

SECTION A: ADMINISTRATIVE INFORMATION

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

A0050. Type of Record

A0050. Type of Record	
Enter Code <input type="text"/>	<ol style="list-style-type: none"> 1. Add new assessment/record 2. Modify existing record 3. Inactivate existing record

Item Rationale

This item indicates whether an LCDS assessment record is a new record to be added to the internet Quality Improvement and Evaluation System (iQIES) or if the LCDS 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 LCDS assessment records that have been accepted into iQIES.

A **Modification Request** (A0050 = 2) is used when an LCDS 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 LCDS 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 LCDS 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)
- A0810: Sex
- 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 LCDS 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 LCDS 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 LCDS 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)
- A08100: Sex
- 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 LCDS 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.

Note: Specific user roles within iQIES will allow the provider to modify or inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.

Please refer to Chapter 4 of this manual for more details on the submission and correction of LCDS assessment records.

Coding Instructions

- **Code 1, Add new assessment/record,** if this is a *new* LCDS 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 LCDS 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* LCDS items for an LCDS 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 LCDS 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)

- A0810: Sex
- A0900: Birth Date
- **Code 3, Inactivate existing record**, if this is a *request to inactivate* an LCDS 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 LCDS 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)
- A0810: Sex
- 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 LCDS 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, Sex, 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

A0100. Facility Provider Numbers. Enter Code in boxes provided.

A. National Provider Identifier (NPI):

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B. CMS Certification Number (CCN):

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C. State Medicaid Provider Number:

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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 healthcare 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 <input type="text"/>	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 the 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 general 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

A0210. Assessment Reference Date									
Observation end date:									
<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year					

Item Rationale

- 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 LCDS. The ARD for an admission record is **at most** the fourth calendar day of the patient's stay.

For example, if a patient is admitted to the LTCH on December 3, 2023, the assessment information would be based on the period starting with the date of admission on December 3, 2023, and ending at the ARD, which is no later than 11:59 p.m. on December 6, 2023 (admission date plus 3 calendar days).

- The ARD is not intended to replace a time frame used by the facility for carrying out patient assessments, and LTCHs should follow facility policy related to 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**.
 - Note: Although the ARD for the admission assessment may occur by the fourth calendar day of the LTCH stay (the day of admission plus three calendar days), Item 00150 (Spontaneous Breathing Trial) must still be completed by Day 2 of the LTCH stay (the day of admission plus one calendar day).
- 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.

DEFINITION

ASSESSMENT REFERENCE DATE (ARD)

The end-point of the assessment period for the LCDS assessment record.

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, 2023, should be entered as 10-02-2023.
- For detailed information related to the ARD for all LCDS assessments, refer to Chapter 2.

Coding Tips

- 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, 2023, assessment information would be based on the time period starting with the date of admission on December 3, 2023, and ending at the ARD, which is 11:59 p.m. on December 6, 2023 (admission date plus 3 calendar days). If the patient is absent during December 3, 4, or 5, 2023, for any reason, the ARD remains December 6, 2023.

A0220. Admission Date

A0220. Admission Date									
			-			-			
Month		Day		Year					

Item Rationale

- To document the date of admission into the LTCH.
- Allows iQIES 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, 2023, would be entered as 11-01-2023.

DEFINITION

ADMISSION DATE

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

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:

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 LCDS, code the item with the default response of a dash (-), if allowed. 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 LCDS assessments, see Chapter 2 of this manual.

A0270. Discharge Date

A0270. Discharge Date																													
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Month			Day			Year																							

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 LCDS (i.e., when A0250 = 12, Expired) is the date of death.
- Use the format month-day-year (MM-DD-YYYY). For example, October 9, 2023, would be entered as 10-09-2023.
- For Discharge assessments, the Discharge Date (A0270) and ARD (A0210) must be the same date.

A0500. Legal Name of Patient

A0500. Legal Name of Patient	
A. First name:	<input type="text"/>
B. Middle initial:	<input type="text"/>
C. Last name:	<input type="text"/>
D. Suffix:	<input type="text"/>

Item Rationale

- Records patient's legal name for identification purposes.
- Allows records for the same patient to be matched in iQIES.

DEFINITION

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

- Ask patient, family, significant other, guardian, or legally authorized representative to state the patient's legal name.
- Check the patient's name on their Medicare card, or, if not on Medicare, check Medicaid card or other government-issued document.
- Be sure to carefully check the spelling of the patient's name each time an LCDS assessment record is submitted, because typographical errors that are made in the patient's 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

[illegible]

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

- 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 contains both letters and numbers.
 - In an effort to fight identity theft for Medicare beneficiaries, CMS replaced the SSN-based Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI). After December 31, 2019, only the MBI will be accepted. Do not report the patient's SSN-based HICN.
 - Railroad Retirement Medicare Beneficiaries (RRBs) have a Medicare card with an MBI.
 - To enter the MBI 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 LCDS assessment record (A0500) matches the patient's legal name on the Medicare 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

A Medicare number is an identifier assigned to an individual for participation in national health insurance program(s). The Medicare number contains both letters and numbers.

**MEDICARE BENEFICIARY IDENTIFIER
(MBI)**

An MBI is 11 characters in length and made up of only numbers and uppercase letters. This identifier is used for Medicare transactions like billing, eligibility status, and claim status, and should be treated as Personally Identifiable Information.

- If the patient does not have a Medicare/MBI number, the item may be left blank.

Coding Tips

- To avoid inaccuracies in patient record matching, A0600A should only be left blank if the patient does not have an SSN or in rare instances where the SSN is unavailable.
- A0600B can only be a Medicare number.

A0700. Medicaid Number

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

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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, 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

- 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 LCDS assessment record (A0500) matches the patient's legal name on the Medicaid card.

A0810. Sex

A0810. Sex	
Enter Code <input type="text"/>	1. Male 2. Female

Item Rationale

- Records the sex 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 sex.

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

A0900. Birth Date

A0900. Birth Date									
<input type="text"/>		-	<input type="text"/>		-	<input type="text"/>			
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 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.

A1005. Ethnicity

A1005. Ethnicity	
Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
<input type="checkbox"/>	A. No, not of Hispanic, Latino/a, or Spanish origin
<input type="checkbox"/>	B. Yes, Mexican, Mexican American, Chicano/a
<input type="checkbox"/>	C. Yes, Puerto Rican
<input type="checkbox"/>	D. Yes, Cuban
<input type="checkbox"/>	E. Yes, another Hispanic, Latino, or Spanish origin
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond

Item Rationale

- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple healthcare settings and is an important step in improving quality of care and health outcomes.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Steps for Assessment

- Ask the patient to select the category or categories that most closely correspond to the patient's ethnicity from the list in A1005, Ethnicity.
 - Individuals may be more comfortable if this and the subsequent question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their ethnic background."
- Respondents should be offered the option of selecting one or more ethnic designations.
- If a patient is **unable to respond**, a proxy response may be used.
- If neither the patient nor a proxy is able to provide a response to this item, use medical record documentation.
- If a patient **declines to respond**, do not code based on a proxy response or medical record documentation.

Coding Instructions

Complete based on an assessment that occurs within the 4-day admission assessment time period. Check all that apply.

- If the patient **can provide** a response, check the box(es) indicating the ethnic category or categories identified by the patient.
- Code X, Patient unable to respond**, if the patient was **unable to respond**.
 - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record

documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X, Patient unable to respond.

- If the patient was unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, Code X, Patient unable to respond.
- **Code Y, Patient declines to respond**, if the patient declines to respond.
 - In cases where the patient declines to respond, Code Y, Patient declines to respond, only.
 - If the patient **declines to respond** do not code based on a proxy input or medical record documentation.

Coding Tips

- Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or healthcare representative.

Examples

1. The patient is admitted following an acute cerebrovascular accident (CVA) with mental status changes and is unable to respond to questions regarding the patient's ethnicity. The patient's caregiver informs the nurse that the patient is Cuban.

Coding: A1005, Ethnicity would be coded as **D, Yes, Cuban** and **X, Patient unable to respond**.

Rationale: If a patient is unable to respond but the proxy provides the response, code both the proxy response and X, Patient unable to respond.

2. The patient is admitted following a total hip arthroplasty (THA) and declines to respond to questions regarding their ethnicity.

Coding: A1005, Ethnicity would be coded as **Y, Patient declines to respond**.

Rationale: If a patient declines to respond to this item, then the only response option that should be coded is Y, Patient declines to respond. No attempts should be made to use proxy input or medical record documentation to complete A1005, Ethnicity when a patient declines to respond.

A1010. Race

A1010. Race	
What is your race?	
↓	Check all that apply
<input type="checkbox"/>	A. White
<input type="checkbox"/>	B. Black or African American
<input type="checkbox"/>	C. American Indian or Alaska Native
<input type="checkbox"/>	D. Asian Indian
<input type="checkbox"/>	E. Chinese
<input type="checkbox"/>	F. Filipino
<input type="checkbox"/>	G. Japanese
<input type="checkbox"/>	H. Korean
<input type="checkbox"/>	I. Vietnamese
<input type="checkbox"/>	J. Other Asian
<input type="checkbox"/>	K. Native Hawaiian
<input type="checkbox"/>	L. Guamanian or Chamorro
<input type="checkbox"/>	M. Samoan
<input type="checkbox"/>	N. Other Pacific Islander
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond
<input type="checkbox"/>	Z. None of above

Item Rationale

- Standardizing self-reported data collection for race allows for the equal comparison of data across multiple healthcare settings and is an important step in improving quality of care and health outcomes.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Steps for Assessment

- Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race.
- Respondents should be offered the option of selecting one or more race category.
- If a patient is **unable to respond**, a proxy response may be used.
- If neither the patient nor a proxy is able to provide a response to this item, use medical record documentation.
- If a patient **declines to respond**, do not code based on a proxy response or medical record documentation.

Coding Instructions

Complete based on an assessment that occurs within the 4-day admission assessment time period. Check all that apply.

- If the patient can provide a response, check the box(es) indicating the race category or categories identified by the patient.
- **Code X, Patient unable to respond**, if the patient was **unable to respond**.
 - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X, Patient unable to respond.
 - If the patient is unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, Code X, Patient unable to respond, only.
- **Code Y, Patient declines to respond**, if the patient **declines to respond**.
 - In the cases where the patient declines to respond, Code Y, Patient declines to respond, **only**.
 - If the patient **declines to respond** do not code based on proxy input or medical record documentation to complete this item.
- **Code Z, None of the above**, if the patient reports or it is determined from proxy or medical record documentation that none of the listed races apply to the patient.

Coding Tips

- Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or healthcare representative.

Examples

1. The patient has severe dementia with agitation. During the admission assessment, the patient is unable to provide their race. The patient's caregiver informs the nurse that the patient is Korean and African American.

Coding: A1010, Race would be coded as **B, Black or African American, H, Korean, and X, Patient unable to respond**.

Rationale: If a patient is unable to respond but the proxy provides the response, code both the proxy response and X, Patient unable to respond.

2. The patient declines to provide their race during the admission assessment stating, "I'd rather not answer."

Coding: A1010, Race would be coded as **Y, Patient declines to respond**.

Rationale: If a patient declines to respond to this item, then code only Y, Patient declines to respond. No attempts should be made to use proxy input or medical record documentation to complete A1010, Race when a patient declines to respond.

3. The patient is admitted to the LTCH following a recent CVA resulting in confusion and is unable to inform the admitting nurse which race applies to them. The proxy reports that none of the listed races apply to the patient.

Coding: A1010, Race would be coded as **X, Patient unable to respond** and **Z, None of the above**.

Rationale: If a patient is unable to respond, proxy input may be used to code A1010, Race. When a patient is unable to respond but proxy input can provide the necessary information, code both the information from the proxy input, in this case Z, None of the above, **and** X, Patient unable to respond.

A1110. Language

A1110. Language	
Enter Code <input type="text"/>	A. What is your preferred language? <div style="border: 1px solid black; width: 100px; height: 1.2em; margin-top: 5px;"></div>
	B. Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes 9. Unable to determine

Item Rationale

- Language barriers can lead to social isolation, depression, and patient safety issues.
- Language barriers can interfere with accurate assessment.

Steps for Assessment

1. Ask for the patient's preferred language.
2. Ask if the patient needs or wants an interpreter to communicate with a doctor or healthcare staff.
3. If the patient themselves – or with the assistance of an interpreter – is unable to respond to A1110A, What is your preferred language? or A1110B, Do you need or want an interpreter?, a proxy response is permitted.
4. If neither the patient nor a proxy is able to provide a response to A1110A or A1110B, medical record documentation may be used.

Coding Instructions for A1110A

- Enter the preferred language the patient primarily speaks or understands.
- If the patient or any available source cannot or does not identify preferred language, enter a dash (“-”) in the first box. A dash indicates “no information.” CMS expects dash use to be a rare occurrence.

Coding Instructions for A1110B

1. **Code 0, No**, if the patient indicates there is no need or want of an interpreter to communicate with a doctor or healthcare staff.
 - If the patient is unable to indicate the need or want of an interpreter, proxy input may be used.
 - If the patient is unable and a proxy response is not available, then medical record documentation may be used.
2. **Code 1, Yes**, if the patient indicates the need or want of an interpreter to communicate with a doctor or healthcare staff. Ensure that preferred language is indicated.
 - If the patient is unable to indicate the need or want of an interpreter, proxy input may be used.

- If the patient is unable and a proxy response is not available, then medical record documentation may be used.
- **Code 9, Unable to determine,** if no **source** can identify whether the patient wants or needs an interpreter.

Coding Tips

Complete based on an assessment that occurs within the 4-day admission assessment time period.

- 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.
- Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health-care representative.

A1200. Marital Status

A1200. Marital Status	
Enter Code <input type="text"/>	<ol style="list-style-type: none">1. Never married2. Married3. Widowed4. Separated5. 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 their 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**

A1255. Transportation

A1255. Transportation	
Enter Code <input type="text"/>	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? 0. Yes 1. No 7. Patient declines to respond 8. Patient unable to respond
<p><i>Questions on transportation and housing have been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.prapare.org.</i></p>	

Item Rationale

- Access to transportation for ongoing healthcare and medication access needs, particularly for those with chronic diseases, is essential to successful care management.
- Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.

Steps for Assessment

1. Ask the patient:
 - “In the past 12 months, has lack of reliable transportation kept you from medical appointments, meeting, work, or from getting things needed for daily living?”
2. Ask the patient to select the response that most closely corresponds to the patient’s transportation status from the list in A1255.
3. If the patient declines to respond, code 7, Patient declines to respond, and do not code based on proxy input or medical record documentation.
4. If the patient is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
5. Only use medical record documentation to code A1255, Transportation if the patient is unable to respond and no family member, significant other, and /or guardian/legally authorized representative provides a response to this item.

Coding Instructions

Complete based on assessments that occur within the 4-day admission assessment time period or the 3-day discharge assessment time period.

- **Code 0, Yes**, if the patient indicates that in the past 12 months, a lack of reliable transportation has kept them from medical appointments, meetings, work, or from getting things needed for daily living.
- **Code 1, No**, if the patient indicates that in the past 12 months, a lack of reliable transportation has not kept them from medical appointments, meetings, work, or from getting things needed for daily living.

- **Code 7, Patient declines to respond**, if the patient declines to respond.
 - If the patient **declines to respond** do not code based on other resources (family, significant other, or legally authorized representative, or medical records).
- **Code 8, Patient is unable to respond**, if the patient was unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information.

Coding Tips

- If the patient is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical records, select the response that applies.

Examples

1. The patient is admitted with multiple sclerosis. The patient is confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No family, significant other, or legally authorized representative with information about transportation is available, but the patient's medical record indicates that in the past 12 months, the patient's caregiver used their car to transport the patient wherever the patient needed to go.

Coding: A1255, Transportation would be **coded as Code 1, No**.

Rationale: Neither the patient nor their family, significant other, or legally authorized representative was able to provide a response, but the medical record documentation provided the necessary information regarding transportation.

2. The patient indicates that in the last 12 months, they have not had reliable transportation, which has occasionally kept them from attending medical appointments.

Coding: A1255, Transportation would be **coded as Code 0, Yes**.

Rationale: The patient reported they have not had access to reliable transportation in the last 12 months, which has kept them from medical appointments, meetings, work or from getting things needed for daily living.

A1400. Payer Information

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

A1805. Admitted From

Pre-Admission Service Use	
A1805. Admitted From	
Enter Code <input type="text"/>	<ol style="list-style-type: none"> 1. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 2. Nursing Home (long-term care facility) 3. Skilled Nursing Facility (SNF, swing bed) 4. Short-Term General Hospital (acute hospital, IPPS) 5. Long-Term Care Hospital (LTCH) 6. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 7. Inpatient Psychiatric Facility (psychiatric hospital or unit) 8. Intermediate Care Facility (ID/DD facility) 9. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service organization 99. Not Listed

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 their stay and may also inform discharge planning.

Steps for Assessment

- Review Transfer and Admission records.
- 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, Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements),** 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.
- Code 02, Nursing Home (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, swing bed),** 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, Short-Term General Hospital (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 05, 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 06, Inpatient Rehabilitation Facility (IRF, free standing facility or unit),** 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 07, Inpatient Psychiatric Facility (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 08, Intermediate Care Facility (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 with intellectual disabilities (ID) or with developmental disabilities (DD).
- **Code 09, Hospice (home/non-institutional),** if the patient was admitted from a home/non-institutional 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 10, Hospice (institutional facility),** 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 11, Critical Access Hospital (CAH),** CAHs represent a separate provider type as well as a separate payment method.

- **Code 12, Home under care of organized home health service organization**, if the patient received any services from a Medicare certified home health agency.
- **Code 99, Not Listed**, if the patient was admitted from none of the above.

Coding Tips

- If an individual was enrolled in a home-based hospice program, code as **09, Hospice**, instead of **01, Home/Community**.

A1990. Patient Discharged Against Medical Advice

A1990. Patient Discharged Against Medical Advice?	
Enter Code	0. No
<input type="text"/>	1. Yes

Item Rationale

- Allows identification of unplanned discharges that occurred against medical advice.
- Defined as situations where the patient elects to leave the facility prior to the managing physician's recommendation for discharge.
- Discharges against medical advice are a predictor for 30-day readmissions and may also put patients at greater risk for adverse clinical outcomes.

Steps for Assessment

1. Confirm the patient's record does not contain a discharge order from the managing physician.

Coding Instructions

Complete only if A0250 = 11 Unplanned discharge.

- **Code 0, No**, if the patient was not discharged against medical advice.
- **Code 1, Yes**, if the patient was discharged against medical advice.

Coding Tips

- Although not required, individual facilities may elect to use their own Discharge Against Medical Advice form to be signed by the patient and/or family.

A2105. Discharge Location

A2105. Discharge Location	
Enter Code <input type="text"/>	<ol style="list-style-type: none"> 1. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 2. Nursing Home (long-term care facility) 3. Skilled Nursing Facility (SNF, swing bed) 4. Short-Term General Hospital (acute hospital, IPPS) 5. Long-Term Care Hospital (LTCH) 6. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 7. Inpatient Psychiatric Facility (psychiatric hospital or unit) 8. Intermediate Care Facility (ID/DD facility) 9. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service organization 99. Not Listed

Item Rationale

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

Steps for Assessment

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

Coding Instructions

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

Select the two-digit code that corresponds to the patient's discharge location. Please refer to **A1805, Admitted From**, for definitions of the services and settings listed below.

- 01. Home/Community** (e.g., private home/apartment, board/care, assisted living, group home, transitional living, other residential care arrangements)
- 02. Nursing Home** (long-term care facility)
- 03. Skilled Nursing Facility** (SNF, swing bed)
- 04. Short-Term General Hospital** (acute hospital, IPPS)
- 05. Long-Term Care Hospital** (LTCH)
- 06. Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
- 07. Inpatient Psychiatric Hospital** (psychiatric hospital or unit)
- 08. Intermediate Care Facility** (ID/DD facility)
- 09. Hospice** (home/non-institutional)
- 10. Hospice** (institutional facility)
- 11. Critical Access Hospital** (CAH)
- 12. Home under care of organized home health service organization**
- 99. Not Listed**

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge	
At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code	0. No – Current reconciled medication list not provided to the subsequent provider → <i>Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge</i>
<input type="checkbox"/>	1. Yes – Current reconciled medication list provided to the subsequent provider

Item Rationale

- The transfer of a current reconciled medication list at the time of discharge can improve care coordination and quality of care, help subsequent providers reconcile medications, and may mitigate adverse outcomes related to medications. Communication of medication information at discharge is critical to ensure safe and effective transitions from one healthcare setting to another.

Steps for Assessment

- Determine if the patient was discharged to one of the subsequent providers defined below under Coding Tips, based on discharge location item A2105.
- If yes, determine if, at the time of discharge, your facility provided a current reconciled medication list to the patient's subsequent provider.

Coding Instructions

*Complete only if A0250 = 10 Planned discharge; or A0250 = 11 Unplanned discharge.
Complete as close to the time of discharge as possible.*

DEFINITION

MEANS OF PROVIDING A CURRENT RECONCILED MEDICATION LIST

Providing the current reconciled medication list at the time of discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record [EHR], giving providers access to a portal).

- Code 0, No**, if at discharge to a subsequent provider, your facility did not provide the patient's current reconciled medication list to the subsequent provider.
 - For planned discharges, skip to B0100, Comatose.
 - For unplanned discharges, skip to C1310, Signs and Symptoms of Delirium.
- Code 1, Yes**, if at discharge to a subsequent provider, your facility did provide the patient's current reconciled medication list to the subsequent provider.

Coding Tips

- At the time of discharge** – This is the period of time as close to the actual time of discharge as possible. This time may be based on facility, State, or Federal guidelines for data collection at discharge.

- **A subsequent provider** – For the purposes of this item, a subsequent provider is based on the discharge locations in A2105 and defined as any of the following:

02. Nursing Home (long-term care facility)

03. Skilled Nursing Facility (SNF, swing bed)

04. Short-Term General Hospital (acute hospital, IPPS)

05. Long-Term Care Hospital (LTCH)

06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit)

07. Inpatient Psychiatric Facility (psychiatric hospital or unit)

08. Intermediate Care Facility (ID/DD facility)

09. Hospice (home/non-institutional)

10. Hospice (institutional facility)

11. Critical Access Hospital (CAH)

12. Home under care of organized home health service organization

- While the patient may receive care from other providers after discharge from your facility, such as primary care providers, other outpatient providers, and residential treatment centers, these locations are not considered to be a subsequent provider for the purpose of coding this item.
- **Current Reconciled Medication list** – This refers to a list of the patient's current medications at the time of discharge that was reconciled by the facility prior to the patient's discharge.
- Your facility should be guided by current standards of care and any applicable regulations and guidelines (e.g., Conditions of Participation) in determining what information should be included in a current reconciled medication list.

Additional Considerations for Important Medication List Content

Defining the completeness of that medication list is left to the discretion of the providers and patient who are coordinating this care.

Examples of items that could be on a reconciled medication list can be but are not limited to a list of the current prescribed and over-the-counter medications, nutritional supplements, vitamins, and/or homeopathic and herbal products administered by any route at the time of discharge. A reconciled medication list could also include important information about: (1) the patient, including their name, date of birth, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions; and (2) each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, and/or any special instructions. However, this information serves as guidance and as stated prior, the completeness of the medication list is left to the discretion of the providers and patient.

Documentation sources for reconciled medication list information include electronic and/or paper records. Some examples of such records are discharge summary records, a Medication

Administration Record, an Intravenous Medication Administration Record, a home medication list, and physician orders.

Examples

1. The patient is being discharged from an LTCH to an acute-care hospital in the same healthcare system which uses the same electronic health record (EHR), also sometimes referred to as an electronic medical record (EMR) (see definition of EHR/EMR). The patient's current reconciled medication list at the time of discharge from the LTCH unit is accessible to the subsequent acute-care hospital staff admitting the patient and this is how the medication list is shared.

Coding: A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge would be **coded 1, Yes**.

Rationale: Having access to the patient's medication list through the same EHR system is one way to transfer a medication list. This code of 1, Yes, is used for this passive means of transferring the medication list when the sending and receiving provider can access the same EHR system.

2. The patient is not taking any prescribed or over-the-counter medications at the time of discharge.

Coding: If the lack of any medications for a patient is clearly documented and communicated to the subsequent provider when the patient is discharged, **code 1, Yes**, that the medication list was transferred. If this information is not communicated to the subsequent provider, **code 0, No**.

Rationale: Information confirming that the patient is not taking any medications at discharge is important for the subsequent provider.

3. The patient was transferred to an acute-care hospital with a reconciled medication list that included a list of their current medications, but with less additional information than usually provided by the LTCH at discharge due to the urgency of the situation. Some of the contraindications for the medications, patient weight and height, and dates taken were omitted from the medication list.

Coding: A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge would be **coded 1, Yes**.

Rationale: As long as a current reconciled list of medications is provided to the admitting provider, this item should be coded 1, Yes.

4. The patient's reconciled medication list was electronically faxed to the subsequent provider and this action is documented in the patient's clinical record. However, the subsequent provider's records do not show documentation that the fax was successfully received.

Coding: A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge would be **coded 1, Yes**.

Rationale: Documentation of the subsequent provider's successful receipt of the reconciled medication list is not a required component of this item.

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

See guidance starting on page A-42 for coding the route(s) of transmission of the medication list to the subsequent provider. The guidance addresses coding the route(s) of transmission to the subsequent provider (A2122) and to the patient (A2124) together because of the overlap in the definitions of the routes.

A2123. Provision of Current Reconciled Medication List to Patient at Discharge

Planned Discharge

A2123. Provision of Current Reconciled Medication List to Patient at Discharge	
At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?	
Enter Code <input type="text"/>	0. No – Current reconciled medication list not provided to the patient, family and/or caregiver → <i>Skip to B0100, Comatose</i> 1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver

Unplanned Discharge

A2123. Provision of Current Reconciled Medication List to Patient at Discharge	
At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?	
Enter Code <input type="text"/>	0. No – Current reconciled medication list not provided to the patient, family and/or caregiver → <i>Skip to C1310, Signs and Symptoms of Delirium (from CAM©)</i> 1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver

Item Rationale

- Communication of medication information to the patient at discharge is critical to ensuring safe and effective discharges. The item, collected at the time of discharge, can improve care coordination and quality of care, aids in medication reconciliation, and may mitigate adverse outcomes related to medications.
- It is recommended that a reconciled medication list that is provided to the patient, family, and/or caregiver use consumer-friendly terminology and plain language to ensure that the information provided to patients and caregivers is clear and understandable. (For examples of plain language resources for healthcare information see: <https://digital.gov/guides/plain-language>)

Steps for Assessment

1. Based on item A2105, determine if discharge location is 01, Home/Community or 99, Not Listed.
2. If yes, determine if, at discharge, your facility provided the patient's medication list to the patient, family, and/or caregiver.

Coding Instructions

*Complete only if A0250 = 10 Planned discharge; or A0250 = 11 Unplanned discharge.
Complete as close to the time of discharge as possible.*

- **Code 0, No**, if at discharge to a home setting (A2105 = 01), or a not listed location (A2105 = 99), your facility did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver.
 - For planned discharges, skip to B0100, Comatose.
 - For unplanned discharges, skip to C1310, Signs and Symptoms of Delirium.

- **Code 1, Yes**, if at discharge to a home setting (A2105 = 01), or a not listed location (A2105 = 99), your facility did provide the patient's current reconciled medication list to the patient, family, and/or caregiver.

Coding Tips

- **At the time of discharge** – This is the period of time as close to the actual time of discharge as possible. This time may be based on facility, State, or Federal guidelines for data collection at discharge.
- **A home setting** – A home setting is defined as any of the following as coded in A2105:
 - 01, Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
 - 99, Not Listed**
- **Patient/family/caregiver** – The recipient of the current reconciled medication list can be the patient and/or a family member and/or other caregiver in order to code 1, Yes, a current reconciled medication list was transferred. It is not necessary to provide the current reconciled medication list to all of these recipients in order to code 1, Yes.

Examples

1. The patient will not be taking any prescribed or over-the-counter medications at the time of discharge.

Coding: If it is clearly documented that the patient is taking no medications and this is then clearly communicated to the patient, family, and/or caregiver when the patient is discharged, A2123, Provision of Current Reconciled Medication List to Patient at Discharge would be **coded 1, Yes**, that the medication list was transferred. If this information is not communicated to the patient, family, and/or caregiver, **code 0, No**.

Rationale: Information confirming that the patient is not taking any medications at discharge is important for the patient, family, and/or caregiver.

2. The patient is cognitively impaired and unable to manage their medications after discharge. The patient's medication list is provided to the patient's sister, who will be the patient's primary caregiver.

Coding: A2123, Provision of Current Reconciled Medication List to Patient at Discharge would be **coded 1, Yes**.

Rationale: The medication list must be provided to the patient, a family member, or a caregiver in order to code 1, Yes. In this example, the patient's sister is a family member and a caregiver, so code 1, Yes.

3. The patient chooses to leave the facility before their treatment is completed. The patient tells the charge nurse on the way out the door that the patient's ride is waiting for them and the patient is going home. The charge nurse explains that the patient has not completed their course of treatment and is not ready to be discharged, but the patient insists on leaving now and proceeds out of the facility.

Coding: A2123, Provision of Current Reconciled Medication List to Patient at Discharge would be **coded 0, No**.

Rationale: No medication list review was completed, and no medication list was provided to the patient as they discharged against medical advice (AMA) and did not want to keep their ride waiting.

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider	
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.	
Route of Transmission	Check all that apply ↓
A. Electronic Health Record	<input type="checkbox"/>
B. Health Information Exchange	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>

Item Rationale

- This item collects important data to monitor how medication lists are transmitted at discharge.

Steps for Assessment

- Identify all routes of transmission that were used to provide the patient's current reconciled medication list to the subsequent provider.

Coding Instructions

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

Complete as close to the time of discharge as possible.

Select the codes that correspond to the routes of transmission used to provide the medication list to the subsequent provider.

- Check A2122A, Electronic Health Record,** if your facility has an EHR, sometimes referred to as an electronic medical record (EMR) and used it to transmit or provide access to the reconciled medication list to the subsequent provider. This would include situations where both the discharging and receiving provider have direct access to a common EHR system. Checking this route does not require confirmation that the subsequent provider has accessed the common EHR system for the medication list.
- Check A2122B, Health Information Exchange,** if your facility participates in a Health

DEFINITIONS

EHR/EMR

An electronic health record (EHR), sometimes referred to as an electronic medical record (EMR), is an electronic version of a patient's medical history that is maintained by the provider over time.

(<https://www.healthit.gov/fag/what-electronic-health-record-ehr>)

HEALTH INFORMATION EXCHANGE

An organization used by provider facilities to electronically exchange patients' health information, including medical records, current reconciled medication lists, etc.

PORTAL

A secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, providers and patients can view health information, such as current medications, recent doctor visits and discharge summaries.

(<https://www.healthit.gov/fag/what-patient-portal>)

Information Exchange (HIE) and used the HIE to electronically exchange the current reconciled medication list with the subsequent provider.

- **Check A2122C, Verbal,** if the current reconciled medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider.
- **Check A2122D, Paper-based,** if the current reconciled medication list was transmitted to the subsequent provider using a paper-based method, such as a printout, fax, or efax.
- **Check A2122E, Other Methods,** if the current reconciled medication list was transmitted to the subsequent provider using another method not listed above (e.g., texting, email, CDs).

A2124. Route of Current Reconciled Medication List Transmission to Patient

A2124. Route of Current Reconciled Medication List Transmission to Patient	
Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.	
Route of Transmission	Check all that apply ↓
A. Electronic Health Record (e.g., electronic access to patient portal)	<input type="checkbox"/>
B. Health Information Exchange	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>

Item Rationale

- This item collects important data to monitor how medication lists are transmitted at discharge.

Steps for Assessment

- Identify all routes of transmission that were used to provide the patient's current reconciled medication list to the patient, family, and/or caregiver.

Coding Instructions

*Complete only if A0250 = 10 Planned discharge; or A0250 = 11 Unplanned discharge.
Complete as close to the time of discharge as possible.*

Select the codes that correspond to the routes of transmission used to provide the medication list to the patient.

- Check A2124A, Electronic Health Record**, if your facility has an EHR and used it to transmit or provide access to the reconciled medication list to the patient, family, and/or caregiver. This could include providing the patient with direct access to their EHR medication information through a patient portal. Checking this route does not require confirmation that the patient has accessed the medication list from the portal.
- Check A2124B, Health Information Exchange**, if your facility participates in a Health Information Exchange (HIE) and used the HIE to exchange the current reconciled medication list electronically with the patient, family, and/or caregiver.
- Check A2124C, Verbal**, if the current reconciled medication list information was verbally communicated to the patient, family, and/or caregiver.
- Check A2124D, Paper-based**, if the current reconciled medication list was transmitted to the patient, family, and/or caregiver using a paper-based method, such as a printout, fax, or efax.

- **Check A2124E, Other Methods,** if the current reconciled medication list was transmitted to the patient, family, and/or caregiver using another method, not listed above (e.g., texting, email, CDs).

Coding Tips for A2122 and A2124

- The route of transmission usually is established with each subsequent provider, depending on how they are able to receive information from your facility. The route(s) may not always be documented in the patient's record. It will be helpful to understand and document how your facility typically transmits information to each subsequent provider at discharge to prepare for coding this item.
- More than one route of transmission may apply. Check all that apply.

Examples

1. An LTCH is discharging and sending a patient to a hospital by ambulance. The driver obtains a printout and brings the patient's medication list to the hospital. The facility follows up with a call to the subsequent provider and discusses the patient's medications.

Coding: Check **D, Paper-based and C, Verbal** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

Rationale: Two routes for transmitting the medication list information were used – a paper copy of the list (D) and follow-up verbal discussion (C). Both of these occurred at the time of discharge.

2. One of an LTCH's referral home health agencies (HHAs) is preparing to admit a patient who will be discharged soon. The HHA intake nurse has secure access to the LTCH's EHR to obtain important care planning information from the patient's records, including the medication list.

Coding: Check **A, Electronic Health Record** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

Rationale: The LTCH provided access to the patient's medication list through its EHR. Even if there is no confirmation that the intake nurse accessed the medication list from the LTCH's EHR system, code A, Electronic Health Record because it was made available by the LTCH.

3. The patient receives a paper copy of their medication list, receives education about their medications by the LTCH pharmacist at discharge, and is notified that the LTCH's patient portal is another means by which the patient can obtain their discharge medication list.

Coding: Check **A, Electronic Health Record, C, Verbal, and D, Paper-based** for A2124, Route of Current Reconciled Medication List Transmission to Patient.

Rationale: The copy of the medication list is paper-based (D). The information about the patient's medication list was also communicated verbally by the pharmacist at the time of discharge (C). The patient portal uses the LTCH's EHR to provide access to the medication list (A). It is not necessary to confirm that the patient is a registered user of and accessed the patient portal in order to code A, Electronic Health Record as a route.

4. A post-acute care (PAC) provider participates in a regional HIE, as does a local acute-care hospital. When patients are discharged to this acute-care hospital, the PAC provider's discharge medication list is included in the medications section of a transfer summary document from its EHR, which is electronically exchanged through the HIE.

Coding: Check **A, Electronic Health Record** and **B, Health Information Exchange** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

Rationale: The medication information is exchanged by the regional HIE. Code as A, Electronic Health Record since it was used to generate and exchange the information, and as B, Health Information Exchange since it is the means through which information exchange is possible with external providers.

5. An LTCH has developed an interface that allows documents from its EHR to be electronically faxed to the subsequent provider.

Coding: Check **D, Paper-based** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

Rationale: Faxing information is considered paper-based as faxed documents are comparable to hard copy documents, and not computable.

6. A PAC facility generates and sends the current reconciled medication list electronically from the medication administration record (MAR) and treatment administration record (TAR) and electronically sends via email to the subsequent provider.

Coding: Check **E, Other Method** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

Rationale: Providing the medication list through email is considered "Other Method" for coding this item. The source of the medication list is not the EHR and it is not transmitted directly to the subsequent provider's EHR so do NOT check A, Electronic Health Record.