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

This chapter details the submission and correction process for the LTCH CARE Data Set assessment records and requirements for data submission by LTCHs for the LTCHQR Program starting October 1, 2012. These requirements are applicable to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. This includes Medicare-participating LTCHs located within acute care (or other) hospitals or skilled nursing facilities as well as free-standing LTCHs. It is **not** applicable to patients receiving services in LTCH units that are not designated as LTCHs under the Medicare program.

4.1 Submitting LTCH Data

All Medicare-participating LTCHs must submit required LTCH CARE Data Set Assessment Records to CMS' Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for all patients, regardless of payer. Each provider must create electronic transmission files that meet the requirements detailed in the current LTCH CARE Data Submission Specifications accessible via the CMS LTCH Quality Reporting Program Web site at http://www.cms.gov/LTCH-Quality-Reporting/.

Providers must establish communication with the QIES ASAP system to submit a file. This is accomplished by using specialized communications software and hardware and the CMS wide area network. Details about these processes are available on the QIES Technical Support Office (QTSO) Web site at https://www.qtso.com.

Once communication is established with the QIES ASAP system, the provider can access the LTCH Information Page in the QIES ASAP system. This site allows providers to submit LTCH CARE Data Set Assessment Records and access various information sources such as Bulletins and Questions and Answers. The LTCH CARE Data Set Technical Users Guide provides more detailed information about the QIES ASAP system and will be made available on the QTSO LTCH Web site at https://www.qtso.com/ltch.html.

When the transmission file is received by the QIES ASAP system, the system performs a series of validation edits to evaluate whether the data submitted meet the required standards. LTCH records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by the QIES ASAP system for the same patient. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in The LTCH CARE Data Set Technical Users Guide.

4.2 Timeliness Criteria

- **Completion Timing for LTCH CARE Data Sets:** The LTCH CARE Data Set Completion Date (Z0500B) may be no later than 5 days from the Assessment Reference Date (ARD) (A0210). Therefore, Z0500B (LTCH CARE Data Set Completion Date) minus A0210 (Assessment Reference Date) must be less than or equal to 5 days.

- **Submission Format**: For submission, the data in the LTCH CARE Data Set must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS. These requirements are in the LTCH CARE Data Submission Specifications documents accessible at http://www.cms.gov/LTCH-Quality-Reporting/05_LTCHTechnicalInformation.asp#TopOfPage and also via the CMS LTCHQR Program web site at http://www.cms.gov/LTCH-Quality-Reporting/ .

- **Submission of Data:** Submission files are transmitted to the QIES ASAP system using the CMS wide area network. Submission requirements apply to all LTCH CARE Data Set Assessment Records used to meet Federal requirements.

- **Assessment Submission:** All assessments must be submitted electronically within 7 days of the LTCH CARE Data Set Completion Date (Submission Date minus Z0500B (LTCH CARE Data Set Completion Date) should be less than or equal to 7 days).

4.3 Validation Edits

The QIES ASAP system validation edits are designed to monitor the timeliness and accuracy of LTCH CARE Data Set Assessment Record submissions. If submitted LTCH CARE Data Set Assessment Records do not meet the edit requirements, the system will provide error messages on the provider's Final Validation Report.

1. **Initial Submission Feedback.** For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation information includes the file submission number, as well as the date and time the file was received for processing. Providers should print and maintain a copy of this confirmation.

2. **Validation and Editing Process.** Each time a user accesses the QIES ASAP system and submits an LTCH CARE Data Set file, the LTCH system performs three types of validation:

    - **Fatal File Errors.** If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Error(s). Files that are rejected must be corrected and resubmitted.

    - **Fatal Record Errors.** If the file structure is acceptable, then each LTCH CARE Data Set 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 the item are 1, 2, 3, and 4 and the submitted value is 6).
- Inconsistent relationships between items. For example, an inconsistent date pattern, such as the Patient's Birth Date (Item A0900) is later than the Admission Date (Item A0250).

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

- **Non-Fatal Errors (Warnings).** The record is also validated for Non-Fatal Errors. Non-Fatal Errors 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 are timing errors. Timing errors for an assessment includes (1) the submission date is more than 7 days after the LTCH CARE Data Set Assessment Completion Date (Z0500B) or (2) the Assessment Completion Date is more than 5 days after the ARD (A0210).

  Another example is a record sequencing error, where an Admission assessment record is submitted after a previous Admission assessment record and there was no Discharge assessment record submitted in between. A third example is a sequencing warning that will be issued if any record is submitted for the patient after an Expired assessment record has been submitted. Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.

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

Detailed information on the validation edits and error and warning messages is available in the LTCH CARE DATA Set Data Submission Specifications, accessible at http://www.cms.gov/LTCH-Quality-Reporting/05_LTCHTechnicalInformation.asp and via the CMS LTCHQR Program web site at http://www.cms.gov/LTCH-Quality-Reporting/ and in the LTCH CARE Data Set Technical Users Guide, which will be made available on the QTSO LTCH web site at https://www.qtso.com/ltch.html.

4.4 LTCH CARE Data Set Correction Policy

The LTCH CARE Data Set Assessment Record should be accurate when submitted and accepted into the QIES ASAP system. When a provider determines that any data elements in an accepted record are inaccurate based on the established ARD, the provider must take the necessary steps to correct the erroneous record (see Section 4.6).

When a patient's health status changes after the ARD of the LTCH CARE Data Set Assessment Record that has been accepted into the QIES ASAP system, no action is required by the provider

to update the submitted record. Changes in and updates to a patient's health 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 is a part of the provider's responsibility to provide necessary care and services. The LTCH CARE Data Set Assessment Record is a "snapshot" of the patient's condition for a specified time period.

The electronic LTCH CARE Data Set Assessment Record submitted to and accepted by the QIES ASAP system is the legal assessment of the patient as of the ARD. Changes made to the provider's copy of the LTCH CARE Data Set Assessment Record *after* the record is accepted into the QIES ASAP system will not be recognized. It is the provider's responsibility to correct any errors that exist in a submitted LTCH CARE Data Set Assessment Record according to the LTCH CARE Data Set Assessment Record Correction Policy. This ensures that the information in the QIES ASAP system accurately reflects the patient's identification, location, and overall clinical status, as of the ARD. A correction can be submitted for any accepted record, even if there has been a submission and acceptance of subsequent records for the patient.

Several processes have been put in place to ensure that the LTCH CARE Data Set Assessment Records are accurate both at the provider level and in the QIES ASAP system:

- It is the providers' responsibility to make sure the record is complete and accurate prior to submission to the QIES ASAP system.
- Software used by the provider to encode the LTCH CARE Data Set must run all standard edits as defined in the data specifications released by CMS.
- Enhanced record rejection standards have been implemented in the QIES ASAP system. If an LTCH CARE Data Set Assessment Record contains responses that are out of range, (e.g., a 4 is entered when only 0–3 are allowable responses for an item), or item responses are inconsistent (e.g., a skip pattern is not observed), the record is rejected. Rejected records are not stored in the QIES ASAP database.
- If an error is discovered in a record that has been accepted by the QIES ASAP system, Modification or Inactivation procedures *must* be implemented by the provider to ensure that the QIES ASAP system information is corrected.

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

4.5 Correcting Errors in LTCH CARE Data Set Assessment Records That Have Not Yet Been Accepted into the QIES ASAP System

If an LTCH CARE Data Set Assessment Record is found to have errors that incorrectly reflect the patient's status within the ARD and the respective assessment period, then that assessment must be corrected. The correction process will depend on the type of error. LTCH CARE Data Set Assessment Records that have not yet been accepted in the QIES ASAP system include records that have been submitted and rejected, or records that have not been submitted at all. Records that have been submitted and rejected can usually be corrected and resubmitted without any special correction procedures because they were never accepted by the QIES ASAP system.

LTCHs are responsible for correcting any errors to the record prior to submission or re-submission of the record to the QIES ASAP system.

4.6 Correcting Errors in LTCH CARE Data Set Assessment Records That Have Been Accepted into the QIES ASAP System

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

An error identified in a QIES ASAP system 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 LTCH CARE Data Set Assessment Records (Admission, Planned Discharge, Unplanned Discharge, or Expired) that were accepted into the QIES ASAP system:

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

A *Modification* Request archives the inaccurate record within the QIES ASAP system and replaces it with a new, corrected record. An *Inactivation* Request also archives the inaccurate record within the QIES ASAP system but does not replace it with a new record.

It is suggested that a hospital maintain the original LTCH CARE Data Set Assessment Record electronically, along with any corrected versions of the LTCH CARE Data Set Assessment Record, in the clinical file to track what was modified. In addition, it is suggested that the hospital keep a copy of the inactivated record. For details on electronic records, see Chapter 2.

Modification Requests

A Modification Request is used when an LTCH CARE Data Set Assessment Record (Admission, Planned Discharge, Unplanned Discharge, or Expired) is accepted into the QIES ASAP system, but the information in the record contains clinical or demographic errors.

The Modification Request record is used to correct most LTCH CARE Data Set items that are erroneous. The items listed below **cannot be corrected** with a Modification Request; rather the invalid record must be inactivated and a new record submitted to the QIES ASAP system:

- A0210: Assessment Reference Date (ARD)
- A0220 Admission Date (on an Admission record A0250 = 01)
- A0250: Reason for Assessment
- A0270: Discharge Date (on a Discharge or Expired record A0250 = 10,11,12)

Note: As indicated in Chapter 3, Section A, only one patient identifier can be changed with each modification request record. To make multiple patient identifier corrections, you must complete

an **inactivation record** for the incorrect record and create a new record with the correct information.

When an error is discovered (except for those items listed in the preceding bullets) in an LTCH CARE Data Set Assessment Record, the provider must submit a Modification Request to the QIES ASAP System.

When a Modification Request is submitted, the QIES ASAP System will process the records as follows:

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

Inactivation Requests

An Inactivation Request should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur, and for when more than one patient identifier is found to be in error and therefore a Modification Request cannot be used. For example, a Discharge assessment record was submitted for a patient but there was no actual discharge.

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

- A0210: Assessment Reference Date (ARD)
- A0220: Admission Date (on an Admission record A0250 = 1)
- A0250: Reason for Assessment
- A0270: Discharge Date (on a Discharge or Expired record A0250 = 10, 11, 12)

If an ARD (A0210), Admission Date (A0220), Reason for Assessment (A0250) or Discharge Date (A0270) is incorrect, or if more than one patient identifier is found to be in error and therefore a Modification Request cannot be used, the provider must inactivate the record in the QIES ASAP system, and then complete and submit a new LTCH CARE Data Set Assessment Record with the correct date or reason for assessment, and ensure that the clinical information is accurate.

When an inactivation request is submitted, the QIES ASAP system will process the record as follows:

1. The system will attempt to locate the existing record in the QIES ASAP database for this LTCH using specific items which are located in Chapter 3, Section A, and this includes the patient identifiers (last name, first name, SSN, birth date, gender), the facility identifier (facility and state code), the reason for assessment and the assessment-related dates (assessment reference date, admission date, or discharge date).
2. If the existing record is not found in the QIES ASAP database, the submitted inactivation request will be rejected and a fatal error will be reported to the LTCH on the Final Validation Report.
3. If the existing record is found, the original record will be removed from the active records in the QIES ASAP database and stored in an archive file within the QIES ASAP database.

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 the QIES ASAP system that cannot be corrected with an automated Modification or Inactivation request. There is only one type of error to which this applies. A Manual Record Deletion Request must be performed when the record has the wrong facility ID in the control item FAC_ID. This type of error is likely to have occurred at the time of software development, or when initializing the software, and not during the routine entry of the patient's administrative or assessment data.

If a QIES ASAP system record has the wrong facility ID (control item FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record also should be resubmitted with the correct FAC_ID value when indicated. All data items must be complete and correct on the newly submitted record.

In the event that this error has occurred, the provider must contact the QTSO Help Desk at help@qtso.com or 1-800-339-9313 to obtain the Manual LTCH CARE Data Set Assessment Record Correction form. The provider is responsible for completing the form. The provider must submit the completed form to the QTSO Help Desk at the address on the form via certified mail through the United States Postal Service (USPS). The QTSO Help Desk will contact CMS for approval upon receipt of such a request.