

## LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 1.01 PATIENT ASSESSMENT FORM - PLANNED DISCHARGE

Section A	Administrative Information
<b>A0050. Type of Record</b>	
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	1. <b>Add new assessment/record</b> 2. <b>Modify existing record</b> 3. <b>Inactivate existing record</b>
<b>A0055. Correction Number</b>	
Enter Number <input style="width: 40px; height: 20px;" type="text"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one. Enter 00 for new record
<b>A0100. Facility Provider Numbers.</b> Enter Code in boxes provided.	
	<b>A. National Provider Identifier (NPI):</b>  <b>B. CMS Certification Number (CCN):</b>  <b>C. State Provider Number:</b>
<b>A0200. Type of Provider</b>	
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	3. <b>Long-term Care Hospital</b>
<b>A0210. Assessment Reference Date</b>	
	Observation end date: _____ - _____ - _____ Month                  Day                  Year
<b>A0220. Admission Date</b>	
	_____ - _____ - _____ Month                  Day                  Year
<b>A0250. Reason for Assessment</b>	
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	01. <b>Admission</b> 10. <b>Planned discharge</b> 11. <b>Unplanned discharge</b> 12. <b>Expired</b>

**Section A****Administrative Information****A0270. Discharge Date**

— —  
 Month Day Year

**Patient Demographic Information****A0500. Legal Name of Patient****A. First name:****B. Middle initial:****C. Last name:****D. Suffix:****A0600. Social Security and Medicare Numbers****A. Social Security Number:**

— —

**B. Medicare number** (or comparable railroad insurance number):**A0700. Medicaid Number** - Enter "+" if pending, "N" if not a Medicaid recipient**A0800. Gender**

Enter Code

1. Male
2. Female

**A0900. Birth Date**

— —  
 Month Day Year

**A1000. Race/Ethnicity**

↓ Check all that apply

- A. American Indian or Alaska Native**
- B. Asian**
- C. Black or African American**
- D. Hispanic or Latino**
- E. Native Hawaiian or Other Pacific Islander**
- F. White**

**Section A****Administrative Information****A1400. Payer Information**

↓ Check all that apply

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <b>A. Medicare</b> (traditional fee-for-service)            |
| <input type="checkbox"/> | <b>B. Medicare</b> (managed care/Part C/Medicare Advantage) |
| <input type="checkbox"/> | <b>C. Medicaid</b> (traditional fee-for-service)            |
| <input type="checkbox"/> | <b>D. Medicaid</b> (managed care)                           |
| <input type="checkbox"/> | <b>E. Workers' compensation</b>                             |
| <input type="checkbox"/> | <b>F. Title programs</b> (e.g., Title III, V, or XX)        |
| <input type="checkbox"/> | <b>G. Other government</b> (e.g., TRICARE, VA, etc.)        |
| <input type="checkbox"/> | <b>H. Private insurance/Medigap</b>                         |
| <input type="checkbox"/> | <b>I. Private managed care</b>                              |
| <input type="checkbox"/> | <b>J. Self-pay</b>  |
| <input type="checkbox"/> | <b>K. No payor source</b>                                   |
| <input type="checkbox"/> | <b>X. Unknown</b>   |
| <input type="checkbox"/> | <b>Y. Other</b>   |

**A1955. Discharge Delay**

Enter Code

**Was the patient's discharge delayed for at least 24 hours?**

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | 0. <b>No</b> → Skip to A1970, Discharge Return Status |
| <input type="checkbox"/> | 1. <b>Yes</b>   |

**A1960. Reason for Discharge Delay**

Enter Code

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | 01. <b>No bed available at receiving hospital/facility</b>  |
| <input type="checkbox"/> | 02. <b>Services, equipment or medications not available</b> (e.g., home health care, durable medical equipment, IV medications) |
| <input type="checkbox"/> | 03. <b>Family/support</b> (e.g., family could not pick patient up)  |
| <input type="checkbox"/> | 04. <b>Medical</b> (patient condition changed)  |
| <input type="checkbox"/> | 98. <b>Other</b>  |

**A1970. Discharge Return Status**

Enter Code

- |                          |                           |
|--------------------------|---------------------------|
| <input type="checkbox"/> | 1. <b>Anticipated</b>     |
| <input type="checkbox"/> | 2. <b>Not Anticipated</b> |

**A2100. Discharge Location**

Enter Code

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | 01. <b>Community residential setting</b> (e.g., private home/apt., board/care, assisted living, group home, adult foster care) |
| <input type="checkbox"/> | 02. <b>Long-term care facility</b>   |
| <input type="checkbox"/> | 03. <b>Skilled nursing facility</b> (SNF)  |
| <input type="checkbox"/> | 04. <b>Hospital emergency department</b>   |
| <input type="checkbox"/> | 05. <b>Short-stay acute hospital</b> (IPPS)  |
| <input type="checkbox"/> | 06. <b>Long-term care hospital</b> (LTCH)  |
| <input type="checkbox"/> | 07. <b>Inpatient rehabilitation facility or unit</b> (IRF)   |
| <input type="checkbox"/> | 08. <b>Psychiatric hospital or unit</b>  |
| <input type="checkbox"/> | 09. <b>ID/DD facility</b>  |
| <input type="checkbox"/> | 10. <b>Hospice</b>   |
| <input type="checkbox"/> | 12. <b>Discharged Against Medical Advice</b>   |
| <input type="checkbox"/> | 98. <b>Other</b>   |

**Section B**

**Hearing, Speech, and Vision**

**B0100. Comatose**

Enter Code

**Persistent vegetative state/no discernible consciousness at time of assessment.**

- 0. **No**
- 1. **Yes**

**Section GG****Functional Status: Usual Performance****GG0160. Functional Mobility**

(Complete during the 3-day assessment period.)

**Code the patient's usual performance using the 6-point scale below.****CODING:**

**Safety and Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.
07. **Patient refused**
09. **Not applicable**
- If activity was not attempted, code:**
88. Not attempted due to **medical condition or safety concerns**

**Enter Codes in Boxes**

<input type="text"/>	<b>A. Roll left and right:</b> The ability to roll from lying on back to left and right side, and roll back to back.
<input type="text"/>	<b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<b>C. Lying to Sitting on Side of Bed:</b> The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.

**Section H****Bladder and Bowel****H0400. Bowel Continence**

(Complete during the 3-day assessment period.)

Enter Code

**Bowel continence** - Select the one category that best describes the patient.0. **Always continent**1. **Occasionally incontinent** (one episode of bowel incontinence)2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)3. **Always incontinent** (no episodes of continent bowel movements)9. **Not rated**, patient had an ostomy or did not have a bowel movement for the entire 3 days

**Section I****Active Diagnoses**

**For this section, indicate the presence of the following conditions, based on a review of the patient's clinical records at the time of assessment.**

↓ **Check all that apply**

**Heart/Circulation**

**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

**Metabolic**

**I2900. Diabetes Mellitus (DM)**

**Nutritional**

**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

<b>Section K</b>	<b>Swallowing/Nutritional Status</b>
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**K0200. Height and Weight** - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

<input style="width: 100%; height: 20px;" type="text"/> inches	<b>A. Height</b> (in inches). Record most recent height measure since admission
<input style="width: 100%; height: 20px;" type="text"/> pounds	<b>B. Weight</b> (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)



**Section M****Skin Conditions**

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

**M0210. Unhealed Pressure Ulcer(s)**

- Enter Code  **Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**
0. **No** → Skip to Z0400, Signature of Persons Completing the Assessment
  1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage**

- Enter Number  **A. Number of Stage 1 pressure ulcers**  
**Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
- Enter Number  **B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3
  2. **Number of these Stage 2 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
  3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:  
 \_\_\_\_\_  
 Month                  Day                  Year
- Enter Number  **C. Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling
1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4
  2. **Number of these Stage 3 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
- Enter Number  **D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing
  2. **Number of these Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
- Enter Number  **E. Unstageable - Non-removable dressing:** Known but not stageable due to non-removable dressing/device
1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar
  2. **Number of these unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission
- Enter Number  **F. Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar
1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable: Deep tissue injury
  2. **Number of these unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

**M0300 continued on next page**

**Section M****Skin Conditions****M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued**

Enter Number <input type="text"/>	<b>G. Unstageable - Deep tissue injury:</b> Suspected deep tissue injury in evolution
Enter Number <input type="text"/>	<ol style="list-style-type: none"> <li><b>Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</b> - If 0 → <i>Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</i></li> <li><b>Number of <u>these</u> unstageable pressure ulcers that were present upon admission</b> - enter how many were noted at the time of admission</li> </ol>

**M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar**

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the patient has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

<input type="text"/> . <input type="text"/> cm	<b>A. Pressure ulcer length:</b> Longest length in any direction
<input type="text"/> . <input type="text"/> cm	<b>B. Pressure ulcer width:</b> Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text"/> . <input type="text"/> cm	<b>C. Pressure ulcer depth:</b> Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

**M0700. Most Severe Tissue Type for Any Pressure Ulcer**

Enter Code <input type="text"/>	<p>Select the best description of the most severe type of tissue present in any pressure ulcer bed, consider all pressure ulcers</p> <ol style="list-style-type: none"> <li><b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</li> <li><b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance</li> <li><b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</li> <li><b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</li> </ol>
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**M0800. Worsening in Pressure Ulcer Status Since Prior Assessment**Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment.

If no current pressure ulcer at a given stage, enter 0

Enter Number <input type="text"/>	<b>A. Stage 2</b>
Enter Number <input type="text"/>	<b>B. Stage 3</b>
Enter Number <input type="text"/>	<b>C. Stage 4</b>

**Section Z Assessment Administration**

**Z0400. Signature of Persons Completing the Assessment**

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that submitting false information may subject my organization to a 2% reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

**Z0500. Signature of Person Verifying Assessment Completion**

<p><b>A. Signature:</b></p>  	<p><b>B. LTCH CARE Data Set Completion Date:</b></p> <p style="text-align: center;">             _____              Month          Day          Year           </p>
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