Section A

Administrative Information

Objectives

- State the intent of Section A Administrative Information.
- Describe the information required to complete Section A.
- Code Section A correctly and accurately.

Intent of Section A

- Obtain key information to uniquely identify:
  - Each patient
  - LTCH where patient has been admitted
  - Information related to assessment
- Items to be completed vary by data set.

Item A0050

Type of Record

A0050 Type of Record

- Documents the action requested for the LTCH CARE record:
  - Add new assessment/ record
  - Modify existing record
  - Inactivate existing record

A0050. Type of Record	
Enter Code ☐	1. Add new assessment/record 2. Modify existing record 3. Inactivate existing record

Add New Assessment/ Record

- Used for a new record that has **not** been previously submitted and accepted into the QIES ASAP system.

Modify Existing Record

- Used to correct a record already submitted and accepted into QIES ASAP but that contains incorrect data.
- Modification request record should include correct values for all data set items.
- Do not include values just for items previously in error.

Inactivate Existing Record

- Used to request inactivation of a record already submitted and accepted into QIES ASAP.
- Request inactivation when an event that was reported did **not** occur.
  - Example: Discharge was reported, but the patient was not discharged.

Inactivate Existing Record$_2$

- Inactivation request is **required** if incorrect information was submitted for:
  - **A0210** Assessment Reference Date
  - **A0220** Admission Date (on Admission record)
  - **A0250** Reason for Assessment
  - **A0270** Discharge Date (on a Discharge or Expired record)
- Inactivation request must also include completion of items A0055-A0900.

A0050 Coding Instructions

- Enter the code that corresponds to the purpose of this submission.
  - **Code 1.** Add new assessment/ record
  - **Code 2.** Modify existing record
  - **Code 3.** Inactivate existing record

A0050. Type of Record	
Enter Code ☐	1. **Add new assessment/record** 2. **Modify existing record** 3. **Inactivate existing record**

Item A0055

Correction Number

A0055 Correction Number

- Indicates number of times the record has been corrected in the QIES ASAP database.
- This value includes the change represented by the current record.

A0055. Correction Number	
Enter Number 	**Enter the number of correction requests to modify/inactivate** **Enter 00 for new record**

A0055 Coding Instructions

- Enter the number of correction requests.
- Include the present record in this number.
- Code as a two-digit number.
- For a new record, enter **00**.

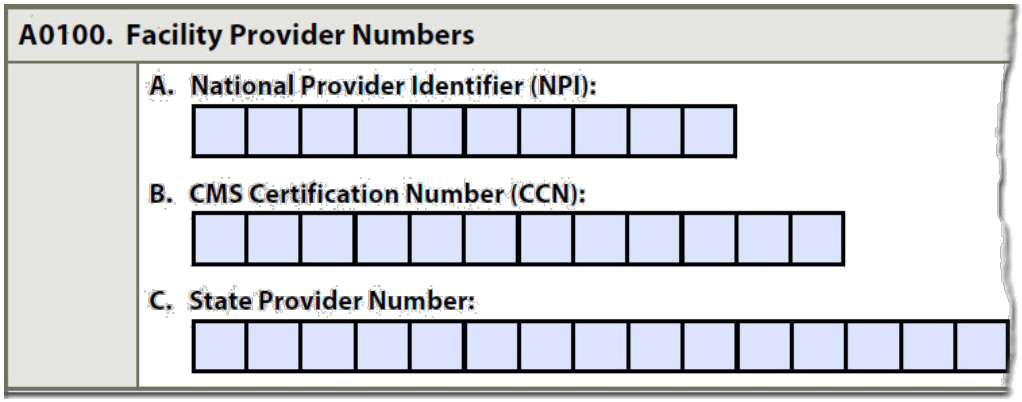
A0055. Correction Number	
Enter Number 0 1	Enter the number of correction requests to modify/inactivate Enter 00 for new record

Items A0100 & A0200

Facility Provider Numbers
&
Type of Provider

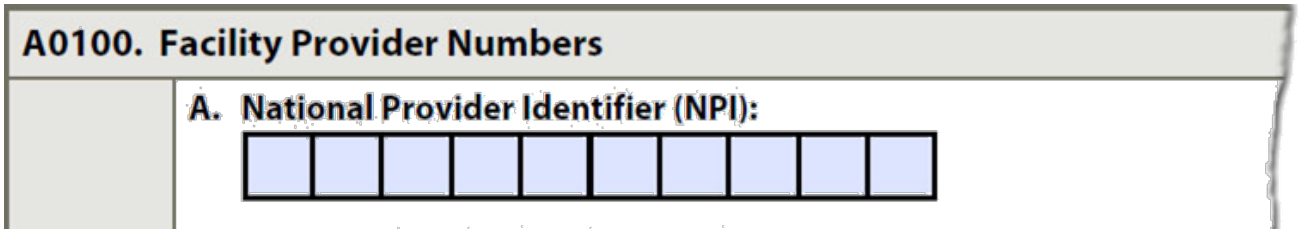
A0100 Facility Provider Numbers

- Documents the LTCH's Facility Provider Numbers.
  - National Provider Identifier (NPI)
  - CMS Certification Number (CCN)
  - State Provider Number



A0100 Coding Instructions

- Enter identification numbers in the spaces provided.
- Enter one number per space.
- Left-justify (start with left space).
- Leave extra spaces blank.
- Leave blank if not available or not known.



A0200 Type of Provider/ Coding Instructions

- Designates type of provider.
- Allows the QIES ASAP system to match records.
- Enter **3** to indicate Long-term Care Hospital.

A0200. Type of Provider	
Enter Code **3**	3. **Long-term Care Hospital**

Items A0210 & A0220

Assessment Reference Date (ARD)

Admission Date

A0210 Assessment Reference Date

- Records the Assessment Reference Date (ARD).
- ARD designates the end of the assessment period.
- All assessment items refer to the patient's status during the same period.
- Information from assessment done **after** the ARD will not be captured on that LTCH CARE Data Set.

Determining the Assessment Reference Date

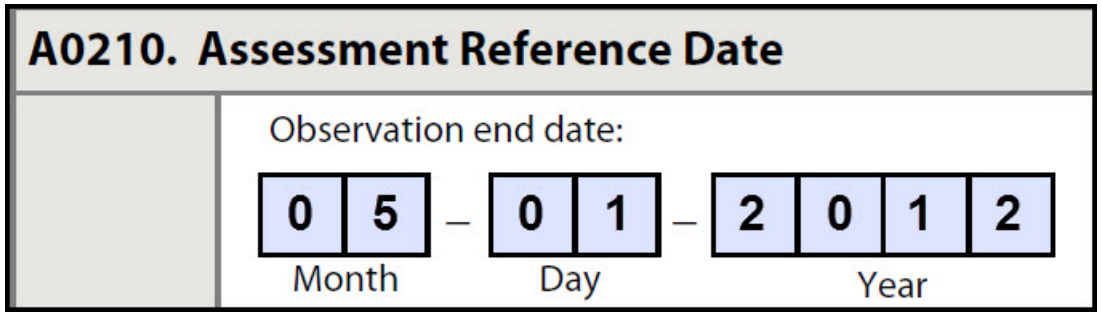
- Determined by the reason for the assessment and compliance with timing requirements.
- ARD for an Admission assessment is at most the third calendar day of the patient's stay.
  - Admission Date plus 2 calendar days
- ARD for Discharge and Expired assessments is the date of discharge or death.

Determining the Assessment Reference Date$_2$

- ARD may not be extended because the patient receives services elsewhere during the assessment period.
- Admission assessments: ARD must be the same as Discharge or Expired date if patient is discharged or dies prior to completion.
- Discharge and Expired assessments: ARD (A0210) and Discharge Date (A0270) must be the same.

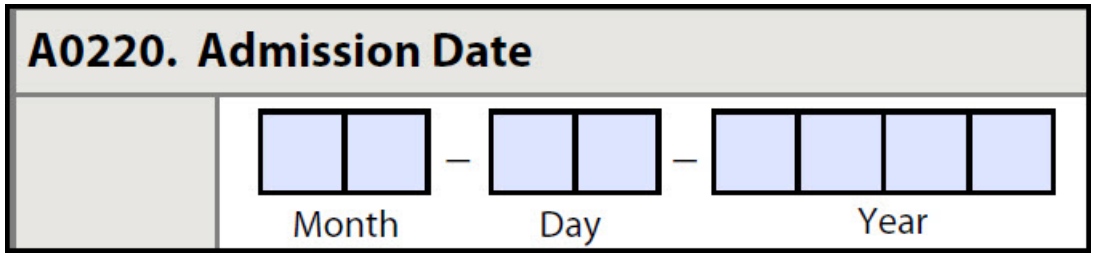
A0210 Coding Instructions

- Enter the Assessment Reference Date.
- Use the format MM — DD — YYYY.
- Do not leave any spaces blank.
- Use leading zero for one-digit months/ days.



A0220 Admission Date/ Coding Instructions

- Documents date of admission into the LTCH.
- Enter date of this admission to the LTCH.
- Use the format MM — DD — YYYY.
- Use leading zero for one-digit months/ days.

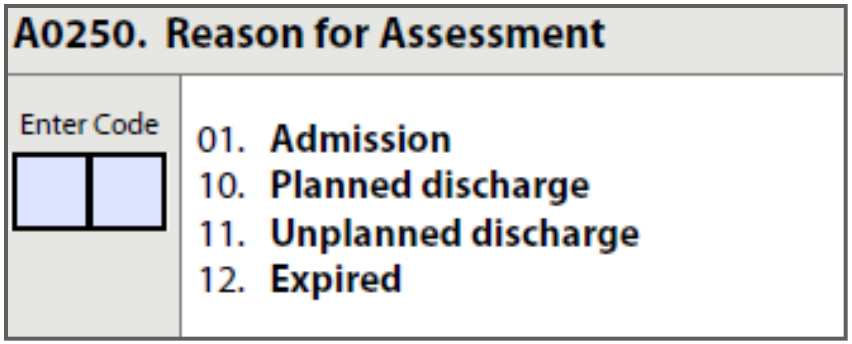


Item A0250

Reason for Assessment

A0250 Reason for Assessment

- Documents reason for completing assessment:
  - Admission
  - Planned discharge
  - Unplanned discharge
  - Expired
- Identifies items required to complete the assessment.



A0250 Coding Instructions

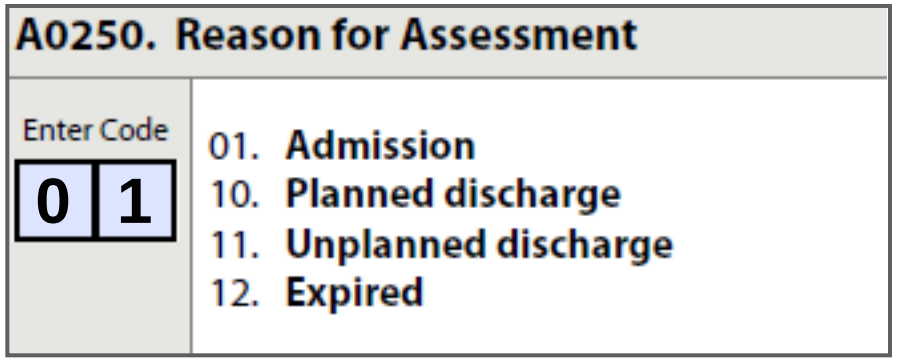
- Enter the code corresponding to reason for completing the assessment:

01. Admission

10. Planned discharge

11. Unplanned discharge

12. Expired



Item A0270

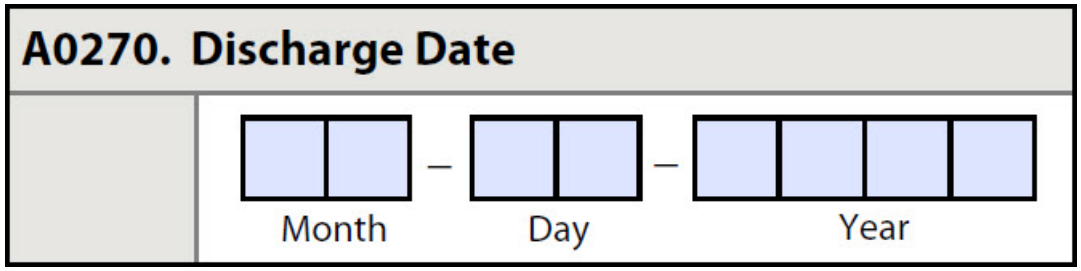
Discharge Date (Discharge & Expired Data Sets)

A0270 Discharge Date

- Appears on Planned Discharge, Unplanned Discharge, and Expired data sets only.
- Documents the patient's discharge date.
- Identifies record as a discharge record in QIES ASAP.
- Obtain date from medical, admissions, discharge, and/ or transfer records.

A0270 Coding Instructions

- For Discharge: Enter date the patient was discharged (date the patient leaves the LTCH).
- For Expired: Enter date of death.
- Format MM — DD — YYYY.



Items A0500 – A1300

Patient Demographic Information

A500-A1300 Patient Information

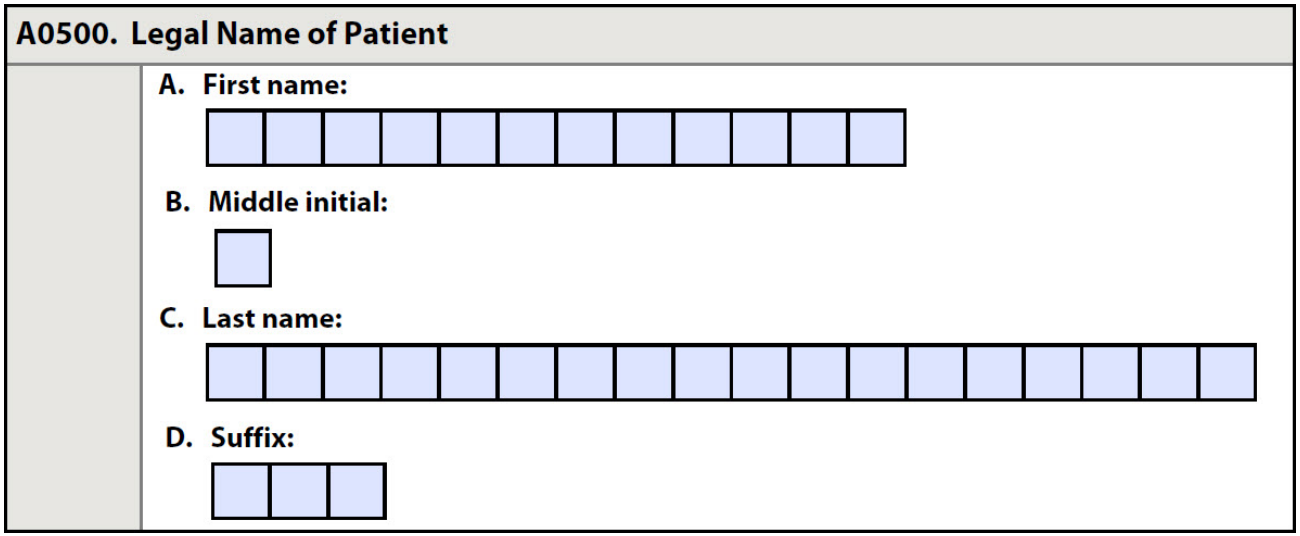
- Documents personal data about patient.
- Identifies patient in the QIES ASAP system.
- Allows multiple patient records to be matched in the system.

A0500 Legal Name of Patient

- Enter the patient's name as it appears on the patient's Medicare card or other government-issued document.
  - Driver's license
  - Birth certificate
  - Passport
  - Social Security card

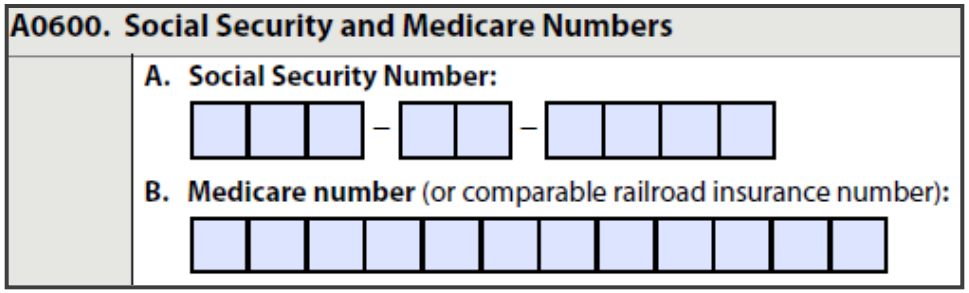
A0500 Coding Instructions

- Enter the patient's name:
  - First name
  - Middle initial
  - Last name
  - Suffix



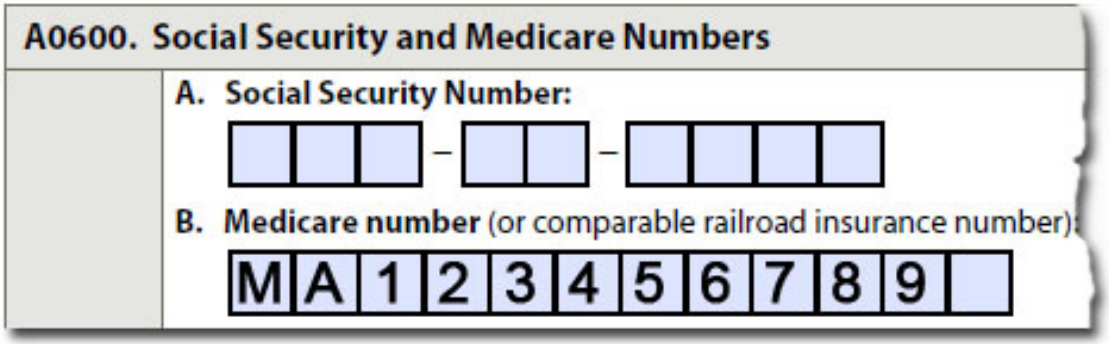
A0600 Coding Instructions

- Enter patient's Social Security Number (SSN).
- Leave blank if patient does not have a SSN.
- Enter the patient's Medicare Number.
- If no Medicare number is available, can use RRB Number.



A0600 Coding Instructions$_2$

- Enter the numbers one digit or letter per space.
- Left-justify (start with left space).

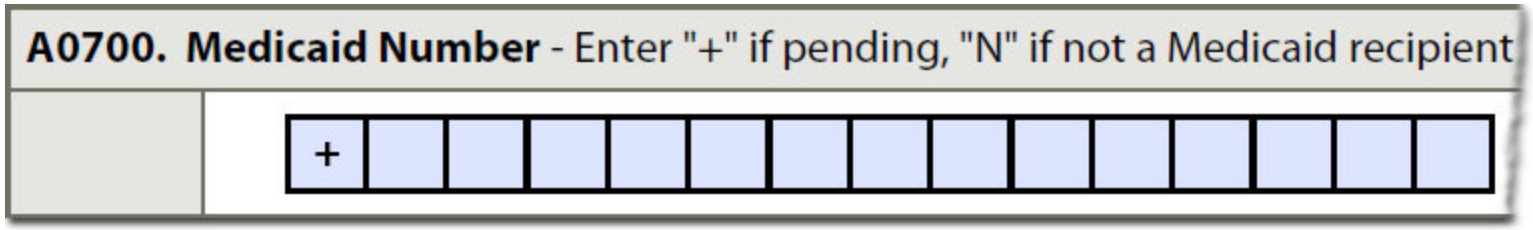


A0700 Medicaid Number

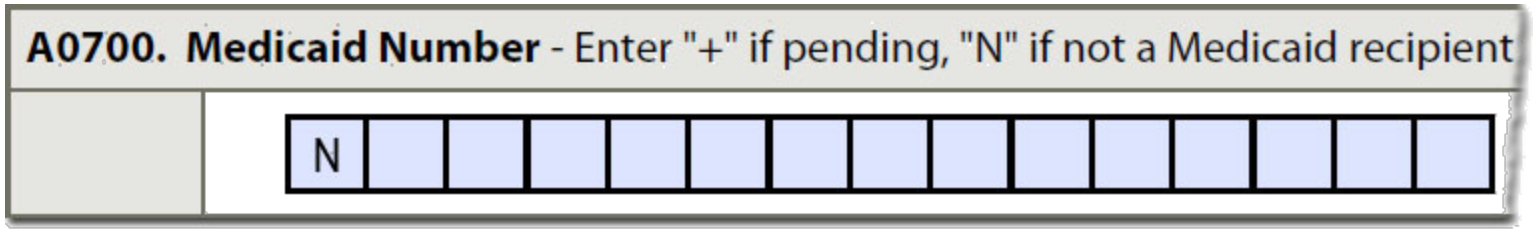
- Record a Medicaid number if patient is a Medicaid recipient.
- Obtain number from patient's Medicaid card, admission or transfer records, or medical record.
- Confirm the patient name on the LTCH CARE Data Set matches name on Medicaid card.

A0700 Coding Instructions

- Enter one digit per space, starting in left space.
- Enter “+” in the left space if pending.



- Enter “N” in the left space if not applicable.

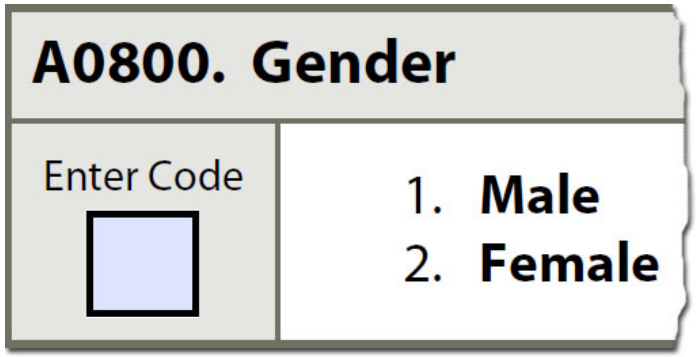


A0800 Gender/ Coding Instructions

- Assists in correctly identifying patient in QIES ASAP.
- Provides demographic gender-specific health trend information.
- Enter code for patient's gender.

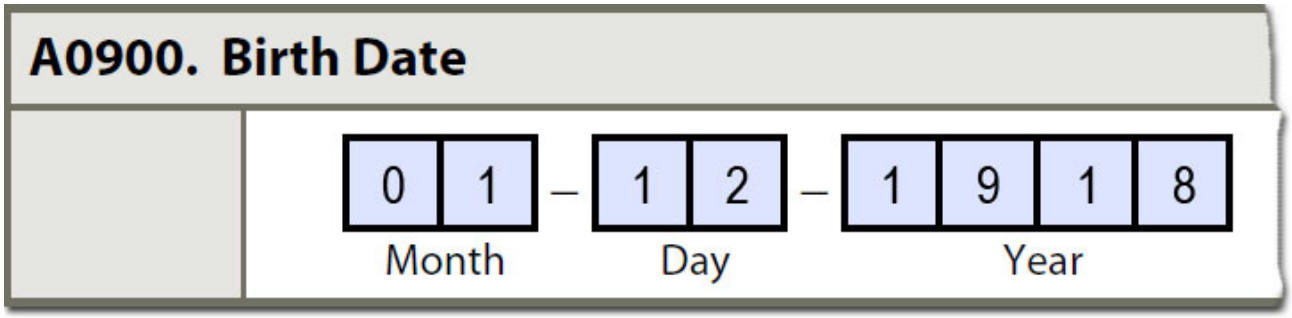
1. Male

2. Female



A0900 Birth Date

- Allows determination of age.
- Provides demographic health trend information.



A0900 Coding Instructions

- If the patient's birth date is known:
  - Enter the patient's birth date in the spaces.
  - Use the format MM — DD — YYYY.
  - Use a leading zero for single-digit month or day.
- If the patient's birth date is unknown:
  - Enter the field(s) that are known.
  - Leave unknown fields blank.

A1000 Race/Ethnicity

- Indicates patient's race/ethnicity.
- Categories in this item follow the common uniform language approved by OMB.

Assessing Race/Ethnicity

- Ask the patient to select race/ethnicity from categories in A1000.
- Use suggested language.
- Offer option of selecting more than one category.
- Provide category definitions only if requested.
- If the patient is unable to respond, ask a family member or significant other.
- Check the medical record only if necessary.

A1000 Coding Instructions

- Check all that apply.
- More than one category may be checked.

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

A1050 Highest Level of Education/ Coding Instructions

- Documents the highest level of education the patient has completed.
- Included on Admission Data Set only.
- Enter the code corresponding to the appropriate level of education.

1. No schooling completed
2. Nursery or preschool through grade 12
3. High school graduate or GED
4. Bachelor's degree or some college
5. Graduate level degree or coursework

A1100 Language

- Inability to make needs known and to engage in social interaction because of a language barrier:
  - Can be very frustrating.
  - Can result in isolation, depression, and unmet needs.
- Identifies patients who may need interpreter services.
- LTCH should make sure an interpreter is available.
- Should also make alternative methods of communication available.

Assessing the Need for an Interpreter

- To determine if an interpreter is needed:
  - Ask patient if he/ she needs or wants interpreter.
  - Consult a family member or significant other.
  - Review the medical record if no other source is available.
- Ask for the preferred language if needed.
- A family member or significant other can be an interpreter only under certain conditions.

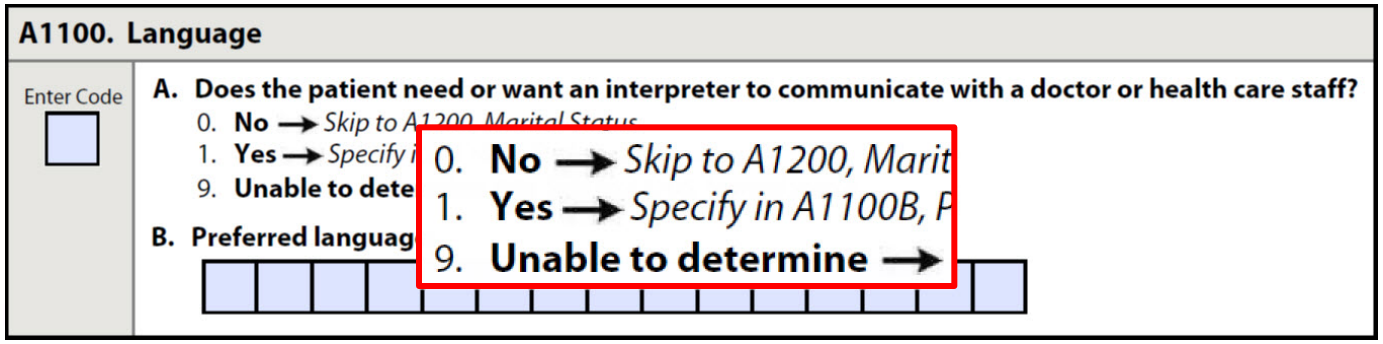
A1100A Coding Instructions

- Enter code that reflects whether patient wants or needs an interpreter.

Code 0. Interpreter not wanted or needed.

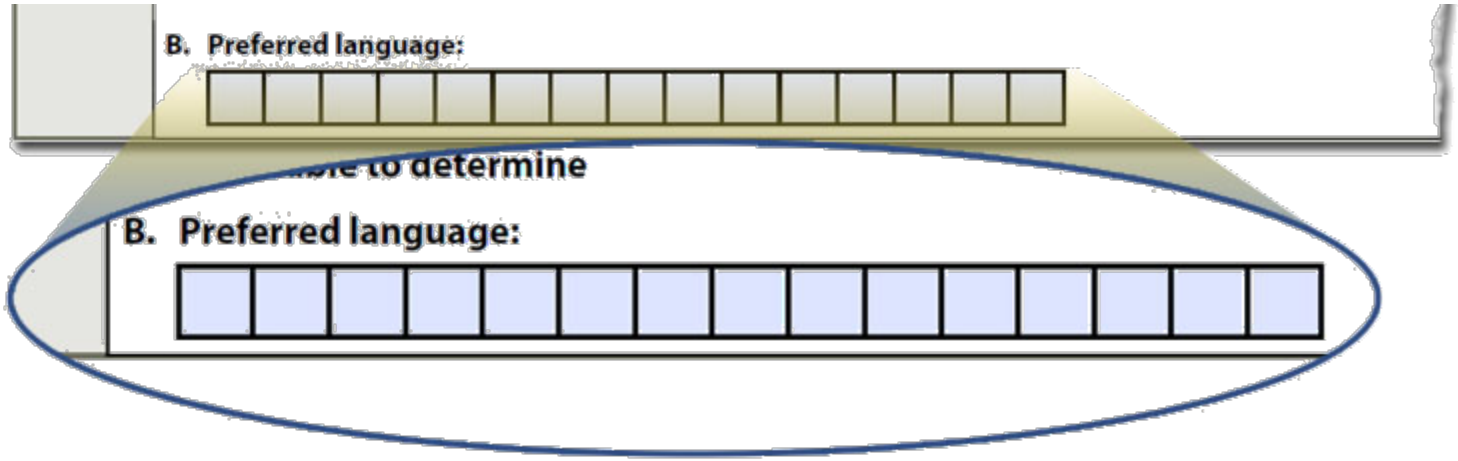
Code 1. Interpreter is wanted or needed.

Code 9. Unable to determine.



A1100B Coding Instructions

- If an interpreter **is** needed or wanted, enter the preferred language.

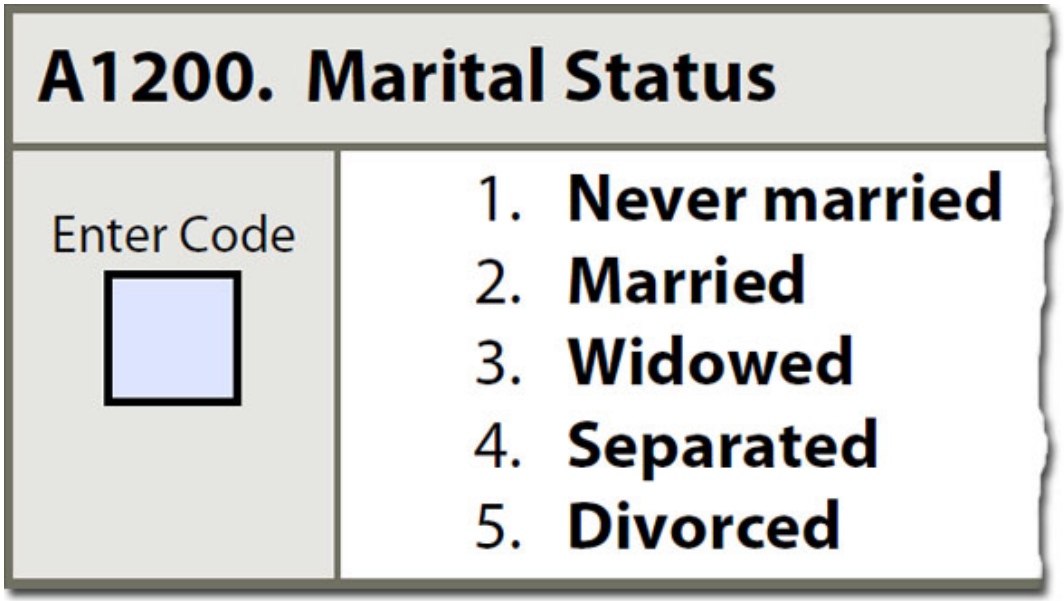


A1200 Marital Status

- Included on Admission Data Set only.
- Allows understanding of the patient's formal relationship.
- Can be important for care and discharge planning.
- Assess marital status:
  - Ask the patient.
  - Ask family member or significant other.
  - Review the medical record.

A1200 Coding Instructions

- Enter the code that reflects the patient's current marital status.



A1300D Other Patient Items

- Documents patient's lifetime occupation(s).
- Information is helpful for conversation and care planning.
- Enter the job title/ profession that describes the patient's main occupation(s) before retiring or entering the LTCH.

A1300D Coding Instructions

- If a patient has more than one occupation, place a slash (/) between each occupation.
- Leave item blank if unknown or not available.

A1300D. Other Patient Items	
	Lifetime occupation(s) - put "/" between two occupations:

Item A1400

Payer Information

A1400 Payer Information/ Coding Instructions

- Documents the patient's source of payment for services received in the LTCH.
- Check the box(es) that correspond to the patient's current payment sources.
- Check all that apply.

A1400. Payer Information	
↓ Check all that apply	
☐	**A. Medicare** (traditional fee-for-service)
☐	**B. Medicare** (managed care/Part C/Medicare Ad
☐	**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**

A1400 Payment Source Options

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 payer source

X. Unknown

Y. Other

Item A1800

Admitted From

A1800 Admitted From

- Completed for Admission data set only.
- Documents the patient's setting immediately prior to admission to the LTCH.
- Informs care planning as well as discharge planning and discussions.

Assessing A1800 Admitted From

- Review transfer and admission records.
- Ask the patient.
- Ask family and/or significant others.

A1800 Coding Instructions

- Enter two-digit code that best describes the setting in which the patient was staying immediately prior to admission to the LTCH.

Pre-Admission Service Use

A1800. Admitted From. Immediately preceding

Enter Code

01.	**Community residential setting** (e.g
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**
08.	**Psychiatric hospital or unit**
09.	**ID/DD Facility**
10.	**Hospice**
99.	**None of the above**

Item A1810

Other Medical Services in Last 2 Months

A1810 Other Medical Services

- Completed for Admission data set only.
- Documents medical services patient has received in the two months immediately prior to LTCH admission.
- Helps inform care that patient receives during his or her stay.
- May also inform discharge planning.

A1810 Coding Instructions

- Check box(es) that best corresponds to service(s) the patient received in the last two months.
- Identify only services received **<u>other than</u>** those identified in A1800 Admitted From.
- Check all that apply.

A1810. In the last 2 months, what other medic	
↓ Check all that apply	
☐	A. Short-stay acute hospital (IPPS)
☐	B. Community residential setting (e.g.,
☐	C. Long-term care facility
☐	D. Skilled nursing facility (SNF)
☐	E. Hospital emergency department
☐	F. Long-term care hospital (LTCH)

A1810 Services Options

A. Short-stay acute hospital (IPPS)

B. Community residential setting

C. Long-term care facility

D. Skilled nursing facility (SNF)

E. Hospital emergency department

F. Long-term care hospital (LTCH)

G. Inpatient rehabilitation hospital or unit (IRF)

H. Home health agency (HHA)

I. Hospice

J. Outpatient services

K. Psychiatric hospital or unit

L. ID/ DD facility

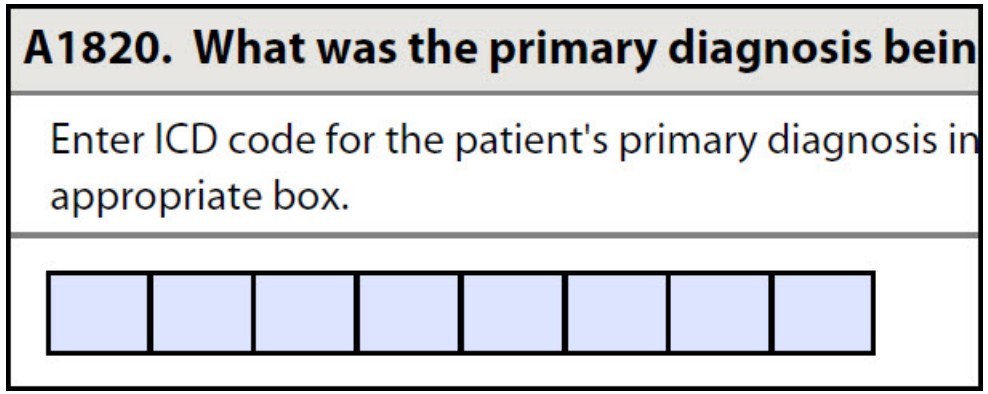
Z. None of the above

Item A1820

Diagnosis in Previous Setting

A1820 Diagnosis in Previous Setting

- Documents the diagnosis for which the patient was being treated in the previous setting.
- Helps inform the care that the patient receives during his/ her stay in the LTCH.
- May also inform discharge planning and discussions.



A1820 Coding Instructions

- Enter ICD code of the primary diagnosis for which patient was being treated in previous medical or residential setting (e.g., 411.81).
- Place ICD code decimal point in its own box.

Items A1955 - A2100

Discharge Information
(Discharge Sets)

A1955 - A2100
Discharge Information

- Address areas related to patient discharge.
  - **A1955** Discharge Delay
  - **A1960** Reason for Discharge Delay
  - **A1970** Discharge Return Status
  - **A2100** Discharge Location

A1955 - A2100
Discharge Information$_2$

- All discharge items are included on the Planned Discharge data set.
- Two items are included on the Unplanned Discharge data set.
  - **A1970** Discharge Return Status
  - **A2100** Discharge Location
- No discharge items are included on the Admission or Expired data sets.

A1955 Discharge Delay/ Coding Instructions

- Complete for Planned Discharge data set only.
- Documents whether patient's discharge has been delayed at least 24 hours.
- Enter the code that indicates whether patient's discharge was delayed for at least 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**

A1960 Reason for Discharge Delay/ Coding Instructions

- Complete for Planned Discharge data set only.
- Documents reason for the discharge delay.
- Enter the code that best describes the reason discharge was delayed, if applicable.

A1960. Reason for Discharge Delay

Enter Code	
	01. **No bed available at receiving hospital/facility**
	02. **Services, equipment or medications not available**
	03. **Family/support** (e.g., family could not pick patient up
	04. **Medical** (patient condition changed)
	98. **Other**

A1970 Discharge Return Status/ Coding Instructions

- Included on both Planned and Unplanned Discharge data sets.
- Documents whether it's anticipated that patient will return to the same LTCH following this discharge.
- Enter the code that indicates whether the patient will return to the facility.

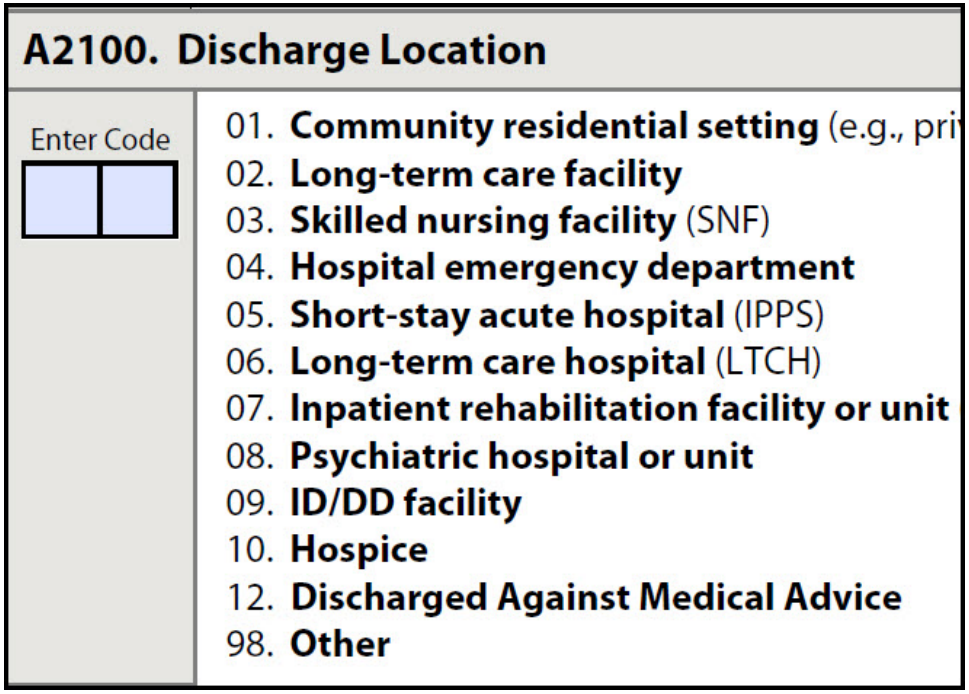
A1970. Discharge Return Status	
Enter Code ☐	1. **Anticipated** 2. **Not Anticipated**

A2100 Discharge Location

- Complete for both Planned and Unplanned Discharge data sets.
- Indicates discharge location (type of facility) at time of discharge.
- Review the medical record including the discharge plan and discharge orders for documentation.

A2100 Coding Instructions

- Enter the two-digit code that best describes the location to which the patient is discharged.



Section Z

Assessment Administration

Z0400 & Z0500 Signatures

- Provide signatures of those who completed LTCH CARE data set assessment.
- Staff who completed assessment (Z0400)
- Person verifying completion of the assessment (Z0500)

Z0400 & Z0500
Coding Guidelines

- Obtain signatures of all persons who completed any part of the LTCH CARE assessment.
- Becomes a legal attestation of accuracy/ completeness
- Importance of accurately completing and submitting LTCH CARE data cannot be overemphasized.

Z0400 Signatures of Persons Completing Assessment

- Persons completing assessment provide:
  - Signature
  - Title
  - Sections contributed to
  - Date of assessment
- Read the Attestation Statement carefully.
- Two or more staff members may complete the same section.
  - Identify which items a staff member completed within a section in Z0400.

Z0400 Signatures of Persons Completing Assessment$_2$

- Facilities may use electronic signatures:
  - Permitted by state and local law
  - Authorized by LTCH policy
- Whenever copies of the LTCH CARE data sets are printed and dates are automatically encoded, be sure to note that it is a “copy” and not the original.

Z0500 Signature of Person Verifying Assessment Completion

- Federal regulation requires signature to certify that the LTCH CARE Data Set is **complete**.
- Not certifying accuracy of assessment items.
- Verify that all sections are complete.
- Verify that Z0400 contains attestation of accuracy for all LTCH CARE Data Set sections.

Z0500 Signature of Person Verifying Assessment Completion$_2$

- Use the actual date the LTCH CARE assessment was completed, reviewed, and signed as complete by the Assessment Coordinator.
- Use the actual date it is signed if the assessment cannot be signed on the date it is completed.
- Same rules apply as for Z0400:
  - Electronic signatures
  - Electronic storage
  - Printing subsequent copies