CHAPTER 4: SUBMISSION AND CORRECTION OF THE LTCH CARE DATA SET (LCDS) ASSESSMENT RECORDS

This chapter details the submission and correction process for the LCDS assessment records and requirements for data submission by LTCHs for the LTCH Quality Reporting Program (QRP).

4.1 Submitting the LCDS

All Medicare-participating LTCHs must complete and submit required LCDS assessment records to the Centers for Medicare & Medicaid Services (CMS) Internet Quality Improvement and Evaluation System (iQIES) for all patients, regardless of payer. After completion of the required assessment(s), each provider must create electronic transmission files that meet the technical requirements detailed in the current LCDS Data Submission Specifications, available on the CMS LTCH Quality Reporting Technical Information Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Technical-Information.html

When the submission file is received by iQIES, the system performs a series of validation edits to evaluate whether the data submitted meet the required data specifications. LCDS assessment records are edited to verify that responses are within valid ranges and are consistent, dates are reasonable, and the submitted record is in the proper order with regard to records that were previously accepted by iQIES for the same patient. The provider is notified of the results of this evaluation by fatal error and warning messages on a Provider Final Validation Report. All error and warning messages are detailed and explained in Section 5 of the *LTCH Submission User's Guide* which is available on the QIES Technical Support Office (QTSO) Web site at https://qtso.cms.gov/providers/long-term-care-hospital-ltch-providers/reference-manuals

4.2 Timeliness Criteria

- **Completion Timing for LCDS:** The LCDS Completion Date (Z0500B) may be no later than 5 days from the Assessment Reference Date (ARD) (A0210). Therefore, Z0500B (LCDS Completion Date) minus A0210 (ARD) should be less than or equal to 5 days.
- **Assessment Submission:** All LCDS assessment records should be submitted electronically within 7 days of the LCDS Completion Date. Therefore, Submission Date minus Z0500B (LCDS Completion Date) should be less than or equal to 7 days.

4.3 Validation of Records and Files

The iQIES validation edits are designed to monitor timeliness and to ensure that the submitted records conform to the LCDS Data Submission Specifications. The most recent version of these specifications can be found under the Downloads section of the following Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Technical-Information.html
If submitted LCDS assessment records do not meet the edit requirements, the system will provide fatal error and/or warning messages on the Provider Final Validation Report. The following describes the validation, storage, and reporting of records in a submission file.

1. **Submission Feedback.** For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by iQIES. A Provider Final Validation Report containing the file submission ID and submission date will be auto-generated for review.
2. **Validation and Editing Process.** Each time a user accesses iQIES and submits an LCDS file, iQIES performs three types of validation:
   - **Fatal File Errors.** The file structure is validated to ensure that it follows the requirements outlined in the LCDS Submission Specifications provided by CMS. The most recent version of these specifications can be found under the Downloads section of the following Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Technical-Information.html
     The file is rejected by iQIES if the file structure does not meet these requirements. Examples of Fatal File Errors include the following:
     - The file is not a ZIP file.
     - The records in the ZIP file cannot be extracted.
     - The file cannot be read.

     The provider cannot be identified when these fatal file errors occur with the submission file. Therefore, the Provider Final Validation Report cannot be automatically generated.

     The Fatal File Errors instead will appear only on the Submitter Final Validation Report.

     Files that are rejected must be corrected and resubmitted.
   - **Fatal Record Errors.** If the file structure is acceptable, then each LCDS assessment record in the file is validated individually for Fatal Record Errors. These errors include, but are not limited to, the following:
     - Out-of-range responses (e.g., the valid codes for an item are 1, 2, 3, and 4, and the submitted value is 6).
     - Inconsistent relationships between items (e.g., an inconsistent date pattern, such as the patient's Birth Date [A0900] is later than the Admission Date [A0220]).

     Fatal Record Errors result in rejection of individual records by iQIES. The provider is informed of Fatal Record Error(s) on the Provider Final Validation Report and Submitter Validation Report. Rejected records must be corrected and resubmitted. If the provider

cannot be identified in the rejected record, then the rejected record will appear on the Submitter Final Validation Report and not on the automatically generated Provider Final Validation Report, because the system does not know which provider's report should contain the record.

- **Warnings (Non-Fatal Errors).** The record is also validated for Warnings (Non-Fatal Errors). Warnings include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature.

  Examples of warnings include the following:

  - Timing errors
    - Submission date is more than 7 days after the LCDS Assessment Completion Date (Z0500B), or
    - Assessment Completion Date (Z0500B) is more than 5 days after the ARD (A0210).
  - Record sequencing errors
    - LCDS Admission assessment record is submitted after a previous LCDS Admission assessment record, and there was no LCDS Discharge assessment record submitted in between, or
    - A record is submitted for a patient after an LCDS Expired assessment record has been accepted into the national database.

  Any Warnings (Non-Fatal Errors) are reported to the provider in the Submitter Validation Report and the Provider Final Validation Report. The provider must evaluate each warning to identify necessary corrective actions.

3. **Storage to iQIES.** If there are any Fatal Record Errors, the record will be rejected and not stored in iQIES. If there are no Fatal Record Errors, the record is stored in iQIES, even if the record has Warnings (Non-Fatal Errors).

Detailed information on the validation of fatal and warning messages is available in Section 5 of the *LTCH Submission User's Guide*, which is available on the QTSO Web site at https://qtso.cms.gov/providers/long-term-care-hospital-ltch-providers/reference-manuals

4.4 LCDS Correction Policy

The LCDS assessment record should be accurate when submitted and accepted into iQIES. When a provider determines that one or more data elements in an accepted record are inaccurate based on the assessment period as established by the ARD, the provider must take the necessary steps to correct the erroneous record (see *Section 4.6*).

When a patient's clinical status changes after the ARD of an LCDS assessment record that has been accepted into iQIES, no action is required by the provider to update the submitted record. Changes in and updates to a patient's clinical status should be noted in the patient's record (e.g., progress notes) in accordance with standards of clinical practice and documentation. Such monitoring and documentation are part of the provider's responsibility to provide necessary care and services. The LCDS assessment record is a "snapshot" of the patient's condition for a specified time period.

The electronic LCDS assessment record submitted to and accepted by iQIES is an assessment of the patient as of the ARD. Any corrections or changes made to the provider's copy of the LCDS assessment record *after* the record is accepted into iQIES will not be recognized by the system. The same corrections or changes must also be made to the electronic version of the LCDS assessment record and that record must be submitted to and accepted by iQIES. It is the provider's responsibility to correct any errors that exist in an accepted LCDS assessment record according to the LCDS assessment record Correction Policy. This ensures that the information in iQIES accurately reflects the patient's identification, location, and overall clinical status, as of the ARD. A correction can be submitted for any record accepted by the system, even if there has been a submission and acceptance of subsequent records for the patient. Further, it is the provider's responsibility to ensure that the record is complete and accurate prior to submission to iQIES.

Several processes have been put in place to ensure that the LCDS assessment records are accurate both at the provider level and in iQIES:

- Software used by the provider to create electronic LCDS records must run all standard edits as defined in the LCDS Data Submission Specifications released by CMS (available under the Downloads section of the following Web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Technical-Information.html).
- Record rejection standards have been implemented in iQIES whereby, if an LCDS assessment record contains responses that are out of range (e.g., the valid codes for a specific item are 0-3 and the submitted value is 4) or item responses are inconsistent (e.g., a skip pattern is not followed), the record is rejected. Rejected records are not stored in the iQIES database.
- If an error is discovered in a record that has been accepted by iQIES, modification or inactivation procedures *must* be implemented by the provider to ensure that iQIES information is corrected.

- 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 its provider software system.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps.

4.5 Correcting Errors in LCDS Assessment Records That Have Not Yet Been Accepted into iQIES

If an LCDS assessment record is found to have errors that incorrectly reflect the patient's clinical status within the respective assessment period as established by the ARD, then that assessment must be corrected. The correction process depends on the type of error. LCDS assessment records that have not yet been accepted in iQIES include records that have been submitted and rejected, or records that have not been submitted at all. Records that have been submitted and rejected and records that have not been submitted at all can usually be corrected and resubmitted/submitted without any special correction procedures because they had never been accepted by iQIES. LTCHs are responsible for correcting any errors to the record prior to submission or resubmission of the record to iQIES.

4.6 Correcting Errors in LCDS Assessment Records That Have Been Accepted into iQIES

Providers should correct any errors necessary to ensure that the information in iQIES accurately reflects the patient's identification, location, or clinical status. A record may be corrected even if subsequent records have been accepted for the patient.

An error identified in an LCDS assessment record must be corrected. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors, or other errors. The following two processes exist for the correction of LCDS assessment records that have been accepted into iQIES:

- **Modification Request**
- **Inactivation Request**

Completion of a **Modification Request record** will archive the inaccurate LCDS assessment record within iQIES and replace the record with the new, corrected record. Completion of an **Inactivation Request record** will also archive an inaccurate LCDS assessment record within iQIES, but it will not replace the record with the new record.

It is suggested that the LTCH maintain the original LCDS assessment records electronically or in hard copy, along with any corrected versions of the LCDS assessment records, in the clinical file to track what was modified. In addition, it is suggested that the LTCH keep a copy of inactivated records. For details on electronic records, see Chapter 2.

4.6.1 Modification Requests

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)
- A0800: Gender
- A0900: Birth Date

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

When an error is discovered (except for those items listed in the preceding bullets) in an 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.

Note: File creation software varies in how Modification Request records are created. Please contact your software vendor for specific instructions.

When a Modification Request record (A0050 = 2) is submitted, iQIES will process the record as follows:

1. The system will attempt to locate the existing record in the iQIES database for this LTCH using specific items, which are located in Chapter 3, Section A, and this includes the patient identifiers (e.g., last name, first name, SSN, birth date, gender), the facility identifier (i.e., facility and state code), the reason for assessment, and the assessment-related dates (i.e., assessment reference date, admission date, or discharge date).
2. If the existing record is not found, the submitted Modification Request record will be rejected and not accepted in iQIES. A fatal error will be reported to the LTCH on the Submitter Validation Report and the Provider Final Validation Report.
3. If the existing record is found, then the items in all sections of the submitted Modification Request record will be edited. If there are any fatal errors, the Modification Request record will be rejected and not accepted in iQIES. The fatal error(s) will be reported to the LTCH on the Submitter Validation Report and the Provider Final Validation Report.
4. If the Modification Request record passes all the edits, it will replace the prior erroneous record in the iQIES database. The prior erroneous record will be stored in an archive file within the iQIES database.
    - **Note:** Specific user roles within iQIES will allow the provider to modify 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.

4.6.2 Inactivation Requests

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)
- A0800: Gender
- A0900: Birth Date

Note: Any item in the previous list that was submitted as part of the original record must also be submitted as part of the Inactivation Request, and values for each item must match in the erroneous record and the inactivation record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record.

If an ARD (A0210), Admission Date (A0220), Reason for Assessment (A0250), or Discharge Date (A0270) is incorrect or if one or more patient identifiers are found to be in error, the provider must inactivate the erroneous record in iQIES, complete and submit a new LCDS assessment record with the event and patient identifiers, and ensure that the clinical information is accurate.

When an Inactivation Request is submitted, iQIES will process the record as follows:

1. The system will attempt to locate the existing record in the iQIES database for the LTCH using specific items (given in Chapter 3, Section A), including the patient identifiers (e.g., last name, first name, SSN, birth date, gender), the facility identifier (i.e., facility and state code), the reason for assessment, and the assessment-related dates (e.g., ARD, admission date, or discharge date).

2. If the existing record is not found in the iQIES database, the submitted Inactivation Request will be rejected, and a fatal error will be reported to the LTCH on the Submitter Validation Report and the Provider Final Validation Report.
3. If the existing record is found, the erroneous record will be removed from the active records in the iQIES database and archived within the iQIES database.
    - **Note:** Specific user roles within iQIES will allow the provider to 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.

4.7 Special Manual Record Deletion Request

A special Manual Record Deletion Request is only necessary when there has been an error in a record that has been accepted into iQIES that cannot be corrected with an automated Modification or Inactivation Request. There are only two items to which this applies. A Manual Record Deletion Request must be performed when the record has the wrong state code and/or facility ID in the control items STATE_CD and FAC_ID. Control items are items created by the file submission software. These error(s) most likely occurred at the time of software development, or when initializing the software, and not during the entry of the provider's administrative or patient's data.

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

In the event that this error has occurred, the provider must contact the iQIES Help Desk at iQIES@cms.hhs.gov or 1-800-339-9313 to obtain the LTCH CARE Manual Assessment Deletion Request form. The provider is responsible for completing the form. The provider must submit the completed form to the iQIES Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The iQIES Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the iQIES Help Desk will work through the request with the provider.