SECTION A: ADMINISTRATIVE INFORMATION

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

A0050: Type of Record

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

Item Rationale

This item indicates whether an LTCH CARE Data Set Assessment Record is a new record to be added to the QIES ASAP system or if the LTCH CARE Data Set Assessment Record that has been previously submitted and accepted in the QIES ASAP system requires modification or inactivation.

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

LTCHs should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects patient identification, location, or clinical information. 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 when an LTCH CARE Data Set Assessment Record has been previously submitted and accepted in the QIES ASAP system, but the information in the record contains inaccurate data item values. The process for completing a Modification Request entails the completion of a corrected record, which will replace the previous erroneous record in the QIES ASAP system. The data item values that are submitted in the corrected record should contain accurate data item values for **all** items (not just those that were previously inaccurate).There are exceptions to which data item values on an LTCH CARE Data Set Assessment Record can be corrected with a Modification Request. These exceptions are listed below:

- A0210: Assessment Reference Date (ARD)
- 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)

  Any patient identifier (i.e., First name, Last name, Social Security Number (SSN), Gender, Birth Date) found to be inaccurate.

In order to correct the above data item values, the Inactivation Request process must be followed.

An **Inactivation Request** is used when an LTCH CARE Data Set Assessment Record has been previously submitted and accepted in the QIES ASAP system but:

- The corresponding event did not occur (e.g., a Discharge LTCH CARE Data Set Assessment Record was submitted, but the patient was not discharged),
- The following data item values are inaccurate:
  - A0210: Assessment Reference Date (ARD)
  - 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)
  - Any patient identifier (i.e., First name, Last name, Social Security Number (SSN), Gender, Birth Date) found to be inaccurate.

The Inactivation Request record should include the following data item values from the LTCH CARE Data Set Assessment Record that is being inactivated. Any of the following items that were submitted as part of the original record *must also* be submitted as part of this inactivation request and values for each item must match across the original record and the inactivation request record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record.

- A0050: Type of Record
- 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

An Inactivation Request, unlike a Modification Request, does not replace the erroneous record with a corrected record. It allows for the archiving of the erroneous record from the QIES ASAP database.

Neither the Modification Request nor the Inactivation Request processes *completely* removes the prior erroneous record from the QIES ASAP database. Rather, in each instance, the erroneous record is archived in a history file so that it will not be used for quality reporting purposes. New or corrected LTCH CARE Data Set records that are completed and submitted under the Modification or Inactivation Request processes will replace the erroneous records and thus will be used for quality reporting purposes. There is only one instance in which it is necessary to delete a record permanently and not retain any information about the record in the QIES ASAP database, which is when the record was submitted for the wrong facility. Only in this instance is it necessary to complete a **Manual Deletion Request** to ensure that the patient record is not associated with an incorrect facility and does not appear on the reports of the incorrect facility. Manual Deletion Requests must come from the LTCH to CMS so that all traces of this record will be manually and permanently 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 **A0100, Facility Provider Numbers,** and complete the items in all other LTCH CARE Data Set Assessment Record 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) (i.e., 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* LTCH CARE Data Set items for 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 2**, the LTCH staff should proceed to **A0100, Facility Provider Numbers**, and complete the items in all other LTCH CARE Data Set Assessment Record sections.

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

  — A0210 Assessment Reference Date (ARD)

  — 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)

— Any patient identifier (i.e., First name, Last name, Social Security Number (SSN), Gender, Birth Date) found to be inaccurate.

Only *one* patient identifier can be changed with each Modification Request record. If a single patient identifier (e.g., First name, Last name, SSN, Gender, Birth Date) needs to be corrected, enter the correct information in the appropriate item (and proceed to complete the items in all other LTCH CARE Data Set sections). However, when *multiple* patient identifier corrections must be made, the LTCH **must** complete an **Inactivation Request** record for the erroneous record **and** create a new record with the correct information.

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

  If this item is **coded as 3**, then the following Section A items should be completed and all other LTCH CARE Data Set Assessment Record items should be left blank. Any item in the following list that was submitted as part of the original record must also be submitted as part of the inactivation request, and values for each item must match across the original record and the inactivation request record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record):

  — A0050: Type of Record

  — 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

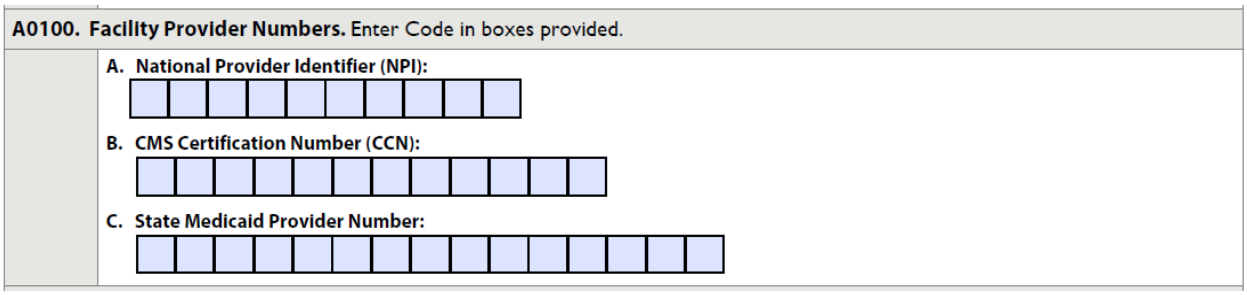
  — A0800: Gender

  — A0900: Birth Date

  These items are required to be submitted for an **Inactivation Request** in order for the QIES ASAP system to find the erroneous record to be archived. A new LTCH CARE Data Set Assessment Record with the correct information must be submitted to the QIES ASAP system to replace the inactivated record.

  If *multiple* patient identifier corrections (e.g., First name, Last name, SSN, Gender, Birth Date) must be made, the LTCH **must** complete an **Inactivation Request** record for the erroneous record **and** create a new record with the correct information. If only *one* patient identifier needs to be corrected, a **Modification Request** is used.

A0100: Facility Provider Numbers



Item Rationale

- Identifies the LTCH submitting the assessment record.

Coding Instructions

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

  A. National Provider Identifier (NPI)

  B. CMS Certification Number (CCN)

  C. State Medicaid Provider Number. When known, enter the State Medicaid Provider Number in A0100C.

DEFINITIONS

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

CMS CERTIFICATION NUMBER (CCN)
Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities.

STATE MEDICAID 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.

Coding Tips

- LTCHs and Long-Term Acute Care Hospitals (LTACs) are different names for the same type of hospital.
- Medicare uses the term long-term care hospitals, therefore, throughout this manual we will use this term and the abbreviated term, LTCHs.
- LTCHs are certified as acute-care hospitals that treat patients requiring extended hospital-level care, typically following initial treatment at a short-stay acute-care hospital.
- If a hospital is classified as a LTCH for purposes of Medicare payments (as denoted by the last four digits of its six-digit CCN in the range of 2000–2299), it is subject to the requirements of the LTCH Quality Reporting Program (QRP).

A0210: Assessment Reference Date

Item Rationale

DEFINITIONS

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

- The Assessment Reference Date (ARD) 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 December 3, 2014, the assessment information would be based on the period starting with the date of admission on December 3, 2014, and ending at the ARD, which is no later than 11:59 pm on December 5, 2014 (admission date plus 2 calendar days).

  — The ARD is not intended to replace a timeframe used by the facility for carrying out patient assessments, and LTCHs should follow facility policy related to patient assessment timing. Therefore, the assessment data that are captured ***by*** the ARD may likely include patient 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**.
- The ARD for Planned or Unplanned Discharge and Expired assessments is equal to the date of discharge or death, respectively. If the patient's discharge has been delayed, the ARD on the Discharge assessment should be the patient's actual discharge date.
- 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 the 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, 2014, should be entered as 10-02-2014.
- 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 to 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, 2014, assessment information would be based on the time period starting with the date of admission on December 3, 2014, and ending at the ARD, which is 11:59 pm on December 5, 2014 (admission date plus 2 calendar days). If the patient is absent during December 3 or December 4, 2014, for any reason, the ARD remains December 5, 2014.

A0220: Admission Date

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, 2014, would be entered as 11-01-2014.

DEFINITIONS

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.

A0250: Reason for Assessment

Item Rationale

- Allows identification of needed assessment content.

Coding Instructions

- Document the reason for completing the assessment, using the categories of assessment types. This item contains two digits. For code 01, enter "0" in the first box and place "1" in the second box.

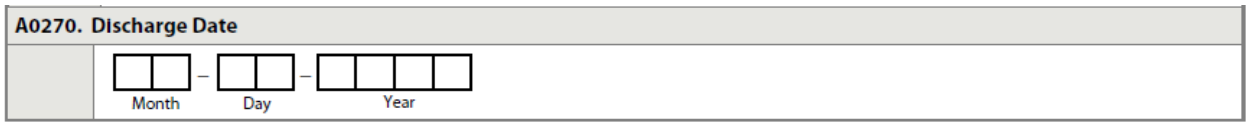
  01. Admission
  10. Planned discharge
  11. Unplanned discharge
  12. Expired

- For unplanned discharges, the facility should complete the Unplanned 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 is unable to determine the response for an item.
- Planned discharge with a change in discharge date should be coded as a "Planned discharge" and is not considered an "Unplanned discharge."

Coding Tips

- For detailed information on the requirements for scheduling and timing of the assessments, see ***Chapter 2*** on LTCH CARE Data Set Assessment Record schedules.

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, 2014, would be entered as 10-09-2014.
- For Discharge assessments, the Discharge Date (A0270) and ARD (A0210) must be the same date.

DEFINITIONS

PLANNED DISCHARGE

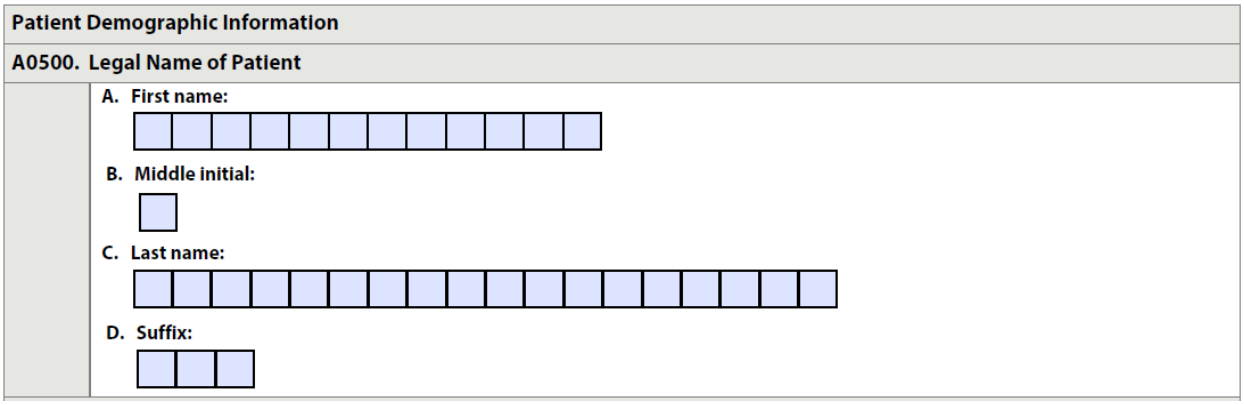
A planned discharge is one where the patient is nonemergently, medically released from care at the LTCH for some reason that was arranged for in advance.

UNPLANNED DISCHARGE

An unplanned discharge is:

- An unplanned 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 the patient's discharge from the LTCH; or
- A transfer of the patient to an emergency department of another hospital 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 longer than 3 days; or
- When a patient unexpectedly decides to go home or to another hospital/facility (e.g., due to the patient deciding to complete treatment in an alternate setting).
- Does not include planned transfers to acute-care inpatient hospitals for admission for planned interventions, treatments, or procedures, unless the patient does not return to the LTCH within 3 calendar days.

A0500: Legal Name of Patient



Item Rationale

- Records patient's legal name for identification purposes.
- Allows records for the same 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.
3. Be sure to carefully check the spelling of the patient's name each time a LTCH CARE Data Set Assessment Record is submitted because typographical errors that are made in the patient name item may cause creation of a new record for the same patient in the QIES ASAP.

Coding Instructions

Use printed letters. Enter in the following order:

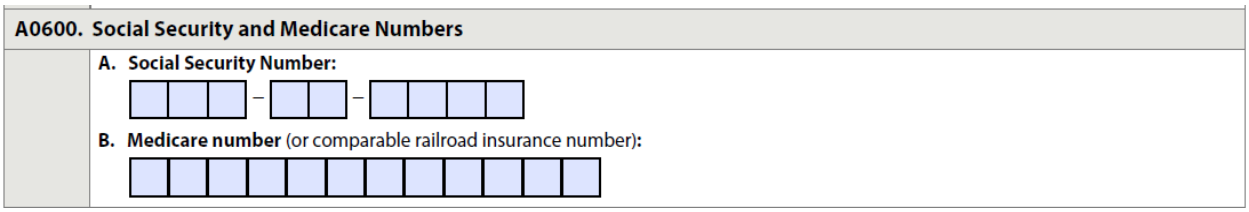
A. First name.

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 to prevent the QIES ASAP system from creating a new person).

D. Suffix (e.g., Jr., Sr.).

A0600: Social Security and Medicare Numbers



Item Rationale

- Records the patient's Social Security Number (SSN) and Medicare number for identification purposes.
- Allows records for the same patient to be matched in the QIES ASAP system.

Coding Instructions

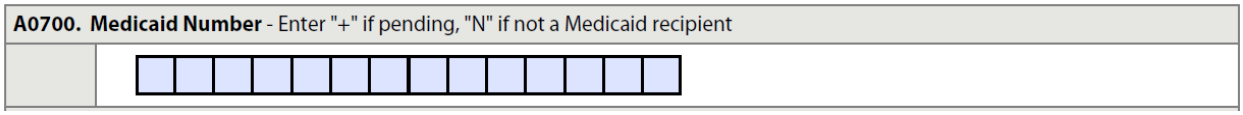
- Enter the SSN in item A0600A, one number per space, starting with the left-most space. If the patient does not have a SSN, the item may be left blank.
- Enter the Medicare number in item A0600B exactly as it appears on the patient's Medicare card.
- If the patient does not have a Medicare number, a 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 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 RRB number.
- Confirm that the patient's legal name on the LTCH CARE Data Set Assessment Record (Item A0500) matches the patient's legal name on the Medicare or RRB card.

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 the 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.

A0700: Medicaid Number



Item Rationale

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

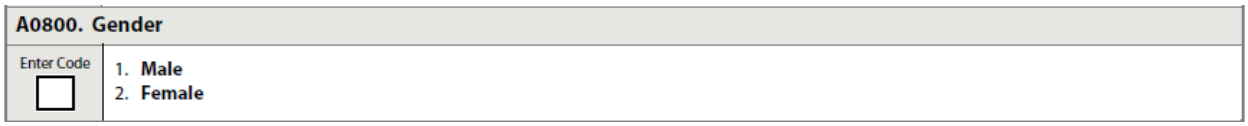
Coding Instructions

- Record this number if the patient is a Medicaid recipient.
- Enter one number per box beginning in the left-most box, ensuring that you have entered the digits correctly.
- 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.
- Enter the Medicaid number (if available), even if Medicaid is the secondary payer.
- Confirm that the patient's legal name on the LTCH CARE Data Set Assessment Record (Item A0500) matches the patient's legal name on the Medicaid card.

A0800: Gender



Item Rationale

- Records the gender of the patient for identification purposes.
- Allows records for the same 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 records for the same 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, significant other, guardian, or legally authorized representative.
3. Provide category definitions to the patient, family, significant other, guardian, or legally authorized representative only if they request them to answer the item.
4. Offer 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, significant other, guardian, or legally authorized representative is available.

Coding Instructions

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

A1100: Language

A1100. Language

Enter Code ☐

A. Does the patient need or want an interpreter to communicate with a doctor or health care staff?
0. **No** → *Skip to A1200. Marital Status*
1. **Yes** → *Specify in A1100B. Preferred language*
9. **Unable to determine** → *Skip to A1200. Marital Status*

B. Preferred language:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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 in and understand the consent process.

Steps for Assessment

1. Ask the patient if he or she needs or wants an interpreter to communicate with a doctor or health care staff.
2. If the patient is unable to respond, ask a family member, significant other, guardian, or legally authorized representative.
3. If none of these sources is available, review record for evidence of a need for an interpreter.
4. If an interpreter is wanted or needed, request one and note the preferred language in A1100B, Preferred Language.

- It is acceptable for a family member, significant other, guardian, or legally authorized representative 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, significant other, guardian, or legally authorized representative interpret. No person under the age of 18 may act as an interpreter under any circumstances. For more guidelines on using interpreters, please read the U.S. 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, guardian, legally authorized representative, 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, guardian or legally authorized representative 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 entering the patient's preferred language.
- Code 9, Unable to determine if none of these sources 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, guardians, or legally authorized representatives, 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

A1200. Marital Status	
Enter Code ☐	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

Item Rationale

- Allows understanding of any current formal relationship the patient may have 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, significant other, guardian or legally authorized representative.
3. If the patient is unable to respond, or there is no family member, significant other, guardian or legally authorized representative, 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

Coding Tips and Special Populations

- If the patient is in a domestic partnership, the person is not legally married according to the current Federal definition. Hence, the item should be coded as "Never Married."

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

A1802: Admitted From

A1802. 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

- Knowing 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, significant others, guardians, or legally authorized representatives.

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 noninstitutional 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 nonmedical 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 nonskilled 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 (SNF) 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 (CAHs) participating in Medicare that have CMS approval to provide post-hospital SNF care and meet 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 accepts 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 rehabilitation hospital, or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients.
- Code 08, Psychiatric hospital or unit 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.**

A2110: Discharge Location

A2110. Discharge Location	
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** 12. **Discharged Against Medical Advice** 98. **Other**

Item Rationale

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

Steps for Assessment

1. 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 **A1802, Admitted From,** for definitions of the services and settings listed below.

01. Community residential setting (e.g., 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
12. Discharged Against Medical Advice
98. Other

A2500: Program Interruption(s)

A2500. Program Interruption(s)	
Enter Code	**Program Interruptions** 0. **No** → *Skip to B0100. Comatose* 1. **Yes** → *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*

Item Rationale

- Identifies the existence of program interruptions during the patient's current stay.
- Allows CMS to evaluate the effect of program interruptions on quality of care.

Steps for Assessment

- Review the medical record for documentation of program interruptions.

Coding Instructions

Complete only if A0250 = 10 Planned discharge; or A0250 = 11 Unplanned discharge

Enter the one-digit code that corresponds to whether or not there were program interruptions during the patient's current stay in this facility.

DEFINITIONS

PROGRAM INTERRUPTION
Refers to an interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per contractual agreement for services (e.g., when the patient requires a higher level of care and is transferred to an acute-care hospital). Such an interruption must not exceed 3 calendar days, whereby day 1 begins on the day of transfer, regardless of hour of transfer. For such an interruption, the LTCH should not complete and submit an LTCH CARE Data Set Discharge record (planned or unplanned).

- Code 0, No, if there were no program interruptions during the patient's current stay in this facility
- Code 1, Yes, if there was at least one program interruption during the patient's current stay in this facility.

A2510: Number of Program Interruptions During This Stay in This Facility

A2510. Number of Program Interruptions During This Stay in This Facility	
Enter Code ☐☐	**Number of Program Interruptions During This Stay in This Facility**. *Code only if A2500 is equal to 1.*

Item Rationale

- Determines the number of program interruptions during the patient's current stay.
- Allows CMS to evaluate the association of program interruptions with quality of care.

Steps for Assessment

1. If there is documentation of program interruptions during this stay (i.e., A2500 is coded as 1), review the medical record to determine number of program interruptions.

Coding Instructions

Complete only if A0250 = 10 Planned discharge; or A0250 = 11 Unplanned discharge

- Enter the number of program interruptions that occurred during the patient's current stay in this LTCH.

A2525: Program Interruption Dates

A2525. Program Interruption Dates. *Code only if A2510 is greater than or equal to 01.*	
A1. First Interruption Start Date	Month – Day – Year
A2. First Interruption End Date	Month – Day – Year
B1. Second Interruption Start Date *Code only if A2510 is greater than 01.*	Month – Day – Year
B2. Second Interruption End Date *Code only if A2510 is greater than 01.*	Month – Day – Year
C1. Third Interruption Start Date *Code only if A2510 is greater than 02.*	Month – Day – Year
C2. Third Interruption End Date *Code only if A2510 is greater than 02.*	Month – Day – Year
D1. Fourth Interruption Start Date *Code only if A2510 is greater than 03.*	Month – Day – Year
D2. Fourth Interruption End Date *Code only if A2510 is greater than 03.*	Month – Day – Year
E1. Fifth Interruption Start Date *Code only if A2510 is greater than 04.*	Month – Day – Year
E2. Fifth Interruption End Date *Code only if A2510 is greater than 04.*	Month – Day – Year

Item Rationale

- Determines the dates of program interruptions during the patient's current stay.
- Allows CMS to evaluate the effect of program interruptions on quality of care.

Steps for Assessment

1. If one or more program interruptions occurred (i.e., A2510 is greater than or equal to 1), review the medical record for documentation of program interruption dates.

Coding Instructions

Complete only if A0250 = 10 Planned discharge or A0250 = 11 Unplanned discharge

- Enter the start and end dates of the first five program interruptions during the patient's LTCH stay, beginning with the interruption closest to the patient's date of admission.

DEFINITIONS

PROGRAM INTERRUPTION START DATE
The start date of the program interruption is the day the patient leaves the LTCH. It is considered calendar day 1.

PROGRAM INTERRUPTION END DATE
The end date of the program interruption is the day the patient returns to the LTCH. An absence from the LTCH is considered a program interruption when the program interruption end date is no later than calendar day 3 of the patient's absence.