	• Added colon after "limited to"
I-2	I	If, however, it comes to light that a **documented** active diagnosis but it was not indicated on the LTCH CARE Data Set, the LTCH should modify the LTCH CARE Data Set in accordance with the instructions in Chapter 4, pp. 4-5 through 4-7 under *Correcting Errors in LTCH CARE Data Set Assessment Records That Have Been Accepted into the QIES ASAP System.*	If, however, it comes to light that a **documented** active diagnosis was not indicated on the LTCH CARE Data Set, the LTCH should modify the LTCH CARE Data Set in accordance with the instructions in Chapter 4, pp. 4-5 through 4-7 under *Correcting Errors in LTCH CARE Data Set Assessment Records That Have Been Accepted into the QIES ASAP System.*	• Rephrased sentence for clarity
I-3	I	Specific documentation areas in the medical record may include but are not limited to: progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.	Specific documentation areas in the medical record may include, but are not limited to: progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.	• Added comma after "may include"
M-2	M0210	When considering this, recognize that Stage 1, Suspected Deep Tissue Injury (sDTI), and unstageable pressure ulcers although "closed," (i.e. may be covered with tissue, eschar, slough, etc.) would not be considered "healed."	When considering this, recognize that Stage 1, Suspected Deep Tissue Injury (sDTI), and unstageable pressure ulcers although "closed," (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered "healed."	• Added comma after "i.e."

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M-2	M0210	For LTCH CARE Data Set assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen and palpated, i.e. visible tissue, palpable bone) during the 3-day assessment period.	For LTCH CARE Data Set assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen and palpated, i.e., visible tissue, palpable bone) during the 3-day assessment period.	• Added comma after "i.e."
M-5	M0300	If the pressure ulcer that is identified on admission increases in numerical staging (i.e. worsens) within the 3-day LTCH assessment period, the **initial** stage of the pressure ulcer and staging would be documented on the LTCH CARE Data Set Admission Assessment.	If the pressure ulcer that is identified on admission increases in numerical staging (i.e., worsens) within the 3-day LTCH assessment period, the **initial** stage of the pressure ulcer and staging would be documented on the LTCH CARE Data Set Admission Assessment.	• Added comma after "i.e."
M-15	M0300E	M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device	M0300E: Unstageable Pressure Ulcers Related to Nonremovable Dressing/Device	• Removed hyphen in "non-removable"
M-15	M0300E	Although the wound bed cannot be visualized due to the non-removable dressing/device, and hence the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit activity and be painful.	Although the wound bed cannot be visualized due to the nonremovable dressing/device, and hence the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit activity and be painful.	• Removed hyphen in "non-removable"
M-19	M0300F	Patient is admitted to an LTCH with a short leg cast to the right lower extremity. He has no visible wounds on admission but arrives with documentation that a pressure ulcer exists under the cast.	Patient is admitted to an LTCH with a short leg cast to the right lower extremity. He has no visible wounds on admission, but arrives with documentation that a pressure ulcer exists under the cast.	• Added comma after "on admission"
M-19	M0300F	The right heel eschar remained stable and dry, i.e. remained unstageable.	The right heel eschar remained stable and dry, i.e., remained unstageable.	• Added comma after "i.e."

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M-26	M0610	Measurement of tunneling and undermining is not recorded on the LTCH CARE Data Set assessment record but should be assessed, monitored, and treated as part of the comprehensive care plan.	Measurement of tunneling and undermining is not recorded on the LTCH CARE Data Set assessment record, but should be assessed, monitored, and treated as part of the comprehensive care plan.	• Added comma after "assessment record"
M-26	M0700	The "most severe" types of tissue are those that are devitalized and non-viable (i.e. necrotic), healthier tissue includes granulation and epithelial tissue.	The "most severe" types of tissue are those that are devitalized and non-viable (i.e., necrotic), healthier tissue includes granulation and epithelial tissue.	• Added comma after "i.e."
M-26	M0700	What is coded on the LTCH CARE Data Set is the tissue type identified that corresponds to the most devitalized/non-viable (i.e. most severe) tissue identified in the wound.	What is coded on the LTCH CARE Data Set is the tissue type identified that corresponds to the most devitalized/non-viable (i.e., most severe) tissue identified in the wound.	• Added comma after "i.e."
M-27	M0700	For example, if a mixture of necrotic tissue, i.e. both eschar and slough are present, code for eschar tissue.	For example, if a mixture of necrotic tissue, i.e., both eschar and slough are present, code for eschar tissue.	• Added comma after "i.e."
M-29	M0800	If a numerically staged pressure ulcer that was POA becomes unstageable during the stay (i.e. cannot be numerically staged), is debrided, and after debridement is able to be restaged numerically, if that reassessed stage is higher than the previous numerical stage, the pressure ulcer is considered to have worsened and is no longer considered POA.	If a numerically staged pressure ulcer that was POA becomes unstageable during the stay (i.e., cannot be numerically staged), is debrided, and after debridement is able to be restaged numerically, if that reassessed stage is higher than the previous numerical stage, the pressure ulcer is considered to have worsened and is no longer considered POA.	• Added comma after "i.e."

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M-30	M0800	However, if a numerically staged pressure ulcer that was POA becomes unstageable (i.e. cannot be numerically staged), is debrided, and after debridement is able to be restaged numerically, if that reassessed stage is the same as the previous numerical stage, the pressure ulcer is considered NOT to have worsened and is still considered POA.	However, if a numerically staged pressure ulcer that was POA becomes unstageable (i.e., cannot be numerically staged), is debrided, and after debridement is able to be restaged numerically, if that reassessed stage is the same as the previous numerical stage, the pressure ulcer is considered NOT to have worsened and is still considered POA.	• Added comma after “i.e.”
M-33	M0800	**M0800B is coded as 1** on discharge assessment because the Stage 3 pressure ulcer noted on discharge was not present on the admission assessment but developed in the LTCH.	**M0800B is coded as 1** on discharge assessment because the Stage 3 pressure ulcer noted on discharge was not present on the admission assessment, but developed in the LTCH.	• Added comma after “admission assessment”

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