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 Continuity Assessment Record and Evaluation (CARE) Data Set assessment record is a new record to be added to the Internet Quality Improvement and Evaluation System (iQIES) or if the LTCH CARE Data Set assessment record that was previously submitted and accepted in iQIES requires modification or inactivation.

A **new assessment/record** is a record that has not been previously submitted and accepted in iQIES.

LTCHs should correct any errors necessary to ensure that the information in iQIES 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 iQIES.

A **Modification Request** (A0050 = 2) is used when an LTCH CARE Data Set assessment record is accepted into iQIES, but the information in the record contains clinical or non-key demographic errors.

The **Modification Request** (A0050 = 2) record is used to correct most LTCH CARE Data Set assessment record items that are erroneous. However, there are items that **cannot be corrected** with a Modification Request; rather, the erroneous record must be inactivated with an Inactivation Request record and a new LTCH CARE Data Set assessment record submitted to iQIES.

These items **cannot** be corrected with a Modification Request:

Record Event Identifiers

- 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)

Patient Identifiers

- A0500A: First name
- A0500C: Last name
- A0600A: Social Security Number (SSN)
- A0800: Gender
- A0900: Birth Date

Note: To make corrections to a record event identifier and/or patient identifier you must complete an **Inactivation Request** record for the incorrect record and create a new record with the correct information.

When an error is discovered (except for those items listed in the preceding bullets) in an LTCH CARE Data Set assessment record, the provider must submit a Modification Request (A0050 = 2) to iQIES. When completing a Modification Request record, the Modification Request record should contain correct values for all items (not just the values previously in error). This means if A0050 is coded as 2, the LTCH staff should proceed to A0100, Facility Provider Numbers, and complete all items in all other LTCH CARE Data Set assessment record sections. For more information on Modification Requests, please refer to Chapter 4.

An **Inactivation Request** (A0050 = 3) should be used when a record has been accepted into iQIES, but the corresponding event did not occur, for example, an LTCH CARE Data Set Discharge Assessment Record was submitted for a patient but there was no actual discharge. This request should also be used when one or more event identifiers and/or patient identifiers are found to be in error.

An Inactivation Request (A0050 = 3) **must** be completed when any of the following items are inaccurate:

Record Event Identifiers

- 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)

Patient Identifiers

- A0500A: First name
- A0500C: Last name
- A0600A: Social Security Number (SSN)

- A0800: Gender
- A0900: Birth Date

Note: Any item in the previous 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 in the erroneous record and the inactivation record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record.

If an ARD (A0210), Admission Date (A0220), Reason for Assessment (A0250), or Discharge Date (A0270) is incorrect, or if one or more patient identifiers are found to be in error, the provider must inactivate the erroneous record in iQIES, complete and submit a new LTCH CARE Data Set assessment record with the event and patient identifiers, and ensure that the clinical information is accurate. For more information on Inactivation Requests, please refer to Chapter 4.

A special **Manual Record Deletion Request** is only necessary when there has been an error in a record that has been accepted into iQIES that cannot be corrected with an automated Modification or Inactivation Request. There are only two items to which this applies.

A **Manual Record Deletion Request** must be performed when the record has the wrong state code and/or facility ID in the control items STATE_CD and FAC_ID. Control items are items created by the file submission software. These error(s) most likely occurred at the time of software development, or when initializing the software, and not during the entry of the provider's administrative or patient's data.

If a record has the wrong state code or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in iQIES. The record must be resubmitted with the correct STATE_CD and/or FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record.

In the event that this error has occurred, the provider must contact the QTSO Help Desk at help@qtso.com or 1-877-201-4721 to obtain the LTCH CARE Manual Assessment Deletion Request form. The provider is responsible for completing the form. The provider must submit the completed form to the QTSO Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The QTSO Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the QTSO Help Desk will work through the request with the provider.

Please refer to ***Chapter 4*** of this manual for more details on the submission and correction of LTCH CARE Data Set assessment records.

Coding Instructions

- 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 iQIES.

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 iQIES, 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 an LTCH CARE Data Set assessment record that already was submitted and accepted in iQIES.

  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:

  Record Event Identifiers

  - 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)

  Patient Identifiers

  - A0500A: First name
  - A0500C: Last name
  - A0600A: Social Security Number (SSN)
  - A0800: Gender
  - A0900: Birth Date

- Code 3, Inactivate existing record, if this is a *request to inactivate* an LTCH CARE Data Set assessment record that has already been submitted and accepted in iQIES.

  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 in the erroneous record and the inactivation record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record:

Record Event Identifiers

- 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)

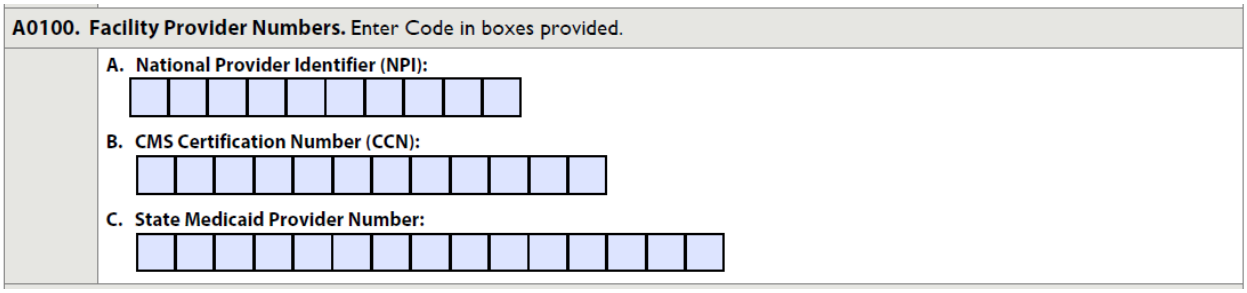
Patient Identifiers

- A0500A: First name
- A0500C: Last name
- A0600A: Social Security Number (SSN)
- A0800: Gender
- A0900: Birth Date

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

If *multiple* patient identifier corrections (e.g., First name, Last name, Social Security Number, 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.

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 LTCH 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

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

Item Rationale

- Designates type of provider.
- Allows iQIES to match records.

Coding Instructions

- Code 3, Long-Term Care Hospital, if facility is an LTCH.

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 an 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/injury 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 iQIES to match records.

Steps for Assessment

1. 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 iQIES to match records.

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.

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.

A0250. Reason for Assessment

A0250. Reason for Assessment	
Enter Code	01. **Admission** 10. **Planned discharge** 11. **Unplanned discharge** 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. 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. If you are unable to assess the patient on a particular item and therefore unable to enter a response on the LTCH CARE Data Set, code the item with the default response of a dash (–). The -3900 edit (warning) is in place as a helpful reminder to staff completing the assessment that the item is required and may result in a 2% reduction to the LTCH's applicable fiscal year annual payment update (APU).
- Planned discharge with a change in discharge date should be coded as a "Planned discharge" and is not considered an "Unplanned discharge."

DEFINITIONS

PLANNED DISCHARGE

A planned discharge is one where the patient is nonemergently, medically released from care at the LTCH, for longer than 3 days, for some reason that was arranged for in advance.

UNPLANNED DISCHARGE

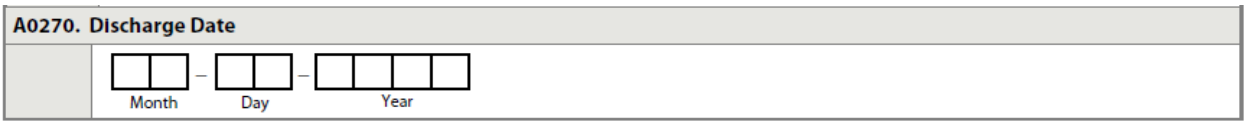
An unplanned discharge is

- 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 calendar 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., patient prefers to complete treatment in an alternate setting).

Coding Tips

- For detailed information on the requirements for completing LTCH CARE Data Set assessments, see ***Chapter 2*** of this manual.

A0270. Discharge Date



Item Rationale

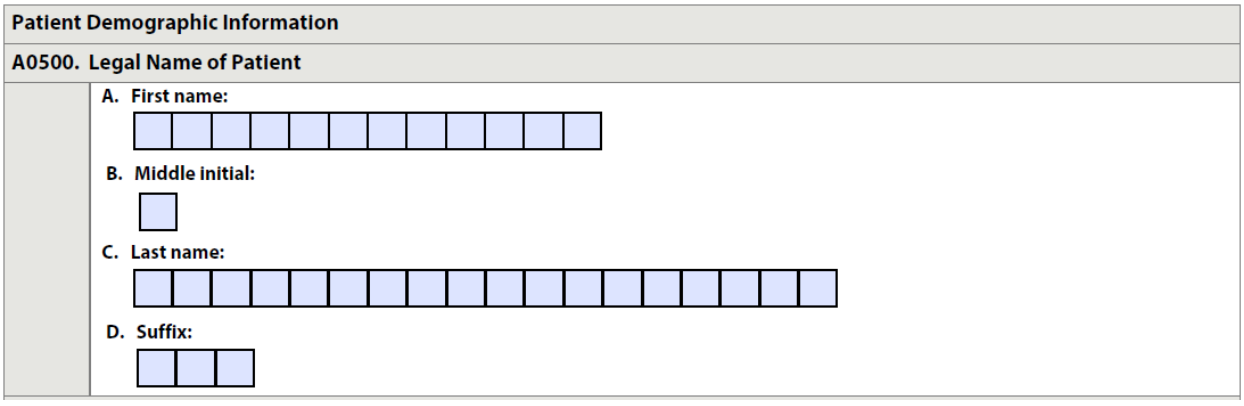
- To document the date of discharge from the LTCH.

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.

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 iQIES.

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

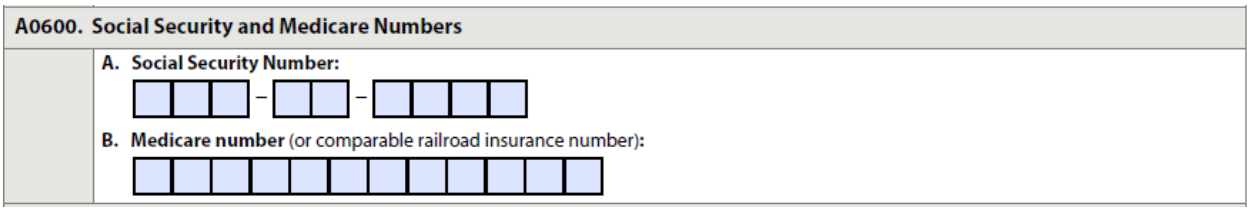
1. Ask patient, family, significant other, guardian, or legally authorized representative to state the patient's legal name.
2. Check the patient's name on his or her Medicare card, or, if not on Medicare, check Medicaid card or other government-issued document.
3. Be sure to carefully check the spelling of the patient's name each time an 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 iQIES.

Coding Instructions

- Use printed letters. Enter in the following order:

  A. First name.
  B. Middle initial (if the patient has no middle initial, leave 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 iQIES 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 iQIES.

Coding Instructions

A. Social Security Number

- Enter the SSN in item A0600A, one number per space, starting with the left-most space. If the patient does not have an SSN or the SSN is unavailable, the item may be left blank.

B. Medicare Number (or comparable railroad insurance number)

- Enter the Medicare number in item A0600B exactly as it appears on the patient's Medicare card.
- A Medicare number is an identifier assigned to an individual for participation in national health insurance program(s). The Medicare number may contain both letters and numbers.
  - In an effort to fight identity theft for Medicare beneficiaries, CMS is replacing the SSN-based Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI).
  - **Prior to April 1, 2018**: Enter the HICN, identified as the Medicare Claim Number on the patient's Medicare card. The HICN may differ from the patient's SSN. For example, many patients receive Medicare benefits based on a spouse's Medicare eligibility.
  - **April 1, 2018–December 31, 2019**: Enter the patient's HICN, or the patient's new MBI.
  - **After December 31, 2019**: Enter the MBI. Do not report the patient's SSN-based HICN.
- 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.
- Confirm that the patient's legal name on the LTCH CARE Data Set assessment record (A0500) matches the patient's legal name on the Medicare or RRB card.
- If the person has neither a Medicare number nor an RRB number, the item may be left blank.

DEFINITIONS

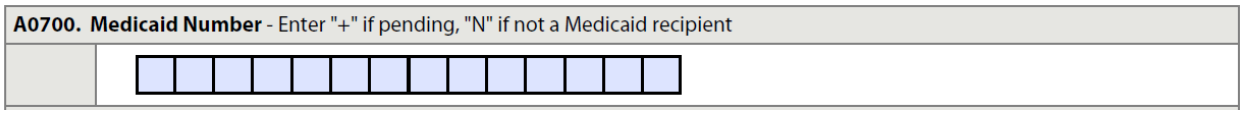
SOCIAL SECURITY NUMBER (SSN)
A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

MEDICARE NUMBER (OR COMPARABLE RAILROAD INSURANCE NUMBER)
A Medicare number is an identifier assigned to an individual for participation in national health insurance program(s). The Medicare number may contain both letters and numbers.

Coding Tips

- To avoid inaccuracies in patient record matching, A0600 should only be left blank if the patient does not have a SSN or in rare instances where the SSN is unavailable.
- A0600B can only be a Medicare number or a RRB number.

A0700. Medicaid Number



Item Rationale

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

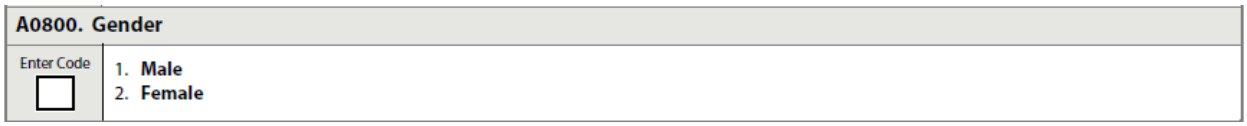
Coding Instructions

- 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 iQIES.

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

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 iQIES.

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.