



Long-Term Care Hospital Quality Reporting Program Provider Training



Section A: Administrative Information (Updates)

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Acronyms Used in This Presentation

- Assessment Reference Date (ARD)
- Assessment Submission and Processing (ASAP)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Certification Number (CCN)
- Health Insurance Claim Number (HICN)
- Long-Term Care Hospital (LTCH)
- LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set)



Acronyms Used in This Presentation (cont.)

- Medicare Beneficiary Identifier (MBI)
- National Provider Identifier (NPI)
- Quality Improvement and Evaluation System (QIES)
- Social Security Number (SSN)
- Social Security Number Removal Initiative (SSNRI)

Overview

- Define Section A: Administrative Information.
- Explain the intent of Section A.
- Explain new items and/or changes between Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set v3.00 and v4.00.
- Discuss coding instructions and needed information for items.

Objectives

- Identify items removed from Section A.
- Explain how the Social Security Number Removal Initiative (SSNRI) transition impacts the LTCH CARE Data Set.



Intent

- Obtain information that uniquely identifies:
 - Each patient.
 - The LTCH in which he or she receives services.
 - Reasons for the assessment.

Section A: Administrative Information

Changes Between LTCH CARE Data Set v3.00 and v4.00

Item Changes (cont.)

Removed

- Program interruption items A2500, A2510, and A2525 removed to reduce provider burden.

Updated

- SSNRI
 - A0600, Coding Instructions.

Section A: Administrative Information

Coding Guidance

A0050. Type of Record

A0050. Type of Record

Enter Code

1. Add new assessment/record
2. Modify existing record
3. Inactivate existing record

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Item indicates whether an LTCH CARE Data Set Assessment Record:
 - Is new.
 - Has been previously submitted and accepted in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, but requires modification or inactivation.
- No change to A0050.

A0050. Type of Record (cont. 1)

Modification Request:

- Used when the LTCH CARE Data Set Assessment Record was previously submitted and accepted in the QIES ASAP System with inaccurate information.
- Exceptions to a Modification Request:
 - A0210: Assessment Reference Date (ARD).
 - A0220: Admission Date (on 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).
 - Changing patient identifiers (i.e., Social Security number (SSN), birth date).

A0050. Type of Record (cont. 2)

Inactivation Request:

- Used to correct Modification Request Exceptions.
- Corresponding event did not occur (e.g., an LTCH CARE Data Set Planned Discharge Assessment was submitted, but the patient was not discharged).

A0200. Type of Provider

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

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Designates type of provider.
- Allows the QIES ASAP System to match records.
 - **Code 3, Long-Term Care Hospital** for an LTCH.
- LTCHs and Long-Term Acute Care Hospitals are different names for the same type of hospital.
 - Medicare uses the term long-term care hospitals, and the abbreviated term, LTCHs.
 - LTCHs are certified acute care hospitals.
 - LTCH patients require extended hospital-level care, typically following initial treatment at a short-stay acute care hospital.
 - The last 4 digits of LTCH's 6-digit CCN range from 2000–2299.
- No change to A0200.



A0210. Assessment Reference Date

- The Assessment Reference Date (ARD) is the end of the assessment period ensuring that:
 - Assessment items refer to the patient's status during the same period of time.
 - 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.
- No change to A0210.

A0210. Assessment Reference Date (cont. 1)

- The ARD is equal to the date of discharge for:
 - Planned Discharge Assessments.
 - Unplanned Discharge Assessments.
- The ARD is equal to the date of death for:
 - Expired Assessments.
- In the case of delay, the ARD should reflect the patient's actual discharge date.

A0210. Assessment Reference Date (cont. 2)

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			

Applies to the Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Use the format Month-Day-Year (MM-DD-YYYY) to enter the appropriate date for the ARD.
 - If the month or day contains only a single digit, code a “0” in the first box.
 - For example: “07-09-2018.”

A0220. Admission Date

A0220. Admission 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			

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Documents the date of admission into the LTCH.
- Allows the QIES ASAP System to match records.
- Enter the most recent date of admission to this LTCH.
 - Use the format: Month-Day-Year (MM-DD-YYYY).
 - If the month or day contains only a single digit, code a “0” in the first box.
- No change to A0220.

A0250. Reason for Assessment

A0250. Reason for Assessment	
Enter Code	01. Admission
<input type="text"/>	10. Planned discharge
<input type="text"/>	11. Unplanned discharge
	12. Expired

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Allows identification of needed assessment content.
- No change to A0250.

A0250. Reason for Assessment (cont. 1)

Coding tips for Planned and Unplanned Discharge Assessments.

- For Unplanned Discharges:
 - Complete the Unplanned Discharge Assessment to the best of your ability.
 - 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, you would code the item with the default response of a dash (-). CMS expects dash use to be a rare occurrence.

A0250. Reason for Assessment (cont. 2)

Coding tips for Planned and Unplanned Discharge Assessments.

- Planned Discharge with a change in discharge date remains a “Planned Discharge” and is not considered an “Unplanned Discharge.”

A0270. Discharge Date

A0270. Discharge 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			

Applies to the Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Documents the date of discharge from the LTCH.
 - Enter the date that the patient was discharged (whether or not return is anticipated).
 - On the LTCH CARE Data Set Expired Assessment, the Discharge Date is the date of death.
 - Use the format Month-Day-Year: MM-DD-YYYY.
 - For Discharge Assessments, the Discharge Date (A0270) and ARD (A0210) must be the same date.
- No change to A0270.

A0500. Legal Name of Patient

Patient Demographic Information	
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"/>

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Identifies the patient by legal name.
- Allows for matching in QIES ASAP.
- Patient name can be determined by:
 - Asking the patient, family, significant other, guardian, or legally authorized representative.
 - Checking the patient's Medicare or Medicaid card or other Government-issued document.
- Carefully spell the patient's first name, middle initial, and last name on each assessment record to avoid creating duplicate records.
- No change to A0500.

A0600. Social Security and Medicare Numbers

A0600. Social Security and Medicare Numbers	
A. Social Security Number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
B. Medicare number (or comparable railroad insurance number):	<input type="text"/>

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Identifies patient by SSN and Medicare number.
- Allows for matching in QIES ASAP System:
 - Enter the SSN, one number per space, starting with the left-most space in A0600A.
 - Enter the Medicare number in A0600B exactly as it appears on the patient's Medicare card.

A0600. Social Security and Medicare Numbers (cont.)

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

Changes To A0600:

- Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN).

Key Dates:

- **Prior to April 1, 2018:**
 - Enter the HICN.
- **April 1, 2018, to 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.*

A0800. Gender

A0800. Gender	
Enter Code <input type="checkbox"/>	1. Male 2. Female

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Identifies the patient by gender.
- Allows for matching in the QIES ASAP System.
- Enter the code that corresponds to the patient's gender.
 - **Code 1** if patient is male.
 - **Code 2** if patient is female.
- No change to A0800.

A0900. Birth Date

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Identifies the patient by birth date and records age.
- Allows for matching in the QIES ASAP System.
- No change to A0900.

A0900. Birth Date (cont. 1)

A0900. Birth Date									
				-					
Month		Day		Year					

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Use the format: Month-Day-Year (MM-DD-YYYY).
- If the complete birth date is known, do not leave any boxes blank.

A0900. Birth Date (cont. 2)

A0900. Birth Date											
	0	5	-			-	1	9	5	6	
	Month			Day			Year				

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- If only a partial birth date is known:
 - Enter the known information.
 - Leave the boxes corresponding to the unknown information blank.

A1000. Race/Ethnicity

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Records the race/ethnicity of the patient for quality-of-care purposes.

The race/ethnicity codes use the common uniform language approved by the Office of Management and Budget to report racial and ethnic categories. The categories in this classification are social–political constructs and should not be interpreted as being scientific or anthropological in nature.

- No change to A1000.

A1000. Race/Ethnicity (cont.)

A1000. Race/Ethnicity	
↓	Check all that apply
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

- Ask the patient to select the category or categories that best represent his or her race/ethnicity.
- If the patient is unable to respond:
 - Ask a family member, significant other, guardian, or legally authorized representative.
 - Provide category definitions if requested.
 - Offer the option of selecting one or more racial designations.
- Observer identification or medical record documentation to code this item can only be used if:
 - The patient is unable to respond.
 - No family member, significant other, guardian, or legally authorized representative is available.
- Check all that apply.

A1100. Language

- Records preferred language and identifies patients who need interpreter services.
- Ask the patient if he or she wants or needs an interpreter.
 - Consult a family member, significant other, guardian, or legally authorized representative, if the patient is unable to communicate.
 - If none of these sources are available, review the medical record for evidence of a need for an interpreter.
- No changes to A1100.

A1100. Language (cont.)

A1100. Language																						
Enter Code <input type="checkbox"/>	<p>A. Does the patient need or want an interpreter to communicate with a doctor or health care staff?</p> <p>0. No → Skip to A1200. Marital Status 1. Yes → Specify in A1100B. Preferred language 9. Unable to determine → Skip to A1200. Marital Status</p> <p>B. Preferred language:</p> <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																					

Applies to the Admission Assessment.

- **Code 0, No** if the patient does not need or want to use an interpreter.
- **Code 1, Yes** if the patient needs or wants to use an interpreter.
 - Enter the patients preferred language under item A1100B.
- **Code 9, Unable to determine** if no appropriate source is accessible.

A1200. Marital Status

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

Applies to the Admission Assessment.

- Identifies and records the patient's current formal relationships.
- Ask the patient about his or her marital status.
 - Consult a family member, significant other, guardian, or legally authorized representative if the patient is unable to communicate.
 - If none of these sources are available, review the medical record.
- Choose the answer that best describes the current marital status of the patient and enter the corresponding number in the code box.
- No change to A1200.

A1400. Payer 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

Applies to the Admission, Planned Discharge, Unplanned Discharge, and Expired Assessments.

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

A1802. Admitted From

A1802. Admitted From. Immediately preceding this admission, where was the patient?	
Enter Code	01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
<input type="text"/>	02. Long-term care facility
<input type="text"/>	03. Skilled nursing facility (SNF)
	04. Hospital emergency department
	05. Short-stay acute hospital (IPPS)
	06. Long-term care hospital (LTCH)
	07. Inpatient rehabilitation facility or unit (IRF)
	08. Psychiatric hospital or unit
	09. Intellectually Disabled/Developmentally Disabled (ID/DD) facility
	10. Hospice
	99. None of the above

Applies to the Admission Assessments.

- Helps inform the delivery of services and may inform discharge planning.
 - Review Transfer and Admission records.
 - Ask the patient, family members, significant others, guardians, or legally authorized representatives.
- Enter the two-digit code that best describes the setting in which the patient was staying immediately preceding this admission.
- No change to A1802.

A2110. Discharge Location

A2110. Discharge Location	
Enter Code	01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
<input type="text"/>	02. Long-term care facility
<input type="text"/>	03. Skilled nursing facility (SNF)
	04. Hospital emergency department
	05. Short-stay acute hospital (IPPS)
	06. Long-term care hospital (LTCH)
	07. Inpatient rehabilitation facility or unit (IRF)
	08. Psychiatric hospital or unit
	09. Intellectually Disabled/Developmentally Disabled (ID/DD) facility
	10. Hospice
	12. Discharged Against Medical Advice
	98. Other

Applies to the Planned Discharge and Unplanned Discharge Assessments.

- Documents the location to which the patient is being discharged:
 - Review the medical record, including the discharge plan and discharge order, for documentation of discharge location.
- Select the two-digit code that corresponds to the patient's discharge location.
- No change to A2110.

Program Interruption

- A2500, A2510, and A2525 have been removed from the LTCH CARE Data Set v4.00.
- LTCH QRP definition and guidelines for program interruptions still apply.

Program Interruption (cont. 1)

Program Interruption

- Refers to an interruption in a patient's care given by an LTCH because of the transfer of that patient to another hospital/facility per agreement for medical services.
- Interruption must not exceed 3 calendar days.
- Day one begins on the day of transfer, regardless of hour of transfer.

Program Interruption (cont. 2)

- In the case of a program interruption, an LTCH CARE Data Set Discharge Assessment (Planned or Unplanned) should not be submitted.

Summary

- The majority of Section A is unchanged.
- Program interruption items were removed to reduce provider burden:
 - A2500, A2510, A2525.
- Social Security Number Removal Initiative (SSNRI).
 - A0600, coding instructions.

Action Plan

- Review Section A intent, rationale, and steps for assessment.
- Review the transition timeline for HICN to MBI and inform staff of key dates.
- Review the definition and implication of program interruptions.
 - Note that the definition still applies even though the related items have been removed.