# SECTION A: ADMINISTRATIVE INFORMATION

Intent: This section obtains key information that uniquely identifies each patient, the LTCH in which he or she receives health care services, and the reason(s) for assessment.

## A0050: Type of Record


### Item Rationale

Indicate whether an LTCH CARE Data Set assessment record is a new record to be added to the QIES ASAP system or a request to modify or inactivate a record that has been previously submitted and accepted in the QIES ASAP system.

A **new assessment/record** is a record that has not been previously submitted and accepted in the QIES ASAP system.

Corrections should be made to any LTCH CARE Data Set assessment record(s) that have any known errors to insure that the information in the QIES ASAP system accurately reflects the resident's identification, location, and reason(s) for assessment. The **modification request** and **inactivation request** are two processes that have been established to correct errors identified on LTCH CARE Data Set assessment records that have been accepted into the QIES ASAP system.

A **modification request** is used to correct incorrect data item values on a LTCH CARE Data Set assessment record that has been previously submitted and accepted in the QIES ASAP system. The types of errors that may be corrected in a modification request include errors in:

- transcription,
- data entry,
- software product,
- item coding, and/or
- other errors requiring correction.

The modification request record should contain correct values for all LTCH CARE Data Set items (not just the values for the LTCH CARE Data Set items previously in error). The corrected record, once submitted and accepted in the QIES ASAP system, will replace the prior erroneous record in the QIES ASAP database. A modification request cannot be used if more than one patient identifier (i.e., last name, first name, SSN, birth date, gender) is found to be in error. In this instance an inactivation request must be used.

An **inactivation request** is used to move an existing record that has been previously submitted and accepted in the QIES ASAP system from the active file to an archive (history file) so that it will not be used for reporting purposes. An inactivation should be used when the event did not

occur (e.g., a discharge assessment record was submitted to QIES ASAP system when the patient was not discharged) and for when more than one patient identifier (i.e., last name, first name, SSN, birth date, gender) is found to be in error.

An inactivation request is also *required* when *incorrect* data were submitted and accepted into the QIES ASAP system for the following items on the LTCH CARE Data Set assessment record:

| | |
|---|---|
| A0210 | Assessment Reference Date |
| A0220 | Admission Date (on an Admission record A0250= 01) |
| A0250 | Reason for Assessment |
| A0270 | Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12) |

The inactivation request should include the following items of the LTCH CARE Data Set assessment record:

| | |
|---|---|
| A0050 | Type of Record |
| A0055 | Correction Number |
| A0200 | Type of Provider |
| A0210 | Assessment Reference Date |
| A0220 | Admission Date (on an Admission record A0250= 01) |
| A0250 | Reason for Assessment |
| A0270 | Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12) |
| A0500A | First Name |
| A0500C | Last Name |
| A0600A | Social Security Number |
| A0800 | Gender |
| A0900 | Birth Date |

The modification and inactivation processes are automated, and neither *completely* removes the prior erroneous record from the QIES ASAP database. The erroneous record is archived in a history file.

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. In this instance, a **Manual Deletion Request** is necessary to ensure that the patient record is not associated with the incorrect facility and does not appear on reports to the incorrect facility. Manual Deletion Requests must come from the LTCH to CMS so that all traces of this record will be manually deleted from the QIES ASAP database. A new record must then be submitted to the QIES ASAP system for the correct facility. The policy and procedures for a Manual Deletion Request are provided in Chapter 4 of this manual.

## Coding Instructions for A0050, Type of Record

- Code 1, Add new assessment/record if this is a *new* LTCH CARE Data Set *assessment/record* that has not been previously submitted and accepted in the QIES ASAP system.

  If this item is **coded as 1**, the LTCH staff member should proceed to **A0055, Correction Number**, and complete the items in all other LTCH CARE Data Set sections.

If there is an existing record for the same patient, the same LTCH, with the same reason for assessment, and the same event date(s) (assessment reference date, admission date, or discharge date), then the current record would be a duplicate and not a new record. In this case, when submitted, the record will be rejected by the QIES ASAP system and a "fatal" error will be reported to the facility on the **Final Validation Report**. Further details on the Final Validation Report can be found in Chapter 4 of this manual.

- Code 2, Modify existing record if this is a *request to modify* the LTCH CARE Data Set data for a record that already has been submitted and accepted in the QIES ASAP system.

  If this item is **coded as 2**, the LTCH staff should proceed to **A0055, Correction Number**, and complete the items in all other LTCH CARE Data Set sections.

  If a single patient identifier (last name, first name, SSN, birth date, gender) is to be modified, enter the corrected information in the appropriate item (and proceed to complete the items in all other LTCH CARE Data Set Sections). However, only *one* patient identifier can be changed with each modification request record. To make *multiple* patient identifier corrections, you **must** complete an **inactivation request** for the incorrect record **and** create a new record with the correct information.

  The following items *cannot* be corrected with a Modification Request:

  — A0210 Assessment Reference Date

  — A0220 Admission Date (on an Admission record A0250= 01)

  — A0250 Reason for Assessment

  — A0270 Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12)

  For these items, an **inactivation request** is required in order for the incorrect record to be removed from an active file to an archive (history file). A new record with the correct information must be submitted to the QIES ASAP system to replace the inactivated record.

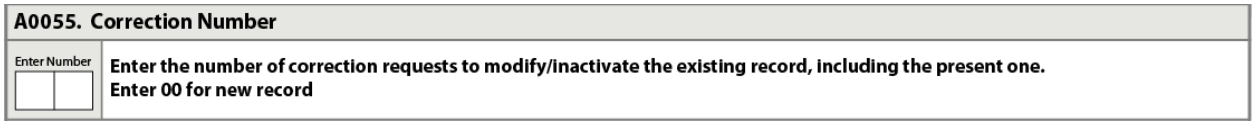
- Code 3, Inactivate existing record if it is a *request to inactivate* a LTCH CARE Data Set assessment record that already has been submitted and accepted in the QIES ASAP system.

  If this item is **coded as 3**, then the following Section A items must be completed and <u>all other LTCH CARE Data Set items should be left blank</u>:

  A0050 Type of Record
  A0055 Correction Number
  A0200 Type of Provider
  A0210 Assessment Reference Date
  A0220 Admission Date (on an Admission record A0250= 01)
  A0250 Reason for Assessment
  A0270 Discharge Date (on a Planned or Unplanned Discharge or on an Expired record A0250 = 10, 11, or 12)

A0500A First Name
A0500C Last Name
A0600A Social Security Number
A0800 Gender
A0900 Birth Date

# A0055: Correction Number




## Item Rationale

- This item indicates the number of times the patient record has been corrected in the QIES ASAP database, including the present record.
- Note that item **A0055, Correction Number,** is used to track successive correction requests in the QIES ASAP database. This item may be populated automatically by the LTCH's data entry software, however, if it is not, the LTCH must track and manually enter this information.

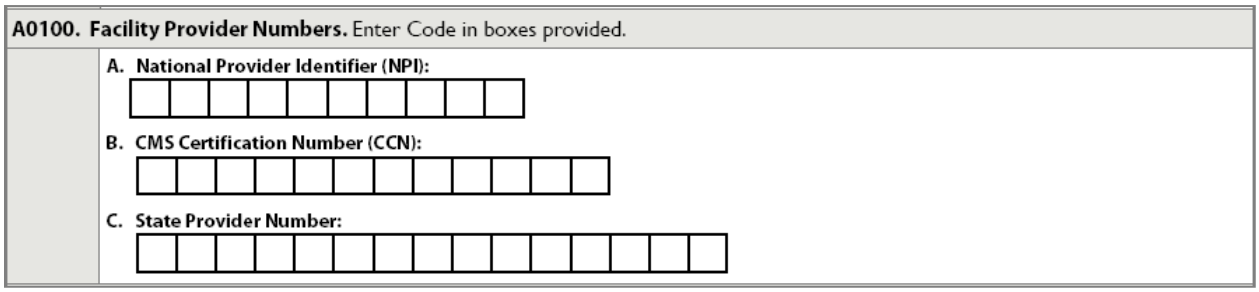
## Coding Instructions for A0055, Correction Number

- Enter the total number of correction requests to modify/inactivate the QIES ASAP record that is in error. Include the present modification/inactivation request in this number.
- For a **new assessment/record, code a value of 00** (zero-zero) to indicate that it is an original assessment/record and not a correction request.
- For the **first correction request (modification or inactivation), code a value of 01** (zero-one). Similarly, for the **second correction request (modification or inactivation), code a value of 02** (zero-two). With each subsequent request, item **A0055** is incremented by one (e.g., for the **third correction request, code a value of 03** (zero-three).

  For the first through ninth correction requests, a leading zero should be coded in the first box. For example, for the first correction request (modification/inactivation), enter "0" in the first box and "1" into the second box.

  For subsequent requests, a leading zero should not be coded in the first box. For example, for the tenth correction request (modification/inactivation), code a value of 10 (one-zero) to denote this is the tenth correction request.

# A0100: Facility Provider Numbers




## Item Rationale

- Identifies the LTCH submitting the assessment record.

## Coding Instructions

- LTCHs must have a National Provider Number (NPI) and a CMS Certification Number (CCN).
- Enter the LTCH provider numbers:
  - A. National Provider Identifier (NPI)
  - B. CMS Certification Number (CCN)
  - C. State Provider Number

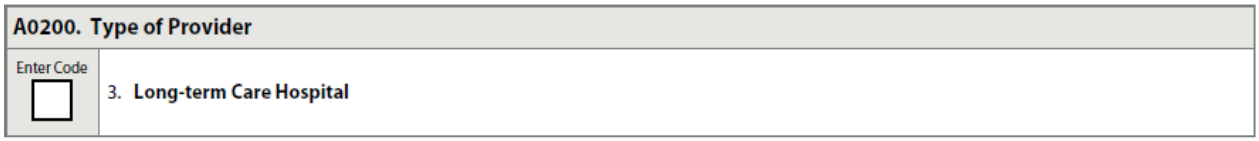
### DEFINITIONS

**NATIONAL PROVIDER IDENTIFIER (NPI)**
A unique Federal number that identifies providers of health care services. The NPI applies to the LTCH and all of its patients.

**CMS CERTIFICATION NUMBER (CCN)**
This is the hospital's identification number and is linked to its Medicare provider agreement. The CCN is used for CMS certification, submitting and reviewing the hospital's cost reports, and assessment-related activities.

**STATE PROVIDER NUMBER**
This is the Medicaid Provider Number established by a State.

# A0200: Type of Provider




## Item Rationale

- Designates type of provider.
- Allows QIES ASAP system to match records.

## Coding Instructions

- Code 3, Long-term Care Hospital if facility is a long-term care hospital.

# A0210: Assessment Reference Date

| A0210. Assessment Reference Date | |
|---|---|
| | Observation end date: ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year |

## Item Rationale

- Designates the end of the assessment period so that all assessment items refer to the patient's status during the same period of time.

  Any information from an assessment done after the ARD will not be captured on that particular LTCH CARE Data Set. The ARD for an admission record is **at most** the third calendar day of the patient's stay.

  For example, if a patient is admitted to the LTCH on the December 3, 2012, assessment information would be based on the period starting with the time of admission on December 3, 2012, and ending at the ARD, which is 11:59 pm on December 5, 2012 (admission date plus 2 calendar days).

  — The ARD is not intended to replace a time frame used by the facility for carrying out patient assessments, and LTCHs should follow facility policy related to assessment timing. Therefore, the assessment data that is captured ***by*** the ARD may likely include assessment data collected ***prior*** to that date, such as assessment findings that pertain to an admission assessment conducted upon patient arrival as would be carried out normally as part of practicing basic standards of care. For example, the assessment finding of a pressure ulcer wound that was **present on admission** would reflect what was assessed **on admission**.

  DEFINITION

  ASSESSMENT REFERENCE DATE (ARD) The end point of the assessment period for the LTCH CARE Data Set assessment record.

- The ARD for Planned or Unplanned Discharge and Expired assessments is equal to the date of discharge or death.
- Allows QIES ASAP system to match records.

## Steps for Assessment

- The ARD will be determined by the reason for the assessment and in compliance with the timing requirements as outlined in Chapter 2.

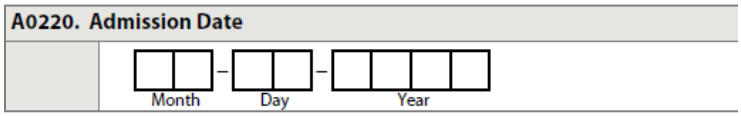
## Coding Instructions

- Use the format Month-Day-Year (MM-DD-YYYY) to enter the appropriate date for ARD. Do not leave any spaces blank. If the month or day contains only a single digit, code a "0" in the first box. For example, October 2, 2012, should be entered as 10-02-2012.
- For detailed information related to the ARD for all LTCH CARE Data Set assessments, refer to Chapter 2.

## Coding Tips and Special Populations

- When the patient is discharged or dies prior to the completion of an Admission assessment, the ARD of the Admission assessment must be equal the Discharge Date (or date of death on an Expired record) (A0270).
- For Planned or Unplanned Discharge and Expired assessments, the ARD item (A0210) and Discharge Date item (A0270) must contain the same date.
- The ARD may not be extended simply because the patient receives services in a facility other than the LTCH during part of the assessment period (e.g., a patient receives services in a short-stay acute care hospital during an observation stay or an inpatient stay and returns to the same LTCH within 3 calendar days). For example, if the date of admission to the LTCH is December 3, 2012, assessment information would be based on the time period starting with the date of admission December 3, 2012, and ending at the ARD, which is 11:59 pm on December 5, 2012 (admission date plus 2 calendar days). If the patient is absent during December 3 or December 4, 2012, for any reason, the ARD remains December 5, 2012.

# A0220: Admission Date




DEFINITION

ADMISSION DATE
The date a person enters the LTCH and is admitted as a patient. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the first day of admission.

## Item Rationale

- To document the date of admission into the LTCH.
- Allows QIES ASAP system to match records.

## Coding Instructions

- Enter the most recent date of admission to this LTCH. Use the format: Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month or day contains only a single digit, code a “0” in the first box. For example, November 1, 2012, would be entered as 11-01-2012.

# A0250: Reason for Assessment

| A0250. Reason for Assessment | |
|---|---|
| Enter Code ☐☐ | 01. **Admission**<br>10. **Planned discharge**<br>11. **Unplanned discharge**<br>12. **Expired** |

## Item Rationale

- Allows identification of needed assessment content.

## Coding Instructions

- Document the reason for completing the assessment, using the categories of assessment types. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on LTCH CARE Data Set assessment schedules. This item contains two digits. For code 01, enter "0" in the first box and place "1" in the second box.
  - 01. Admission
  - 10. Planned discharge
  - 11. Unplanned discharge
  - 12. Expired

- For unplanned discharges, the facility should complete the Discharge assessment to the best of its abilities. In some cases, the facility may have already completed some items of the assessment or may be in the process of completing an assessment. The use of the dash, "-" is appropriate when the staff are unable to determine the response for an item.

- Planned discharge with a change in discharge date does not constitute an unplanned discharge.

### DEFINITIONS

#### PLANNED DISCHARGE

A planned discharge is one where the patient is non-emergently, medically released from care at the long-term care hospital due to some reason arranged for in advance.

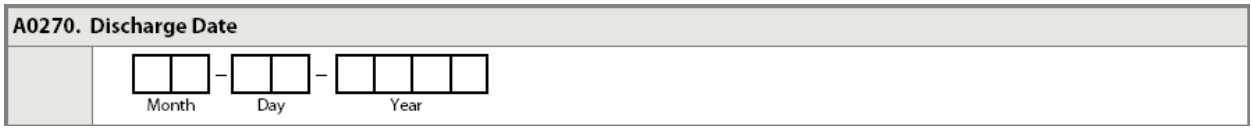
#### UNPLANNED DISCHARGE

An unplanned discharge is:

- 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; or
- When a patient unexpectedly leaves the LTCH against medical advice; or
- When a patient unexpectedly decides to go home or to another setting (e.g., due to the patient deciding to complete treatment in an alternate setting).

- Does not include *planned transfers* to an acute-care inpatient hospital for admission for a planned intervention, treatment, or procedure, unless the patient does not return to the LTCH within 3 days.

# A0270: Discharge Date




## Item Rationale

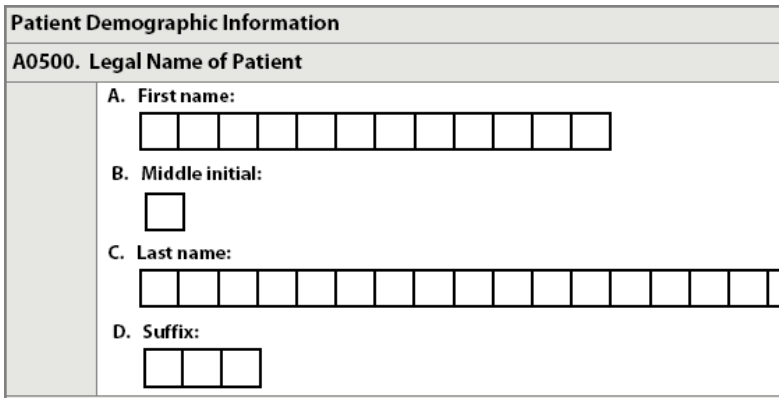
- To document the date of discharge from the LTCH.

## Coding Instructions

*Complete only if A0250=10, Planned discharge; A0250=11, Unplanned discharge; or A0250=12, Expired.*

- Enter the date that the patient was discharged (whether or not return is anticipated). This is the date the patient leaves the LTCH.
- The Discharge Date item on the Expired LTCH CARE Data Set (i.e., when A0250=12, Expired), is the date of death.
- Use the format: Month-Day-Year: MM-DD-YYYY. For example, October 9, 2012, would be entered as 10-09-2012.
- For Discharge assessments, the Discharge Date (A0270) and ARD (A0210) must be the same date.

# A0500: Legal Name of Patient




## Item Rationale

- Records patient's legal name for identification purposes.
- Allows multiple records for patient to be matched in the QIES ASAP system.

DEFINITIONS

LEGAL NAME
Patient's name as it appears on the Medicare card. If the patient is not enrolled in the Medicare program, the patient's name as it appears on a Medicaid card or other government-issued document is used.

## Steps for Assessment

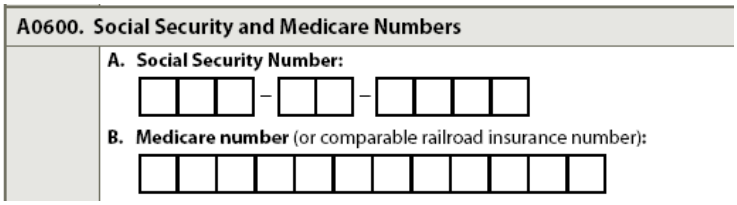
1. Ask patient, family, significant other, guardian, or legally authorized representative to state the patient's legal name.
2. Check the patient's name on his or her Medicare card, or, if not on Medicare, check Medicaid card or other government-issued document.

## Coding Instructions

*Use printed letters. Enter in the following order:*

A. First Name.
B. Middle Initial (if the patient has no middle initial, leave Item A0500B blank; if the patient has two or more middle names, use the initial of the first middle name).
C. Last Name (this field has a limit of 18 characters; the LTCH must be consistent when entering last name from assessment to assessment or a new person will be created in the QIES ASAP system).
D. Suffix (e.g., Jr., Sr.).

# A0600: Social Security and Medicare Numbers




## Item Rationale

- Records the patient's Social Security and Medicare Numbers for identification purposes.
- Allows records for patient to be matched in the QIES ASAP system.

## Coding Instructions

- Enter the Social Security Number (SSN) in item A0600A, one number per space, starting with the leftmost space. If the patient does not have a SSN, the item may be left blank.
- Enter the Medicare number in item A0600B exactly as it appears on the patient's Medicare card.
- If the patient does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. These RRB numbers contain both letters and numbers. To enter the RRB number, enter the first letter of the code in

### DEFINITIONS

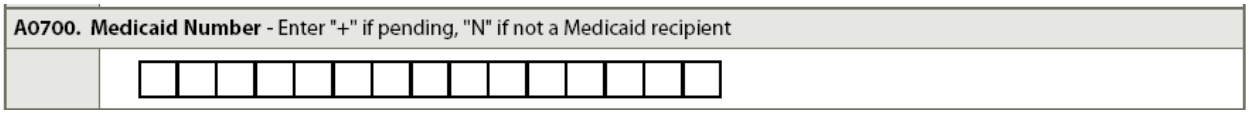
SOCIAL SECURITY NUMBER (SSN)
A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

MEDICARE NUMBER (OR COMPARABLE RAILROAD INSURANCE NUMBER)
An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier may differ from the patient's SSN, and may contain both letters and numbers. For example, many patients receive Medicare benefits based on a spouse's Medicare eligibility. This number may also be referred to as a Health Insurance Claim (HIC) number.

the left-most space followed by one letter/digit per space. If the person has neither a Medicare number nor an RRB number, the item may be left blank.

- Item A0600B can only be a Medicare (Health Insurance Claim [HIC]) number or a Railroad Retirement Board number.
- Confirm that the patient's name on the LTCH CARE Data Set matches the patient's name on the Medicare or RRB card.

# A0700: Medicaid Number




## Item Rationale

- Records the patient's Medicaid number for identification purposes.

## Coding Instructions

- Record this number if the patient is a Medicaid recipient.
- Enter one number per box beginning in the left-most box.
- Enter a "+" in the left-most box if the number is pending. If you are notified later that the patient does have a Medicaid number, just include it on the next assessment.
- If the patient is not a Medicaid recipient, enter "N" in the left-most box or leave this item blank.

## Coding Tips and Special Populations

- To obtain the Medicaid number, check the patient's Medicaid card, admission or transfer records, or medical record.
- Confirm that the patient's name on the LTCH CARE Data Set matches the patient's name on the Medicaid card.

# A0800: Gender


## Item Rationale

- Records the gender of the patient for identification purposes.
- Allows multiple records for patient to be matched in the QIES ASAP system.

## Coding Instructions

Enter the one-digit code that corresponds to the patient's gender.

- Code 1 if patient is male.
- Code 2 if patient is female.

# A0900: Birthdate

| A0900. Birth Date | |
|---|---|
| | ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year |

## Item Rationale

- Records the birth date of the patient for identification purposes.
- Allows determination of age.
- Allows multiple records for patient to be matched in QIES ASAP system.

## Coding Instructions

- Fill in the boxes with the patient's birth date. Use the format: Month-Day-Year (MM-DD-YYYY). For example: November 30, 1930, should be entered as 11-30-1930.
  - — If the patient's complete birth date is known, do not leave any boxes blank. If the month or day contains only a single digit, fill in the first box with a "0." For example: February 1, 1928, should be entered as 02-01-1928.
- If only the birth year or the birth year and birth month of the patient are known, handle each situation as follows:
  - — If only the birth year is known, enter the year in the "year" boxes of A0900, and leave the "month" and "day" boxes blank.
  - — If the birth year and birth month are known, but not the day of the month, enter the year in the "year" boxes of A0900, enter the month in the "month" portion, and leave the "day" boxes blank.

# A1000: Race/Ethnicity

| 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 |

## Item Rationale

- Records the race/ethnicity of the patient for quality of care purposes.
- The race/ethnicity codes use the common uniform language approved by the Office of Management and Budget (OMB) to report racial and ethnic categories. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.

## Steps for Assessment: Interview Instructions

1. Ask the patient to select the category or categories that most closely correspond to his or her race/ethnicity from the list in item A1000.
   - Individuals may be more comfortable if this question is introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and racial background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care" (Baker et al., 2005).
2. If the patient is unable to respond, ask a family member or significant other.
3. Provide category definitions to the patient or family only if they request them in order to answer the item.
4. Offer patients the option of selecting one or more racial designations.
5. Observer identification or medical record documentation to code this item can only be used if the patient is unable to respond and/or no family member or significant other is available.

## Coding Instructions

Check the box(es) that correspond(s) to the race or ethnic category or categories the patient, family, or significant other uses to identify himself or herself. **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

# A1050: Highest Degree/Level of School Completed

| A1050. What is the highest degree or level of school this patient has completed? | |
|---|---|
| Enter Code ☐ | If currently enrolled, mark the previous grade or highest degree received.<br>1. No schooling completed<br>2. Nursery or preschool through grade 12<br>3. High school graduate or GED<br>4. Bachelor's degree or some college<br>5. Graduate level degree or coursework |

## Item Rationale

- Records level of schooling for patient quality of care purposes.

## Coding Instructions

*Complete only if A0250 = 01, Admission.*

Select the highest degree or level of schooling that the patient has completed.

- Code 1, No schooling completed if patient has completed no schooling.
- Code 2, Nursery or preschool through grade 12 if patient has completed nursery or preschool or some primary or secondary schooling (grades 1 through grade 12), but did not receive a high school diploma or a General Equivalency Degree (GED).
- Code 3, High school graduate or GED if patient is a high school graduate or received a GED or other alternative credential.
- Code 4, Bachelor's degree or some college if patient holds a bachelor's degree (e.g., BA, BS, AB), an associate's degree (e.g., AA, AS), or has completed some college coursework.
- Code 5, Graduate-level degree or coursework if patient holds a master's degree (e.g., MA, MS, MBA, MSW), a professional school degree (e.g., MD, DDS, JD), a doctorate degree (e.g., Ph.D. Ed.D.), or has completed some graduate-level coursework.

# A1100: Language

| A1100. Language | |
|---|---|
| Enter Code ☐ | A. Does the patient need or want an interpreter to communicate with a doctor or health care staff?<br>0. No → *Skip to A1200, Marital Status*<br>1. Yes → *Specify in A1100B, Preferred language*<br>9. Unable to determine → *Skip to A1200, Marital Status*<br>B. Preferred language:<br>☐☐☐☐☐☐☐☐☐☐☐☐☐☐ |

## Item Rationale

- Language barriers can interfere with accurate assessment of patient condition, treatment planning, and health care delivery.
- Inability to make needs known and engage in social interaction because of a language barrier can be very frustrating and can result in isolation, depression, and unmet needs.

- When a patient needs or wants an interpreter, the LTCH should ensure that an interpreter is available.
- An alternate method of communication also should be made available to help ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the patient to point to (if able).
- Records preferred language and identifies patients who need interpreter services to communicate with health care staff, participate in their care decisions or participate and understand the consent process.

## Steps for Assessment

1. Ask the patient if he or she needs or wants an interpreter in order to communicate with a doctor or health care staff.
2. If the patient is unable to respond, ask a family member or significant other.
3. If neither source is available, review record for evidence of a need for an interpreter.
4. If an interpreter is wanted or needed, request one and note in A1100B, Preferred language.
    - It is acceptable for a family member or significant other to be the interpreter if the patient so chooses, and provided the patient understands that an official interpreter can be provided to him/her at no charge and chooses to request that a family member or significant other interpret. No person under the age of 18 may act as an interpreter under any circumstances. For more guidelines on using family members as interpreters, please read the Department of Health and Human Services guidance document available here: http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html

## Coding Instructions for A1100A

*Complete only if A0250 = 01, Admission.*

- Code 0, no if the patient (or family member, significant other, or medical record if the patient is unable to communicate) indicates that the he or she does not want or need to use an interpreter to communicate with a doctor or health care staff.
- Code 1, yes if the patient (or family member, significant other, or medical record if the patient is unable to communicate) indicates that he or she needs or wants to use an interpreter to communicate with health care staff. Specify preferred language by proceeding to A1100B and enter the patient's preferred language.
- Code 9, unable to determine if no source can identify whether the patient wants or needs an interpreter.

## Coding Instructions for A1100B

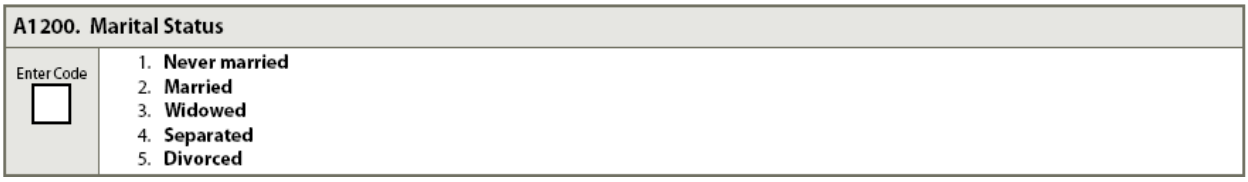
*Complete only if A0250 = 01, Admission.*

- Enter the preferred language the patient primarily speaks or understands after interviewing the patient, family members, significant others, observing the patient and listening, and reviewing the medical record.

## Coding Tips and Special Populations

- 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.

# A1200: Marital Status




## Item Rationale

- Allows understanding of the formal relationship the patient has and can be important for care and discharge planning.

## Steps for Assessment

1. Ask the patient about his or her marital status.
2. If the patient is unable to respond, ask a family member or other significant other.
3. If neither source can report, review the medical record for information.

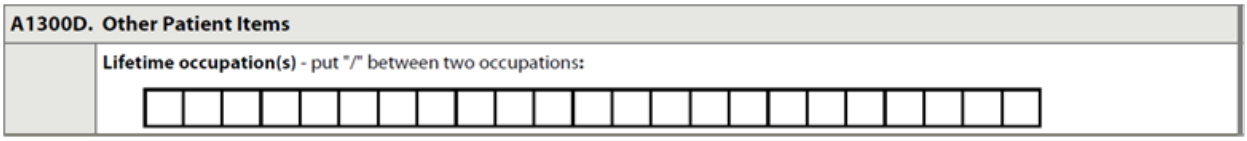
## Coding Instructions

*Complete only if A0250 = 01, Admission.*

Choose the answer that best describes the current marital status of the patient and enter the corresponding number in the code box:

1. Never Married
2. Married
3. Widowed
4. Separated
5. Divorced

# A1300D: Lifetime Occupation(s)




## Item Rationale

- Can be helpful to capture the patient's lifetime occupation to help LTCH staff personalize their interactions with the patient.

## Coding Instructions for A1300D, Lifetime Occupation(s)

*Complete only if A0250 = 01, Admission*

- Enter the job title or profession that describes the main occupation(s) before retiring or entering the long-term care hospital. When two occupations are identified, place a slash (/), in its own box, between each occupation.
- The lifetime occupation of a person whose primary work was in the home should be recorded as "homemaker." For a patient who has never had an occupation, record as "none."
- Leave item blank if unknown or not available.

# A1400: Payer Information

| A1400. Payer Information | |
|---|---|
| ↓ Check all that apply | |
| ☐ | A. **Medicare** (traditional fee-for-service) |
| ☐ | B. **Medicare** (managed care/Part C/Medicare Advantage) |
| ☐ | C. **Medicaid** (traditional fee-for-service) |
| ☐ | D. **Medicaid** (managed care) |
| ☐ | E. **Workers' compensation** |
| ☐ | F. **Title programs** (e.g., Title III, V, or XX) |
| ☐ | G. **Other government** (e.g., TRICARE, VA, etc.) |
| ☐ | H. **Private insurance/Medigap** |
| ☐ | I. **Private managed care** |
| ☐ | J. **Self-pay** |
| ☐ | K. **No payor source** |
| ☐ | X. **Unknown** |
| ☐ | Y. **Other** |

## Item Rationale

- Provides information on patient's source of payment for services received in the LTCH.

## Coding Instructions

Check the box(es) that best correspond(s) to the patient's current payment sources. Check all that apply.

A. Medicare (traditional fee-for-service)

B. Medicare (managed care/Part C/Medicare Advantage)

C. Medicaid (traditional fee-for-service)

D. Medicaid (managed care)

E. Workers' compensation

F. Title programs (e.g., Title III, V, or XX)

G. Other government (e.g., TRICARE, VA, etc.)
H. Private insurance/Medigap
I. Private managed care
J. Self-pay
K. No payor source
X. Unknown
Y. Other

# A1800: Admitted From

**A1800. Admitted From.** Immediately preceding this admission, where was the patient?

Enter Code

01. **Community residential setting** (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
02. **Long-term care facility**
03. **Skilled nursing facility** (SNF)
04. **Hospital emergency department**
05. **Short-stay acute hospital** (IPPS)
06. **Long-term care hospital** (LTCH)
07. **Inpatient rehabilitation facility or unit** (IRF)
08. **Psychiatric hospital or unit**
09. **ID/DD Facility**
10. **Hospice**
99. **None of the above**

## Item Rationale

- Understanding the setting the patient was in immediately prior to admission to the LTCH helps inform the delivery of services that the patient receives during his or her stay and may also inform discharge planning.

## Steps for Assessment

1. Review transfer and admission records.
2. Ask the patient, family members or significant others.

## Coding Instructions

*Complete only if A0250 = 01, Admission.*

Enter the two-digit code that best describes the setting in which the patient was staying immediately preceding this admission.

- Code 01, Community residential setting if the patient was admitted from a private home, apartment, board and care, assisted living facility, group home, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community whether owned by the patient or another person, retirement communities, or independent housing for the elderly. Also included in this category are non-institutional community residential settings that provide the following types of services: home health, homemaker/personal care, or meals.
- Code 02, Long-term care facility if the patient was admitted from an institution that is primarily engaged in providing medical and non-medical care to people who have

a chronic illness or disability. These facilities provide care to people who cannot be cared for at home or in the community. Long-term care facilities provide a wide range of personal care and health services for individuals who cannot take care of themselves due to physical, emotional, or mental health issues. The provision of non-skilled care and related services for residents in long-term care can include, but are not limited to: supportive services such as dressing, bathing, using the bathroom, diabetes monitoring, and medication administration.

- 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 post-hospital SNF care and meets certain requirements.
- Code 04, Hospital emergency department if the patient was admitted from an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.
- Code 05, Short-stay acute hospital (IPPS) if the patient was admitted from a hospital that is contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.
- Code 06, Long-term care hospital (LTCH) if the patient was admitted from an acute-care hospital that provides treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.
- 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 08, Psychiatric hospital if the patient was admitted from an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients.
- Code 09, ID/DD facility if the patient was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are intellectually disabled (ID) or who have developmental disabilities (DD).
- Code 10, Hospice if the patient was admitted from a program for terminally ill persons. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.
- Code 99, None of the above if the patient was admitted from none of the above.

## Coding Tips and Special Populations

- If an individual was enrolled in a home-based hospice program, code as **10, Hospice,** instead of **01, Community residential setting.**

# A1810: In the last 2 months, what other medical services besides those identified in A1800 has the patient received?

| **A1810. In the last 2 months,** what other medical services besides those identified in A1800 has the patient received? | |
|---|---|
| ↓ **Check all that apply** | |
| ☐ | **A. Short-stay acute hospital** (IPPS) |
| ☐ | **B. Community residential setting** (e.g., private home/apt., board/care, assisted living, group home, adult foster care) |
| ☐ | **C. Long-term care facility** |
| ☐ | **D. Skilled nursing facility** (SNF) |
| ☐ | **E. Hospital emergency department** |
| ☐ | **F. Long-term care hospital** (LTCH) |
| ☐ | **G. Inpatient rehabilitation facility or unit** (IRF) |
| ☐ | **H. Home health agency** (HHA) |
| ☐ | **I. Hospice** |
| ☐ | **J. Outpatient services** |
| ☐ | **K. Psychiatric hospital or unit** |
| ☐ | **L. ID/DD Facility** |
| ☐ | **Z. None of the above** |

## Item Rationale

- Understanding any and all medical services the patient received during the 2 months preceding the admission to the LTCH helps inform the delivery of services that the patient receives during his or her stay and may also inform discharge planning.

## Coding Instructions

*Complete only if A0250 = 01, Admission.*

Check the box(es) that best correspond(s) to the service(s) the patient has received in the last 2 months other than those identified in **A1800, Admitted From**. Please refer to **A1800, Admitted From,** for definitions of the services and settings listed below. **Check all that apply.**

A. Short-stay acute hospital (IPPS)

B. Community residential setting (e.g., private home/apartment, assisted living, group home, adult foster care)

C. Long-term care facility

D. Skilled Nursing Facility (SNF)

E. Hospital emergency department

F. Long-term care hospital (LTCH)

G. Inpatient rehabilitation facility or unit (IRF)

H. Home health agency (HHA)

### DEFINITIONS

**OUTPATIENT SERVICES**
A service received at a hospital outpatient department or community mental health center that does not include an overnight stay.

**HOME HEALTH AGENCY (HHA)**
An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

I. Hospice
J. Outpatient services
K. Psychiatric hospital or unit
L. ID/DD Facility
Z. None of the above

# A1820: Primary Diagnosis in Previous Setting

**A1820. What was the primary diagnosis being treated in the previous setting?**

Enter ICD code for the patient's primary diagnosis in the previous setting in the boxes provided. Include the decimal for the code in the appropriate box.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## Item Rationale

- Understanding the diagnosis for which the patient was being treated in the previous setting helps inform the delivery of services that the patient receives during his or her stay in the LTCH and may also inform discharge planning and discussions.

## Coding Instructions

*Complete only if A0250 = 01, Admission.*

- Write the (etiologic) ICD code of the patient's primary diagnosis that was being treated in the previous medical or residential setting (e.g., 411.81).
- The decimal for the code should be appropriately placed in its own box. For example, 411.81 should take up six boxes.
- Medical record or transfer record should be used when possible. If the information is not available, then code this item with a dash.

# A1955: Discharge Delay > 24 Hours

**A1955. Discharge Delay**

Enter Code ☐

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

0. **No** → *Skip to A1970, Discharge Return Status*
1. **Yes**

## Item Rationale

- Records whether the patient's discharge from the LTCH to the receiving facility was delayed for at least 24 hours.

## Coding Instructions

*Complete only if A0250 = 10, Planned discharge.*

Enter the code that best describes whether the patient's discharge was delayed for at least 24 hours.

- Code 0, no if the patient's discharge from the LTCH was not delayed for at least 24 hours or if there was no delay in discharge from the LTCH.

- Code 1, yes if the patient's discharge from the LTCH was delayed for at least 24 hours from the scheduled or expected discharge time.

# A1960: Reason for Discharge Delay

| A1960. Reason for Discharge Delay | |
|---|---|
| Enter Code ☐☐ | 01. **No bed available at receiving facility**<br>02. **Services, equipment or medications not available** (e.g., home health care, durable medical equipment, IV medications)<br>03. **Family/support** (e.g., family could not pick patient up)<br>04. **Medical** (patient condition changed)<br>98. **Other** |

## Item Rationale

- To document the reason that the patient's discharge was delayed.

## Coding Instructions

*Complete only if A0250 = 10, Planned discharge and A1955 = 1, Yes.*

Enter the code that best describes the reason the patient's discharge was delayed.

- Code 01, No bed available at receiving facility if the facility to which the patient was to be discharged did not have any available beds on the intended day and time of discharge.
- Code 02, Services, equipment or medications not available if necessary services (e.g., home health care), equipment (e.g., durable medical equipment), or medications (e.g., IV medications) following discharge were not available on the intended day and time of discharge.
- Code 03, Family/support if the reason for the discharge delay was related to the patient's family or caregiver support (e.g., family was unable to pick the patient up from the long-term care hospital).
- Code 04, Medical if the patient's condition changed in such a way that discharge was no longer appropriate.
- Code 98, Other if the options above do not explain the reason for the patient's discharge delay.

# A1970: Discharge Return Status

| A1970. Discharge Return Status | |
|---|---|
| Enter Code ☐ | 1. **Anticipated**<br>2. **Not Anticipated** |

## Item Rationale

- To document whether it is anticipated that the patient will return to the same LTCH following this discharge.

## Coding Instructions

*Complete only if A0250 = 10, Planned discharge or A0250 = 11, Unplanned discharge.*

Enter the number corresponding to the patient's discharge return status.

- Code 1, Anticipated: if it is anticipated that the patient will return to this LTCH following this discharge. For example, if the patient is discharged to another hospital/facility for a planned procedure or an ongoing treatment lasting for more than 3 calendar days, **Code 1, Anticipated.**
- Code 2, Not anticipated: if it is not anticipated that the patient will return to this LTCH following this discharge. For example, if the patient has been discharged to a community residential setting, inpatient rehabilitation facility or unit, or another facility or was discharged against medical advice, C**ode 2, Not Anticipated.**

# A2100: Discharge Location

| A2100. Discharge Location | |
|---|---|
| Enter Code ☐☐ | 01. **Community residential setting** (e.g., private home/apt., board/care, assisted living, group home, adult foster care)<br>02. **Long-term care facility**<br>03. **Skilled nursing facility** (SNF)<br>04. **Hospital emergency department**<br>05. **Short-stay acute hospital** (IPPS)<br>06. **Long-term care hospital** (LTCH)<br>07. **Inpatient rehabilitation facility or unit** (IRF)<br>08. **Psychiatric hospital or unit**<br>09. **ID/DD facility**<br>10. **Hospice**<br>12. **Discharged Against Medical Advice**<br>98. **Other** |

## Item Rationale

- To document the location that the patient is being discharged to at time of discharge.

## Steps for Assessment

- Review the medical record, including the discharge plan and discharge order, for documentation of discharge location.

## Coding Instructions

*Complete only if A0250 = 10, Planned discharge or A0250 = 11, Unplanned discharge.*

Select the two-digit code that corresponds to the patient's discharge location. Please refer to **A1800, Admitted From,** for definitions of the services and settings listed below.

01. Community residential setting (private home/apartment, board/care, assisted living, group home adult foster care)
02. Long-term care facility
03. Skilled nursing facility (SNF)
04. Hospital emergency department
05. Short-stay acute hospital (IPPS)
06. Long-term care hospital (LTCH)
07. Inpatient rehabilitation facility or unit (IRF)
08. Psychiatric hospital
09. ID/DD facility
10. Hospice
11. Discharged against medical advice
12. Other