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20140207-001	A - LASER	I have been locked out of Laser 1.0.0 I am the administrator. How do I reset my password?	First, please try to reset using the "Forgot Password" option: In LASER to reset password: • Enter your user id • Select Forgot Password • Three security questions will be presented. • Once the three entered questions are answered correctly then you will be able to change your password and access LASER again. If you are unable to answer the security questions or continue to experience issues, please call the QIES Help Desk for further assistance at: 1-877-201-4721.
20140207-002	A - LASER	We are working on our pressure ulcer data and got to a stopping point when trying to edit an assessment. We change the date enter field reflecting the day it was modified as well as changed the "Type of record" 2. Modify existing record once we were done we chose "Save and Validate" from File. This gave us an A0055 error to enter a Correction number which in most cases will be 01. When try to enter 01 in the field it does not allow me to type anything. Therefore, does not allow me to change the status of the record from Entry Data to Ready to Export. Is there any way that you may help us with this?	This field is auto populated based on how you started w/the assessment. A) If you used the wizard and created a new assessment the correction number will be 00. If it's the first assessment the A0050 should be 1. We are guessing that you may have created a new assessment (using the wizard), and then tried to select 02 for A0050 (based on the screen shot). And, you received a message stating: [-1025];If A0050 is equal to [2,3], then A0055 must not equal [00].(A055) Then, if you tried to correct A0055, it won't allow that. If you have a new record the count is 00. You can open and close any assessment as many times as you want prior to exporting and it will remain as 00. Once you save, validate the assessment and make sure it doesn't have fatal errors, then you may export

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			the assessment. Export the assessment. **<u>If you haven't submitted,</u>** you may reopen it and keep the correction count at 00. This allows you to fix whatever was discovered as an error. When the pop up displays you should select Reset Status and Edit – 1st screen shot below. This keeps the correction count as 00. Then make the needed changes. Save>validate making sure there are no fatal errors>export again. Assessment **<u>has been submitted and requires correction</u>** If you have already submitted and need to make a correction: Select the submitted assessment and open. When the pop up box displays, select the radio button for 'Create a correction record'. This will automatically set the correction number count to 01 or whatever the next number should be for your correction, i.e. if you made a correction 01 before, this would now be 02, etc. A00500 would have to be equal to 2 or it won't allow you to save, validate and change the status to export. Please let us know if this is where you are currently and we will continue to assist you. Basically, once you export the assessment, how you make the correction is based on if it's been submitted or not. a) Not submitted = Reset Status and Edit b) Submitted and accepted = Create a correction record c) Submitted and rejected = Reset Status and Edit.

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20121210-001	A - LASER	We began using the demo version of LASER for a trial of the LTCH CARE data collection process in our facility. We noticed some odd things about the way it works. When I called the QIES Helpdesk to report these issues, they told me LASER was acting according to your documented specs so I should contact you with my questions / concerns. 1. Assessment Reference Date field. Why do we have to type this in? If we provide the type of assessment (Admission, Discharge, Expired, Unplanned Discharge) and the relevant date (Admission Date, Discharge Date, Date of Death), then shouldn't the software calculate the ARD? According to the documentation, the ARD is a static formula based on those two variables so allowing us to type the ARD just provides opportunity for error. 2. Assessment Reference Date field. My real problem is that we are trying to be proactive and enter information into LASER as soon as we have it. We have trained our nurses to conduct the Pressure Ulcer assessment on the day of admission. They turn that information in to our data entry person the next day (Admission Date + 1). The data entry person then enters it as soon as they receive it. But when the data entry person gets to the screen to enter the dates of the assessment: Admission = 9/5/2012, ARD = 9/7/2012. LASER won't allow him to enter it. He gets an error message saying that the ARD can't be a future date (today is 9/6/2012). That doesn't make sense. Why can't the ARD be a future date? The only way around this is for my data entry person to hold on to the information	1. The ARD can't be automatically set. According to the LTCH QRP manual, chapter 3, section A, page A-6, "the ARD for an admission record is at most the third calendar day of the patient's stay." The provider may choose day one, two or three of the patient's stay. Thus, the setting of the ARD may not be coded/automatic. 2. According to the data specifications there are several date consistency rules. One is that a date may not be in the future. Another example is that the birth date may not occur after the admission date. LASER provides runs and enforces edits throughout the application, thus the ARD may not be in the future. Thank you for your feedback. We will take this into consideration for future changes to the LASER application in order for a provider to enter data as it is collected.

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		for one more day. You've dictated that he can't process data as soon as it comes to him. The longer he has to wait to process information, the more opportunity there is for error - something will be overlooked eventually.	
20121210-002	A - LASER	LASER is requiring us to answered three fields that are not mandatory according to your last update. They are: 1. A1000 - Race 2. A1800 - Admitted from 3. A1810 - Services in the past two months Both A1800 and A1810 have an answer choice of "None of the above" but this is different than being able to answer "-Not Assessed/Not Answered" like the choices we have in the rest of the laser software. We have been forced to answer "None of the above" though we do not feel that is accurate (because you could also deduce that the patients came from a different kind of facility or had different services from that answer) but LASER will not allow us to Save/Validate and therefore create the exported file that we need, without doing so. For race we have had to do medical record extraction that we did not expect to have to do since it was deemed not mandatory. Elsewhere in LASER we are allowed to choose ""-Not Assessed/Not Answered" and create an export file even on questions that are mandatory! Please provide feedback on what is best to do with these three fields.	A1000 – Race – is still a mandatory field on all but the XX ISC types. Please refer to the specifications. Also, there are 3 stages to these check boxes – not checked, checked, and if you click on each box a 2nd time, the Checked becomes Not assessed. A1800 – Admitted from - is mandatory on an ISC equal to LA. Please refer to the specifications. At this time, Not assessed is not an allowable option. A1810 – Services in the past two months – is mandatory on an LA. Not assessed is an option, however, as per the specifications, there are rules related to using not-assessed: -3844 Consistency Warning If A1800=[05], then A1810A must not equal [1]. -3860 Consistency Fatal If A1810Z=[0], then at least one item from A1810A through A1810L must equal [1]. -3861 Consistency Fatal If A1810Z=[1], then all items from A1810A through A1810L must equal [0]. -3862 Consistency Fatal If A1810Z=[-], then at least one item from A1810A through A1810L must equal [-] and all remaining items must equal [0,-]. Further information about item A1810 is that the Not Assessed option is available if the user hits the check box a 2nd time. It's the same as with the A1000, Race, question. If the user hits it once, the box is checked.

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			If they hit it again, the answer becomes Not Assessed. But, they have to be careful if they do select Not Assessed for A1810, as they may get a Warning message.
20121210-003	A - LASER	Can we import the LASER database into a current MySQL database?	No, there is not a direct way to import the LASER database into a different database.
20121210-004	A - LASER	What is the LASER MySQL database server spec?	The specs for MySQL are identical to those of the standalone app. They can be found at the following website: http://www.mysql.com/products/enterprise/techspec.html. Some general information about the database for the server/standalone is below. It has been broken down into several variables which tell which version of MySQL LASER is running as well as the version of the OS: **Variable_name**: innodb_version **Value:** 1.1.5 **Variable_name**: protocol_version **Value:** 10 **Variable_name:** slave_type_conversions **Value:** null **Variable_name:** version **Value:** 5.5.9 **Variable_name:** version_comment **Value:** MySQL Community Server (GPL) **Variable_name:** version_compile_machine **Value:** x86 **Variable_name:** version_compile_os **Value:** Win32

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20120831-001	A - LASER	We currently have some desktops in our hospital that run Window 7 Professional 64bit. Do we have to reload these with 32bit operating system to get the LASER software to work at those desktops?	The LASER Tool will work on a 64-bit Win 7 desktop because there is a 32-bit subsystem built-in to Win 7; there is no need to uninstall Win 7 64-bit from your desktops.
20120831-002	A - LASER	Will the CMS LASER system provide data backup, security, upgrades, updates for new LTCH CARE requirements, etc?	Yes, LASER has a backup feature. When exiting the application, a prompt to back up the data will appear; however, users have the option of declining the backup. Each user is required to have a password and must initially answer 6 security questions. As new LTCH CARE requirements are established that impact the assessment instrument, LASER will be updated to reflect the changes.
20120831-003	A - LASER	Where is the documentation for LASER system requirements?	The documentation is located on the QTSO website: https://www.qtso.com/index.php.
20120831-004	A - LASER	Are there three security types, System Administrator, Data Entry and Read Only?	The user roles are System Administrator, Data Entry and View Only. **System Administrator:** May add, edit, and delete assessments. Deletion of assessments is allowed on non-exported assessments. They may also add and edit a facility. For the Patient they may add, edit, hide or delete. If the patient has assessments they cannot be deleted. System Administrators may add, edit, delete and terminate a user. They cannot delete or terminate the only System Administrator and they cannot delete their own user account. System Administrators can see all info for all facilities. Also, the default System Administrator (laser\laser) may only add new users and add facility. Once the new password has been established or new system administrator and password have been created, then

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			they may add patients and assessments. Only System Administrator may import, export modify or inactivate an assessment. **Data Entry:** May add or edit assessments. They cannot delete assessments. They may edit facility information. They may not add or delete a facility. They may add or edit a patient. They cannot delete a patient. Data entry will only see information related to the facility they are associated to during the user set up process. **View Only:** They may only view assessments and within that assessment they'll see the patient information and the facility information. View Only will only see information related to the facility they are associated to during the user set up process.
20120831-005	A - LASER	Is there a way to modify the System Administrator role to only include Add, Edit, or Delete Facility, Users, and Patient Accounts?	No, the user roles are pre-defined within the LASER system. We will take your request into consideration for a possible future requirement.
20120831-006	A - LASER	During the conference and demonstration of Laser "optional fields" were referenced. Are any of the fields on the LTCH CARE Dataset Tool optional?	All fields on the assessment form follow the data set. The assessment form does not contain 'optional fields'. LASER has a facility, patient and user windows which contain items noted on the data set or required for access to the application. The facility and patient windows contain what is required for the assessment, plus a few optional fields for the benefit of the users, i.e. facility has Contact person, contact phone number. The User window has first, middle and last name, phone number and e-mail address and termination date. These 'optional' items are not carried forward to the assessment and are not submitted to ASAP. They are for 'housekeeping' at the facility level.

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20120831-007	A - LASER	Is there a timestamp mechanism in LASER that tracks if the fields have been completed with the 3 day assessment and the 5 additional days for form completion? We are looking for functionality to help track the timeframes required.	There is not a time stamp in LASER. However, there are edits within the LASER tool that are displayed when the user clicks the 'Save and Validate' button/function. There are reports that may be generated and utilized for tracking which assessments have been started or completed, e.g. Assessment event tracking.
20120628-001	A - LASER	Our understanding is that the LASER tool will provide the ability for the LTCH provider to enter all assessment data manually. The LASER tool will then transmit the data to CMS in the required data format. Please confirm if this is true.	LASER is the CMS free software for Long Term Care Hospitals to use to enter individual patient data (Long Term Care Hospital CARE Data Set). The software uses the required data format. However, you would need to transmit the data to CMS. The production and demonstration versions of LASER are available on the QTSO website: https://www.qtso.com/laser.html.
20120628-002	A - LASER	Will the LASER tool have the ability to accept an upload of an electronic data file with partial assessment data (such as patient demographic information and other data that could be pulled from our electronic medical record), and then permit the user to manually enter or edit data prior to submission?	No, LASER doesn't interface with other systems. You will need to manually enter all data. Facility information will only need to be entered once. Certain patient demographic information will only need to be entered once. However, all clinical information will need to be entered manually.
20120628-003	A - LASER	Is there going to be a client server version of the LASER software?	There will be a standalone install and a network install.

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20120628-004	A - LASER	For the network install of LASER, please address the following: 1. How many facilities will it handle? 2. Will it be able to handle time zones? 3. How many concurrent users logged into the software? 4. Is the software handle record locking? (Meaning that two people cannot access the same assessment at the same time or will LASER allow two users on the same assessment and the last one saved overwrites the first person's changes?) 5. Is there a way for a batch submission (through ASAP or other way) of assessments from a central location? (possibly for several locations/facilities)	1. There is not a limit in the LASER software; either the Java Virtual Machine or machine will limit the number of facilities the software can handle. 2. No, it uses the system date of the machine it is installed on. 3. Standalone, 1; client server, 1 per machine. 4. Yes, it will provide an error message stating that the record is in use and the identifier for that user. 5. We are unclear regarding your actual question. Are you asking about the ASAP system?
20120628-005	A - LASER	Questions on LASER security permissions: 1. Can a user ID have access to more than one facility? 2. Will the LASER software integrate with active directory?	No, users can be assigned to one facility at a time No
20120628-006	A - LASER	Is there a way to archive off old assessment data (over a year old, for example)? Since we admit roughly 5500 patients a month it would be good for us to have a way to archive out old patient data; otherwise we will have an incredibly long list of patients. We would prefer archiving as to deleting so we could get back the data of	LASER does not have an archive feature.

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		the assessments if necessary. This is strictly the patient list in LASER as we know that the xml file of the saved assessment needs to be stored externally.	
20120628-007	A - LASER	1. Will LASER be updated electronically automatically or have a field that can be marked once the submission has been successfully completed to CMS (through ASAP)? 2. Will LASER be updated electronically automatically with info from CASPER that the records in the transmission were accepted or rejected?	1. No. It will show that the file was exported. It doesn't know if the record was accepted by the ASAP system. You must review you final validation report. LASER will not know if the submission file was in acceptable format. 2. No, as per previous response, you must review your final validation report.
20120628-008	A - LASER	Are there any kind of reports that tell the user when an assessment has not been completed and/or transmitted? An assessment is started in LASER but not completed and therefore not ready for transmission--is there a report or mechanism in LASER that can notify or pull assessments that have not been completed? Or is this a manual tracking mechanism that a user at the facility has to do?	There are various reports, as well as, search capability.
20120628-009	A - LASER	What date will LASER be available so that we can load the software, prepare for deployment to all of our facilities, and start training staff?	The demonstration and production versions are available. WebEx trainings for LASER are available on the QTSO website: https://www.qtso.com/laser.html.
20120628-010	A - LASER	1. What database will LASER use for the client/server? 2. What are the licensing requirements for the database?	3. MYSQL 2. There are none. MYSQL is open source with a General Public License.

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20140207-003	B - General	What is the deadline for submissions of the LTCH CARE records?	The timelines related to the data collection periods and data submission periods can be found in the FY 2012 IPPS/PPS LTCH Final Rule, as well as in the LTCH Quality Reporting Program Manual, provided under downloads on the LTCH Quality Reporting web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment.
20140207-004	B - General	Is there a way to get a report to know how your decubs are trending in CASPER?	If you are asking about reviewing the assessments that you submitted, you may run the assessment print report on any assessment. If you are inquiring if you are improving, QIES has no reports on any measures for LTCH.
20140207-005	B - General	I have a Planned discharge assessment that should have not been submitted to QIES because it was a Program of Interruption and I am trying to make an Inactivation request. The completion date for this Planned Discharge assessment was 8/6 and date of transmission was 8/13.	The Z0500B LTCH CARE Data Set Completion Date for an Inactivation request record is the date the Inactivation request is completed. Please ensure all assessment ID and resident ID items (identified in Chapter 3, Section A, Item A0050) for the Inactivation record are identical to the original Planned Discharge assessment.
20121210-006	B - General	Three of our four facilities had the incorrect Facility ID numbers to enter on the CARE Data Sets. We took the number from the original CMS FAC ID Crosswalk list and have been using them. Evidently, the list has changed and so the assessments we have submitted thus far were rejected because the system doesn't recognize the facility number. My question is.... it doesn't seem that we can change the facility ID on the assessments that are already completed which would allow us to submit them again. Instead, all of the data has to be re-entered and then re-submitted and I would like to know if there is any other way of doing this	Directions on updating your Facility ID on completed assessments in your software should be directed to your software vendor.

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		besides entering the data all over again?	
20121210-007	B - General	I have questions regarding correction numbers for LTCH data submissions. Specifically the question regards to what correction numbers to send when a change to CARE tool data happens and corrections and/or inactivations need to be sent for both an admission and discharge records.	The correction policy is documented in Chapter 4 beginning with Section 4 on page 4-3. When an assessment is to be modified or inactivated, the correction number must be increased by one (1). If there are 2 records to be modified (an admission and a discharge), each record must be individually modified and the modification number increased by one from the correct number on the prior record. Correction numbers only apply to a single assessment. Please note that modifications and inactivations can only be submitted for records that have been accepted into the QIES ASAP system. If the original record was rejected due to errors, then the original record must be corrected and resubmitted as an original not a modification. Example: An admission assessment is submitted - Correction number = 00 and this admission assessment is accepted into the QIES ASAP system. An error is discovered in the value of an item. Since the admission was accepted, a modification record with the correction number of 01 must be created and submitted. Modification record is submitted and accepted into the QIES ASAP system - Correction number = 01. Another error is discovered in the value of an item: Since the admission modification 01 was accepted, a new modification record with the correction number of 02 must be created and submitted. Modification record is submitted and accepted into the QIES ASAP system - Correction number = 02.

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			It is discovered that this record needs to be inactivated. Since the admission modification 02 was accepted, an inactivation record with the correction number of 03 must be created and submitted. Inactivation record is submitted and accepted into the QIES ASAP system - Correction number = 03. While the above admission is being modified, another record, a discharge is discovered to have an error. The same process happens for the discharge record in error. A discharge assessment is submitted - Correction number = 00. This discharge assessment is accepted into the QIES ASAP system. The person was not discharge so the record is to be inactivated. Inactivation record is submitted and accepted into the QIES ASAP system - Correction number = 01.
20121210-008	B - General	We tried to register for a QIES password today but I was unable to locate a link that would allow us to do that. Are we able to do that without our CMSNet User ID and if so, where is the registration website?	A CMSNet User ID is needed prior to registering for a QIES User ID. After receiving your CMSNet User ID and password, download and install the Verizon software. After installation of the software is complete, you will be able to log into the CMS Network with your CMSNet User ID and password. A link is provided to access the CMS LTCH CARE System Welcome page. On the LTCH CARE Welcome page there is a link to access the LTCH User Registration application where you may register for your QIES User ID. A recorded WebEx, training session, titled Provider User ID Training Processes, is available. The information on this training is located under the **Provider User Registration Training WebEx**

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			Available section on the QTSO website at: https://www.qtso.com/ltchtrain.html.
20121210-010	B - General	Apparently CMS allows LTCH providers to use the same CCN for physically separated locations that are within 30 miles. In talking with other vendor's staff, they are telling me this is a common occurrence within their corporation. They are wondering how they will handle the online registration with a limit of two individual IDs per CCN. They both assure me that they have different staff submitting at each of these locations and it will be difficult for them to adhere to the limit of two IDs. So, just wondering the best way to handle this – 1. If we know in advance the CCNs affected, can be bump the level to 4 or 6 users for an individual user id? 2. Or, do we need to have them fill out a paper form if they need more than 2 individual ids per CCN? 3. Another option?	CMS will maintain 2 per CCN at this time and use our current procedure/policy, the paper form. We will reassess after we are comfortable that most LTCHs have user ids. CMS does allow third parties (vendors and corporate office) to submit on behalf of multiple providers.
20121210-011	B - General	I am creating EMR assessments in converting LTCH's from paper to EMR. In doing this I am attempting to incorporate the LTCH quality reporting data set and new standards affecting LTCH's. I wanted to inquire if you have any collaborative documents in assessments being used to obtain this information to easily facilitate reporting to CMS? or perhaps any resources to implement the required fields to facilitate seamless communication for LTCH's with CMS reporting requirements.	Information on LTCH CARE quality data submission is available on the CMS quality reporting website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html. Technical information on LTCH CARE submission including the Data Specifications is available on the CMS website:http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html Additional technical information on the LTCH CARE submission is available on the QIES Technical

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			Support Office Website: https://www.qtso.com/. There are 2 places on QTSO to obtain LTCH CARE information 1 - Click on the LTCH link in the left panel. 2 - Click on the Vendors link on the left panel - then click on the LTCH link at the top of the page.
20121210-013	B - General	One item of feedback that we're getting is that it's apparently common for a patient to be admitted from a short stay acute hospital (A1800) and also have had a second, past stay in a short-stay acute hospital within the previous two months (A1810). That combination (checking short-stay acute for both A1800 and A1810) throws a consistency warning -- Edit 3844 -- which is very confusing to users. They're answering the questions accurately, but they're getting a warning.	A1810 was intended to identify other medical services the patient received aside from the services just prior to hospitalization. If you indicate the same service provider type in 1810 as was coded in 1800, you will receive the consistency warning message you indicated in your email, but your record will not be rejected. We recognize that because 1810 requests responses related to services besides those identified in 1800, it was not set up to allow that patients might have received the same services in the last 2 months that they received just prior to the LTCH admission. Thus, your feedback was helpful.
20120831-008	B - General	Will there be a data submission vendor for this quality reporting initiative? CMS is offering the LASER application, but we want to know if we can use a different vendor solution for data collection and file submission.	Decisions related to vendor use are up to the LTCH. CMS does not provide, or require, vendor services for LTCHs for the purposes of the LTCH Quality Reporting Program. LTCHs must meet the technical submission specifications as provided on the CMS LTCH Quality Reporting Technical Information Web Page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html. LTCHs may choose to hire a vendor to do this for them. LTCHs also have the option to use the free, downloadable LASER software that is provided by CMS as this software meets the technical submission specifications.

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20120831-009	B - General	Will the LTCH need to utilize the secure side of Q net for any transactions related to the pressure ulcer quality metrics? We are familiar with data uploads, vendor designations, file retrieval, etc which are transacted in quality net as part of the IPPS and the OPPS quality reporting programs.	The LTCH CARE Data Item Set is submitted to the QIES ASAP system. This process is different from the IPPS and OPPS processes.
20120831-010	B - General	If we build an EHR tool to collect all the data elements needed, can we then write a report and upload aggregate rather than patient level assessment files to QIES – instead of using LASER?	You are required to submit patient level data via the LTCH CARE Data Item set for the pressure ulcer quality reporting. Please refer to the technical data specifications.
20120831-011	B - General	Where can we find the timelines (in terms of data collection periods and data submission periods) associated with this program?	The timelines related to the data collection periods and data submission periods can be found in the FY 2012 IPPS/PPS LTCH Final Rule, as well as in the LTCH Quality Reporting Program Manual, provided under downloads on the LTCH Quality Reporting web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html.
20120831-012	B - General	What is the policy on filling in the signature lines when using an electronic medical record?	If a provider has an Electronic Health Care Record (EHR), then they would need to follow their facility's policies related to electronic signatures. Please note, that CMS does not receive the signatures provided in Section Z of the data set. However, LTCHs should retain this document in with the record. CMS does receive the submission date provided in Z0500B.
20120831-013	B - General	How can an LTCH vendor receive information?	Users who register on the QTSO Vendor website will receive technical email announcements from CMS. CMS will use your contact information to provide you

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			with important news, updates, and conference call notices. These announcements are also posted on the QTSO vendor page located at: https://www.qtso.com/vendor.html.
20120831-014	B - General	For the October 1, 2012 start date: Please clarify whether the CARE Data Set to be submitted by LTAC Hospitals is for patients ADMITTED on Oct 1 and thereafter, or for patients DISCHARGED, transferred or died on Oct 1 and thereafter?	All applicable LTCH CARE Data Set Assessments must only be completed for eligible patients who have been admitted on or after 12:00 a.m. on October 1, 2012. If the patient was admitted prior to October 1, no records are required to be submitted for the patient.
20120831-017	B - General	I see the question A0050 and A0055 to indicate that this is a modification and the correction number - but where does the user that is making the correction enter their name or do they not do that in this form. If they enter the name/date in Z - they will get edits if after the Z0500 date. I guess I am looking for questions seen in section X for the MDS but perhaps this item set operates different	The LTCH CARE data set does not have a section X. The information in Section A is used to locate the record to be modified/inactivated. Instructions on how to fill out Section Z for a modification should be directed to the policy mailbox: LTCHQualityQuestions@cms.hhs.gov
20120628-013	B - General	Will automated report retrieval be possible? Is it fair to state that all interactions will be manual and we can expect automated support in the future?	The system does not accommodate automated scripting, nor do we anticipate allowing it in the future, as there are other requirements to be met before this is addressed.
20140207-006	C - Specs	Looking for some guidance - we have a client with a Medicare Number that falls outside of the edits below - They have double checked this number in other systems and it appears to be correct The number is in this format: 12345678C9	12345678C9 does not pass edit -1004: -1004 Incorrect Format: If the first character is numeric (0-9), then the first 9 characters must be numeric (0-9). The first character is numeric (the digit 1) but only the first 8 characters are digits (1,2,3,4,5,6,7,8) The ninth character should also be a digit, but it is the letter C.

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		This would be a fatal error per edit ID -1004 - any suggestions on what they should enter?	No Medicare numbers are issued with 8 digits followed by a letter. They have an incorrect numeric portion of the Medicare (HIC) number. A digit must be inadvertently omitted when they when wrote it down or entered it.
20140207-007	C - Specs	We are receiving errors on our expired discharge assessments **LTCH Item(s):** ITM_SBST_CD, Calculated ITM_SBST_CD, A0250 **Data Submitted:** LA, LE, 12 **Message Number/Severity:** -1034 FATAL **Message:** Invalid ISC: The submitted ISC (item subset code) does not match the ISC calculated by the QIES ASAP System.	The Item Subset Code you have entered in your XML file is an incorrect value. Please refer to the LTCH 1.00.3 Data Submission Specifications Overview section 9.1 for information on determining the ISC that corresponds to the LTCH CARE data record.
20140207-008	C - Specs	I have Medicare Advantage patients in our hospitals, so I need to know if I should enter their Medicare Advantage number in the "Medicare Number section A0600B"? Our patients Medicare Advantage number starts with an Alphabet and then has 10 numbers behind them. It is giving me a fatal error (message -1005) on both of these accounts. If it is not to be included in this section, do we just leave the Medicare section blank?	Item A0600B can only be a Medicare (HIC) number or a Railroad Retirement Board number. If no Medicare number or RRB number is known or available, the item may be left blank. Edit -1004, -1005, or -1017 applies when the number entered does not meet the format criteria for a Medicare or Railroad Retirement Board Number. We will update the LTCH Quality Reporting Manual in the future with this additional information.
20140207-009	C - Specs	I have a question about how to apply the updated CARE Set / validation rules. My understanding is that the new validation rules will need to be in place on April 1 2014. If I have a patient assessment that I submit on March 31st I will need to validate that assessment against the current care set. If QIES rejects the assessment and I make corrections,	The item set for the LTCH assessment record is based on the target date of the assessment. The target date is defined as follows: a) If A0250=[01], then the target date is equal to A0220 (admission date) b) If A0250=[10,11,12], then the target date is equal to A0270 (discharge date)

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		and resubmit on April 1st, will I need to resubmit against the new care set?	Your correction LTCH record will be for the same LTCH CARE set as your original.
20140207-010	C - Specs	I have a question about the date value for item O0250B (date influenza vaccine received). There don't appear to be any parameters around this date. For example, should it be within the assessment admit & discharge date? after birthdate? anything else?	There are no restrictions/parameters on the O0250B date field for this version of the data specifications.
20140207-011	C - Specs	Is this a typo ... on page 8 of the errata, Issue ID 19, re: edit -9002 If A0050 = [1,2] and A0250 = [12] then ITM_SBST_CD = [LU] should this be LE?	Yes, this is a typo. It should say, "If A0050 = [1,2] and A0250 = [12] then ITM_SBST_CD = [LE]".
20121210-014	C - Specs	1. Is there a particular convention we need to use in naming the zip files that we upload on the LTCH website 2. Is there a particular way we need to name the patient data file within the zip file? 3. Is it permissible to place more than one patient's file in a single zip file?	Please note that this information is documented on page 11 of the LTCH Data Specifications Overview which is part of the LTCH Data Specifications posted on the CMS website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html.
20121210-015	C - Specs	Our XML file contains a data element that is not present in the spec - <fac_doc_id>. This element was in the sample file included with xml documentation. We do not think it is causing the problem reading xml files since our files are validating with the VUT, but wanted to verify this with you.	The ASAP system ignores and does not process additional tags.
20121210-016	C - Specs	We have a user who needs to inactivate a discharge assessment. According to our reading, the inactivation record contains nothing that makes it clear which of the patient's previous records should be inactivated. Does the inactivation only effect the most	All items required on an LTCH Inactivation record are identified as 'Active' on Item Subsets (XX) in the LTCH CARE Data Submission Specifications (v1.00.3). An inactivation record is identified by item A0050 response value of 3. Assessment items (Section A items) used to locate the record for

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		recently sent assessment? For future reference, how would we specify the inactivation record if we need an admission inactivated if the patient already has a discharge assessment submitted?	inactivation are: A0050 Type of Record A0200 Type of Provider A0210 Assessment Reference Date A0220 Admission Date A0250 Reason for Assessment A0270 Discharge Date (if A0250 = 10, 11, or 12) A0500A Patient First Name A0500C Patient Last Name A0600 Social Security Number A0800 Gender A0900 Birth Date The above assessment items submitted on an Inactivation record (A0050 = 3) must match the same items on the record to be inactivated. When they do match it is clear which of the patient's previous records should be inactivated. Therefore, inactivations may be done out of order (i.e. even after a Discharge assessment has been successfully submitted). If they do not match, the ASAP system cannot locate the record and fatal error -3745 “No Match Found: This modification/inactivation record does not match a previously accepted record in the QIES ASAP System.” will occur.
20121210-017	C - Specs	I have Medicare Advantage patients in our hospitals, so I need to know if I should enter their Medicare Advantage number in the “Medicare Number section A0600B”. Our patients Medicare Advantage number starts	Item A0600B can only be a Medicare (HIC) number or a Railroad Retirement Board number. If no Medicare number or RRB number is known or available, the item may be left blank. Edits -1004, -1005, or -1017 applies when the number entered does not meet

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		with an Alphabetic character and then has 10 numbers following. It is giving me a fatal error (message -1005) on both of these accounts. If it is not to be included in this section, do we just leave the Medicare section blank?	the format criteria for a Medicare or Railroad Retirement Board Numbers.
20121210-018	C - Specs	I am working with an LTCH on submitting their CARE Data using the ASAP system. We keep running into the below error and want to ensure our file spec is written appropriately. Can you provide more detail around this error or let me know what field is causing the problem? We did not see an issue in the VUT when running the file through. Upload details Error: Invalid XML File Format: The submitted file is not structured properly or contains tags longer than 30 characters an cannot be processed" Date of upload/export attempt: *mm/dd/yyyy* Submission ID: *xxxx*	There are three main reasons for receiving error -901: 1 - The zip file contains folders/subfolders. The zip file should not contain any folders 2 - The encoding used for the XML file is UTF-8. ANSI encoding should be used not UTF-8 3 - An invalid tag that is longer than 30 characters was sent in the file. No tag for an item submitted in the LTCH submission file is longer than 30 characters. Please refer to Section 5 of the Long Term Care Hospital (LTCH) Provider User's Guide for the QIES ASAP System for a complete explanation of error -901 (and all other ASAP errors).
20120831-018	C - Specs	Re: Transmission Specs v 1.00.3. It sounds like there is nothing new here that wasn't in 1.00.2 plus the errata. Is that correct?	As stated on the technical web page, V1.00.3 addresses all of the issues that were addressed in the errata document that was posted in June, 2012. In addition (also stated on the web page), the version history document had been replaced with an Item Change Report and an Edit Change Report; the detailed data specifications report is included as a single file and as a set of files; and the HTML zip file now contains a file that was missing in the previous version, INDEX.HTML.

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20120831-019	C - Specs	Is there to be one XML file per patient admission or discharge? Or is there a provision for creating single xml files with multiple patient records?	One and only one assessment (admission, discharge, etc.) can be encoded in each XML file. XML files cannot be submitted directly; ZIP files containing one or more XML files must be submitted instead. ZIP files must be 5 MB in size or less.
20120831-020	C - Specs	Will each admission and discharge assessment need to be submitted individually or can multiple assessments be submitted in the same file?	One or more assessments can be submitted in the same file. See the Overview document of the LTCH Care Data Submission Specifications for details.
20120831-021	C - Specs	What are the naming conventions for the XML file?	The rules for the XML and ZIP file names are found on page 11 of the LTCH 1.00.3 Data Submission Specifications Overview. The naming conventions are as follows: a) File names for ZIP files cannot exceed 260 characters, including the file extension. A file extension of .zip is required. b) File names for XML files cannot exceed 260 characters, including the file extension. A file extension of .xml is required.
20120628-014	C - Specs	Some data elements indicate a caret be placed if there is no value. Not all data elements indicate that. If a data element can't take a caret, should I believe that data element is required?	That is correct. The use of the caret is to accommodate skip patterns. If the answer to item 1 can cause you to skip item 2, then item 2 will allow a caret as a valid value. Items that cannot be skipped won't have a caret as a valid value. Skipping an item is different from an item being inactive. On a particular type of assessment, some items are inactive and not collected; you won't submit those items on that type of assessment. If active in the item subset code (ISC) and can be skipped, the item would have a caret as a valid value.
20140207-012	D – Submission	If an LTCH is to submit an assessment record out of sequence, the LASER software will issue a warning - this I understand. When the LTCH realizes that they have done this, can they go ahead and just submit the missing assessment	The ASAP system does the following: If an LTCH submits a discharge record and has not had the corresponding admission record accepted for this patient, then the ASAP system will issue warning

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		(i.e. - they submit a d/c assessment, LASER issues an "out of sequence" warning, they realize they never submitted the admission assessment) - can they just go ahead and submit it? Will the QIES/ASAP system accept this record - or will IT now be considered out of sequence as the LTCH originally submitted a d/c on this patient?	message -909 Inconsistent Record Sequence: Under CMS sequencing guidelines, the type of assessment in this record does not logically follow the type of assessment in the record received prior to this one. If the LTCH then submits the admission record, the admission record will be accepted (if it passes the edits) and will not receive an out of sequence message provided the above discharge record has a discharge date after the admission date of the admission record. The sequencing looks at the target date of the submitted record, finds the record in the database (if it exists) with the latest target date PRIOR to the submitted record and then checks the sequence of the 2 records. The admission record will probably receive a late submission warning message -3810 Record Submitted Late: The submission date is more than 7 days after Z0500B for this new (A0050 equals 1) record.
20140207-013	D - Submission	We are having difficulty determining where to upload the export files to CMS.	Technical information on submitting the LTCH assessments to CMS can found on the QTSO website located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html. To submit the LASER created submission files, the provider must have a QIES User ID. Prior to registering for a QIES User ID, the provider must obtain a CMSNet User ID. The CMSNet information is located on the main page of the http://www.qtso.com/ website at the top right of this page. There is an information document and an Access Request form. Fill out the form under the IRF

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			/ Swing Bed / LTCH subheading of the Access Request Information section on the top right of the main page. After receiving your CMSNet User ID and password, download and install the Verizon software. After installation of the software is complete, you will be able to log into the CMS Network with your CMSNet User ID and password. A link is provided to access the CMS LTCH CARE System Welcome page. On the LTCH CARE Welcome page there is a link to access the LTCH User Registration application where you may register for your QIES User ID. A recorded WebEx training session, titled Provider User ID Training Processes, is available. The information on this training is located under the Provider User Registration Training WebEx Available section on the QTSO website at: https://www.qtso.com/ltchtrain.html. A submission user's guide and other relevant information is located under the LTCH link on the blue navigation bar at the left side of the QTSO main page. There is detailed information on the registration process on this page. If after following this information, you still are having submission issues, please contact the QTSO Help Desk by Phone: 1-877-201-4721 or E-mail: help@qtso.com.
20140207-014	D - Submission	In the past week, we have seen three corrections to previously submitted assessments rejected under circumstances that suggest to us that the resident matching criteria for the ASAP database have changed.	There has been no change to the Resident Match Criteria. The information in the Resident table in the QIES database contains the latest information about a

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		All three rejections occurred under identical circumstances as follows: -- First, an original assessment was sent with values for all of the fields used in matching: State ID, Fac ID, SSN, Last Name, First Name, Date of Birth and Gender. That assessment was accepted. -- The user corrected the assessment changing only the Date of Birth. -- Following the logic of the resident matching process, we created a modification record. -- The user submited the modification record and it was rejected with edit -3745 (no match found). Our understanding in each case was that the matching record would be found based on Criteria Set 11 (following the flowchart on Appendix B-5) of the Submission User's Guide for the QIES ASAP System (dated 9/2012). Because an SSN was included in the original assessment, an inactivation should not be necessary to change only the date of birth.	patient/resident that was submitted on an assessment from any collection system (nursing homes, swing bed units, home health agencies, long term care hospitals, and inpatient rehabilitation facilities). There is a date on the Resident table which is the Target date of the last assessment that impacted the Resident table. For LTCHs the Target date is the admission date for an admission assessment, the discharge date for a discharge/death assessment. If the assessment Target date is greater than or equal to the date on the Resident table, then the Resident table is updated with any resident identifiers in the assessment that are different than the resident identifiers on the Resident table. The date on the Resident table is also updated. If the assessment Target date is less than the date on the Resident table, then no changes are made to the Resident table. The submission date is not used to determine whether to update the Resident table. Again, updating of the Resident table information is based on the target date only. Note: If the resident identifier in the assessment is missing (contains a caret [^]), then the Resident table is not updated with this value. First rejection: This modification record was rejected appropriately. In between the submission of the original record and the modification record, there was a record submitted by another facility for this resident/patient that updated the Resident table with a different first name, and different provider ID. The modification record that was then submitted contained a different birth date than what was on the original record. Therefore the match could not occur with a different first name, provider number, and different birth date.

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			Second rejection: This modification record was rejected appropriately due to different target dates (admission dates) on the original and modification records. You cannot modify the target date or the reason for assessment. Third rejection: This modification record was rejected appropriately. In between the submission of the original record and the modification record, there were records submitted with more recent Target dates by another provider for this patient that updated the Resident table with a different SSN and different provider ID. The modification record that was submitted then contained a different birth date than what was on the original record. Therefore the match could not occur with a different SSN, provider number, and different birth date. Since your modifications were submitted much later than the original admission assessments, the patient(s), in the meantime, were treated by a different provider who updated the National Resident Table with more current information.
20140207-015	D - Submission	Please give me the site for submission of quality re: pressure ulcers. From the guidelines, I thought pressure ulcer reporting went to QIES ASAP. I had a problem submitting a file and was told that pressure ulcer reporting goes to the CDC site along with CAUTIs and CLBSI's. I need to know which site is correct for submission of pressure ulcer information.	The LTCH QPR reporting for Pressure Ulcers is done by submitting the LTCH CARE Item Set to the QIES ASAP System. For assistance with this process, please contact the QTSO (QIES Technical Support Office) help desk at 1-877-201-4721. The LTCH Submission User's Guide is also located on http://www.qtso.com/ltch.html along with other helpful information. This manual is also located on the LTCH CARE Submission Welcome page.
20140207-016	D - Submission	I have received the following warning: PLANNED DISCHARGE, NONE,	The error message -909 "Inconsistent Record" correctly identified your missing assessment. Please submit the Admission record that was previously

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		-909 WARNING Inconsistent Record Sequence: Under CMS sequencing guidelines, the type of assessment in this record does not logically follow the type of assessment in the record received prior to this one. I have discovered that I failed to export the admission for this patient. NOTHING in the LTCHQR Manual provides direction for troubleshooting the warning messages, i.e. what to correct if you receive this error. That puts you in a nice catch 22. I am submitting the admission record late, please let me know if I need to re-submit the discharge assessment or make corrections to that record.	missed. There is no need to resubmit the Discharge record. Please refer to Chapter 5 of the LTCH Submission User's Guide for troubleshooting tips. This guide is located at https://www.qtso.com/ltchtrain.html.
20140207-017	D - Submission	Can an individual have access to submit data for 2 separate CCNs? If so, is there a limit to the number an individual can submit data?	Yes, an individual can have access to submit data for multiple CCNs. There is no limit at this time to the number of CCNs to which an individual may submit.
20121210-019	D - Submission	The latest manual for how to use CASPER Reporting Services, including submission validation reports, does not include screenshots for what I actually see on my screens. I have had to call the QTSO help desk for assistance in getting my validation reports and each time the person could not explain why my screens are different from the manual's screenshots. Please respond as to whether or not the manual will be updated to reflect current state.	The screen shots in the manual differ from what is seen when this user logs into CASPER Reporting is due to the User Settings / ViewStyle defaulting to DDLB (Drop Down List Box). To change this option within CASPER Reporting follow the steps below: 1. Log into CASPER Reporting with LTCH User ID 2. Select the 'Options' button in the upper right hand portion of the screen. 3. Change ViewStyle from DDLB to Classic. 4. Select 'Save'. Note: Don't forget to press the "Save" button After changing the ViewStyle to Classic, the CASPER

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			Reporting Users Guide screen prints and the display on the user's screen is now consistent.
20120628-015	D - Submission	My files will upload via CMSNet into the ASAP system, but must get the validation report from CASPER, which is a different system, correct?	That is correct. The ASAP Submission System and the CASPER Reporting System are two different systems, but users can access both from links on the LTCH home page.
20120628-016	D - Submission	Is there a time lag between uploading the file and the time when it has been processed and a validation report available?	The CMS record processing rule indicates that records should be processed within 24 hours of submission, but most are processed rather quickly—within a few minutes. However, due to the potential of heavy traffic, submission may take up to 24 hours to be processed. If you do not receive your final validation report within 24 hours, please call the QTSO Help Desk.
20120628-018	D - Submission	Are there plans to not go through the VPN because that is troublesome for us?	We haven't heard of other providers experiencing issues with the VPN and we have no plans to move away from VPN.
20140207-018	E - VUT	By chance does CMS offer code, a dll, some means to access their error-check logic via other software?	CMS offers an LTCH VUT for vendors to use to check their software. The LTCH VUT is an application that the vendor must download and install to use. Information and downloads for the LTCH VUT are located on the QTSO website: https://www.qtso.com/vendorltch.html under the heading LASER VUT