

LONG TERM CARE HOSPITAL ASSESSMENT SUBMISSION ENTRY & REPORTING TOOL (LASER) USER GUIDE

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INTRODUCTION

The LTCH Assessment Submission Entry and Reporting (LASER) application is developed by the Centers for Medicare & Medicaid Services (CMS). LASER is a free, Java based application which provides an option for Long Term Care Hospital providers to collect and maintain Facility, Patient, and LTCH Continuity Assessment Record and Evaluation (CARE) Data Set information for subsequent submission to the national data repository. LASER displays the LTCH CARE Data Set similar to the paper version of the form. This user guide will cover the functionality found within the LASER application as well as the help and security features.

Please note, all screen shots included in this reference material are meant for sample purposes only and contain only test data. Due to updates made after the release of this document, detailed information displayed within screen shots may not be an exact representation (i.e. Build_ID and/or information posted to the CMS or QTSO websites).

INSTALLATION

INSTALLERS ACCESS RIGHTS

To install LASER the User must be logged into the PC as a Workstation Administrator.

Users of the application MUST have read/write access to the location where the database is installed.

HARDWARE/SOFTWARE SPECIFICATIONS

The Minimum and Recommended System Requirements may be found on the QIES Technical Support Office home page.

SECURITY

Making information security one of your organizations core values ensures the prevention of unauthorized viewing of Personally Identifiable Information (PII) or Protected Health Information (PHI).

It is important that providers work with their Information Technology (IT) team or other resources to build a security-minded organizational culture which enforces strong authentication and access controls as well as limits physical access to devices (e.g., laptops, handhelds, desktops, servers, thumb drives, CDs, backups) containing PII or PHI data.

CMS recommends that providers encrypt the hard drive of any electronic device which has access to data containing PII or PHI, such as exported assessment records. Once assessments have been exported from the LASER application the data will no longer be encrypted. It is also recommended that those electronic devices, which contain PII or PHI, be physically secured and locked (password protected) when not in use.

WINDOWS SETTINGS

In order to ensure the reliable operation of the LASER software application use of a supported Microsoft Windows operating system is imperative. The Font Size property must be set to "Small Fonts". This property can be found under the Settings tab of desktop properties: Start\Control Panel\Appearance and Personalization\Display\.

SYSTEM CONFIGURATION/INSTALLATION TYPE

STANDALONE

The Standalone installation is self-contained on one workstation.

NETWORK CLIENT

The Network Client/Server installation uses a server to support one or more individual workstations, all accessing one database by multiple computers and users.

- Servers hold the central database and must utilize the Server installation file first.
- Network Clients are placed on the users individual workstations which then access the database on the Server. The Network Client is installed after the Server installation has been successfully completed.

Please refer to the LASER Installation Guide for assistance installing and setting up the LASER application. The QTSO Help Desk is available for technical support and assistance if needed and may be contacted by phone at 877-201- 4721.

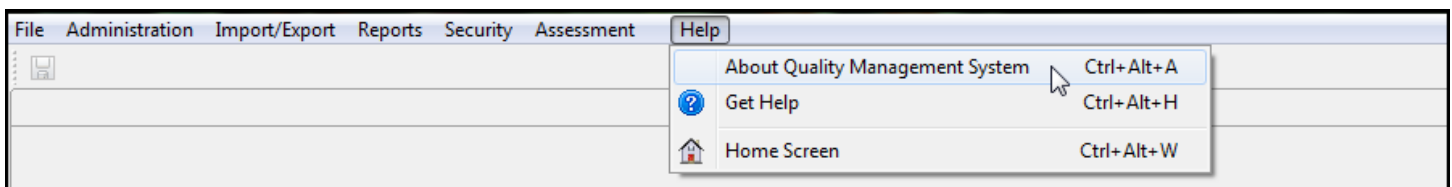
BEST PRACTICES

While it is possible, it is not recommended to have both the Standalone and Network Client configuration of the LASER application installed on the same workstation. It is also not recommended that the Server be installed on the same workstation as the Network Client.

ALL Network Client applications should be closed when upgrading a Server installation or restoring a database. ALL Network Client applications should be upgraded to the most current version prior to logging into the application once the upgrade process has begun. When possible, upgrade incrementally and do not skip installation versions. Failure to comply with these recommendations may result in loss of data.

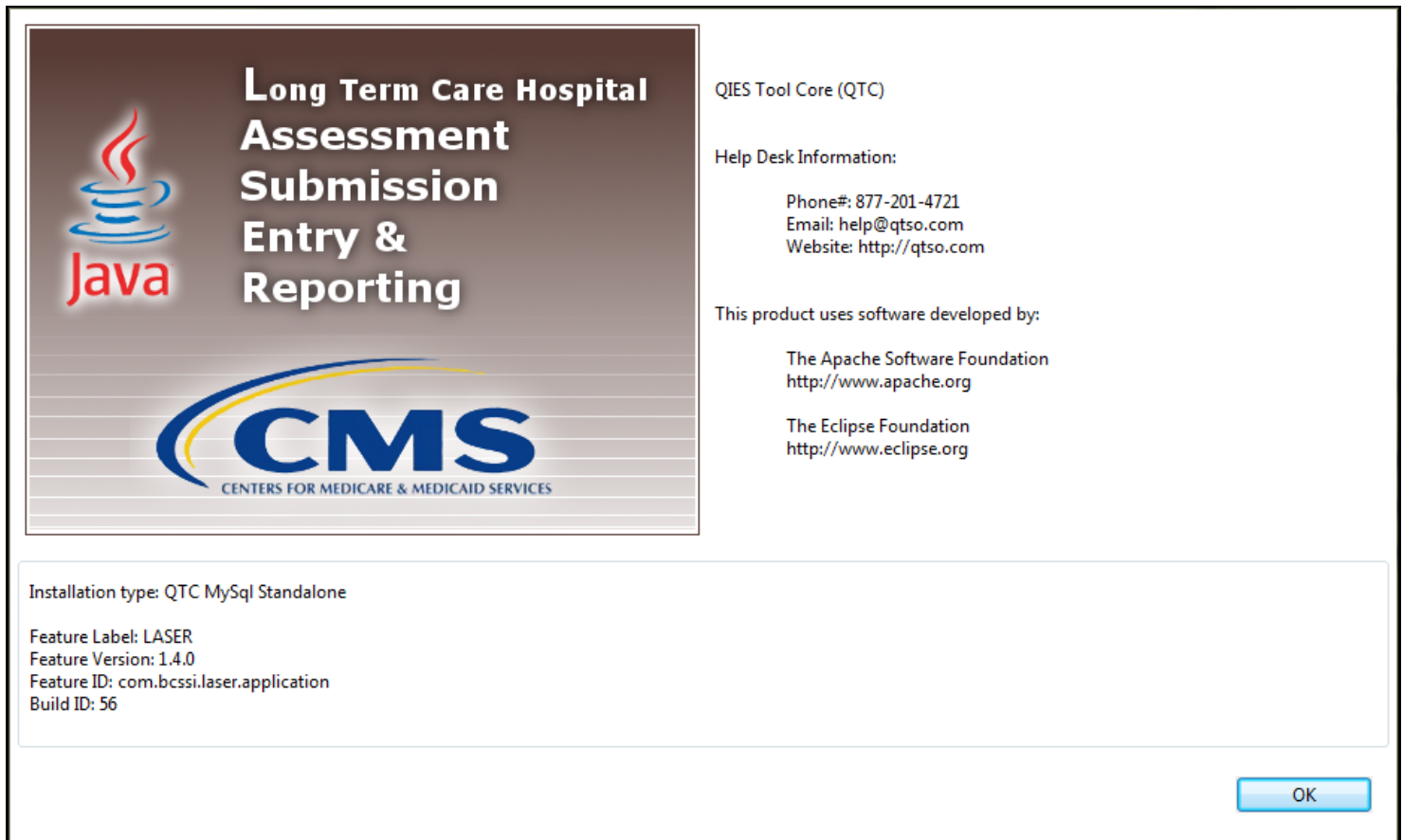
VERSION VERIFICATION

Information about the version of LASER currently installed may be found by selecting ‘About Quality Management System’ from the ‘Help’ drop-down on the Menu Bar.



The following System Configuration information will be displayed in the lower left side of the screen:

- Installation Type
- Feature Label (LASER)
- Feature Version
- Feature ID
- Build ID



When the LASER application is accessed and the computer running LASER has an internet connection, the application will compare the version currently installed with the version available on the QIES Technical Support Office (QTSO) website. If a new version of LASER is available, a message will display directing the user to the QTSO website to download the latest version.

GENERAL OVERVIEW

LASER software provides the following functionality:

- Facility Setup/Maintenance
- User Setup/Maintenance
- Patient Setup/Maintenance
- Assessment Maintenance
- Import/Export
- Reporting

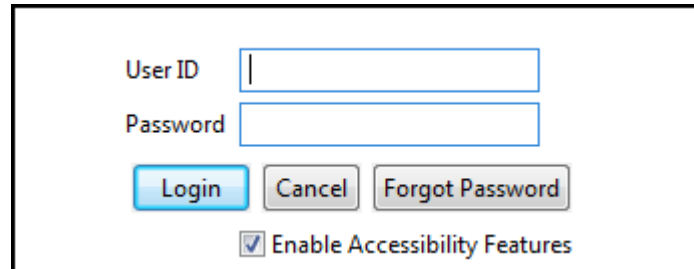
ACCESS

Once LASER has been installed, access the program using one of the following methods:

- Start Menu – Select the LASER icon from the Start Menu
- Desktop – Double click the LASER icon found on the desktop
- Directory – Navigate to the directory where LASER is installed, double click the LASER.exe

ACCESSIBILITY

Selecting the 'Enable Accessibility Features' checkbox at the bottom of the login screen will turn on accessibility features for users requiring assistive technology (e.g. screen readers). Informational messages which describe each screen as well as the associated functionality will be available by selecting Alt + J. Note, when accessibility features are enabled calendar icons will NOT be displayed. Users will also receive more decision messages than when this feature is disabled (e.g. Multiple prompts prior to saving and successfully adding a patient.). The box will remain checked or unchecked until changed by the user.



The screenshot shows a login interface with two text input fields labeled 'User ID' and 'Password'. Below these fields are three buttons: 'Login' (highlighted in blue), 'Cancel', and 'Forgot Password'. At the bottom of the form is a checkbox labeled 'Enable Accessibility Features' which is currently checked.

SCREEN LAYOUT

TITLE BAR

- Displays the name of the software application: LASER.

MENU BAR

- Located just below the Title, the Menu Bar consists of drop-down lists which contain command selections dependent on user role and the screen that is currently active.
- Pressing the Alt key on the keyboard will place the cursor in the menu bar. Using the arrow keys on the keyboard, users can navigate through the selections on the menu bar. For example: On the Assessment Search screen, if the cursor is on the File menu item, pressing the right directional arrow will move the cursor to the next menu item. Pressing the up and/or down directional arrows will provide navigation through the drop-down menu list.

TOOL BAR

- Located just below the Menu Bar, the Tool Bar contains screen specific buttons and icons to assist the user. Hover or "mouse over" the icons to display a description of the available functionality.

SCREEN TABS

- Located just below the Tool Bar, Screen Tabs will display the open screens (e.g. Facility, Patient, User, and Assessment). An asterisk (*) will display on the tab to the left of the tab title if there are screen changes which need to be saved.

SCREEN AND COLUMN SIZE CONTROL

The various screens available are divided into distinct functional sections. Search and Summary sections may be collapsed by a single click of the arrow located next to the section title. Clicking on the arrow a second time will expand the section.

Columns and sections may be resized if needed by hovering over the line which separates the sections or column headers. The cursor will create an arrow. Click and drag the "left-right arrow" icon to the desired width.

FIELD TYPES

TEXT

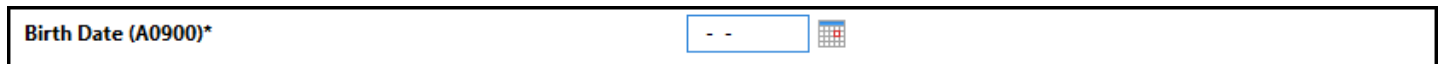
Text fields allow data to be entered manually. Data entered must adhere to the rules of the LTCH data specifications (length, use of special characters etc.). The following is an example of a text field.



A screenshot of a text input field. The label "Patient Last Name (A0500C)*" is on the left, and an empty rectangular text box is on the right.

DATE

Date fields are formatted for the entry of a valid date (MM-DD-YYYY) where MM = 01-12, DD = 01-31, and YYYY = the four digit year. Some date fields allow other data to be entered, such as a (-) for 'not assessed/no information', these fields will be defined by the LTCH data specifications. The following is an example of a date field.



A screenshot of a date input field. The label "Birth Date (A0900)*" is on the left. To its right is a small box containing "--" and a calendar icon.

Please Note: When the 'Enable Accessibility Features' checkbox is checked on the LASER Login Screen the calendar icon will NOT be displayed. When the 'Enable Accessibility Features' checkbox is unchecked on the LASER Login Screen there will be a calendar icon next to each date field that the user may utilize instead of manually entering in a date.

CHECKBOX

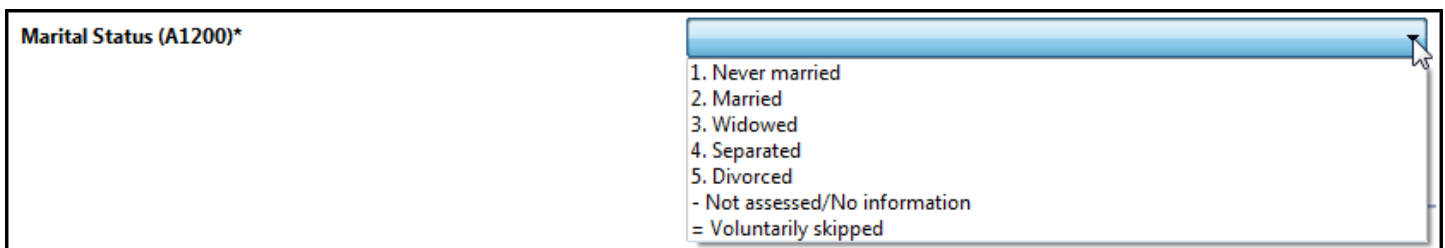
Checkboxes allow the selection of "yes" responses by single clicking the box next to the appropriate value. Double clicking the checkbox will mark the response as 'not assessed' when this is a valid response according to LTCH Data Submission Specifications. Clicking the checkbox a third time will uncheck the box for a selection of "no". The following is an example of a checkbox.



A screenshot of a checkbox form. The label "Race/Ethnicity (A1000) Check all that apply*" is on the left. To its right is a list of checkboxes with labels: "American Indian or Alaska Native", "Asian", "Black or African American", "Hispanic or Latino", "Native Hawaiian/Pacific Islander", "White", and "Voluntarily Skipped".

DROP-DOWN LIST

Drop-down lists contain all allowable responses for a specific item. To respond using a drop-down list, tab to the field and use the arrow keys on the keyboard to navigate through the response options. Once the desired response is displayed, use the 'Tab' key to move to the next item. The mouse may also be used to select a response in a drop-down list. Select the arrow on the right side of the item to expand the list. Select the desired response. Select 'Tab' or use the mouse to move to the next item. The 'Delete' key on the keyboard may be used to clear previous responses. The following is an example of a drop-down list.




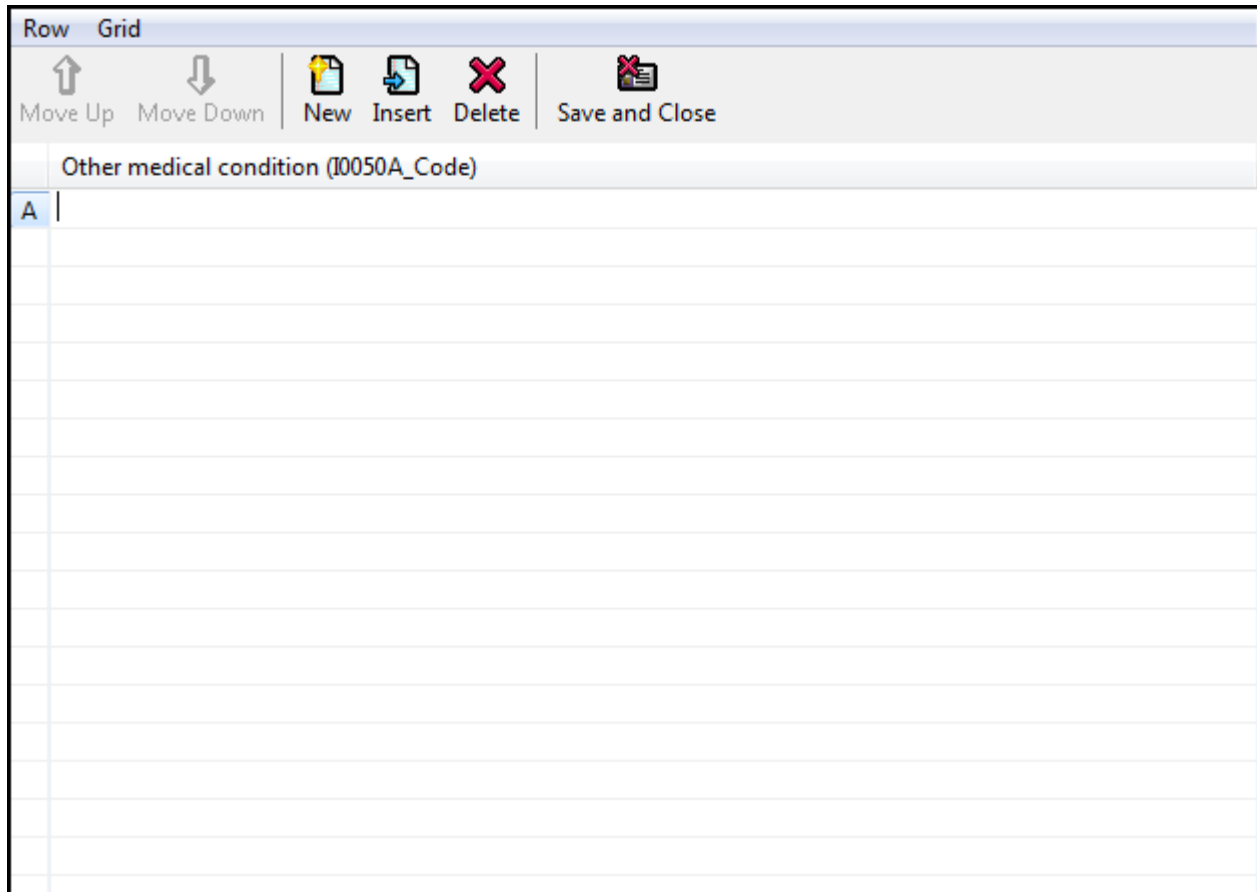
A screenshot of a drop-down list. The label "Marital Status (A1200)*" is on the left. To its right is a drop-down menu with a list of options: "1. Never married", "2. Married", "3. Widowed", "4. Separated", "5. Divorced", "- Not assessed/No information", and "= Voluntarily skipped".

GRID

Similar to text fields grids allow data to be entered manually. Grids will be displayed for items which require the entry of ICD codes. Data entered must adhere to the LTCH Data Submission Specifications (length, use of special characters etc.). LASER does not verify the validity of ICD-9 or ICD-10 codes entered however, the application will verify that a code has been properly formatted. For additional assistance with ICD coding please see the [Help](#) section of this guide.

Complete the following steps to utilize the ICD code grids:

1. Select the grid button  to open the ICD code display window.



2. Begin entering the appropriate ICD codes, using manual data entry, starting with row number one (1).
3. Use the 'Tab' key on the keyboard to navigate to the next row OR select the 'New' icon to add additional rows/ICD codes. Note, LASER will not allow users to exceed the maximum number of rows allowed by the LTCH Data Submission Specifications.
4. Select the 'Save and Close' icon to save the data entered and close the ICD code display window. Note, you must select 'Save and Close' to close the ICD code display window.

To modify the order in which ICD codes appear within the ICD code display window, select the ICD code/row you wish to move. Use the 'Move Up' or 'Move Down' icons to place codes in the desired location. To add an ICD code in between codes that have already been entered, select the row where you would like the new ICD code to be displayed; select the 'Insert' icon. It is not recommended to include blank rows within the ICD code display window. Use the 'Delete' icon to remove previous entries or blank rows as needed.

EDITS

Data integrity edits are applied as information is entered into the LASER application. These unique messages come from the LTCH Data Submission Specifications and are put in place to assist users with the accurate completion of the LTCH CARE Data Set. Some edits will present a pop-up message and must be addressed when displayed in order to proceed, other edits may not appear until the assessment has been validated by selecting 'Save and Validate'.

In an effort to reduce user burden with the release of LASER 1.4.0, warning edits indicating that the failure to submit required quality data may result in a two (2) percentage point reduction in the LTCH's annual payment update (APU), will no longer be presented in a pop-up message. These edits will however continue to be displayed upon 'Save and Validate'. It is recommended that users utilize the [Assessment Error Report](#) once an assessment is complete to ensure all edits have been reviewed and addressed prior to Export or submission to the national data repository.

The following types of edits may occur in LASER:

ERRORS

This type of edit lets the user know information is missing or invalid. It must be entered or corrected before the information will be saved.

WARNINGS

This type of edit indicates there is information entered that should be verified as accurate, or serve as a reminder of how some fields should be populated.

INFORMATIONAL

This type of edit gives the user general information about the assessment.

DATA ENTRY TIPS

- For optimization of the skip patterns and/or edits, it is recommended that assessment data be entered in the order the questions appear on the screen.
- Enter data in each field and use the 'Tab' key on the keyboard to navigate from field to field. This allows skip patterns and edits to be appropriately applied and helps ensure all fields are addressed.
- Some fields require use of additional keys. For example, checkbox fields use the 'Tab' and 'Shift + Tab' keys to scroll through the available responses. Once the desired response is highlighted, pressing the spacebar will make the selection. Press the 'Tab' key to move to the next field and 'Shift + Tab' to go to the previous selection. The mouse may also be used to move to a field and make a selection.

ORDER OF DATA ENTRY:

- Create a facility
- Create a user
- Create a patient
- Create an assessment
- Export the assessment

LOGIN

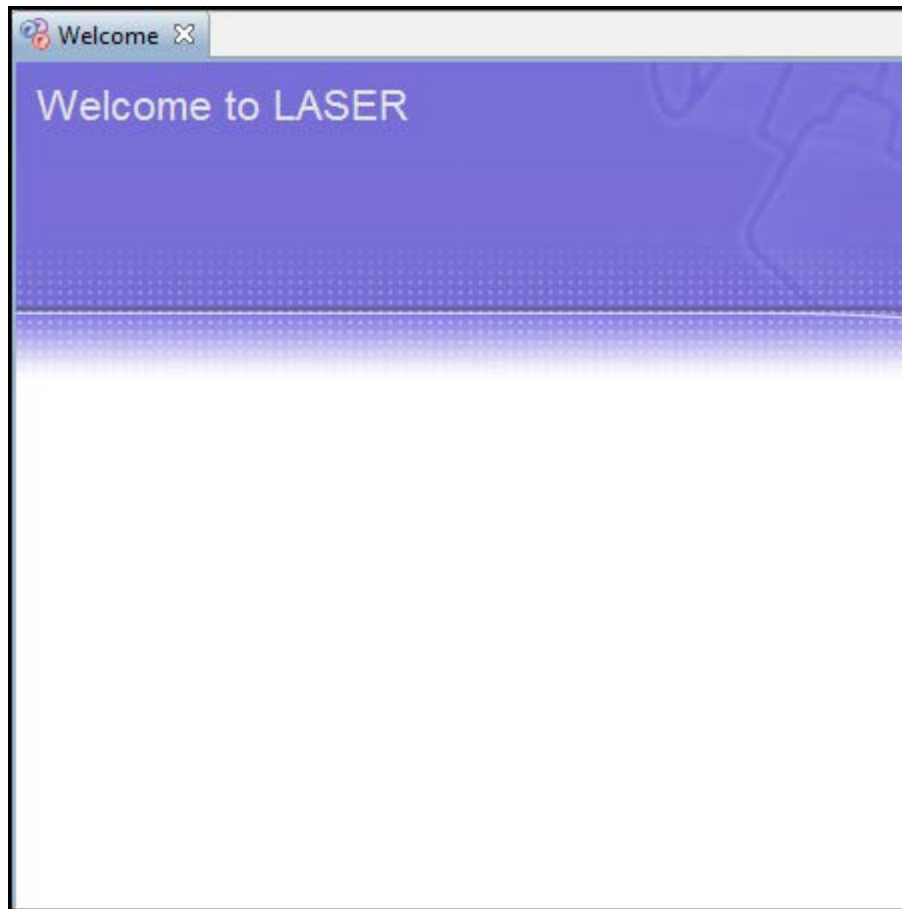
Please Note: The Default User account (laser) cannot be used to create patients or assessments. For detailed instructions regarding the initial login please consult the LASER Installation Guide.

Complete the following steps to login to LASER:

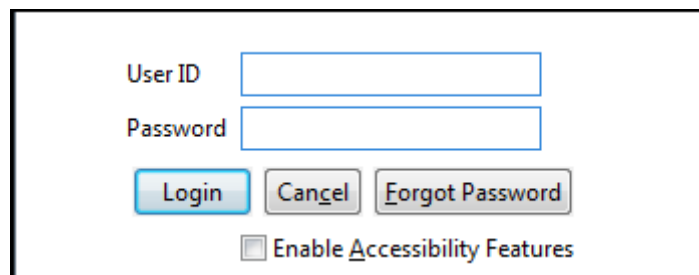
1. Launch the LASER application from the start menu, desktop or directory where installed.
2. The LASER splash screen containing the CMS logo displays momentarily.



3. The 'Welcome to LASER' screen will display while the program is loading. This may take a few minutes and requires no response from the user.



4. The 'Login' screen displays.

A screenshot of a login form. It contains two input fields: 'User ID' and 'Password'. Below the 'Password' field are three buttons: 'Login', 'Cancel', and 'Forgot Password'. At the bottom, there is a checkbox labeled 'Enable Accessibility Features'.

5. Enter the assigned User ID.
6. Enter the Password. When logging in for the first time enter your assigned User ID in both the 'User ID' and 'Password' fields; these are case sensitive.
7. Click 'Login'.
8. When logging in for the first time, the 'Change Password' screen displays as follows:
 - The new password and the confirm new password must match.
 - The new password must be at least 8 characters long.
 - The new password must be no more than 20 characters long.
 - The new password must not contain any space.
 - The new password must not contain the User ID, First Name, Last Name, or Email.
 - The new password must not begin with a number.
 - The new password can only contain a maximum of 3 repetitive characters.
 - The new password must contain at least one for each of the following type of characters:
 - Upper-case Character: A-Z
 - Lower-case Character: a-z
 - Number: 0-9
 - Special Character: &~`!-@#\$\$%^*()_+={}[]\|;:'<>.,?/
 - The new password must not match any of the user's most recent 6 passwords.
 - The new password will be set to expire in 60 days.

The new password and the confirm new password must match.
The new password must be at least 8 characters long.
The new password must be no more than 20 characters long.
The new password must not contain any space.
The new password must not contain the User ID, First Name, Last Name, or Email.
The new password must not begin with a number.
The new password can only contain a maximum of 3 repetitive characters.
The new password must contain at least one for each of the following type of characters:
Upper-case Character: A-Z
Lower-case Character: a-z
Number: 0-9
Special Character: &~`!-@#\$\$%^*()_+={}[]\|;:'<>.,?/
The new password must not match any of the user's most recent 6 passwords.
The new password will be set to expire in 60 days.

New Password

Confirm New Password

9. Enter a new password in the 'New Password' and 'Confirm New Password' fields. The password is case sensitive and must match in both fields.

10. Select 'Continue' to complete the login process.

Please Note: Selecting 'Cancel' will display the following message: "You must change your password before accessing the system. If you do not change your password, you will be logged off the system." Clicking 'Cancel' on this pop-up will take the User back to the previous 'Change Password' pop-up. Clicking 'OK' takes the User to the login screen where they must re-enter the assigned User ID in both the 'User ID' and 'Password' fields.

11. The 'Security Questions' screen displays the following questions:

- What city were you born in?
- What year did you graduate from high school?
- What is your favorite sport?
- What was the make of your first car?
- What was the color of your first car?
- What is your mother's maiden name?
- What was the name of your first pet?
- What size shoe do you wear?
- What is your favorite season of the year?
- What is your favorite movie?

To enable the OK button, a minimum of 6 answers are required.

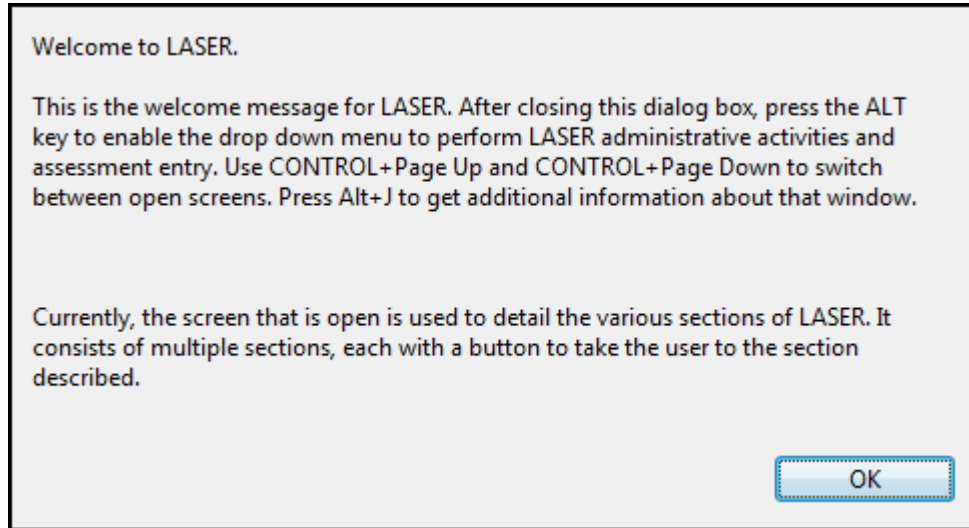
What city were you born in?	<input type="text"/>
What year did you graduate from high school?	<input type="text"/>
What is your favorite sport?	<input type="text"/>
What was the make of your first car?	<input type="text"/>
What was the color of your first car?	<input type="text"/>
What is your mother's maiden name?	<input type="text"/>
What was the name of your first pet?	<input type="text"/>
What size shoe do you wear?	<input type="text"/>
What is your favorite season of the year?	<input type="text"/>
What is your favorite movie?	<input type="text"/>

12. Complete the answers to a minimum of six (6) questions.

13. Tab to the bottom of the list to enable the 'OK' button.

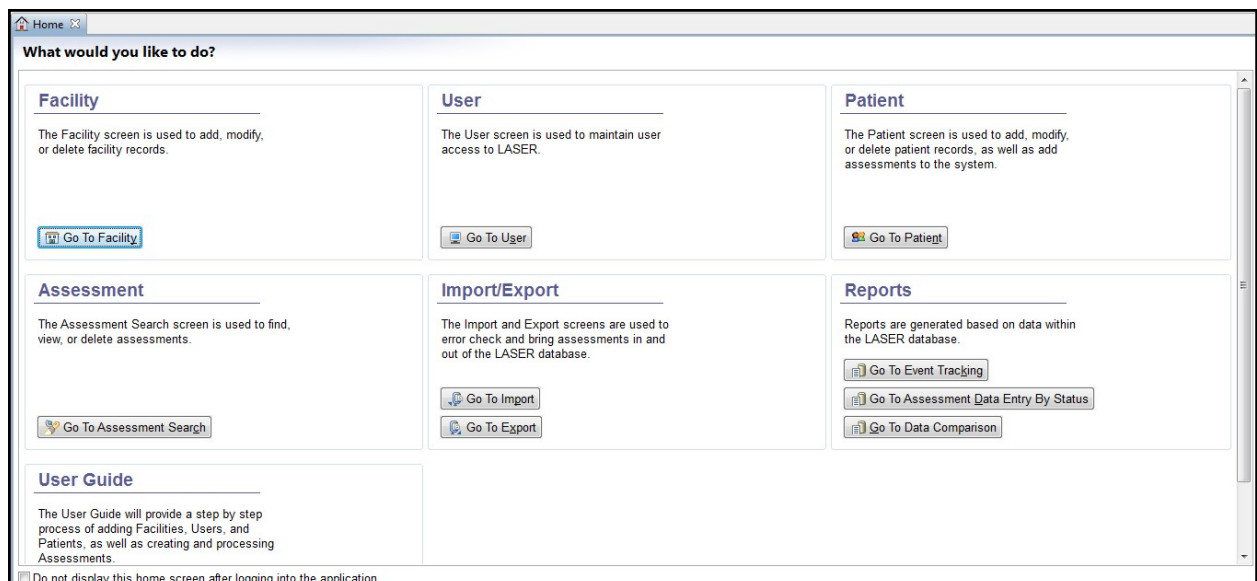
14. Click 'OK' to continue to the 'Home' screen.

The following 'Welcome to LASER' message will be displayed prior to the 'Home' screen only when 'Enable Accessibility Features' has been selected upon login.



HOME SCREEN

The options displayed on the 'Home' screen are dependent upon User Type. A System Administrator will have full access while a Data Entry User will have limited access. Please see the [User Setup and Maintenance](#) section for additional information regarding User Types. Below is an example of the System Administrator's 'Home' screen.



HOME SCREEN DEFAULT

By default, the 'Home' screen will be displayed upon each login. The screen may be closed by selecting the white "X" on the tab titled 'Home'. This will close the 'Home' screen for the remainder of the user's session.

To reactivate the 'Home' screen once it has been closed, select 'Help' from the Menu Bar at the upper right followed by 'Home Screen' OR use the short-cut, Ctrl+Alt+W.

If the user does not wish to see the 'Home' screen upon each login the default setting may be turned off by placing a checkmark into the box at the lower left corner of the screen next to the following statement: "Do not display this home screen after logging into the application". Placing a checkmark into this box will only affect the user currently logged into the application. All other users will continue to see the 'Home' screen.

FACILITY SETUP AND MAINTENANCE

The Default User must create at least one Facility before being permitted to add any further data to the LASER application. Please consult the LASER Installation Guide for detailed instructions regarding the initial login and setup by the Default User.

The 'Facility Information' screen allows users, dependent upon their User Type, to setup and modify facilities. The term "facility" refers to a long term care hospital (LTCH).

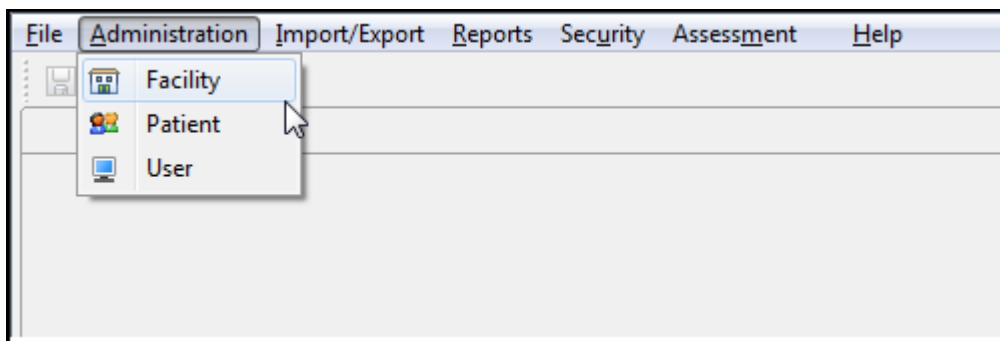
The 'Facility Information' screen displays in two sections:

- Facility Summary (on the left)
- Facility Detail (on the right)




ADD A FACILITY

Complete the following steps to create a new facility:

1. Select 'Facility' from the Administration drop-down on the Menu Bar or 'Go To Facility' from the 'Home' screen.




2. The 'Facility Information' screen displays.

3. Enter the appropriate facility information into the Facility Detail section. Required fields display on the screen in bold type with an asterisk.
4. After facility information has been entered, click the 'Save'  icon. Saved facility information will display in the Facility Summary section on the left side of the screen.
5. To add additional facilities, click the 'New'  icon, enter data and click the 'Save'  icon.


MODIFY A FACILITY

Complete the following steps to modify an existing facility:

1. Locate and highlight the facility in the Facility Summary section.
2. Make the appropriate changes in the Facility Detail section on the right side of the screen.
3. Click the 'Save'  icon.

DELETE A FACILITY

Complete the following steps to delete a facility:

1. Locate and highlight the facility in the Facility Summary section.
2. Click the 'Delete'  icon.
 - Only a System Administrator can delete a facility.
 - Deletions cannot be made if Users, Patients, or Assessments are currently associated to a facility.

USER SETUP AND MAINTENANCE

The Default User must create at least one System Administrator User before being permitted to add any further data to the LASER application. It is highly recommended to set up more than one System Administrator User. In the event the primary System Administrator User's account becomes locked, the second System Administrator will have the ability to unlock the primary account. Please consult the LASER Installation Guide for detailed instructions regarding the Default User and Initial Setup process.

USER TYPES

Government information and information system assets are a high value target. To enhance the security of Patient and Assessment data and to ensure the prevention of unauthorized viewing of Personally Identifiable Information (PII) or Protected Health Information (PHI) there are four User Types available within the LASER application, each having a unique level of access.

The following User Types are available within the LASER application:

- Default User
- System Administrator
- Data Entry
- View Only

The Default User ID (laser) may only be used to add or modify Agencies and/or User accounts, resulting in a limited LASER Menu Bar. The Default User ID should be held by someone who does NOT need access to Personally Identifiable Information (PII) or Protected Health Information (PHI). After successfully creating at least one Agency and one System Administrator, the Default User must log out of the application.

A System Administrator will have the highest level of access. As noted in the LASER Installation Guide it is highly recommended that the Default User set up more than one System Administrator account. In the event the primary System Administrator User's account becomes locked, the second System Administrator will have the ability to unlock the primary account.

While a View Only User will have the ability to view PII and/or PHI they hold the lowest level of access and may not add, edit or delete data. The table below provides a summary of the functions available to each User Type. An "X" denotes that a function will be available to that particular User Type unless otherwise specified. Note, you will not see the Default User in this table summary. As previously noted the Default User account may ONLY be used to add or maintain Agency or User account information.

Features/Functionality	System Administrator	Data Entry	View Only
Assessments	Add/Edit/Delete	Add/Edit	
Create Inactivation Requests	X		
Create Modification Requests	X		
Export Files	X		
Import Files	X		
Maintain Facility Information	Add/Edit	Edit	
Maintain Patient Information	Add/Edit/Hide/Delete	Add/Edit	
Maintain User Information	Add/Edit/Delete*		
Perform Data Entry for LTCH form	X	X	
Print Assessments (Report)	X	X	X
View Assessment Data Entry Report	X	X	X
Data Comparison Report	X	X	
View Event Tracking Report	X		
View Hidden Patients/Assessments	X		
View User List	X		
View Assessments Entered by Any User	X	X	X

*System Administrators are not allowed to change their own User Type or enter a termination date for their own User ID.

ADD A USER

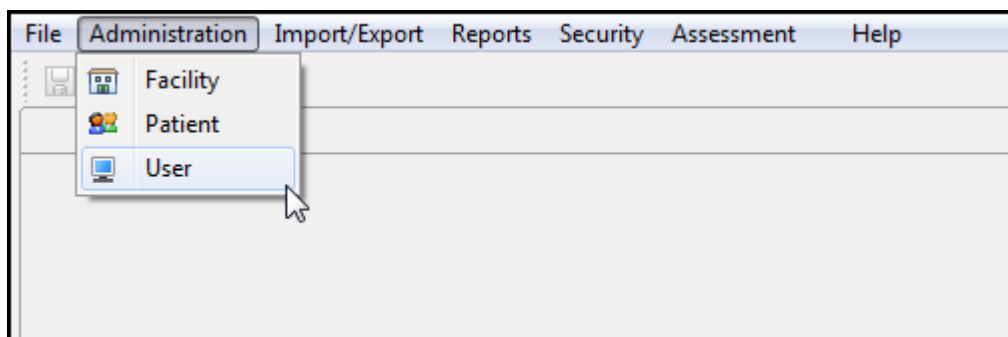
The 'User Information' screen allows users, dependent upon their User Type, to modify and setup new user accounts. The term 'user' refers to the individuals who will be viewing or entering data into the LASER application.

The 'User Information' screen displays in two sections:

- User Summary (on the left)
- User Detail (on the right)

Complete the following steps to add a new user:

1. Select 'User' from the Administration drop-down on the Menu Bar or 'Go to User' from the 'Home' screen.



2. The 'User Information' screen displays.

User Information

▼ User Summary (Alt+L)

User ID	First Name	Last Name	User Type	Facility	Activation Date	Termination Date
SysAdmin1	System	Administrator	System Admini...	Facility Name - ...	01-06-2017	
SysAdmin2	System	Administrator 2	System Admini...	Facility Name - ...	01-06-2017	

User Detail * = Required Field

User ID* SysAdmin1

First Name* System

Middle Name

Last Name* Administrator

Phone () *

Ext.

Email

User Type* System Administrator

☐ Reset Password/Unlock The Account

Activation Detail




Activation Date* 01-06-2017

Termination Date

Account Status Normal

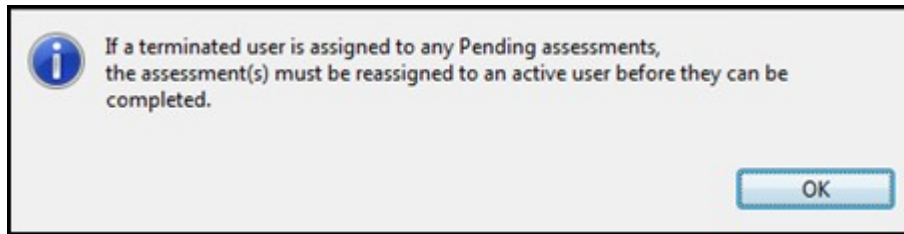
Provider Detail

Facility* Facility Name - 123456789(AL)

3. Enter the appropriate user information into the User Detail section. Required fields display on the screen in bold type with an asterisk.
4. After entering all required user information, click the 'Save'  icon. Saved user information will display in the User Summary section on the left side of the screen.
5. To add additional users, click the 'New'  icon, enter data and click the 'Save'  icon

TERMINATION DATE

A Termination Date should only be entered if an active user is no longer valid (e.g., no longer works for the facility). If a Termination Date is entered for a user with pending assessments, a Termination Date message box will display advising pending assessments should be reassigned to an active user.



If there is only one System Administrator and that person terminates his/her position, a new System Administrator must be set up prior to entering the Termination Date for the existing System Administrator.

MODIFY A USER


Complete the following steps to modify an existing user:

1. Locate and highlight the user in the User Summary section.
2. Make the appropriate changes in the User Detail section on the right side of the screen.
3. Click the 'Save'  icon.

DELETE A USER

User ID's may not be deleted if the user has created or modified Agency, Patient or Assessment data. User ID's which are successfully deleted may not be reused. Use of the Termination Date field is recommended if a user is no longer valid (e.g., no longer employed with the agency).

Complete the following steps to delete a user:

1. Locate and highlight the user in the User Summary section.
2. Click the 'Delete'  icon.
 - a. Deletions cannot be made if the user has created or modified facility, patient, or assessment data.

CHANGE PASSWORD

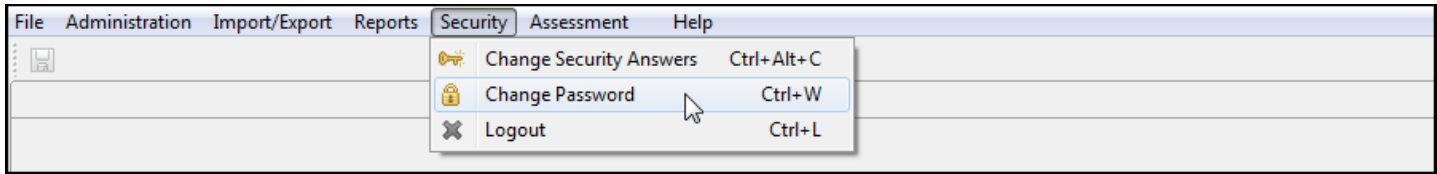
PASSWORD PROTECTION

A strong password for your applications is a basic protection mechanism. While it is tempting to create an easy or generic password that is easy to remember, it is not very secure. Do not use generic information that can be easily obtained like family member names, pet names, birth dates, phone numbers, vehicle information, etc. NEVER share your password with anyone.

Change passwords often. While the LASER application will prompt users when passwords have expired it is best to set up a reminder in your calendar for at least every 60 days, or sooner. Create a different password for each system or application, if applicable. Do not reuse passwords until six other passwords have been used. Contact the QTSO Help Desk if you suspect your password has been compromised or complete the steps below to update. User passwords may be changed at any time.

Complete the following steps to change a password:

1. Login to LASER.
2. Select 'Change Password' from the Security drop-down on the Menu Bar.



3. The 'Change Password' screen displays along with the following rules:
 - The new password and the confirm new password must match.
 - The new password must be at least 8 characters long.
 - The new password must be no more than 20 characters long.
 - The new password must not contain any space.
 - The new password must not contain the User ID, First Name, Last Name, or Email.
 - The new password must not begin with a number.
 - The new password can only contain a maximum of 3 repetitive characters.
 - The new password must contain at least one for each of the following type of characters:
 - Upper-case Character: A-Z
 - Lower-case Character: a-z
 - Number: 0-9
 - Special Character: &~`!-@#\$\$%^*()_+={}[]\|;:'"<>.,?/
 - The new password must not match any of the user's most recent 6 passwords.
 - The new password will be set to expire in 60 days.

The new password and the confirm new password must match.
The new password must be at least 8 characters long.
The new password must be no more than 20 characters long.
The new password must not contain any space.
The new password must not contain the User ID, First Name, Last Name, or Email.
The new password must not begin with a number.
The new password can only contain a maximum of 3 repetitive characters.
The new password must contain at least one for each of the following type of characters:
Upper-case Character: A-Z
Lower-case Character: a-z
Number: 0-9
Special Character: &~!-@#\$%^*()_+={}[]\|;:'"<>.,?/
The new password must not match any of the user's most recent 6 passwords.
The new password will be set to expire in 60 days.

Password

New Password

Confirm New Password

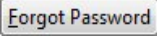
4. Enter the current password in the 'Password' box.
5. Enter a new password in the 'New Password' and 'Confirm New Password' box.
6. Select 'Change Password'. Selecting 'Cancel' will close the 'Change Password' screen and will not change the existing password.

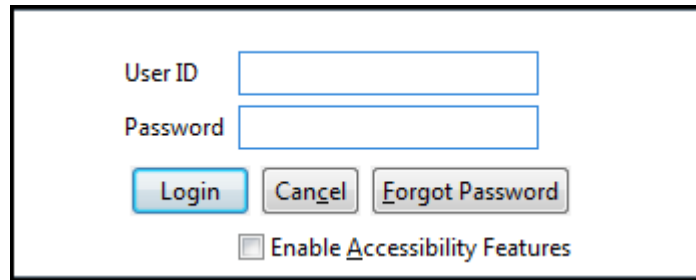
FORGOT PASSWORD

Having trouble remembering passwords? Use a passphrase.

- Use the initials of a song or phrase to create a unique password. Example: "Take me out to the ballgames!" becomes "Tmo2tBGs".
- Commit passwords to memory.
- DO NOT keep passwords near your computer or on your desk.

Complete the following steps if you have forgotten your password:

1. Enter the User ID and select the 'Forgot Password'  button.

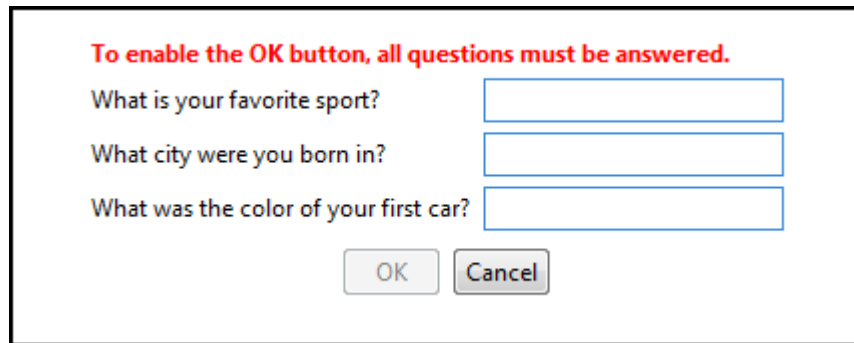


User ID

Password

☐ Enable Accessibility Features

2. The 'Security Questions' pop-up window displays with three (3) of the security questions which were answered during the initial setup of the given User ID.



To enable the OK button, all questions must be answered.

What is your favorite sport?

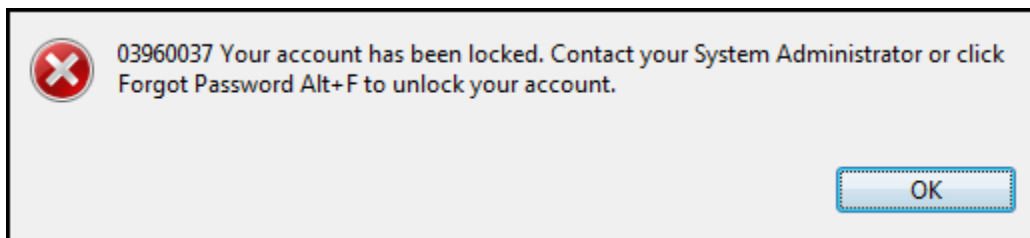
What city were you born in?

What was the color of your first car?

3. Enter responses to the questions provided.
4. Select 'OK' to continue to the 'Change Password' screen. Selecting 'Cancel' will close the security questions and return to the login screen.

LOCKED USER ACCOUNT

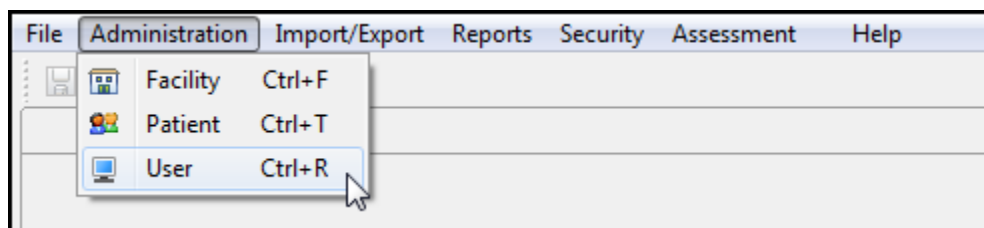
LASER will allow three (3) login attempts prior to locking a user account and removing the ability to login. The following message will be displayed when a user account becomes locked: "Your account has been locked. Contact your System Administrator or click Forgot Password Alt+F to unlock your account."




As stated in the error message there are two options when a user account has become locked. Click 'OK' to return to the 'Login' screen. Follow the instructions for [Forgot Password](#) to unlock the account.

The user may also contact a System Administrator who can reset the account using the following steps:

1. Select 'User' from the Administration drop-down on the Menu Bar.



2. Locate and highlight the locked user account in the User Summary section. Locked user accounts will display in bold type.
3. Check the 'Reset Password/Unlock The Account' checkbox in the User Detail section on the right side of the screen.
4. Click the 'Save'  icon.
5. The user account is now unlocked. The password has been reset to match the User ID. Please note the password is case sensitive and must match in both the 'User ID' and 'Password' fields.

Please Note: In the event the primary System Administrator account becomes locked, a second System Administrator OR the Default User (User ID = laser) may log in and reset the account by following the steps defined above.

If the System Administrator account cannot be unlocked using the [Forgot Password](#) instructions or the [Locked User Account](#) instructions please contact the QTSO Help Desk for further assistance. The Help Desk will reset the Default User account (User ID=laser) which may then be used to unlock the account or setup a new System Administrator.

PATIENT SETUP AND MAINTENANCE

The 'Patient Information' screen allows users, depending on user type, to add, edit, delete and search for patients.

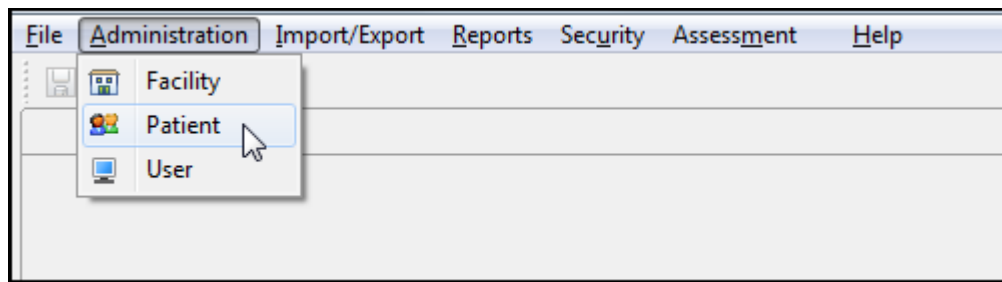
The 'Patient Information' screen displays in 4 sections:

- Search Criteria (top of the screen)
- Patient Summary (on the left)
- Patient Detail (on the right)
- Actions (on lower right)

ADD A PATIENT





Complete the following steps to add a new patient:

1. Select 'Patient' from the Administration drop-down on the Menu Bar.



- The 'Patient Information' screen displays.

 A screenshot of the 'Patient Information' screen. It features a search section at the top with dropdowns for 'Field Name', 'Condition', and 'Field Value', along with 'Search', 'Clear', and 'Show Hidden' buttons. Below the search section is a 'Patient Summary' table with columns for Patient Last Name, Patient First Name, Patient Middle Initial, Patient Name Suffix, Social Security Number, Medicare/Railroad Insurance Number, Medicaid Number, Gender, and Birth Date. To the right of the table is a 'Patient' detail section with various fields, some marked as required with an asterisk. These include Assigned Facility/Provider Submission ID (FAC_ID), Patient First Name (A0500A), Patient Middle Initial (A0500B), Patient Last Name (A0500C), Patient Name Suffix (A0500D), Social Security Number (A0600A), Medicare/Railroad Insurance Number (A0600B), Medicaid Number (A0700), Gender (A0800), Birth Date (A0900), Race/Ethnicity (A1000), Highest Education Completed (A1050), Does Patient need or want an interpreter? (A1100A), Preferred Language? (A1100B), Marital Status (A1200), Lifetime Occupation(s) (A1300), and Hide Patient Record? (A1400). The 'Hide Patient Record?' field is currently set to 'No, do NOT hide record'. At the bottom right, there are 'Add Assignment' and 'Add Patient' buttons.

- Enter the appropriate patient information into the Patient Detail section. Required fields display on the screen in bold type with an asterisk.
- After entering the required patient information, click the 'Save'  icon. Saved patient information will display in the Patient Summary section.
- To add additional patients click the 'New'  icon, or utilize the 'Add Patient'  button located in the Actions section on the right side of the screen. Enter data and click the 'Save'  icon.

HIDE A PATIENT RECORD

The 'Hide Patient Record' field located in the Patient Detail section allows users to hide records that no longer need to be accessed. For example, when a patient is no longer in the facility and all associated assessments have been exported; the user can hide the patient's records. To hide a patient's records, select the "Yes, hide record" option within the Patient Detail section.

 A close-up screenshot of the 'Hide Patient Record?' dropdown menu. The menu is open, showing two options: 'No, do NOT hide record' and 'Yes, hide record'. A mouse cursor is pointing at the 'Yes, hide record' option.

PATIENT SEARCH

The 'Search Criteria' section is located at the top of the 'Patient Information' screen. To retrieve all existing patient records, leave the Search Criteria blank and click the 'Search' button.

The screenshot shows the 'Patient Information' window with a 'Search Criteria (Alt+T)' section. It contains three columns: 'Field Name', 'Condition', and 'Field Value'. Each column has a dropdown menu. To the right of these columns are buttons for 'Search', 'Clear', and a checkbox for 'Show Hidden'. Below these buttons is a status bar with navigation arrows and a text box that says 'No records found.'.

Complete the following steps to retrieve one or more records based on Search Criteria:


1. Select criteria from the 'Field Name' and 'Condition' lists.
2. Enter a 'Field Value'.
3. Select the box next to 'Show Hidden' to include records marked 'Yes, hide record' in the Patient Details section.
4. Click the 'Search' button.
5. Click the 'Clear' button to remove search criteria and begin a new patient search.

Please Note: A System Administrator will see duplicate patients listed in the Patient Summary section if a patient has been at multiple facilities and the System Administrator has access to all of those facilities within the LASER application.

It is also recommended that the user close any open tabs and begin with a new 'Patient Information' screen when conducting a search after updating or modifying patient or facility information.

MODIFY A PATIENT

Complete the following steps to modify an existing patient:

1. Locate and highlight the patient in the Patient Summary section.
2. Make the appropriate changes in the Patient Detail section on the right side of the screen.
3. Click the 'Save'  icon.

The following message will display on the 'Assessment Search' screen when opening an existing assessment after patient information has been modified: "The patient information has changed, would you like to update the assessment to reflect these changes?"

The user will be shown the field name values currently in the assessment (Before Value) as well as the value after selecting 'Yes' on the Patient Data Updated pop-up window (After Value).

The patient information has changed, would you like to update the assessment to reflect these changes?

Field Name	Before Value	After Value
Patient First Name (A0500A)	First Name	First
Patient Last Name (A0500C)	Last Name	Last



Yes No

- Selecting 'Yes' will update the patient information within the selected assessment record to reflect what is in the Patient Detail section of the 'Patient Information' screen.
- Selecting 'No' will open the record without updating patient information within the selected assessment record.

Please Note: This message will continue to be displayed each time an assessment is opened after modifying the patient data until 'Yes' is selected.

DELETE A PATIENT

Complete the following steps to delete a patient:


1. Locate and highlight the patient in the Patient Summary section.
2. Click the 'Delete'  icon or the 'Delete Patient'  button in the Actions section of the 'Patient Information' screen.
 - Deletions cannot be made if one or more assessments have been created for the patient.

MOVE A PATIENT

In the event a patient is moved from one LTCH facility to another within the same corporation, it is necessary to reassign the patient to the appropriate facility. Before reassigning a patient to a new facility ALL existing assessments must be in an 'Exported' or 'Outdated' status.

VERIFY ASSESSMENT STATUS


Complete the following steps to verify the status of a patient's assessments:

1. Perform an assessment search by following the [Assessment Search](#) procedure. It is recommended that the 'show hidden' checkbox be applied to ensure all existing records are shown.
2. If all assessments found have an 'Exported' or 'Outdated' status, proceed to [Assign a New Facility ID](#) below.
3. If 'Non-Exported' assessments are found, enter any remaining applicable data to complete the assessment record. Required fields will appear in bold type in the 'Navigator' section of the 'Assessment' screen. You may also choose to delete an assessment if it has been entered in error.
4. Click the 'Save and Validate'  icon.

5. If the assessment is complete you will have achieved a status of 'Outdated' or 'Export Ready'. Close the assessment.
6. For 'Export Ready' assessments, follow the [Export](#) procedure to set the status appropriately.

ASSIGN A NEW FACILITY ID

Complete the following steps to assign a patient to a new facility:

1. Select 'Patient' from the Administration drop-down on the Menu Bar.
2. The 'Patient Information' screen displays.
3. Perform a [Patient Search](#) for the patient you wish to move.
4. Locate and highlight the patient to be reassigned in the Patient Summary section.
5. Verify the patient information in the Patient Detail section on the right.
6. Select the new facility from the 'Assigned Facility/Provider Submission ID (FAC_ID)' drop-down.
7. Click the 'Save'  icon.
8. The 'Confirm Change Facility' screen displays the following message: "Are you sure you want to change the facility for Patient (patient name)? The following assessments for this patient will remain in the original facility where they were created:"

Are you sure you want to change the facility for patient First Name Last Name?
The following assessments for this patient will remain in the original facility where they were created:

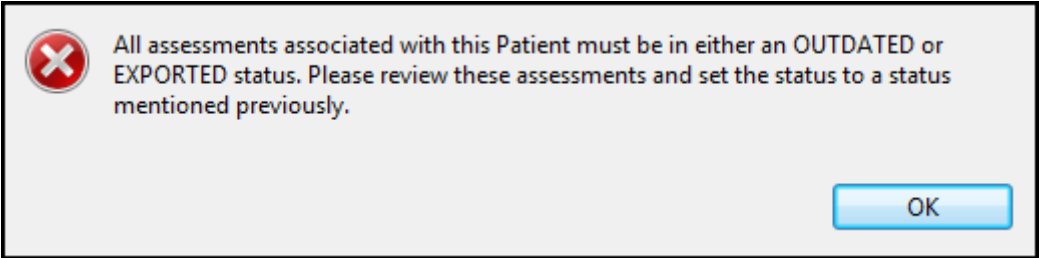
Assessment Information						
Entry Date	Assessment Type	Status	Assessor	Assessment Date	Export Date	
09-15-2015	LA - LTCH Admission	EXPORTED		09-15-2015	10-01-2015	

FinishCancel

9. Click 'Finish' to complete the patient move process and assign the new facility information.
10. Click 'Cancel' to return to the 'Patient Information' screen.

When a patient has been successfully moved the following confirmation message will be displayed: “(Patient Name) has been moved successfully.” Saved patient information will display in the Patient Summary section of the Patient Screen.

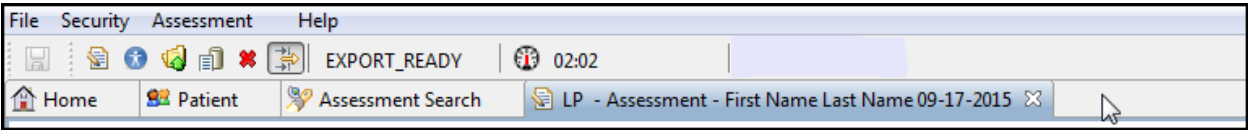
If assessments remain for a patient which are not ‘Exported’ or ‘Outdated’, the following error message will be displayed: “All assessments associated with this Patient must be in either an OUTDATED or EXPORTED status. Please review these assessments and set the status to a status mentioned previously.”



ASSESSMENT NAVIGATION AND MAINTENANCE

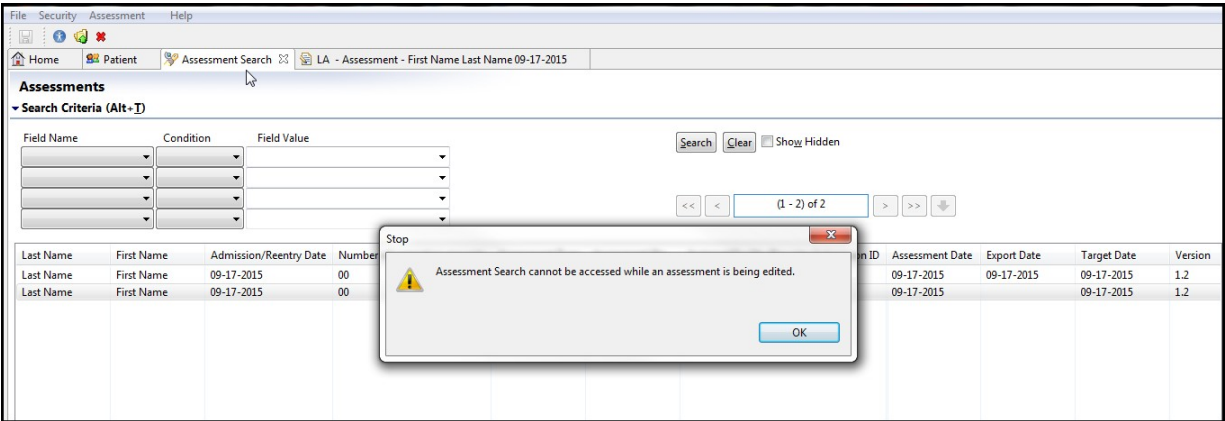
SCREEN TABS

Tabs for active screens (e.g. Home, Patient, Assessment Search, and Assessment) will display below the Toolbar at the top of the screen. The ‘Assessment’ tab will display the assessment type, patient name and assessment date.



When the assessment screen is open no other screens may be accessed.

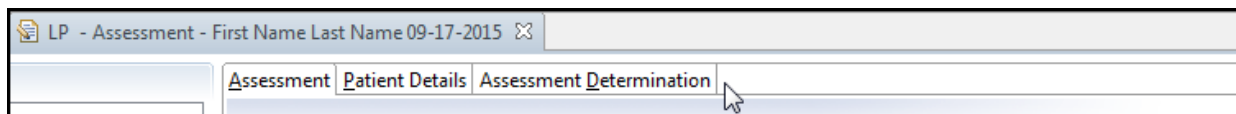
If an attempt to view a subsequent screen tab such as ‘Assessment Search’ while the ‘Assessment’ screen is active, the user will receive an error message stating that this function is not allowed. Click ‘OK’ to close the error message and return to the ‘Assessment’ screen.



ASSESSMENT SCREEN TABS

When an assessment is opened three additional tabs will be displayed:

- Assessment
- Patient Details
- Assessment Determination



ASSESSMENT

The 'Assessment' tab displays the patient assessment; this is where all assessment data entry will be completed.

PATIENT DETAILS


The 'Patient Details' tab displays patient demographic data in a view only, non-editable, format.

ASSESSMENT DETERMINATION

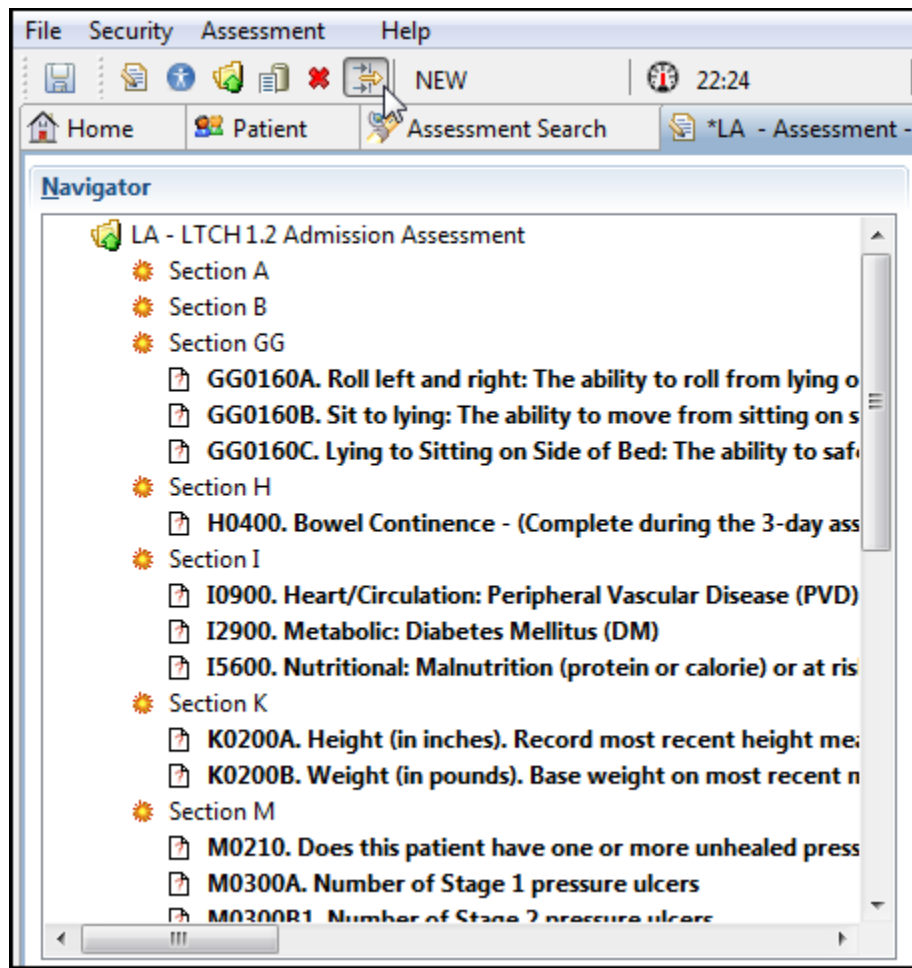
The 'Assessment Determination' tab displays data previously entered on the 'Add Assessment' wizard in a view only, non-editable, format.

NAVIGATOR

The assessment 'Navigator' is located in the top left corner of the 'Assessment' screen and will display all assessment items in a collapsible tree format. Unanswered questions will appear in **bold** type.


As questions are answered, they are removed from the tree. To change the display of the tree to continue showing answered questions utilize the 'Show/Hide'  icon in the Toolbar at the top of the screen.

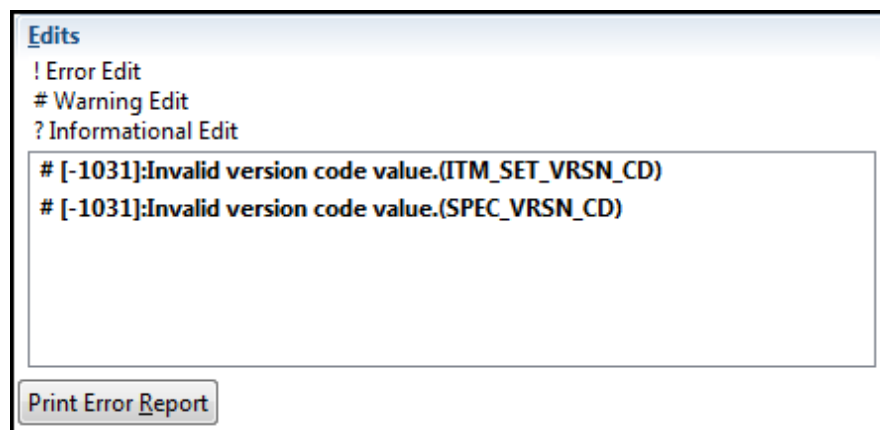
TIP: Clicking on an item in the tree will move the cursor to the selected field within the assessment.



EDITS

Data integrity edits are applied as information is entered into LASER. These edits are unique messages put in place to assist users with the accurate completion of data entry. Some edits will present a pop-up message and must be addressed when displayed in order to proceed. Other edits may not appear until the assessment is saved and validated.

The assessment 'Edits' section is located in the bottom left corner of the 'Assessment' screen. This section displays applicable errors or warnings found within an assessment after selecting the 'Save and Validate'  icon.



The following types of edits may occur in LASER:

ERRORS (!)

This type of edit informs the user that information is missing or invalid. Data must be entered or corrected before the assessment may be completed.

WARNINGS (#)

This type of edit indicates there is data entered that should be verified as accurate, or serves as a reminder regarding how certain fields should be completed.

INFORMATIONAL (?)

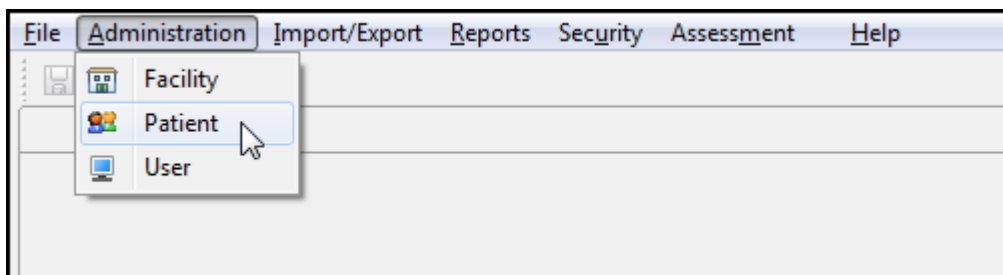
This type of edit gives the user general information about the assessment data entered.

TIP: Clicking on an edit message will move the cursor to the appropriate field within the assessment so it may be verified or corrected. An [Assessment Error Report](#) may be printed which will display all edits shown on the 'Edits' section of the 'Assessment' screen.

ADD AN ASSESSMENT

Complete the following steps to create an assessment:



1. Select 'Patient' from the Administration drop-down on the Menu Bar.



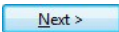
2. Complete a [Patient Search](#) or add a new patient.
3. In the Patient Summary section, double click on the patient you wish to add an assessment for, OR highlight the patient row by clicking on the patient and click the 'Add Assessment' button at the bottom of the Actions Section.
4. The 'Add Assessment' wizard displays.

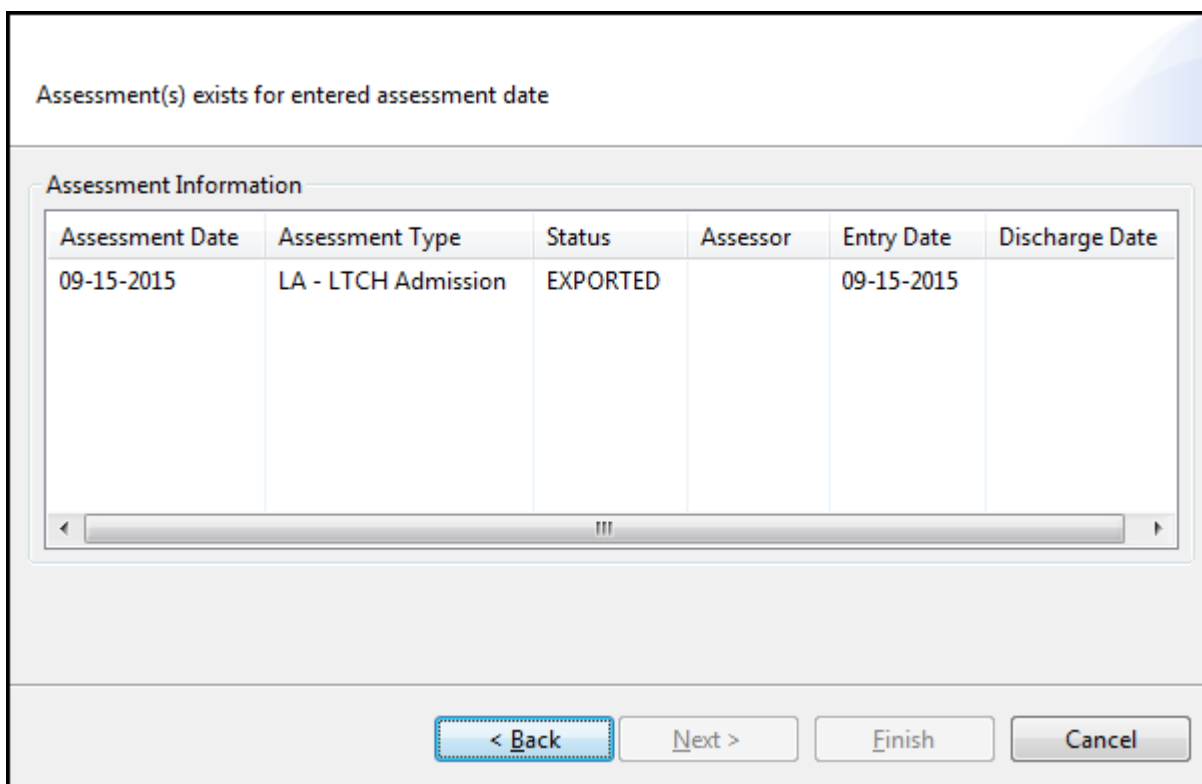
7. Enter data as appropriate on the 'Assessment' screen. Required fields will appear in bold type in the 'Navigator' section at the upper left. Clicking on an item in the 'Navigator' will move the cursor to the selected field within the assessment.

Please Note: For optimization of the skip patterns and/or edits, it is recommended that data be entered in the order the questions appear on the screen.

8. To save progress as data is entered, click the 'Save'  icon or utilize the short-cut, Ctrl+S.
9. When data entry is complete click the 'Save and Validate'  icon to validate the assessment for errors or warnings.

DUPLICATE ASSESSMENTS

In the event that the information entered on the 'Add Assessment' wizard duplicates an existing record within the assessment database, the 'Next'  button will enable on the 'Add Assessment' wizard, instead of the 'Finish' button. The following screen will display with a list of duplicate assessments.



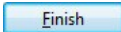

Assessment(s) exists for entered assessment date

Assessment Information

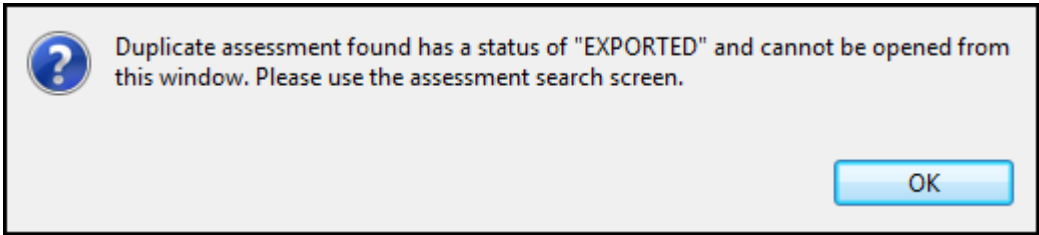
Assessment Date	Assessment Type	Status	Assessor	Entry Date	Discharge Date
09-15-2015	LA - LTCH Admission	EXPORTED		09-15-2015	

< Back Next > Finish Cancel

Complete the following steps to proceed in the event of a duplicate assessment:

1. Click to highlight the assessment.
2. Click the 'Finish'  button to review and continue data entry of the existing assessment or select 'Cancel'  to return to the 'Patient' screen.

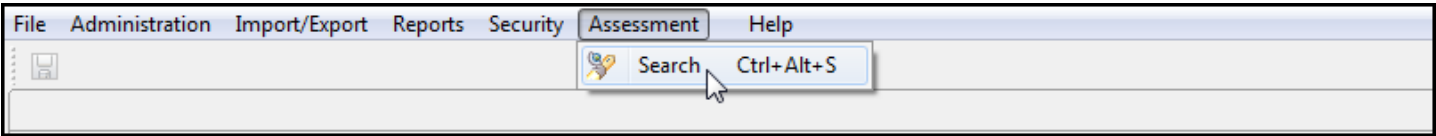
If the assessment found to be a duplicate is already in an exported status, the following message will display: “Duplicate assessment found has a status of “EXPORTED” and cannot be opened from this window. Please use the assessment search screen.” The user will need to navigate to the [Assessment Search](#) screen to modify or remove the assessment before proceeding.



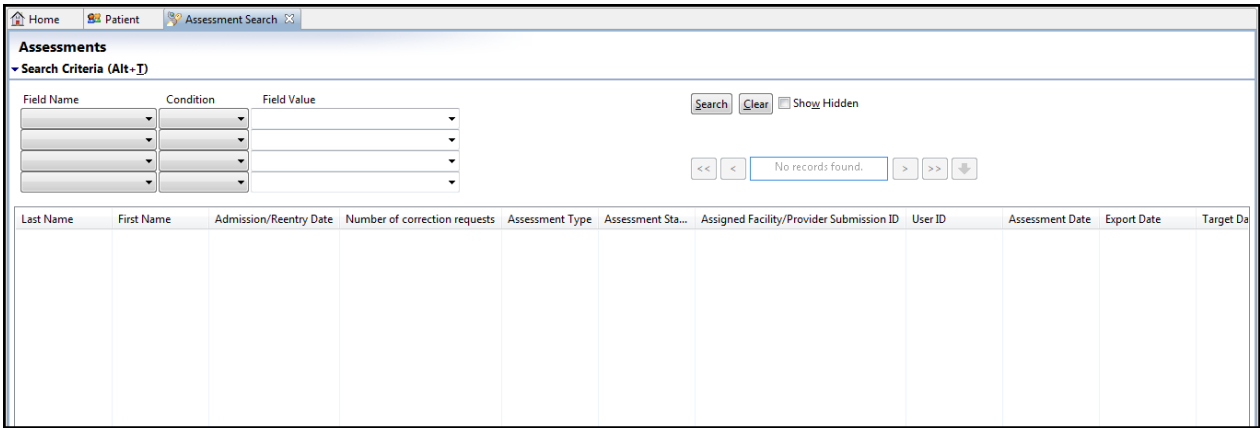
ASSESSMENT SEARCH




Complete the following steps to search for an assessment:

1. Select ‘Search’ from the Assessment drop-down on the Menu Bar.



2. The ‘Assessment Search’ screen displays.



3. To retrieve all existing assessment records leave the Search Criteria blank and click the ‘Search’  button.
4. To retrieve one or more assessment records based on Search Criteria:
 - a) Select criteria from the Field Name and Condition lists.
 - b) Enter a corresponding Field Value.
 - c) Click the ‘Search’  button.
 - d) Click the ‘Clear’  button to remove search criteria.

Please Note: Selecting the box next to ‘Show Hidden’ will include records for patients marked ‘Yes, Hide Record’ on the ‘Patient’ screen.

It is also recommended that the user close any open tabs and begin with a new ‘Assessment Search’ screen when conducting a search after updating or modifying patient or facility information.

VIEW ONLY

Occasionally it may be necessary to view previously entered information where there is not a need to modify or edit the data. To view assessment data without editing or resetting the assessment status (e.g. Exported assessment) users may utilize the ‘View Only’ checkbox.

Complete the following steps to open an assessment in ‘View Only’ mode:

1. Complete an [Assessment Search](#) to locate the desired assessment.
2. Click to place a checkmark into the ‘View Only’ ☒ **View Only** checkbox at the bottom of the screen.
3. Highlight the desired assessment record and select the ‘View Assessment’ **View Assessment** button at the bottom of the ‘Assessment Search’ screen, or double click to open the assessment for viewing.
4. The ‘Assessment’ screen opens in ‘View Only’ mode.

Please Note: Assessments may not be modified in ‘View Only’ mode. To make changes to this assessment OR subsequent assessment records the ‘View Only’ checkbox must be unchecked.

MODIFY AN ASSESSMENT

When modifying an assessment the user must first determine the assessment status. The assessment status may be viewed on the ‘Assessment Search’ screen as shown in the example below or on the Tool Bar once an assessment record has been opened. The following assessment statuses may occur within LASER:

- NEW
- IN_USE
- DATA_ENTRY
- EXPORT_READY
- EXPORTED
- OUTDATED (assessment record greater than 36 months old)

Home

Assessment Search

Assessments

▼ Search Criteria (Alt+T)

Field Name

Condition

Field Value

Search

Clear

Show Hidden

<<

<

(1 - 4) of 4

>

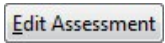
>>

⌵

Last Name	First Name	Admission/Reentry Date	Number of correction requests	Assessment Type	Assessment Sta...	Assigned Facility/Provider Submission ID	Assessment Date	Export Date	Target Date	Version
Test 1	Patient	09-15-2015	00	LA - LTCH Ad...	EXPORT_READY	Test 2 - 321654987 (IA)	09-15-2015	09-29-2015	09-15-2015	1.1
Test 1	Patient	09-22-2015	00	LA - LTCH Ad...	DATA_ENTRY	Test 2 - 321654987 (IA)	09-22-2015		09-22-2015	1.1
Test 1	Patient	09-30-2015	00	LP - LTCH Plan...	IN_USE	Test 2 - 321654987 (IA)	09-30-2015		09-30-2015	1.1
Test 1	Patient	09-20-2015	00	LU - LTCH Unp...	NEW	Test 2 - 321654987 (IA)	09-20-2015		09-20-2015	1.1

NEW, IN USE, DATA ENTRY, EXPORT READY or OUTDATED


Complete the following steps to modify an existing assessment with a status of NEW, IN_USE, DATA_ENTRY, EXPORT_READY or OUTDATED:

1. Complete an [Assessment Search](#) to locate the desired assessment.
2. Highlight the assessment and select the 'Edit Assessment'  button at the bottom of the 'Assessment Search' screen or double click to open the assessment for modification.

Please Note: When an OUTDATED assessment is opened the following decision message will be displayed: “(Target Date) is greater than 36 months old. Would you like to continue and open this assessment?” Select ‘Yes’ to continue.


3. The ‘Assessment’ screen will display.

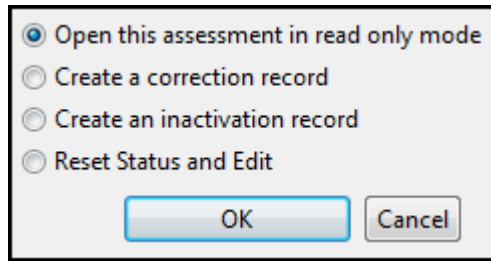
TIP: Unanswered questions will appear in **bold** type in the Navigator section at the upper left corner of the ‘Assessment’ screen. Clicking on an item in the Navigator tree will move the cursor to the selected field within the assessment.

4. Modify the assessment as appropriate.
5. Select the ‘Save and Validate’  icon on the toolbar to display any applicable warnings or errors found within an assessment.

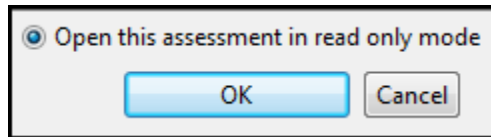
EXPORTED


Only a user with System Administrator access may modify an assessment that has been exported. Complete the following steps to modify an existing assessment with a status of EXPORTED:

1. Complete an [Assessment Search](#) to locate the desired assessment.
2. Highlight the assessment and select the ‘Edit Assessment’  button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment for modification.
3. The ‘Exported Assessment’ pop-up window displays with the following options:
 - **Open this assessment in read only mode** - Assessment opens and displays all previously selected answers in a view only format. This selection checks the ‘View Only’ checkbox at the bottom of the ‘Assessment Search’ screen. All other assessments will be view only until this box is unchecked.
 - **Create a correction record** – Assessment opens and displays all previously selected answers. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard. [Assessment Reference Date (A0210), Admission Date (A0220), Reason for Assessment (A0250) and Discharge Date (A0270)]
 - **Create an inactivation record** – Inactivation assessment opens. All fields are a view only, non-editable, format with the exception of Z0500B which will need to be answered. Once saved the assessment type will be changed to XX- Inactivation.
 - **Reset Status and Edit** – Assessment opens and displays all previously selected answers in an editable format. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard. [Assessment Reference Date (A0210), Admission Date (A0220), Reason for Assessment (A0250), and Discharge Date (A0270)] The assessment status will be changed to IN_USE.



Please Note: Users who do not have System Administrator access will be shown an ‘Exported Assessment’ pop-up with only one option to “Open this assessment in read only mode.” Selecting ‘OK’ will open the assessment for viewing only, selecting ‘Cancel’ will return the user to the ‘Assessment Search’ screen.



4. Select one of the four options provided on the ‘Exported Assessment’ pop-up window.
5. Select ‘OK’ to continue.
6. Modify the assessment if applicable or enter the LTCH Care Data Set Completion Date (Z0500B) if creating an inactivation assessment.
7. Click the ‘Save and Validate’  icon on the toolbar.


COPY AN INACTIVATED ASSESSMENT

Occasionally it may be necessary to inactivate a record which subsequently needs to be modified for re-submission to the national data repository. For example, LTCH policy instructs the provider to submit an inactivation record when the first name, last name, SSN, gender and/or birthdate is to be corrected. A new record with the correct information is then submitted.

After updating the patient information (see [Modify a Patient](#)) a copy of the inactivated record can be made to avoid the need to re-enter all of the assessment data.

Please Note: If modifications need to be made to any fields contained within the ‘Add Assessment’ wizard. [Assessment Reference Date (A0210), Admission Date (A0220), Reason for Assessment (A0250), and Discharge Date (A0270)] a NEW assessment record must be added following an inactivation.

Complete the following steps to copy an inactivated assessment with a status of EXPORTED:

1. Complete an [Assessment Search](#) to locate the inactivated assessment. Note that the assessment type will be shown as XX-Inactivation on the ‘Assessment Search’ screen.
2. Highlight the assessment and select the ‘Edit Assessment’  button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment.
3. The ‘Exported Assessment’ pop-up window displays with the following options:

- **Open this assessment in read only mode** – Inactivation assessment opens and displays all previously selected answers in a view only format. This selection checks the ‘View Only’ checkbox at the bottom of the ‘Assessment Search’ screen. All other assessments will be view only until this box is unchecked.
- **Create a copy** – Assessment opens and displays all previously selected answers in an editable format. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard. [Assessment Reference Date (A0210), Admission Date (A0220), Reason for Assessment (A0250), and Discharge Date (A0270)] Only one copy per inactivated assessment is allowed.
- **Reset Status** – Inactivation Assessment opens and displays all applicable fields in a view only, non-editable format. The Assessment Status will be changed to IN_USE.

☒ Open this assessment in read only mode
☐ Create a copy
☐ Reset Status

OK Cancel

4. Select one of the three options provided on the ‘Exported Assessment’ pop-up window.
5. Select ‘OK’ to continue.


Please Note: The following message will display prior to opening the assessment if patient information has been modified: “The patient information has changed, would you like to update the assessment to reflect these changes?”

- Select ‘Yes’ to update the assessment with the ‘After Value’.
- Select ‘No’ to open the assessment without updating patient information.

The patient information has changed, would you like to update the assessment to reflect these changes?

Field Name	Before Value	After Value
Last Name	Test	Test 1

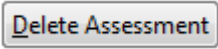
Yes No

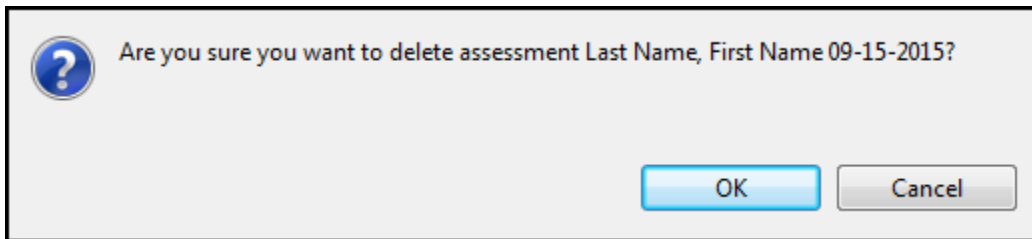
6. The ‘Assessment’ screen opens.
7. Modify the assessment data if applicable.
8. Click the ‘Save and Validate’  icon on the toolbar.
9. Close the assessment.

DELETE AN ASSESSMENT

Only a user with System Administrator access may delete an assessment. Assessments with a status of EXPORTED cannot be deleted; the status of these records must be reset to complete the deletion.

Complete the following steps to delete an assessment:

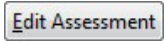
1. Complete an [Assessment Search](#) to locate the desired assessment.
2. Click once to highlight the assessment.
3. Click the 'Delete Assessment'  button at the bottom of the 'Assessment Search' screen to delete the selected assessment.
4. The 'Confirm Assessment Delete' pop-up window displays the following message: "Are you sure you want to delete assessment [patient last name, first name, admission/re-entry date (A0210)]?"

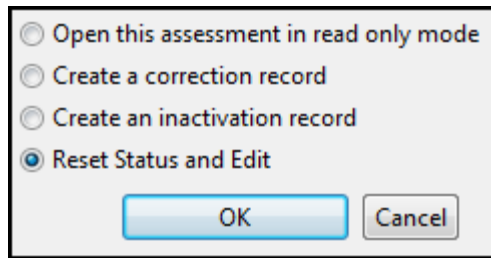


5. Select 'OK' to delete the assessment. Select 'Cancel' to close the pop-up window. The assessment will not be deleted.

If an assessment with a current status of EXPORTED needs to be deleted the user should first verify that the assessment record has not been submitted to the national data repository.

Complete the following steps to delete an assessment that has been previously exported:

1. Complete an [Assessment Search](#) to locate the desired assessment.
2. Highlight the assessment and select the 'Edit Assessment'  button at the bottom of the 'Assessment Search' screen or double click to open the assessment.
3. The 'Exported Assessment' pop-up window displays with the following options:
 - Open this assessment in read only mode
 - Create a correction record
 - Create an inactivation record
 - Reset Status and Edit



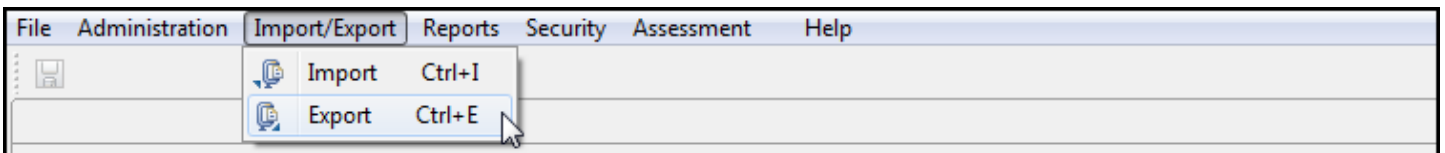
4. Select the 'Reset Status and Edit' radio button.
5. Select 'OK'.
6. The 'Assessment' screen will open setting the status to IN_USE.
7. Close the assessment.
8. Follow the instructions to [Delete an Assessment](#) to complete the removal of the assessment record.

EXPORT

The 'Export Assessments' screen allows the user to export records for subsequent submission to the appropriate national data repository.

Complete the following steps to export an assessment:

1. Select 'Export' from the Import/Export drop-down on the Menu Bar.



2. The 'Export Assessments' screen displays.




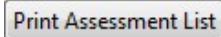
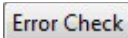
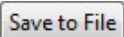


3. The export process will depend upon which Export Type is chosen. Select one of the following Export Types from the drop-down at the upper left corner of the 'Export Assessments' screen:
 - New Export (Assessments marked as "Export Ready")
 - Previous Export (Assessments marked as "Export Ready" or "Exported")

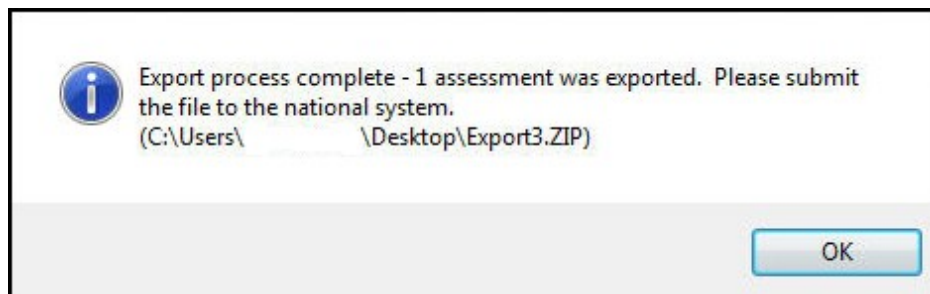
The process for each Export Type has been defined below.

NEW EXPORT

(Assessments marked as “Export Ready”)

Complete the following steps when selecting New Export:

1. Click the ‘Browse’  button to select the Export Path. This is the location where the exported files will be saved.
2. Enter a unique file name into the field labeled Export Name. The Export Name will serve as a reference to the user when submitting the file to the appropriate national data repository. An example of what a user may choose to enter here would be the date the export file is created.
3. Enter the Export Description. This is an optional field which may be used to document additional details regarding the export file.
4. Select the assessments to be included in the export file by placing a checkmark into the boxes next to the desired assessment records. A minimum of one selection is required.
 - The ‘Select All’  button will select all assessments displayed in the list to be included in the export file.
 - The ‘Clear Selection’  button will unselect all assessments previously selected.
5. If desired, select the ‘Print Assessment List’  button to print a list of all assessments selected to be included in the export file. Please note: This report does not have a preview option and will be sent directly to the printer of the user’s choice.
6. If desired, select the ‘Error Check’  button to validate all assessments selected for export. Warnings and/or Error results will display in a new screen.
 - Select the ‘Save to File’  button to save the error report.
 - Select the ‘Close’  icon in the upper right corner to close the error report.
7. Select the ‘Export’  button to complete the export process.
8. The ‘Export Complete’ pop-up window displays notifying the user that the export process is complete. The number of assessments which have been exported as well as the location of the exported files displays within this pop-up window.



PREVIOUS EXPORT

(Assessments marked as “Export Ready or “Exported”)

Complete the following steps when selecting Previous Export:

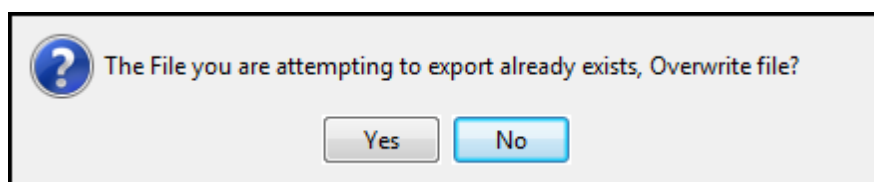
1. Begin by highlighting a previously exported file from the list in the Previous Exports section located in the center of the ‘Export Assessments’ screen.

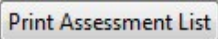
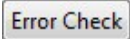
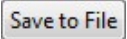


Previous Exports		
Description	Location	
1 assessments.	C:\Users\	\Desktop\ _test2 ZIP

2. A list of assessments included in the previous export will be displayed in the section titled Previously Exported Assessments located at the bottom of the ‘Export Assessments’ screen.
3. Select the assessments to be included in the export file by placing a checkmark into the boxes next to the desired assessment records. While all assessments included in the previous export will be displayed, **ONLY** assessments with a status of “Export Ready” or “Exported” may be selected for inclusion in a new export file. A minimum of one selection is required.
 - The ‘Select All’ button will select all assessments displayed in the list to be included in the export file.
 - The ‘Clear Selection’ button will unselect all assessments previously selected.
4. Click the ‘Browse’ button to select the Export Path. This is the location where the exported files will be saved.
5. Enter a unique file name into the field labeled Export Name. The Export Name will serve as a reference to the user when submitting the file to the appropriate national data repository. An example of what a user may choose to enter here would be the date the export file is created.

Please Note: By default the original Export Path and Export Name will be displayed. It is recommended to use the same Export Path for each export file; however the Export Name should be unique for each export file created. Failure to create a new Export Name may result in the following pop-up window: “The file you are attempting to export already exists, overwrite file?”

- Selecting ‘Yes’ will replace the original export file saved.
- Selecting ‘No’ will return the user to the ‘Export Assessments’ screen so they may select a new ExportName.



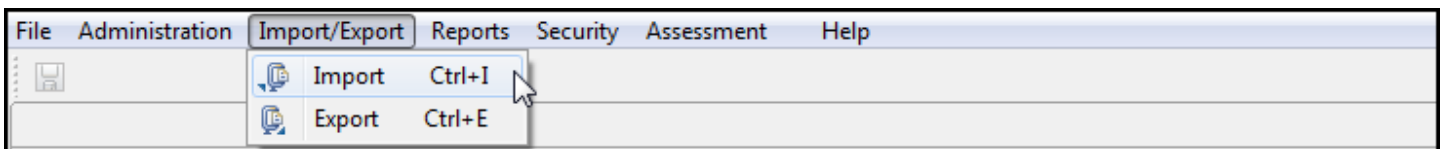
6. Enter the Export Description. This is an optional field which may be used to document additional details regarding the export file.
7. If desired, select the 'Print Assessment List'  button to print a list of all assessments selected to be included in the export file. Please note: This report does not have a preview option and will be sent directly to the printer of the user's choice.
8. If desired, select the 'Error Check'  button to validate all assessments selected for export. Warnings and/or Error results will display in a new screen.
 - Select the 'Save to File'  button to save the error report.
 - Select the 'Close'  icon in the upper right corner to close the error report.
9. Select the 'Export'  button to complete the export process.
10. The 'Export Complete' pop-up window displays notifying the user that the export process is complete. The number of assessments which have been exported as well as the location of the exported files displays within this pop-up window.

IMPORT

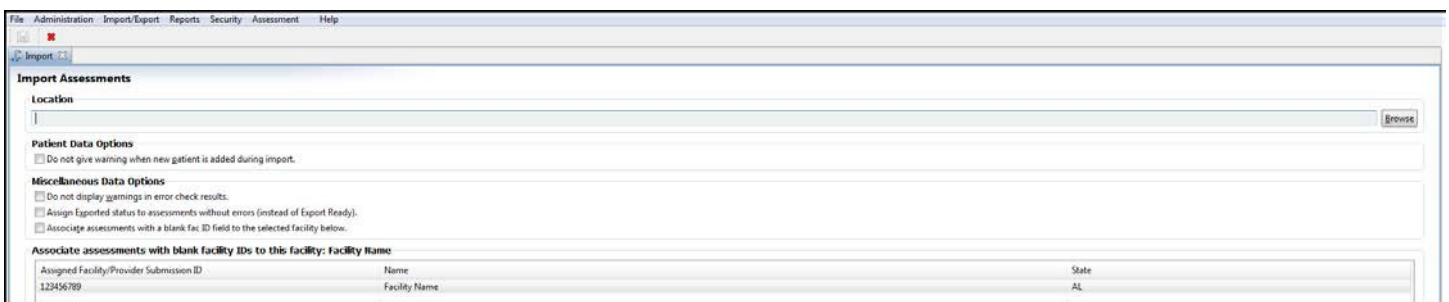
The 'Import Assessments' screen allows users to determine how data is imported into LASER.


Complete the following steps to import an assessment:

1. Select 'Import' from the Import/Export drop-down on the toolbar.



2. The 'Import Assessments' screen displays.



3. Click the 'Browse'  button to navigate to the location of the files to be imported.

Please Note: There may be an increased wait time when importing a large number of assessment records due to database encryption.

4. Set the desired preferences. You may select preferences individually or click the ‘Select All Options’

 button to check or uncheck all checkboxes.

PREFERENCES

PATIENT DATA OPTIONS CHECKBOX

Selecting this checkbox turns off the warning message displayed when a new patient is imported. “Do not give warning when new patient is added during import.”

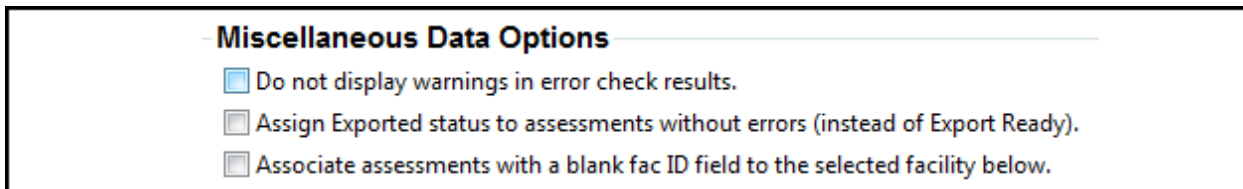


Patient Data Options

☐ Do not give warning when new patient is added during import.

MISCELLANEOUS DATA OPTIONS CHECKBOXES

- “Do not display warnings in error check results.” Selecting this checkbox removes warning messages from the error check results report that displays after importing data. Only fatal errors are included in the report.
- “Assign Exported status to assessments without errors (instead of Export Ready).” Selecting this checkbox sets the status of imported assessments to ‘Exported’ if the assessment record does not contain errors.
- “Associate assessments with a blank Fac ID field to the selected facility below.” Selecting this checkbox links import records which are missing a facility ID to the selected facility.

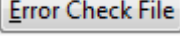
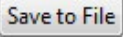




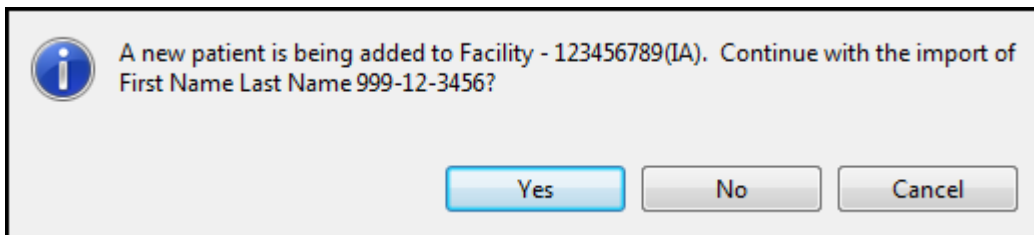
Miscellaneous Data Options


☐ Do not display warnings in error check results.

☐ Assign Exported status to assessments without errors (instead of Export Ready).

☐ Associate assessments with a blank fac ID field to the selected facility below.

5. Select the ‘Error Check File’  button to validate all assessments to be imported. Error results will display in a new screen.
- a. Select the ‘Save to File’  button to save the error report (.txt).
 - b. Click the ‘Close’  icon in the top right corner to close the report.
6. Click the ‘Import’  button to import the selected assessment records into LASER.
7. If the import file chosen contains assessment records for patients who have not previously been entered into LASER a ‘New Patient’ message will be displayed: “A new patient is being added to (Facility – FAC ID). Continue with the import of (Patient Name - SSN)?”

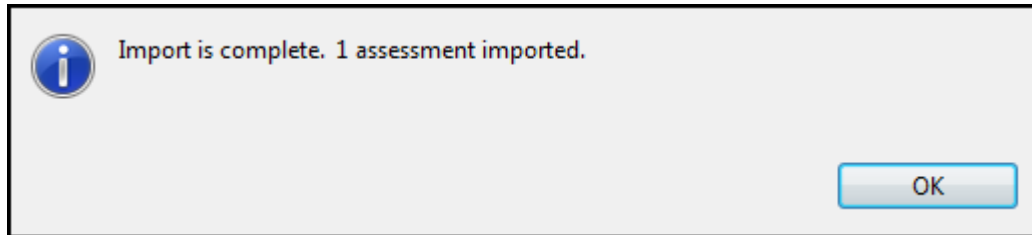


 A new patient is being added to Facility - 123456789(IA). Continue with the import of First Name Last Name 999-12-3456?

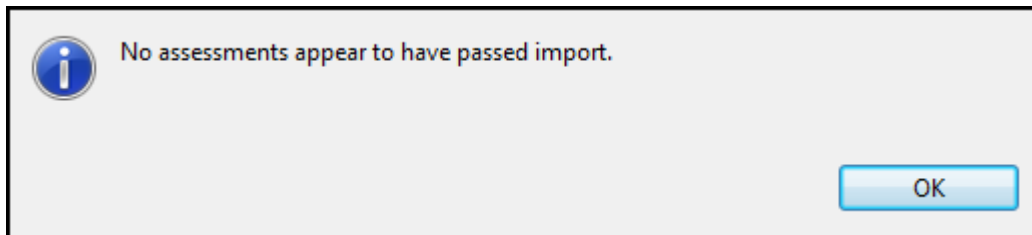
- a. Click 'Yes' to continue.
- b. Click 'No' or 'Cancel' to stop the import process.

Please Note: This message will NOT be shown if the Patient Data Options checkbox has been selected.

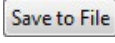
8. The 'Import Complete' message displays along with a Status Report for all assessments included in the import.




9. If none of the selected files are successfully imported, the 'Import Failed' message displays along with a Status Report.



10. Click the 'OK'  button on the 'Import Complete' pop-up window to view the Status Report.

11. Click the 'Save to File'  button on the bottom of the Status Report to save a copy.

It is strongly recommended that a copy of the Import Status Report be saved as this report is ONLY displayed at the time of Import and cannot be retrieved once closed. Only one Import Status Report may be displayed at a time; this report may not be minimized and must be saved or closed to continue use of the LASER application.

12. Click 'Close'  in the top right corner to close the Status Report.

REPORTS

LASER reports allow users to preview and print assessment information as well as detail and summary information for both facilities and patients.

The following reports are available within the LASER application:

- Print Assessment Report
- Assessment Error Report
- Event Tracking
- Assessment Data Entry – By Status
- Data Comparison

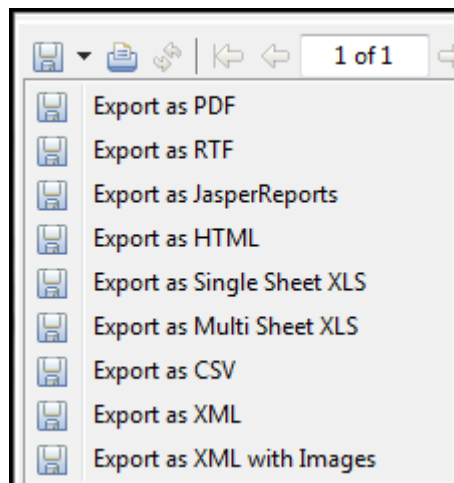
PRINT ASSESSMENT REPORT

The Print Assessment Error Report provides a listing of all data which has been entered into the assessment record. Complete the following stopes to obtain the Print Assessment Report.

1. Begin generating the repot using one of the three available methods.
 - Click the 'Print Assessment Report' icon on the Toolbar.
 - Utilize the shot-cut, Ctrl+A.
 - Select 'Print Assessment Report' from the File drop-down on the Menu Bar.
2. The Print Assessment Report criteria selection window is displayed. This criteria selection window should be used to designate the number of signature lines shown on the printed report. The default number of signature lines will be 12.

Selecting 'Cancel' will close the criteria selection window; the Print Assessment Report will not be generated.

3. Select the 'OK' button to generate the report.
4. The Report Viewer screen displays the assessment record.
5. To print the report, click the 'Print' icon on the Report Viewer screen.
6. To save the report as a PDF document, click the 'Save' icon on the Report Viewer screen.
7. To export and save the repot using a different file type, click the arrow next to the 'Save' icon.
8. The following export type values display:
 - Export as PDF
 - Export as RTF
 - Export as Jasper Reports
 - Export as HTML
 - Export as Single Sheet XLS
 - Export as Multi Sheet XLS
 - Export as CSV
 - Export as XML
 - Export as XML with Images

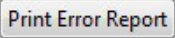



9. Select an export type.
10. Select the location in which you wish to save the report. Below is an example of the Print Assessment Report.

LASER - LTCH Assessment Submission Entry & Reporting	
Facility ID:	987654321
Facility Name:	Facility
Facility State:	IA
Last Name:	Name
Assessment Date:	02/01/2018
Run Date:	03/26/2018
Requested by:	SysAdmin
<hr/>	
Last Entry Date:	03/26/2018
Data Entry Time:	00:01:37
Data Entry User:	SysAdmin
Header Records	
Reason for Assessment:	LA - LTCH Admission
Target Date:	02/01/2018
Patient Name:	Name, Patient
SSN:	111-11-9999
Correction Number:	00
ASSESSMENT DETERMINATION	
A0210 Assessment Reference Date	02/01/2018
A0220 Admission Date	02/01/2018
A0250 Reason for Assessment	01. Admission
Section A - Administration Information	
A0050 Type of record	1. Add new assessment/record
A1400 Payer Information (Check all that apply)	A. Medicare (traditional fee-for-service)
A1802 Admitted From. Immediately preceding this admission, where was the patient?	01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
Section B - Hearing, Speech, and Vision	
B0100 Comatose - Persistent vegetative state/no discernible consciousness	0. No
BB0700 Expression of Ideas and Wants (3-day assessment period) - Expression of ideas and wants (consider both verbal and non-verbal expression and excluding language barriers)	4. Expresses complex messages without difficulty and with speech that is clear and easy to understand
BB0800 Understanding Verbal Content (3-day assessment period) - Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers)	4. Understands: Clear comprehension without cues or repetitions
Section C - Cognitive Patterns	
C1610A Acute Onset - Is there evidence of an acute change in mental status from the patient's baseline?	0. No
C1610B Fluctuating Course - Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity?	0. No
Page 1 of 6	
FOR OFFICIAL USE ONLY - PRIVACY ACT INFORMATION CONTAINED HEREIN.	

ASSESSMENT ERROR REPORT

The Assessment Error Report provides a printable listing of all edits received for an assessment and may be generated in one of the following ways:

- Click the 'Print Error Report'  button located at the bottom of the 'Edits' section.
- Click the 'Print Assessment Error Report'  icon on the Toolbar.
- Utilize the short-cut Ctrl+P.
- Select 'Print Assessment Error Report' from the File drop-down on the Menu Bar.

Run Date: 03/19/2018		Assessment Error Report	
Assessment Type:	LA - LTCH Admission		
Assessment Date:	02/01/2018		
Last Name:	Name		
Target Date:	02/01/2018		
Question	Severity	Error Number	Error Message
Z0500B	Error	-1010	Invalid value for this item - it is not a valid YYYYMMDD date value and it is not a valid alternative value as specified in the Data Specifications. [^]
I7900	Warning	11280	A dash (-) submitted in this quality measure item may result in a payment reduction for your facility of two percentage points for the affected payment determination.

[] = Not Assessed, [^] = Skipped

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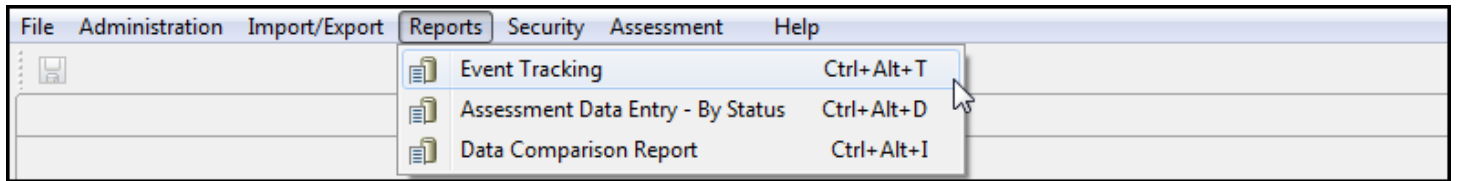
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EVENT TRACKING

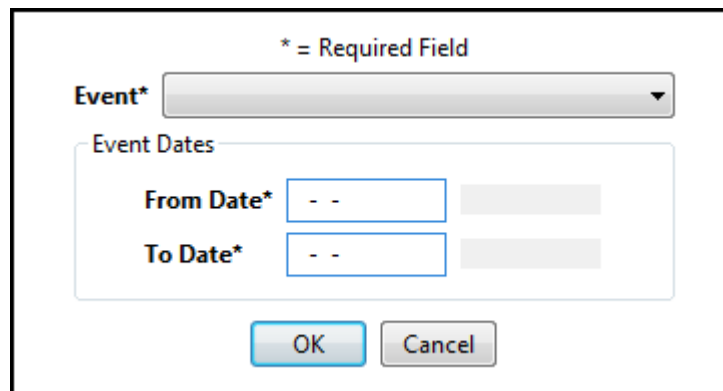
The Event Tracking report is available ONLY to users with System Administrator access. This report may be used to track activity such as additions, deletions and/or modifications which are made to data within the Facility, User, Patient or Assessment screens.






Complete the following steps to run the Event Tracking report:

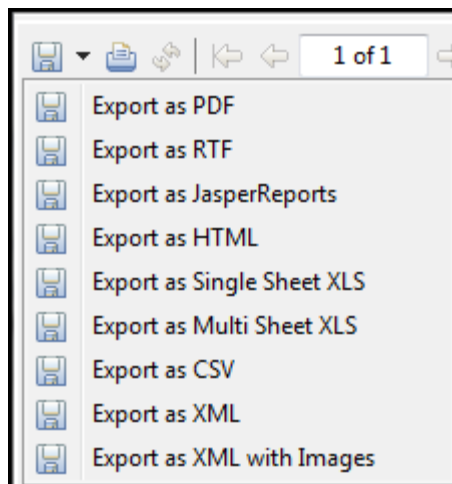
1. Select 'Event Tracking' from the Reports drop-down on the Menu Bar.



2. The 'Event Tracking' criteria selection window displays.

A screenshot of the 'Event Tracking' criteria selection window. At the top, it says '* = Required Field'. Below this is a dropdown menu labeled 'Event*'. Underneath the dropdown is a section titled 'Event Dates' which contains two rows: 'From Date*' and 'To Date*'. Each row has a date input field (showing '-') and a disabled greyed-out field. At the bottom of the window are 'OK' and 'Cancel' buttons.

3. Complete the required fields. Required fields display on the screen in bold type with an asterisk.
4. Select the 'OK'  button to generate the report. Selecting 'Cancel'  will close the 'Event Tracking' criteria selection window.
5. To print the report, click the 'Print'  icon on the Report Viewer screen.
6. To save the report, click the 'Save'  icon on the Report Viewer screen.
7. To export the report, click the arrow next to the 'Save'  icon.
8. The following export type values display:
 - Export as PDF
 - Export as RTF
 - Export as Jasper Reports
 - Export as HTML
 - Export as Single Sheet XLS
 - Export as Multi Sheet XLS
 - Export as CSV
 - Export as XML
 - Export as XML with Images



9. Select an export type.

10. Select the location in which you wish to save the report. Below are examples of the Facility and Patient Event Tracking reports.

LASER - LTCH Assessment Submission Entry & Reporting

Facility Event Tracking

01/01/2018 thru 03/19/2018

Requested by: SysAdmin

Event: Facility

Event Type	User ID	Event Date	Facility Name	Facility City	State	Assigned ID
Add	laser	03/19/2018 03:35 PM	Facility	City	IA	1245789

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LASER - LTCH Assessment Submission Entry & Reporting

Patient Event Tracking

01/01/2018 thru 03/19/2018

Requested by: SysAdmin

Event: Patient

Event Type	User ID	Event Date	Last Name	First Name	SSN	Birth Date	Hide Patient
Add	SysAdmin	03/19/2018	Last	First	999-99-1111	10-10-1910	0
Add	SysAdmin	03/19/2018	Name	Patient	111-11-9999	01-01-1901	0

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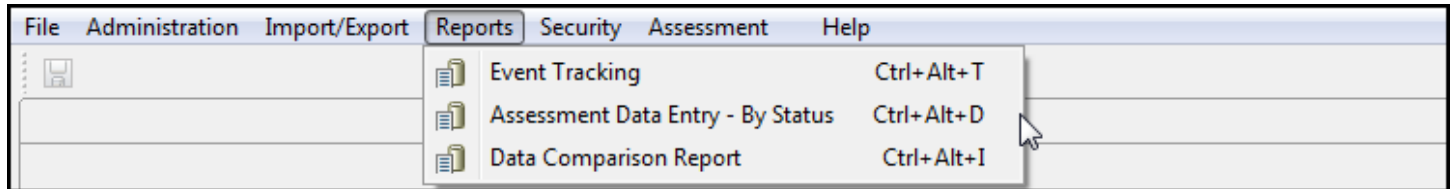
ASSESSMENT DATA ENTRY – BY STATUS

The Assessment Data Entry – By Status report provides a listing of all assessment records for the chosen status. The following statuses are available in LASER:

- New
- In Use
- Data Entry
- Export Ready
- Exported
- Outdated






Complete the following steps to run the Assessment Data Entry – By Status report:

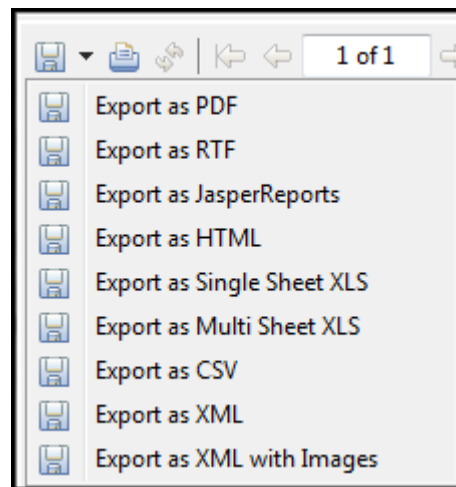
1. Select 'Assessment Data Entry – By Status' from the Reports drop-down on the Menu Bar.



2. The 'Assessment Data Entry – By Status' criteria selection window displays.

A screenshot of the 'Assessment Data Entry – By Status' criteria selection window. The window has a title bar and a main content area. At the top, it says '* = Required Field'. Below this, there are three main sections: 'Facility*' with a dropdown menu, 'Status*' with a list box containing 'DATA_ENTRY', 'EXPORTED', 'EXPORT_READY', and 'IN USE', and 'Data Entry Date' with 'From*' and 'To*' date pickers. At the bottom, there are 'OK' and 'Cancel' buttons.

3. Complete the required fields. Required fields display on the screen in bold type with an asterisk. To select two or more statuses, hold the Ctrl OR the Shift button on your keyboard while you select or scroll through the list.
4. Select the 'OK'  button to generate the report. Selecting 'Cancel'  will close the 'Assessment Data Entry – By Status' criteria selection window.
5. The Report Viewer screen opens displaying the generated report.
6. To print the report, click the 'Print'  icon on the Report Viewer screen.
7. To save the report, click the 'Save'  icon on the Report Viewer screen.
8. To export the report, click the arrow next to the 'Save'  icon. The following export type values display:
 - Export as PDF
 - Export as RTF
 - Export as Jasper Reports
 - Export as HTML
 - Export as Single Sheet XLS
 - Export as Multi Sheet XLS
 - Export as CSV
 - Export as XML
 - Export as XML with Images



9. Select an export type.
10. Select the location in which you wish to save the report. Below is an example of the Assessment Data Entry – By (Data_Entry and New) Status report.

LASER - LTCH Assessment Submission Entry & Reporting

Assessment Status Tracking

Facility - 1245789{IA}

01/01/2018 thru 03/19/2018

Status: DATA_ENTRY, NEW

Requested by: SysAdmin

Patient Name	SSN	Gender	Birth Date	Assessment Type	Status	Assessment Date	User ID
Last, First	999-99-1111	Female	10/10/1910	LA - LTCH Admission	NEW	03/19/2018	SysAdmin
Name, Patient	111-11-9999	Female	01/01/1901	LA - LTCH Admission	DATA_ENTRY	02/01/2018	SysAdmin

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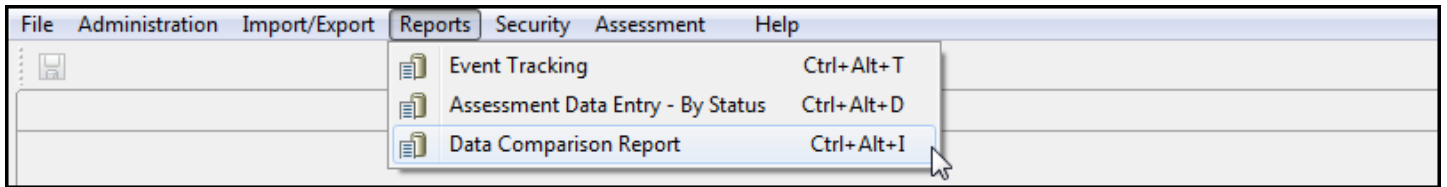
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DATA COMPARISON






The Data Comparison Report will compare facility and patient data within assessment records to data stored within the facility and patient administration screens. It will display the fields where data in the assessment no longer matches what is in the administration records.

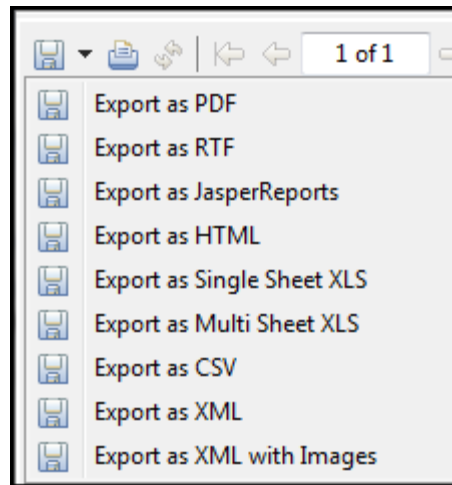
Complete the following steps to pull a Data Comparison Report:

1. Select 'Data Comparison Report' from the Reports drop-down on the Menu Bar.



2. The 'Data Comparison Report' criteria selection window displays.

3. Complete the required fields. Required fields display on the screen in bold type with an asterisk.
4. Select the 'OK'  button to generate the report. Selecting 'Cancel'  will close the 'Data Comparison Report' criteria selection window.
5. To print the report, click the 'Print'  icon on the Report Viewer screen.
6. To save the report, click the 'Save'  icon on the Report Viewer screen.
7. To export the report, click the arrow next to the 'Save'  icon. The following export type values display:
 - Export as PDF
 - Export as RTF
 - Export as Jasper Reports
 - Export as HTML
 - Export as Single Sheet XLS
 - Export as Multi Sheet XLS
 - Export as CSV
 - Export as XML
 - Export as XML with Images



8. Select an export type.
9. Select the location in which you wish to save the report. Below is an example of the Data Comparison report.

LASER - LTCH Assessment Submission Entry & Reporting

Data Comparison Report

Facility - 987654321{IA}

01/01/2018 thru 03/19/2018


Requested by: SysAdmin

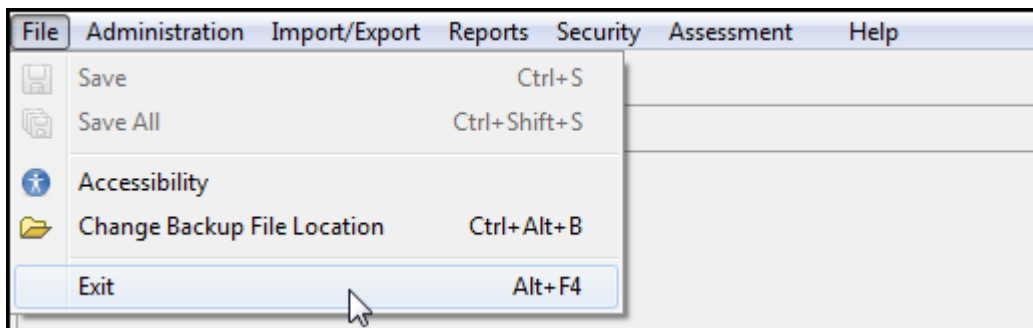
Patient Name	SSN	Reason for Assessment	Status	After Assessment Update	Assessment Date
Last, First	999-99-1111	LA - LTCH Admission	NEW	FACILITY: Facility Address: Address will change to Address_2 Assigned Facility/Provider Submission ID (FAC_ID): 1245789 will change to 987654321	03/19/2018
Name, Patient	111-11-9999	LA - LTCH Admission	DATA_ENTRY	FACILITY: Facility Address: Address will change to Address_2 Assigned Facility/Provider Submission ID (FAC_ID): 1245789 will change to 987654321	02/01/2018

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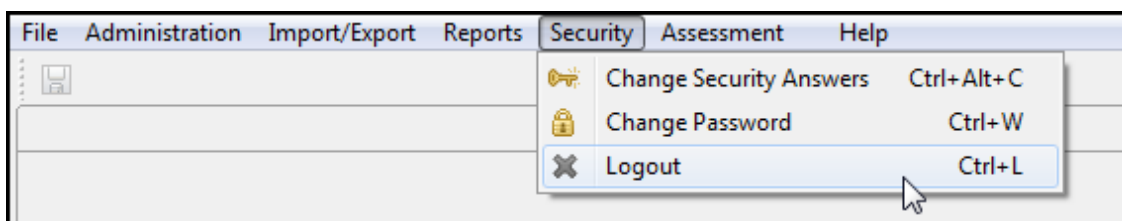
CLOSE THE APPLICATION

To close the LASER application select 'Exit' from the File drop-down on the Menu Bar. LASER may also be closed by selecting the close icon  in the upper right corner of the screen.



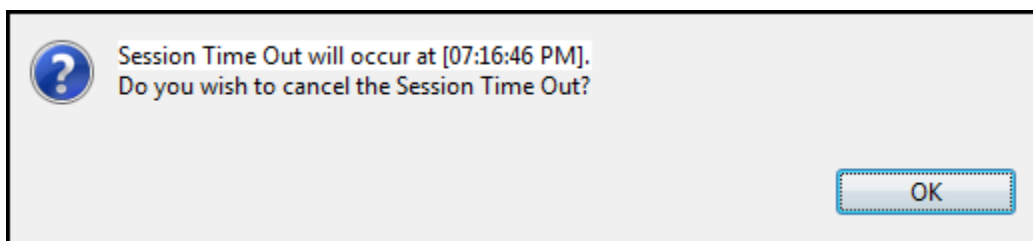
LOGOUT

To log out and return to the LASER 'Login' screen, select 'Logout' from the Security drop-down on the Menu Bar.



SESSION TIME OUT

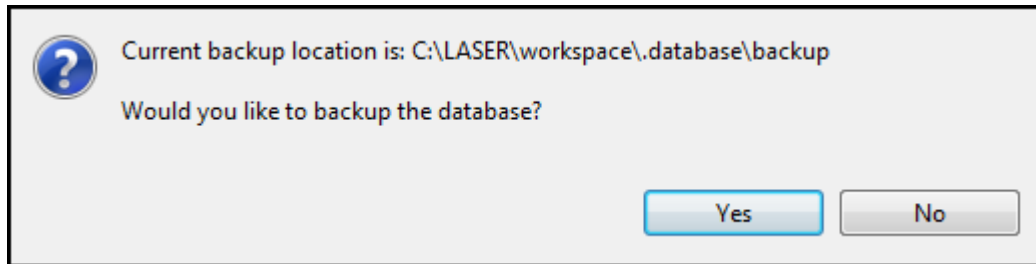
To enhance the security of data stored within the LASER application the system will issue a timeout warning if there has been no activity by the user for ten (10) minutes. The following decision message will be displayed: "Do you wish to cancel the session time out?"



To continue with the session click 'OK'. If the user does not cancel the session time out prior to 15 minutes of inactivity LASER will close the active screens and return the user to the 'Login' screen. If assessment data has been entered but not saved when a time out occurs the application will perform an auto save of the assessment data.

DATA BACKUP

It is strongly recommended that users backup the database each time new data is entered. In the event of data loss database backup files may be used to restore the LASER application to a previous date and time. When closing an active session of LASER the user will receive the following decision message along with a listing of the current backup location: “Would you like to backup the database?”



- Select ‘Yes’ to backup the database and close LASER.
- Select ‘No’ to decline the database backup and close the LASER application.

If a backup has not occurred in the last seven (7) days, LASER will automatically backup the database when the application is closed.

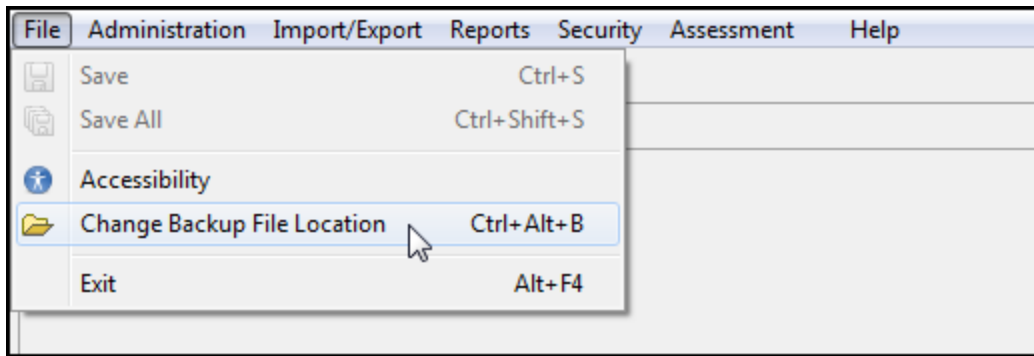
When a database backup is attempted and fails, the following message will be displayed: “The database backup procedure has failed. Please contact your System Administrator.” Users should contact the QTSO Help Desk for additional assistance.

CHANGING THE BACKUP FILE LOCATION

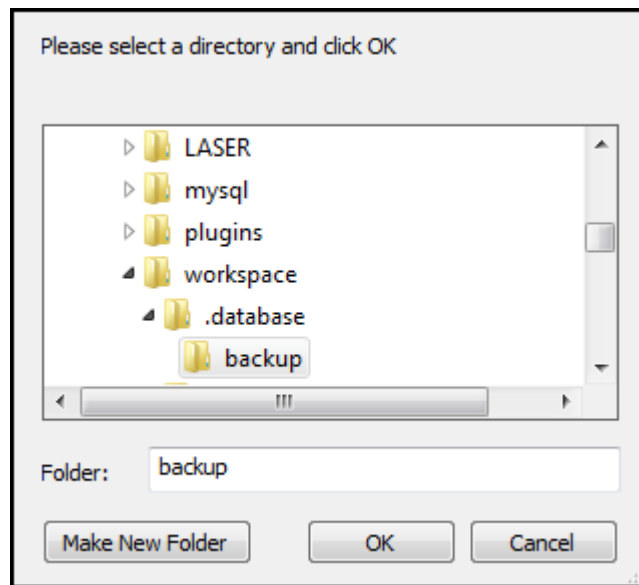
The default location for the database backup is located in a database/backup folder where the application is installed. Only a System Administrator may change the location where the backup will be stored.

Complete the following steps to change the location where the backup will be stored:

1. Select ‘Change Backup File Location’ from the File drop-down on the Menu Bar.



2. The 'Change Backup File Location' pop-up window displays with the current backup location highlighted.



3. Select the desired backup location.
4. Select 'OK' to set the location and close the pop-up window.
5. Selecting 'Cancel' will close the pop-up window without changing the location of the backup files.

DATA RESTORE

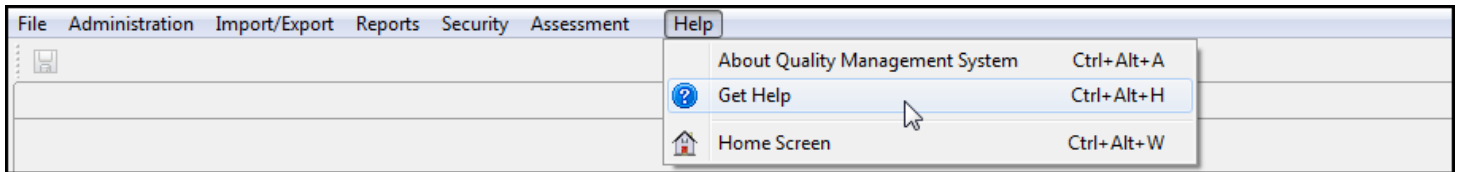
A database restore requires the assistance of the QTSO Help Desk. In the event of data loss, a System Administrator may perform a data restore using a prior database backup. Note, the database backup file must be the same version as the LASER application installed in order to complete this process successfully.

When attempting to restore a database using a backup which is older than that of the installed version of LASER the following error message will be displayed: "The version of the backup you selected is older than the current version of LASER. Please select a backup of the same version." Select 'OK' to return to the 'Login' screen and restore using the appropriate backup file.

HELP

Complete the following steps to access help documentation via the Menu Bar:

1. Select 'Get Help' from the 'Help' drop-down on the Menu Bar.



2. The LASER 'Get Help' screen will be displayed which includes a direct link to the CMS webpage where the LTCH Quality Reporting Manual (QRP) will be found.

Please utilize the LTCH Quality Reporting Program (QRP) Manual for assistance completing the LTCH Care Data Set. For item-by-item guidance Chapter three has been organized to correspond with each section of the LTCH Care Data Set.

The LTCH QRP Manual may be found on the following CMS webpage: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html>.”

For questions relating to ICD-9 coding please visit the following CMS webpage:
<http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html>

For questions relating to ICD-10 coding please visit the following CMS webpage:
<http://www.cms.gov/Medicare/Coding/ICD10/index.html>

QTSO HELP DESK

For additional technical support and assistance please contact the QTSO Help Desk.

Hours: Monday - Friday 7AM – 7PM CST

Phone: 877-201-4721

Email: help@qtso.com