

HIS Manual

Guidance Manual for Completion of the Hospice Item Set (HIS)

Centers for Medicare and Medicaid Services
Hospice Quality Reporting Program

V 1.01 Effective July 1, 2014

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1153**. The time required to complete this information collection is estimated to average **19 minutes** per response for the HIS-Admission and **10 minutes** per response for the HIS-Discharge, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB Control # 0938-1153



[This page intentionally left blank.]

TABLE OF CONTENTS

CHAPTER 1: Background and Overview of the Hospice Item Set Manual	1-1
1.1 Manual Overview	1-2
1.2 Applicable Patients.....	1-2
1.3 Timing and Sequence Policies	1-2
1.4 Maintenance of HIS Records	1-6
CHAPTER 2: Item-Specific Instructions	2-1
2.1 Overview	2-1
2.2 HIS Item Completion Conventions	2-2
Section A: Administrative Information	2A-1
Section F: Preferences	2F-1
Section I: Active Diagnoses	2I-1
Section J: Health Conditions	2J-1
Section N: Medications	2N-1
Section Z: Record Administration	2Z-1
CHAPTER 3: Submission and Correction of Hospice Item Set Records.....	3-1
3.1 Submitting HIS Records	3-1
3.2 Timeliness Criteria	3-1
3.3 Validation of Records and Files.....	3-2
3.4 HIS Record Correction Policy.....	3-4
3.5 Correcting Errors in HIS Records That Have Not Yet Been Accepted into the QIES ASAP System	3-5
3.6 Correcting Errors in HIS Records That Have Been Accepted into the QIES ASAP System	3-5
3.7 Special Manual Record Deletion Request.....	3-9

List of Appendices

A: Acronyms and Glossary	A-1
B: CMS Hospice Quality Reporting Program Resources	B-1
C: Quality Measure Logical Specifications	C-1
D(a): Hospice Item Set—Admission	D(a)-1
D(b): Hospice Item Set—Discharge.....	D(b)-1

[This page intentionally left blank.]

CHAPTER 1: BACKGROUND AND OVERVIEW OF THE HOSPICE ITEM SET MANUAL

Section 3004 of the Patient Protection and Affordable Care Act (ACA) authorizes the Health and Human Services Secretary to establish a quality reporting program for hospices. The ACA specifies that, for fiscal year (FY) 2014 and each subsequent fiscal year, hospice programs shall submit to the Secretary data on quality measures; the ACA also describes measure endorsement requirements for any measures specified by the Secretary. A hospice is not required to obtain patient consent in order to collect data for quality measures for the HQRP since the Centers for Medicare & Medicaid services (CMS) has the statutory authority to collect quality data for hospices under Section 3004(c) of the ACA. CMS established the Hospice Quality Reporting Program (HQRP) in the FY 2012 Hospice Wage Index final rule (76 FR 47318-47324). CMS finalized the requirement for the Hospice Item Set (HIS) as part of the HQRP in the FY 2014 Hospice Wage Index final rule (78 FR 48255-48262). Medicare-certified hospices (hospices) will submit a HIS-Admission record and a HIS-Discharge record for each patient admission on or after July 1, 2014. For the FY 2016 reporting cycle, reporting eligibility for new Medicare-certified hospices will be communicated through provider outreach, and communication efforts listed in Appendix B. Starting with the FY 2017 reporting cycle, reporting eligibility for new Medicare-certified hospices will also be addressed through rulemaking. For the FY 2017 reporting cycle and future years, final rules will state the requirements and reporting eligibility for the Fiscal Year in which the Annual Payment Update will be impacted.

The HIS is a standardized set of items intended to capture patient-level data on each hospice patient admission. Current HIS items can be used to calculate six National Quality Forum (NQF) endorsed measures and a modification of one NQF-endorsed measure (**Table 1**). Please note that the HIS is not an assessment instrument and does not replace a thorough and ongoing assessment of each patient as required by the Medicare Hospice Conditions of Participation, nor does it replace standard clinical practice and judgment.

Table 1: Quality Measures Calculated Using the HIS

NQF Number	Measure Name
NQF #1641	Treatment Preferences
Modified NQF #1647	Beliefs/Values Addressed (if desired by the patient)
NQF #1634	Pain Screening
NQF #1637	Pain Assessment
NQF #1639	Dyspnea Screening
NQF #1638	Dyspnea Treatment
NQF #1617	Patients Treated with an Opioid who are Given a Bowel Regimen

1.1 Manual Overview

The purpose of the HIS Manual is to offer hospices guidance on the collection and submission of HIS data to CMS. The manual is divided into three chapters and appendices:

Chapter 1 – Provides an introduction of contextual information, timing and sequence policies, and general guidance.

Chapter 2 – Contains item-specific guidance for completing each item in the HIS.

Chapter 3 – Includes information on HIS record submission and correction processes.

Appendices – Include the HIS-Admission and HIS-Discharge, quality measure specifications, glossary and resources.

Hospices must submit HIS records to CMS's Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Although this manual contains general submission policies, it does not contain detailed submission procedures. Please see **Chapter 3** for links to additional resources on HIS record submission.

1.2 Applicable Patients

A HIS-Admission and a HIS-Discharge are submitted for all patient admissions to a Medicare-certified hospice program on or after July 1, 2014 regardless of:

- Payer source (Medicare, Medicaid, or private payer)
- Patient age
- Where the patient receives hospice services (home, nursing home, assisted living facility, freestanding hospice)
- Whether the patient is a transfer from another hospice
- Whether the patient previously revoked the hospice benefit or was discharged

1.3 Timing and Sequence Policies

Hospices will submit two HIS records—a HIS-Admission record and a HIS-Discharge record—for each patient admission. Hospices should complete and submit each record in accordance with the policies listed in **Table 2**. Timing is *not* the same for all HIS records, as timing is based on the Admission Date or Discharge Date.

Table 2: Timing Definitions

Admission Date (Item A0220)	The date the patient/family chooses hospice to begin. For Medicare patients, it is the same as the effective date of the hospice benefit election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. ¹
Discharge Date (Item A0270)	The date a patient leaves the hospice. If the patient has expired, it is the date of death. For live discharges, it is the date the patient revoked the hospice benefit or the date the hospice discharged the patient. ²
Completion Date (Item Z0500B)	The actual date on which the hospice completes the record. Defined as the date all required information has been collected and recorded and staff have signed and dated that the record is complete. This date should represent the completion date for the HIS record that has been verified by the individual authorized to do so. This individual signs and dates Item Z0500. The completion date should be no later than the completion deadline.
Completion Deadline	The latest possible date on which a provider should complete an HIS record. The completion deadline for the HIS-Admission record is defined as the Admission Date + 14 calendar days. The completion deadline for the HIS-Discharge record is defined as the Discharge Date + 7 calendar days.
Submission Date	The actual date on which the hospice submits the completed record. Defined as the date on which the completed record is submitted and accepted to the QIES ASAP system. The submission date should be no later than the submission deadline.
Submission Deadline	Defined as the latest possible date on which a provider should submit an HIS record. The submission deadline for the HIS-Admission record is defined as the Admission date + 30 calendar days. The submission deadline for the HIS-Discharge record is no later than the Discharge Date + 30 calendar days.

¹ "Hospice Care." 42 CFR 418.24 (2011).

² Centers for Medicare & Medicaid Services. *Medicare Claims Processing Manual*.

Completion Timing

For HIS-Admission records, the Completion Deadline is defined as the Admission Date + 14 calendar days. For HIS-Admission records, the Completion Date (Z0500B, the actual date on which the record was completed) should be no later than the Admission Date + 14 calendar days. The Completion Date can be *equal* to the Admission Date or Completion Deadline. The QIES ASAP system will issue a warning on the Final Validation Report if the Completion Date is more than 14 days after the Admission Date. For more information on Validation Reports, see **Chapter 3**.

For HIS-Discharge records, the Completion Deadline is defined as the Discharge Date + 7 calendar days. For HIS-Discharge records, the Completion Date (Z0500B, the actual date on which the record was completed) should be no later than the Discharge Date + 7 calendar days. The Completion Date can be *equal* to the Discharge Date, or Completion Deadline. The QIES ASAP system will issue a warning on the Final Validation Report if the Completion Date is more than 7 days after the Discharge Date.

The completion deadlines above only define the latest possible date on which a hospice should complete each HIS record. To better align HIS completion processes with clinical workflow processes, hospices may develop internal policies to complete HIS records early (prior to the Completion Deadline). If a hospice chooses to complete an HIS-Admission record prior to the Completion Deadline, the hospice should consider care processes that were documented in the clinical record up to the Completion Date. If the patient's status with respect to care process items changes between the Completion Date and the Completion Deadline, hospices **should not** update the HIS-Admission record.

Completion timing policies above do not outline timing of care processes that are captured by HIS items for quality measure calculation purposes. For additional information on timeliness criteria, see **Chapter 3**. For more information on timing for quality measure calculation purposes, please see **Appendix C**.

Submission Timing

For HIS-Admission records, the submission deadline is defined as the Admission Date + 30 calendar days. This means the Submission Date should be no later than the Admission Date + 30 calendar days. The Submission Date can be *equal* to the Admission Date, or no greater than 30 days later. The QIES ASAP system will issue a warning on the Final Validation Report if the Submission Date is more than 30 days after the Admission Date.

For HIS-Discharge records, the submission deadline is defined as the Discharge Date + 30 calendar days. This means the Submission Date should be no later than the Discharge Date + 30 calendar days. The Completion Date can be *equal* to the Discharge Date, or no greater than 30 days later. The QIES ASAP system will issue a warning on the Final Validation Report if the Submission Date is more than 30 days after the Discharge Date.

Submission timing policies outlined above only define the latest possible date a hospice should submit each HIS record. For additional information on timeliness criteria, see **Chapter 3**.

Completion and submission timing is further illustrated in the tables below. The first example in **Tables 3** and **4** shows a HIS record that is completed and submitted on the latest possible date. The second example in each table shows a HIS record that is completed and submitted early.

Table 3: Timing for HIS-Admission

Examples	Admission Date (A0220)	Completion Date (Z0500B)	Submission Date
Completed and submitted by latest dates	11/11/2014	11/25/2014 (Admission Date+14)	12/11/2014 (Admission Date+30)
Completed and submitted early	11/11/2014	11/17/2014	11/20/2014

Table 4: Timing for HIS-Discharge

Examples	Discharge Date (A0270)	Completion Date (Z0500B)	Submission Date
Completed and submitted by latest dates	12/22/2014	12/29/2014 (Discharge Date+7)	1/21/2015 (Discharge Date+30)
Completed and submitted early	12/22/2014	12/25/2014	1/3/2015

Hospices should have a system in place to ensure all required item sets are submitted appropriately. If a hospice finds it has not submitted a required item set, the hospice should submit the missing item set as soon as the error is identified. Correction policies are further outlined in **Chapter 3** of this manual.

Submission Sequence

The QIES ASAP system will issue a warning on the Final Validation Report when a record is submitted out of sequence. Examples include

- A HIS-Admission record submitted after a HIS-Discharge record.
- Submission of a HIS-Admission record where the prior record submitted was also a HIS-Admission record.

- Any record that is submitted on a patient after the submission of a HIS-Discharge record indicating that the patient has expired (A2115 = 01).

HIS-Admission and HIS-Discharge records may be completed and submitted on the same day when situations arise that warrant this; for example, when a patient is admitted and discharged on the same day.

1.4 Maintenance of HIS Records

We recommend that hospices retain a copy of the HIS, along with any corrected versions. Note that although the signature page is not transmitted to the QIES ASAP system, we recommend that it be retained by the hospice for potential future validation purposes.

Hospices must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the HIS, regardless of whether the record is in electronic or other form.

CHAPTER 2: ITEM-SPECIFIC INSTRUCTIONS

2.1 Overview

This chapter presents each item in the Hospice Item Set (HIS), along with instructions for completing each item. **Chapter 2** is organized to correspond with each section of the HIS:

- **Section A:** Administrative Information
- **Section F:** Preferences
- **Section I:** Active Diagnoses
- **Section J:** Health Conditions (Pain and Dyspnea)
- **Section N:** Medications
- **Section Z:** Record Administration

The beginning of each section contains an overview of all HIS items in the section, as well as a section rationale, which explains the purpose of items in each section.

For each HIS item, the general order of information presented in **Chapter 2** is:

- **Item Display:** Provides a screenshot of each item as it appears on the HIS.
- **Item-Specific Instructions:** Outlines the proper method for completing each HIS item, including explanations of all response options for each item.
- **Item-Specific Tips¹:** States clarifications, issues of note, and conditions to be considered when completing HIS items.
- **Examples¹:** Illustrates examples of appropriate HIS item completion (coding) based on sample clinical record documentation. This manual provides examples to assist hospices in understanding the rationale for how to select the most accurate responses when completing the HIS. These examples are **not** intended to dictate or endorse language hospices may use in clinical record documentation. Direct quotes that appear in examples are for illustration purposes only and do not represent CMS endorsement of specific documentation language or products.

¹ Not all HIS items in Chapter 2 include item-specific tips and examples. Item display and item-specific instructions are included for all HIS items.

2.2 HIS Item Completion Conventions

General Conventions for Completing the HIS

1. A HIS (HIS-Admission and HIS-Discharge) should be fully and accurately completed on all patient admissions on or after July 1, 2014.
2. To complete each HIS accurately and fully, hospice staff should understand what information and data each item requires, and complete the item based only on what is being requested. Responses to items on the HIS should be based on data in the clinical record that were documented prior to the Completion Date (Item Z0500B).
3. All completed HIS records must be electronically submitted to the QIES ASAP system.
4. HIS record submission should follow the sequence outlined in **Section 1.3 Timing and Sequence Policies**.
5. Policies outlined in **Chapter 3** describe how to correct errors in a HIS record that has already been accepted by the QIES ASAP system.
6. A HIS-Admission and HIS-Discharge should be submitted even if the patient revokes the hospice benefit or is discharged from hospice before all HIS-related care processes are complete.

Who May Complete the HIS

The HIS may be completed by any hospice staff member, which includes volunteers, contractors, and affiliates (for example, staff from the quality division of the health system to which a hospice belongs). The hospice is responsible for the accuracy and completeness of information in the HIS. It is at the discretion of the hospice to determine who can accurately complete the HIS. Each person completing any portion of a HIS record should provide a signature in Section Z: Record Administration in accordance with the instructions provided in **Section Z** of this chapter.

Acceptable Sources of Documentation

- Since the HIS is not a patient assessment, the primary source of information for completing the HIS is data collected through clinical care processes that have been completed and documented in the hospice clinical record. This means that, in general, sources external to the clinical record should not be used when completing the HIS.
- If a particular HIS care process is not documented in the hospice clinical record, the care process is considered not to have occurred. Complete the HIS items accordingly, following skip patterns outlined in the HIS.
- There are some instances where a provider may consult sources other than the hospice clinical record to complete HIS items. For example, completion of Section A: Administrative Information items may require review of claims or

billing records; Section F: Preferences items may require review of POLST (Physician Order for Life-Sustaining Treatment) forms, or other equivalent forms.

Relationship Between Care Processes and the HIS

Most of the items in the HIS-Admission relate to care processes that align with the initial assessment or the comprehensive assessment period, as required by the Conditions of Participation. Thus, completing the HIS-Admission record sometime after the comprehensive assessment period ends and prior to the completion deadline (defined as the Admission Date + 14 calendar days) meets the intent of the HIS. Completion timelines outlined above do not capture timing requirements for quality measure calculation purposes. See **Appendix C** for additional information on how timing of items in the HIS relates to quality measure calculation. See **Chapter 1.3** for additional information on timing and sequence policies.

[This page intentionally left blank.]

SECTION A: ADMINISTRATIVE INFORMATION

Items in this section of the Hospice Item Set (HIS) pertain to administrative information.

RATIONALE

This section obtains key information that uniquely identifies each patient, the hospice from which he or she receives services, and the reason for record.

A0050: Type of Record

Enter Code

☐

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

Item-Specific Instructions

Indicate whether a HIS record is a new record to be added to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system or if a HIS record that was previously submitted and accepted in the QIES ASAP system requires modification or inactivation.

- **Code 1, Add new record:** Select code 1 if this is a **new** HIS record that has not been previously submitted and accepted in the QIES ASAP system.
 - If there is an existing record for the same patient, the same hospice, with the same reason for record, and the same event date(s) (for example, admission date, or discharge date), then the current record would be a duplicate and not a new record. In this case, when submitted, the record will be rejected by the QIES ASAP system and a fatal error will be reported to the provider on the Final Validation Report. Further details on the Final Validation Report can be found in **Chapter 3**.
- **Code 2, Modify existing record:** Select code 2 if this is a request to modify data for a record that already has been submitted and accepted in the QIES ASAP system. Selecting code 2 creates a Modification Request that is used when a HIS record has been previously submitted and accepted in the QIES ASAP system, but the record contains errors. The types of errors that may be corrected in a Modification Request include errors in transcription, data entry, software product, item completion, and/or other errors requiring correction.
 - Errors in most items on a HIS record can be corrected with a Modification Request, with some exceptions. For more details on Modification Requests, see **Chapter 3** of this manual.
- **Code 3, Inactivate existing record:** Select code 3 if this is a **request to inactivate** a HIS record that has already been submitted and accepted in the QIES ASAP system. Selecting code 3 creates an **Inactivation Request** that is used when a HIS record has been previously submitted and accepted in the QIES ASAP system but
 - the corresponding event did not occur (for example, a HIS discharge record was submitted, but the patient was not discharged); or

Item-Specific Instructions (continued)

- particular item values (for example, recent event identifiers or key patient identifiers) are inaccurate.

For more details on Inactivation Requests, see **Chapter 3** of this manual.

Item-Specific Tips

Corrections should be made to any HIS record(s) that have errors to ensure that the information in the QIES ASAP system accurately reflects any of the following: the patient's identification, location, and reason for the record.

A0100: Facility Provider Numbers. Enter code in boxes provided.

A. National Provider Identifier (NPI):

--	--	--	--	--	--	--	--	--	--

B. CMS Certification Number (CCN):

--	--	--	--	--	--	--	--	--	--	--	--

Item-Specific Instructions**A0100: Facility Provider Numbers****A. National Provider Identifier (NPI):**

- **Enter the NPI.** The NPI is a unique federal number that identifies providers of health care services.

B. CMS Certification Number (CCN):

- **Enter the hospice's CCN.** The CCN is also known as the Medicare provider number. It is a six-digit number, usually in the format xx-xxxx.

A0205. Site of Service at Admission

Enter Code

--	--

01. Hospice in patient's home/residence
02. Hospice in Assisted Living facility
03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)
04. Hospice provided in a Skilled Nursing Facility (SNF)
05. Hospice provided in Inpatient Hospital
06. Hospice provided in Inpatient Hospice Facility
07. Hospice provided in Long Term Care Hospital (LTCH)
08. Hospice in Inpatient Psychiatric Facility
09. Hospice provided in a place not otherwise specified (NOS)
10. Hospice home care provided in a hospice facility

Item-Specific Instructions

A0205. Site of Service at Admission

- **Code 01, Hospice in patient's home/residence:** Select code 01 if the patient received hospice care in their home/residence at the time of admission.
 - This would include a patient receiving hospice care in the private home/residence of a family member or caregiver.
- **Code 02, Hospice in Assisted Living facility:** Select code 02 if the patient received hospice care in an assisted living facility at the time of admission.
- **Code 03, Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF):** Select code 03 if the patient received hospice care in a Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF) at the time of admission.
- **Code 04, Hospice provided in a Skilled Nursing Facility (SNF):** Select code 04 if the patient received hospice care in a Skilled Nursing Facility (SNF) at the time of admission.
- **Code 05, Hospice provided in Inpatient Hospital:** Select code 05 if the patient received hospice care in an Inpatient Hospital at the time of admission.
- **Code 06, Hospice provided in Inpatient Hospice Facility:** Select code 06 if the patient received hospice care in an Inpatient Hospice Facility at the time of admission.
- **Code 07, Hospice provided in Long Term Care Hospital (LTCH):** Select code 07 if the patient received hospice care in a Long Term Care Hospital (LTCH) at the time of admission.
- **Code 08, Hospice in Inpatient Psychiatric Facility:** Select code 08 if the patient received hospice care in an Inpatient Psychiatric Facility at the time of admission.
- **Code 09, Hospice provided in a place not otherwise specified (NOS):** Select code 09 if the patient received hospice care in a place not otherwise specified (NOS) at the time of admission.
- **Code 10, Hospice home care provided in a hospice facility:** Select code 10 if the patient received hospice care provided in a hospice residence/facility at the time of admission.

Item-Specific Tips

Response options for Item A0205 are structured to match sites of service found on Medicare claims. Since the site of service must be identified on Medicare claims for the initial level of care billed, identifying site of service the same way when completing this HIS item can reduce administrative burden for the hospice.

A0220. Admission Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

Item-Specific Instructions**A0220. Admission Date**

- **Enter the date of admission to this hospice.** Use the format: Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contains only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014. A day begins at 12:00 a.m. and ends at 11:59 p.m.
- The admission date specifies the date on which the hospice becomes responsible for the care of the patient.
 - For Medicare patients, this is the effective date of election or of re-election.
 - For patient transfers (regardless of payer source), this is the date the patient was transferred to your hospice from another hospice organization; specifically, the date your hospice became responsible for the patient's hospice care.

A0245. Date Initial Nursing Assessment Initiated

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

Item-Specific Instructions**A0245. Date Initial Nursing Assessment Initiated**

- **Enter the date the hospice clinician began the initial nursing assessment.** Use the format: Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contains only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- Item A0245 refers to the initial assessment the registered nurse must complete, as defined in the Medicare Hospice Conditions of Participation.

A0250. Reason for Record

Enter Code

<input type="text"/>	<input type="text"/>
----------------------	----------------------

- 01. Admission
- 09. Discharge

Item-Specific Instructions**A0250. Reason for record**

- **Code 01, Admission:** Select code 01 for a HIS-Admission record.
- **Code 09, Discharge:** Select code 09 for a HIS-Discharge record.

Item-Specific Tips

A HIS-Admission and a HIS-Discharge record must be completed for each patient admission. For detailed information on the requirements for sequencing the completion and submission of the two record types, see **Chapter 1** of this manual.

A0270. Discharge Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year			

Item-Specific Instructions

Complete only if A0250 = 09, Discharge

- **Enter the date the patient was discharged from hospice** (whether or not return is anticipated). Use the format: Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contains only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- If the patient expired, the date of death is the discharge date.
- For live discharges, the date the patient revoked the hospice benefit or the date the hospice discharged the patient is the discharge date.

A0500. Legal Name of Patient**A. First name:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

B. Middle initial:

<input type="text"/>

C. Last name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

D. Suffix:

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

Item-Specific Instructions**A0500. Legal Name of Patient**

The legal name is the patient's name as it appears on the Medicare card. If the patient is not enrolled in the Medicare program, use the patient's name as it appears on a Medicaid card or other government-issued document.

A. First name

- **Enter the patient's first name.**

B. Middle initial

- **Enter the patient's middle initial.** If the patient has no middle initial, leave the item blank. If the patient has two or more middle names, use the initial of the first middle name.

C. Last name

- **Enter the patient's last name.** This field has a limit of 18 characters; the hospice must be consistent when entering the patient's last name since errors made in the patient's name item may cause a new record to be created for the same patient in the QIES ASAP system.

D. Suffix

- **Enter the appropriate suffix** (for example, Jr., Sr.), if any. If the patient has no suffix, leave the item blank.

Item-Specific Tips

Be sure to carefully check the spelling of the patient's name each time a HIS record is submitted since typographical errors that are made in the patient's name item may cause a new record to be created for the same patient in the QIES ASAP system.

A0600. Social Security and Medicare Numbers**A. Social Security Number:**

				-								
--	--	--	--	---	--	--	--	--	--	--	--	--

B. Medicare number (or comparable railroad insurance number):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Item-Specific Instructions**A0600. Social Security and Medicare Numbers****A. Social Security Number**

- **Enter the Social Security Number (SSN)**, one number per space, starting with the left-most space. If the patient does not have an SSN or the SSN is unavailable, the item may be left blank.
 - An SSN is a tracking number assigned to an individual by the U.S. federal government for taxation, benefits, and identification purposes.

Item-Specific Instructions (continued)**B. Medicare Number (or comparable railroad insurance number)**

- **Enter the Medicare number** exactly as it appears on the patient's Medicare card. If the patient does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. RRB numbers contain both letters and numbers; to enter the RRB number, enter the first letter of the code in the left-most space followed by one letter/digit per space. If the person has neither a Medicare number nor an RRB number, the item may be left blank.
 - A Medicare number is an identifier assigned to an individual for participation in national health insurance program. The Medicare number may also be referred to as a Health Insurance Claim (HIC) number. The Medicare Health Insurance Claim (HIC) number may differ from the patient's SSN, and may contain both letters and numbers. For example, many patients receive Medicare benefits based on a spouse's Medicare eligibility.
 - Confirm that the patient's name on the HIS record matches the patient's name on the Medicare or RRB card.

Item-Specific Tips

To avoid inaccuracies in patient record matching, Item A0600 should only be left blank if the patient does not have a SSN or in rare instances where the SSN is unavailable.

- Item A0600B can only be a Medicare (HIC) number or an RRB number.
- **The Medicare Number or RRB number entered in A0600B is not intended to reflect the patient's payer source.** For the purposes of HIS item completion, the Medicare Number or RRB number is used for patient identification purposes only. **If the patient has a Medicare Number or RRB number, enter it in A0600B, even if Medicare is not a payer, or if Medicare is a secondary payer.**
- If the hospice is notified after the record has been submitted that the patient does have a Medicare number, include it on the next record. For instance, if the Medicare number is received after submission of the HIS-Admission record, include the patient's Medicare number on the HIS-Discharge record. Including the Medicare number on the HIS-Discharge record at a later date does not require a Modification Request to the original HIS-Admission Record.

A0700. Medicaid Number. Enter "+" if pending, "N" if not a Medicaid Recipient.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Item-Specific Instructions

A0700. Medicaid Number

- **Enter the Medicaid number** if the patient is a Medicaid recipient. Enter one number per box, beginning in the left-most box.
 - Enter a "+" in the left-most box if the Medicaid number is pending.
 - If the patient is not a Medicaid recipient, enter "N" in the left-most box.
 - Confirm that the patient's legal name on the HIS record matches the patient's legal name on the Medicaid card.

Item-Specific Tips

- To obtain the Medicaid number, check the patient's Medicaid card, admission or transfer records, or hospice clinical record.
- The Medicaid Number entered in A0700 is not intended to reflect the patient's payer source. For the purposes of HIS item completion, the Medicaid Number is used for patient identification purposes only. If the patient has a Medicaid Number, enter it in A0700, even if Medicaid is not a payer, or if Medicaid is a secondary payer.
- If the hospice is notified after the record has been submitted that the patient does have a Medicaid number, include it on the next record. For instance, if the Medicaid number is received after submission of the HIS-Admission record, include the patient's Medicaid number on the HIS-Discharge record. Including the Medicaid number on the HIS-Discharge record at a later date does not require a Modification Request to the original HIS-Admission Record.

A0800. Gender

Enter Code

☐

1. Male
2. Female

Item-Specific Instructions

A0800. Gender

- **Code 1, Male:** Select code 1 if patient is male.
- **Code 2, Female:** Select code 2 if patient is female.

A0900. Birth Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year			

Item-Specific Instructions**A0900. Birth Date**

- **Enter the birth date of the patient.** Use the format: Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contains only a single digit, enter a “0” in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- If only the birth year or the birth year and birth month of the patient are known, handle each situation as follows:
 - If only the birth year is known, enter the year in the “year” boxes of A0900, and leave the “month” and “day” boxes blank.
 - If the birth year and birth month are known, but not the birth day, enter the year in the “year” boxes of A0900, enter the month in the “month” boxes, and leave the “day” boxes blank.

A1000. Race/Ethnicity**↓ Check all that apply**

- | | |
|--------------------------|--|
| <input type="checkbox"/> | A. American Indian or Alaska Native |
| <input type="checkbox"/> | B. Asian |
| <input type="checkbox"/> | C. Black or African American |
| <input type="checkbox"/> | D. Hispanic or Latino |
| <input type="checkbox"/> | E. Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> | F. White |

Item-Specific Instructions**A1000. Race/Ethnicity**

- **Check the box(es) that correspond(s) to the race or ethnic category/categories the patient uses** to identify him or herself, or check the box(es) the patient’s family, significant other, guardian, or legally authorized representative uses to identify the patient. Observer identification can be used to complete this item if the patient is unable to respond and/or no family member, significant other, guardian, or legally authorized representative is available.

Check all that apply.

- **Check A, American Indian or Alaska Native:** if the patient is American Indian or Alaska Native
 - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Item-Specific Instructions (continued)

- **Check B, Asian:** if the patient is Asian
 - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Check C, Black or African American:** if the patient is Black or African American
 - A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
- **Check D, Hispanic or Latino:** if the patient is Hispanic or Latino
 - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
- **Check E, Native Hawaiian or Other Pacific Islander:** if the patient is Native Hawaiian or Other Pacific Islander
 - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **Check F, White:** if the patient is White
 - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

A1802. Admitted From. Immediately preceding this admission, where was the patient?

Enter Code

--	--

01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
02. Long-term care facility
03. Skilled Nursing Facility (SNF)
04. Hospital emergency department
05. Short-stay acute hospital
06. Long-term care hospital (LTCH)
07. Inpatient rehabilitation facility or unit (IRF)
08. Psychiatric hospital or unit
09. ID/DD Facility
10. Hospice
99. None of the above

Item-Specific Instructions

- Enter the two-digit code that best describes the setting in which the patient was staying immediately preceding this admission.
- **Code 01, Community residential setting:** Select code 01 if the patient was admitted from a private home, apartment, board and care, assisted living facility, group home, or adult foster care. A community residential setting is defined as any house, condominium, or

Item-Specific Instructions (continued)

apartment in the community whether owned by the patient or another person, retirement communities, or independent housing for the elderly.

- **Code 02, Long-term care facility:** Select code 02 if the patient was admitted from an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability. These facilities provide care to people who cannot be cared for at home or in the community. Long-term care facilities provide a wide range of personal care and health services for individuals who cannot take care of themselves due to physical, emotional, or mental health issues.
- **Code 03, Skilled Nursing Facility (SNF):** Select code 03 if the patient was admitted from a nursing facility with the staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category includes swing bed hospitals, which are generally small, rural hospitals or critical access hospitals (CAH) participating in Medicare that have CMS approval to provide post-hospital SNF care and meet certain requirements.
- **Code 04, Hospital emergency department:** Select code 04 if the patient was admitted from an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.
- **Code 05, Short-stay acute hospital:** Select code 05 if the patient was admitted from a hospital that is contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.
- **Code 06, Long-term care hospital (LTCH):** Select code 06 if the patient was admitted from an acute-care hospital that provides treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.
- **Code 07, Inpatient rehabilitation facility or unit (IRF):** Select code 07 if the patient was admitted from a hospital, or a distinct unit of a hospital, that provides an intensive rehabilitation program to inpatients.
- **Code 08, Psychiatric hospital or unit:** Select code 08 if the patient was admitted from an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients.
- **Code 09, ID/DD Facility:** Select code 09 if the patient was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are intellectually disabled (ID) or who have developmental disabilities (DD).
- **Code 10, Hospice:** Select code 10 if the patient was admitted from another hospice.
- **Code 99, None of the above:** Select code 99 if the patient was admitted from none of the above.

Item-Specific Tips

- If the patient was in multiple settings prior to hospice admission, enter the code to reflect where the patient was at the time of referral to hospice.
 - For example, if a patient was referred to hospice in the hospital in the week prior to admission to hospice and was discharged from the hospital to the home 2 days prior to the start of hospice services, select code “5, Short-stay acute hospital” since the patient was in the hospital at the time of referral.
- If the patient was enrolled in a hospice program and resided in the community, such as a private home, select code “10, Hospice” rather than code “01, Community residential setting.”
- The term “Admitted from” does not necessarily mean that the patient left the facility to be admitted to hospice. The location immediately before admission may be the same as immediately after (for example, a patient may be residing in a long-term care facility and remain there during and after hospice admission), or the two may be different (for example, a patient may elect hospice while in an acute care hospital and begin receiving hospice services upon returning to their home).

A2115. Reason for Discharge

Enter Code

--	--

- 01. Expired
- 02. Revoked
- 03. No longer terminally ill
- 04. Moved out of hospice service area
- 05. Transferred to another hospice
- 06. Discharged for cause

Item-Specific Instructions

Complete only if A0250 = 09, Discharge

Review the clinical record, including the discharge plan and discharge order, for documentation of discharge reason. Select the code that corresponds to the patient's reason for discharge.

- **Code 01, Expired:** Select code 01 if the patient has died.
- **Code 02, Revoked:** Select code 02 if the beneficiary has chosen to revoke their hospice election.
- **Code 03, No longer terminally ill:** Select code 03 in the case of a discharge when the hospice determines the beneficiary is no longer terminally ill.
- **Code 04, Moved out of hospice service area:** Select code 04 in the case of a discharge when the beneficiary moves out of the hospice's service area.
- **Code 05, Transferred to another hospice:** Select code 05 in the case of a discharge when the beneficiary transfers to another hospice.
- **Code 06, Discharged for cause:** Select code 06 in the case of a discharge for cause.

SECTION F: PREFERENCES

Items in this section of the Hospice Item Set (HIS) pertain to the hospice patient's preferences regarding life-sustaining treatments and spiritual care. Preferences are best obtained directly from the patient, or the caregiver or responsible party if the patient cannot self-report. The items in this section do not represent an exhaustive list of patient preferences that hospices should consider, and completion of this section does not replace a thorough and ongoing discussion of patient preferences throughout an episode of care.

RATIONALE

Seriously ill and dying patients who are given the opportunity to express their preferences regarding life-sustaining treatment are more likely to receive care consistent with their values, improving patient and family outcomes, including greater satisfaction with care.

- Patients may come into hospice with documentation of preferences for life-sustaining treatment. However, pre-existing documentation may not reflect their current preferences since patient preferences may change, particularly as their condition changes.

Care for spiritual needs is a critical element of quality of life at the end of life. Patients and/or caregivers should be given the opportunity to express their needs for spiritual care to help assure their needs are met.

- One of the unique aspects of hospice care is an interdisciplinary approach toward providing care for the physical, psychosocial, and spiritual needs of the patient and caregiver(s). Discussion of spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring that these needs are met.

Items in this section are intended to **capture the process of eliciting patient preferences**; they are intended to **capture evidence of discussion and/or communication about patient preferences**.

F2000. CPR Preference

Enter Code

☐

A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? Select the most accurate response.

0. **No** → Skip to F2100, Other Life-Sustaining Treatment Preferences
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. Date the patient/responsible party was first asked about preference regarding the use of CPR:

Month

Day

Year

Item-Specific Instructions

Review the clinical record for information regarding discussion of patient preference for cardiopulmonary resuscitation (CPR). For this item, it is also permissible to consider care processes documented in the clinical record that may have taken place at pre-admission or educational visits. Item completion (coding) should be based on what is included in the clinical record. Review all response choices before making a selection.

F2000A: Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?

- **Code 0, No:** Select code 0 if there is no documentation that the hospice discussed (or attempted to discuss) preference regarding the use of CPR with the patient or responsible party. Skip to Item F2100, Other Life-Sustaining Treatment Preferences.
 - Code 0 applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party. This could happen if the patient is unable to discuss and/or the responsible party was unavailable.
- **Code 1, Yes, and discussion occurred:** Select code 1 if there is documentation that the hospice discussed preference regarding the use of CPR with the patient or responsible party.
 - Code 1 applies to situations where there is documentation that the hospice brought up the topic of CPR use, and there was a conversation with the patient and/or responsible party. The conversation does not have to result in the patient stating a preference for or against the use of CPR to select code 1 for F2000A. For the purposes of Item F2000, select code 1 if the hospice opened the door for a conversation and there is documentation that the patient or responsible party engaged with the hospice in a discussion regarding CPR.
- **Code 2, Yes, but the patient/responsible party refused to discuss:** Select code 2 if there is documentation that the hospice asked about preference regarding the use of CPR, but the patient or responsible party refused to discuss or was unable to discuss.
 - Code 2 applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and responsible party, but both the patient and responsible party **explicitly refused** to discuss the topic with the hospice. This would include statements such as, “I don’t want to talk about this” or “I’m only going to talk to my priest about this”. In these instances, the hospice was not successful in engaging the patient and/or responsible party in a discussion.
 - Code 2 also applies to situations in which the hospice attempted to discuss the topic, but the patient was unable to discuss because of their clinical status **and** the responsible party **explicitly refused** to discuss.

Item-Specific Instructions (continued)**F2000B: Date the patient/responsible party was first asked about preference regarding the use of CPR**

- **Enter the date** the hospice first discussed (or attempted to discuss) patient preference regarding the use of CPR. Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- It is possible that at the time of HIS completion there will be multiple discussions regarding the use of CPR documented in the clinical record. Complete HIS items based on the *first* dated discussion about preference regarding the use of CPR that appears in the clinical record.
- For this item, it is permissible to consider care processes documented in the clinical record at pre-admission or educational visits (prior to the Admission Date). In these instances, use the date on which the discussion occurred for F2000B.

Item-Specific Tips

F2000 asks whether or not the patient or **responsible party** was asked about preference regarding the use of CPR. "Responsible party" refers to the legally responsible or authorized individual, such as the Health Care Power of Attorney or legal guardian. In cases where there is no legal guardian or power of attorney identified, the hospice should use state law guidance to identify the appropriate surrogate decision-maker.

- In order to code "Yes" to F2000A, if a party other than the patient was asked about preference regarding the use of CPR, there must be evidence in the clinical record that the responsible party **as defined above** was asked about preferences.

F2000 is intended to capture evidence of a **discussion** (or attempted discussion) about patient preference regarding the use of CPR.

- A discussion about CPR preference can be initiated by any member of the hospice staff or interdisciplinary group (IDG).
- Orders alone or short statements in the clinical record, such as "DNR/DNI" or "full code," without evidence of discussion or involvement from patient/responsible party, are **not** sufficient to code "Yes" for F2000A.

Evidence of a discussion could be documented in the clinical record or via a Do Not Resuscitate (DNR) order, Physician Orders for Life-Sustaining Treatment (POLST) order, or equivalent.

- A newly completed DNR order or POLST form that is signed by the hospice clinician after the admission to hospice or during a preadmission visit is sufficient to select code "1, Yes" for F2000A, **provided there is evidence of involvement from patient/responsible party**, such as signature of the patient or responsible party on POLST forms, or clinical documentation, such as "DNR preference confirmed with responsible party."

Item-Specific Tips (continued)

- If a patient is admitted to hospice with a pre-existing DNR order or POLST that was signed in a prior care setting, the hospice should re-affirm the patient's preferences that appear in the pre-existing DNR order or POLST. This reaffirmation should be documented in the clinical record. Clinical record documentation, such as "discussed CPR preference during the admission visit with patient," is sufficient to select code "1, Yes".
 - If the clinical record is ambiguous as to whether the hospice attempted to re-affirm patient preferences documented in a pre-existing DNR order/POLST, select code "0, No" for F2000A and skip to Item F2100.

Examples**Situation A - Patient's clinical record contains the following information:**

Patient admitted on 08-01-2014. Clinical note dated 08-01-2014 shows: "talked with patient about preference for CPR; patient states they are not sure. Requests time to think and wants to discuss later." Clinical note dated 08-05-2014 shows: "discussed patient's preference for CPR; patient stated preference for DNR. DNR order signed and in clinical record."

- **Coding:**
F2000A: Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? Select code "1, Yes, and discussion occurred."
F2000B: Date the patient/responsible party was first asked about preference regarding the use of CPR: Enter "08-01-2014."
- **Explanation:** Although the patient later stated a preference regarding DNR 08-05-2014, F2000 should be completed based on the **first** dated discussion in the clinical record. The most appropriate coding option for F2000A is "1" since although at the first dated discussion the patient did not express a clear preference regarding the use of CPR, a **discussion did occur**. Enter "08-01-2014" for F2000B since it is the first dated discussion that appears in the clinical record.

Situation B - Patient's clinical record contains the following information:

Patient admitted 08-01-2014. Clinical record for the patient includes a DNR order, signed in the prior care setting, which is dated 07-15-2014.

- **Coding:**
F2000A: Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? Select code "0, No." Skip to Item F2100, Other Life-Sustaining Treatment Preferences.
- **Explanation:** Although the patient has a recently dated DNR order, it was signed in a prior care setting. There is no documentation in the clinical record to indicate that the hospice re-confirmed the patient's preferences. If a statement such as "DNR order confirmed with responsible party, patient's daughter" was included, that would be sufficient to select code "1, Yes, and discussion occurred."

F2100: Other Life-Sustaining Treatment Preferences

Enter Code

A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? Select the most accurate response.

0. **No** → Skip to F2200, Hospitalization Preference
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

Item-Specific Instructions

Review the clinical record for information regarding patient preference for life-sustaining treatment other than CPR. For this item, it is permissible to consider care processes documented in the clinical record that may have taken place at pre-admission or educational visits. Item completion (coding) should be based on what is included in the clinical record. Review all response choices before making a selection.

F2100A: Was the patient/responsible party asked about preferences regarding life-sustaining treatment other than CPR?

- **Code 0, No:** Select code 0 if there is no documentation that the hospice discussed (or attempted to discuss) preferences regarding life-sustaining treatment other than CPR with the patient or responsible party. Skip to Item F2200, Hospitalization Preference.
 - Code 0 applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party. This could happen if the patient is unable to discuss and/or the responsible party was unavailable.
- **Code 1, Yes, and discussion occurred:** Select code 1 if there is documentation that the hospice discussed preferences regarding life-sustaining treatment other than CPR with the patient or responsible party.
 - Code 1 applies to situations where there is documentation that the hospice brought up the topic of life-sustaining treatment other than CPR, and there was a conversation with the patient and/or responsible party. The conversation does not have to result in the patient stating a preference for or against the use of life-sustaining treatments other than CPR to select code 1 for F2100A. For the purposes of Item F2100, select code 1 if the hospice opened the door for a conversation and there is documentation that the patient or responsible party engaged with the hospice in a discussion regarding life-sustaining treatment preferences other than CPR.

Item-Specific Instructions (continued)

- **Code 2, Yes, but the patient/responsible party refused to discuss:** Select code 2 if there is documentation that the hospice asked about preferences regarding life-sustaining treatment other than CPR, but the patient or responsible party refused to discuss or was unable to discuss.
 - Code 2 applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and responsible party, but both the patient **and** responsible party **explicitly refused** to discuss the topic with the hospice. This would include statements such as, “I don’t want to talk about this” or “I’m only going to talk to my priest about this”. In these instances, the hospice was not successful in engaging the patient and/or responsible party in a discussion.
 - Code 2 also applies to situations in which the hospice attempted to discuss the topic, but the patient was unable to discuss because of their clinical status **and** the responsible party **explicitly refused** to discuss.

F2100B: Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR

- **Enter the date** the hospice first discussed (or attempted to discuss) patient preferences regarding life-sustaining treatment other than CPR. Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a “0” in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- It is possible that at the time of HIS completion there will be multiple discussions regarding the use of life-sustaining treatments other than CPR documented in the clinical record. Complete HIS items based on the *first* dated discussion about preference regarding life-sustaining treatment other than CPR that appears in the clinical record.
- For this item, it is permissible to consider care processes documented in the clinical record at pre-admission or educational visits (prior to the Admission Date). In these instances, use the date on which the discussion occurred for F2100B.

Item-Specific Tips

F2100 asks whether or not the patient or **responsible party** was asked about preferences regarding life-sustaining treatments other than CPR. “Responsible party” refers to the legally responsible or authorized individual, such as the Health Care Power of Attorney or legal guardian. In cases where there is no legal guardian or power of attorney identified, the hospice should use state law guidance to identify the appropriate surrogate decision-maker.

- In order to code “Yes” to F2100A, if a party other than the patient was asked about preferences regarding life-sustaining treatments other than CPR, there must be evidence in the clinical record that the responsible party **as defined above** was asked about preferences.

Item-Specific Tips (continued)

F2100 is intended to capture evidence of a **discussion** (or attempted discussion) about patient preference regarding life-sustaining treatment other than CPR. Evidence of a discussion could be documented in the clinical record or via a POLST order or equivalent.

- A discussion about preference for life-sustaining treatment other than CPR can be initiated by any member of the hospice staff or IDG.
- Orders alone, without evidence of discussion or involvement from patient/responsible party, are **not** sufficient to code “Yes” for F2100A.
- There is no comprehensive list of life-sustaining treatments. Documentation in the clinical record indicating that a member of the hospice staff or IDG attempted to discuss preference for **any** life-sustaining treatment other than CPR (for example, ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, intravenous [IV] fluids) is sufficient to code either:
 - “1, Yes, and discussion occurred” or
 - “2, Yes, but patient/responsible party refused to discuss” for F2100A.

Evidence of a discussion could be documented in the clinical record or via a POLST order or equivalent:

- A newly completed POLST form that is signed by the hospice clinician after the admission to hospice or during a preadmission visit is sufficient to code “1, Yes” for F2100A, **provided there is evidence of involvement from patient/responsible party**, such as signature of the patient or responsible party on POLST forms, or clinical documentation, such as “treatment preference confirmed with responsible party.”
- If a patient is admitted to hospice with a pre-existing POLST that was signed in a prior care setting, the hospice should re-affirm the patient’s preferences that appear in the pre-existing POLST. This re-affirmation of preferences should be documented in the clinical record. Clinical record documentation, such as “discussed life-sustaining treatment preferences during the admission visit with patient,” is sufficient to select code “1, Yes”.
 - If the clinical record is ambiguous as to whether the hospice attempted to re-affirm patient preferences present in a pre-existing POLST, select code “0, No” for F2100A and skip to Item F2200, Hospitalization Preference.

Examples**Situation A - Patient’s clinical record contains the following information:**

Patient admitted on 08-01-2014. Clinical note dated 08-01-2014 shows: “Had discussion with patient about preference for use of prolonged IV fluids; patient was hesitant and stated they weren’t sure and wanted to discuss later. Told patient we could discuss at later date.”

Examples (continued)

- **Coding:**

F2100A: Was the patient/responsible party asked about preference regarding the use of any life-sustaining treatment other than CPR? Select code “1, Yes, and discussion occurred.”

F2100B: Date the patient/responsible party was first asked about preference regarding the use of CPR: Enter “08-01-2014.”

- **Explanation:** The most appropriate coding option for F2100A is “1” since although the patient did not express a clear preference regarding use of prolonged IV fluids, a discussion did occur.

Situation B - Patient’s clinical record contains the following information:

Patient admitted 08-01-2014. Clinical record for the patient includes an order from the prior care setting, “no life-sustaining treatments desired,” which is dated 07-15-2014.

- **Coding:**

F2100A: Was the patient/responsible party asked about preference regarding life-sustaining treatments other than CPR? Select code “0, No.” Skip to Item F2200, Hospitalization Preference.

- **Explanation:** Although the patient has a recently dated order regarding life-sustaining treatment preferences, it was signed in a prior care setting. There is no documentation in the hospice clinical record to indicate that the hospice re-confirmed the patient’s preferences. If a statement such as “desire to avoid all forms of life-sustaining treatments confirmed with responsible party, patient’s daughter” was included, that would be sufficient to select code “1, Yes, and discussion occurred.”

F2200. Hospitalization Preference

Enter Code

☐

A. Was the patient/responsible party asked about preference regarding hospitalization? Select the most accurate response.

0. **No** → Skip to F3000, Spiritual/Existential Concerns
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. Date the patient/responsible party was first asked about preference regarding hospitalization:

Month

Day

Year

Item-Specific Instructions

Review the clinical record for information regarding patient preference for hospitalization. For this item, it is also permissible to consider care processes documented in the clinical record that may have taken place at pre-admission or educational visits. Item completion (coding) should be based on what is included in the clinical record. Review all response choices before making a selection. For the purposes of this item, “hospitalization” does not include hospice care (such as general inpatient or respite level of care) provided in contracted acute care settings or hospital-based inpatient hospice units..

F2200A: Was the patient/responsible party asked about preference regarding hospitalization?

- **Code 0, No:** Select code 0 if there is no documentation that the hospice discussed (or attempted to discuss) preference regarding hospitalization with the patient or responsible party. Skip to Item F3000, Spiritual/Existential Concerns.
 - Code 0 applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party. This could happen if the patient is unable to discuss and/or the responsible party was unavailable.
- **Code 1, Yes, and discussion occurred:** Select code 1 if there is documentation that the hospice discussed preference regarding hospitalization with the patient or responsible party.
 - Code 1 applies to situations where there is documentation that the hospice brought up the topic of hospitalization, and there was a conversation with the patient and/or responsible party. The conversation does not have to result in the patient stating a preference for or against hospitalization to select code 1 for F2200A. For the purposes of Item F2200, select code 1 if the hospice opened the door for a conversation and there is documentation that the patient or responsible party engaged with the hospice in a discussion regarding hospitalization.
- **Code 2, Yes, but the patient/responsible party refused to discuss:** Select code 2 if there is documentation that the hospice asked about preference regarding hospitalization, but the patient or responsible party refused to discuss or was unable to discuss.
 - Code 2 applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and responsible party, but both the patient **and** responsible party **explicitly refused** to discuss the topic with the hospice. This would include statements such as, “I don’t want to talk about this” or “I’m only going to talk to my priest about this”. In these instances, the hospice was not successful in engaging the patient and/or responsible party in a discussion.
 - Code 2 also applies to situations in which the hospice attempted to discuss the topic, but the patient was unable to discuss because of their clinical status **and** the responsible party **explicitly refused** to discuss.

Item-Specific Instructions (continued)**F2200B: Date the patient/responsible party was first asked about preference regarding hospitalization**

- **Enter the date** the hospice first discussed (or attempted to discuss) patient preference regarding hospitalization. Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- It is possible that at the time of HIS completion there will be multiple discussions regarding hospitalization preferences documented in the clinical record. Complete HIS items based on the *first* dated discussion about preference regarding hospitalization that appears in the clinical record.
- For this item, it is permissible to consider care processes documented in the clinical record at pre-admission or educational visits (prior to the Admission Date). In these instances, use the date on which the discussion occurred for F2200B.

Item-Specific Tips

F2200 asks whether or not the patient or **responsible party** was asked about preferences regarding hospitalization. "Responsible party" refers to the legally responsible or authorized individual, such as the Health Care Power of Attorney or legal guardian. In cases where there is no legal guardian or power of attorney identified, the hospice should use state law guidance to identify the appropriate surrogate decision-maker.

- In order to code "Yes" to F2200A, if a party other than the patient was asked about preference regarding hospitalization, there must be evidence in the clinical record that the responsible party **as defined above** was asked about preferences.

F2200 is intended to capture evidence of a **discussion** (or attempted discussion) about patient preference regarding hospitalization.

- A discussion about hospitalization preference can be initiated by any member of the hospice staff or IDG.

Evidence of a discussion could be documented in the clinical record or via a POLST form:

- A newly completed POLST form that is signed by the hospice clinician after the admission to hospice or during a preadmission visit is sufficient to code "1, Yes" for F2200A, **provided there is evidence of involvement from patient/responsible party**, such as signature of the patient or responsible party on POLST forms, or clinical documentation, such as "hospitalization preference confirmed with responsible party."

Item-Specific Tips (continued)

- If a patient is admitted to hospice with a pre-existing POLST that was signed in a prior care setting, the hospice should re-affirm the patient's preferences that appear in the pre-existing POLST. This re-affirmation of preferences should be documented in the clinical record. Clinical record documentation, such as "discussed preference regarding hospitalization during the admission visit with patient," is sufficient to select code "1, Yes".
 - If the clinical record is ambiguous as to whether the hospice attempted to re-affirm patient preferences present in a pre-existing POLST, select code "0, No" for F2200A and skip to Item F3000, Spiritual/Existential Concerns.

Examples**Situation A - Patient's clinical record contains the following information:**

Patient admitted on 08-01-2014. Clinical note dated 08-01-2014 shows: "Talked with patient about preference for readmission to hospital; patient was hesitant and stated they weren't sure. Told patient we could discuss at later date."

- **Coding:**
F2200A: Was the patient/responsible party asked about preference regarding hospitalization? Select code "1, Yes, and discussion occurred."
F2200B: Date the patient/responsible party was first asked about preference regarding hospitalization: Enter "08-01-2014."
- **Explanation:** The most appropriate coding option for F2200A is "1" since although the patient did not express a clear preference regarding hospitalization, a discussion occurred.

Situation B - Patient's clinical record contains the following information:

Patient admitted 08-01-2014. Clinical record for the patient includes a POLST form completed in the prior care setting indicating selection of comfort-oriented care, including desire to avoid hospitalization, which is dated 07-15-2014.

- **Coding:**
F2200A: Was the patient/responsible party asked about preference regarding the use of re-admission to hospital? Select code "0, No." Skip to Item F3000, Spiritual/Existential Concerns.
- **Explanation:** Although the patient has a recently dated POLST, it was signed in a prior care setting. There is no documentation in the clinical record to indicate that the hospice re-confirmed the patient's preferences for comfort-oriented care and avoidance of hospitalization. If a statement such as "All POLST treatment preferences confirmed with responsible party, patient's daughter" was included, that would be sufficient to select code "1, Yes."

F3000. Spiritual/Existential Concerns

Enter Code

A. Was the patient and/or caregiver asked about spiritual/existential concerns? Select the most accurate response.

- 0. **No** → Skip to I0010, Principal Diagnosis
- 1. **Yes, and discussion occurred**
- 2. **Yes, but the patient and/or caregiver refused to discuss**

B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:

Month

Day

Year

Item-Specific Instructions

Review the clinical record for information regarding spiritual/existential concerns. Item completion (coding) should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns?

- **Code 0, No:** Select code 0 if there is no documentation that the hospice discussed (or attempted to discuss) spiritual/existential concerns with the patient and/or caregiver(s). Skip to Item I0010, Principal Diagnosis.
 - Code 0 applies to situations where there is no documentation that a discussion occurred or was attempted with the patient and/or caregiver. This could happen if the patient is unable to discuss and/or the responsible party was unavailable.
- **Code 1, Yes, and discussion occurred:** Select code 1 if there is documentation that the hospice discussed spiritual/existential concerns with the patient and/or caregiver(s).
 - Code 1 applies to situations where there is documentation that the hospice brought up the topic of spiritual/existential concerns, and there was a conversation with the patient and/or caregiver. The conversation does not have to result in initiation of intervention(s) to address spiritual/existential concerns to select code 1 for F3000A. For the purposes of Item F3000, select code 1 if the hospice opened the door for a conversation and there is documentation that the patient and/or caregiver engaged with the hospice in a discussion regarding spiritual/existential concerns.
- **Code 2, Yes, but patient and/or caregiver refused to discuss:** Select code 2 if there is documentation that the hospice asked about spiritual/existential concerns, but the patient and/or caregiver(s) refused to discuss or were unable to discuss.

Item-Specific Instructions (continued)

- Code 2 applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and caregiver, but both the patient **and** caregiver **explicitly refused** to discuss the topic with the hospice. This would include statements such as, “I don’t want to talk about this” or “I’m only going to talk to my priest about this”. In these instances, the hospice was not successful in engaging the patient and/or caregiver in a discussion.
- Code 2 also applies to situations in which the hospice attempted to discuss the topic, but the patient was unable to discuss because of their clinical status **and** the caregiver **explicitly refused** to discuss.

F3000B: Date the patient and/or caregiver was first asked about spiritual/existential concerns

- **Enter the date** the hospice discussed (or attempted to discuss) spiritual/existential concerns. Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a “0” in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- It is possible that at the time of HIS completion there will be multiple discussions regarding spiritual/existential concerns documented in the clinical record. Complete HIS items based on the *first* dated discussion about spiritual/existential concerns that appears in the clinical record.

Item-Specific Tips

F3000 asks whether the patient and/or **caregiver** was asked about spiritual/existential concerns. For the purposes of completing Item F3000, “caregiver” does not have to be the legally authorized representative.

F3000 is intended to capture evidence of a **discussion** (or attempted discussion) of spiritual/existential concerns with the patient and/or caregiver(s). This item does not capture whether interventions to address concerns were initiated.

- There is no comprehensive list of spiritual/existential concerns. Documentation in the clinical record indicating that a member of the hospice staff or IDG attempted to discuss spiritual/existential concerns is sufficient to code either:
 - “1, Yes, and discussion occurred” or
 - “2, Yes, but the patient and/or caregiver refused to discuss” for F3000A.
- Brief statements or data in the clinical record denoting a patient’s religious affiliation is not sufficient to code “Yes” for F3000A.

Item-Specific Tips (continued)

- If clinical record documentation is ambiguous as to whether discussion about spiritual/existential concerns was attempted, code “0, No” for F3000A and skip to Item I0010, Principal Diagnosis.

A discussion with the patient and/or caregiver(s) about spiritual/existential concerns can be initiated by any member of the hospice staff or IDG.

Examples**Situation A - Patient’s clinical record contains the following information:**

Social worker questionnaire dated 08-01-2014 shows: “Patient’s spouse in great deal of spiritual distress and would like to speak with chaplain. Referral made.”

- **Coding:**
F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns? Select code “1, Yes, and discussion occurred.”
F3000B: Date the patient and/or caregiver was first asked about spiritual/existential concerns. Enter “08-01-2014.”
- **Explanation:** The completed questionnaire is strong evidence that the hospice engaged the patient and/or caregiver in a discussion regarding spiritual/existential concerns. Even though the clinical record does not contain documentation of a visit by the chaplain, select code “1, Yes, and discussion occurred” for F3000A since the intent of F3000 is to capture initiation of a **discussion** about spiritual/existential concerns.

Situation B - Patient’s clinical record contains the following information:

Patient’s initial assessment shows: “patient identifies their religious affiliation as Baptist.”

- **Coding:**
F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns? Select code “0, No” and skip to Item I0010, Principal Diagnosis.
- **Explanation:** The intent of F3000 is to capture initiation of a discussion (or attempted discussion) about spiritual/existential concerns. Clinical record documentation showing only the patient’s religious affiliation is not sufficient evidence that the hospice had (or attempted to have) a **discussion** regarding spiritual/existential concerns with the patient and/or caregiver.

SECTION I: ACTIVE DIAGNOSES

Items in this section of the Hospice Item Set (HIS) pertain to principal diagnosis of the patient; there is only one item in this section, I0010, Principal Diagnosis.

Disclaimer: The HIS is intended for use in quality reporting; it does not imply acceptability for payment purposes.

RATIONALE

Disease processes and conditions can impact service delivery. This section includes the most common principal diagnoses among hospice patients.

I0010. Principal Diagnosis

Enter Code	01. Cancer
<input type="text"/>	02. Dementia/Alzheimer's
<input type="text"/>	99. None of the above

Item-Specific Instructions

Review the clinical record for information regarding principal diagnosis. Item completion (coding) must be based on what is indicated in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection. This item should be completed based on the patient's principal diagnosis at the time of admission to hospice.

I0010: Principal Diagnosis

- **Code 01, Cancer:** Select code 01 if the patient's principal diagnosis is cancer (including leukemia).
- **Code 02, Dementia/Alzheimer's:** Select code 02 if the patient's principal diagnosis is dementia (Alzheimer's Disease; frontotemporal dementia; Pick's disease; other frontotemporal dementia; senile degeneration of brain; dementia with Lewy bodies). Note that some dementia codes have ICD-9-CM and ICD-10-CM manifestation/etiology or sequencing conventions; ensure that coding guidelines have been met for reporting principal diagnosis.
- **Code 99, None of the above:** Select code 99 if the patient's principal diagnosis is a disease/condition other than cancer or dementia/Alzheimer's.

Item-Specific Tips

The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. For hospice patients, this is the diagnosis most contributory to the patient having a life expectancy of six months or less if the illness runs its normal course.

[This page intentionally left blank.]

SECTION J: HEALTH CONDITIONS

Items in this section of the Hospice Item Set (HIS) pertain to physical symptom management for hospice patients. Physical symptoms included in this section are pain and shortness of breath.

SECTION J, PAIN: RATIONALE

Pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Patients and family caregivers rate pain management as a high priority when living with serious and life-limiting illnesses. The consequences of inadequate screening, assessment, and treatment for pain include physical suffering, functional limitation, and development of apathy and depression.

- Inclusion of pain screening items will improve awareness of the presence of pain, which is the first essential step for quality pain management and treatment.
- Inclusion of pain assessment items will improve awareness of assessment of pain severity, etiology, and effect on function, which is the second step for quality pain management and treatment.

J0900. Pain Screening

Enter Code

☐**A. Was the patient screened for pain?**

0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

B. Date of first screening for pain:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

Enter Code

☐**C. The patient's pain severity was:**

0. **None** → Skip to J2030, Screening for Shortness of Breath
1. **Mild**
2. **Moderate**
3. **Severe**
9. **Pain not rated**

Enter Code

☐**D. Type of standardized pain tool used:**

1. **Numeric**
2. **Verbal descriptor**
3. **Patient visual**
4. **Staff observation**
9. **No standardized tool used**

Item-Specific Instructions

Review the clinical record for information regarding pain screening. Item completion (coding) should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection. Consider results of the standardized pain screening tool and any other screening approaches the clinician used that might include asking the patient about their pain comfort.

J0900A: Was the patient screened for pain?

- **Code 0, No:** Select code 0 if there is no documentation that the patient was screened for pain. Skip to Item J2030, Screening for Shortness of Breath (Dyspnea).
- **Code 1, Yes:** Select code 1 if there is documentation that the patient was screened for pain.

J0900B: Date of first screening for pain

- **Enter the date of the first screening for pain.** Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- It is possible that at the time of HIS completion there will be multiple pain screenings documented in the clinical record. Complete HIS pain screening items based on the *first* pain screening documented in the clinical record.

J0900C: The patient's pain severity was

- **Code 0, None:** Select code 0 if the patient's pain severity score was none. This would include a score of 0 on a 10-point numeric scale **or** equivalent on verbal, visual, other numeric, or staff observation scale. Skip to Item J2030, Screening for Shortness of Breath (Dyspnea).
- **Code 1, Mild:** Select code 1 if the patient's pain severity score was mild. This would include a score of 1–3 on a 10-point numeric scale **or** equivalent on verbal, visual, other numeric, or staff observation scale.
- **Code 2, Moderate:** Select code 2 if the patient's pain severity score was moderate. This would include a score of 4–7 on a 10-point numeric scale **or** equivalent on verbal, visual, other numeric, or staff observation scale.
- **Code 3, Severe:** Select code 3 if the patient's pain severity score was severe. This would include a score of 8–10 on a 10-point numeric scale **or** equivalent on verbal, visual, other numeric, or staff observation scale.
- **Code 9, Pain not rated:** Select code 9 if the patient had pain, but the patient's pain severity was not assessed or recorded.

Item-Specific Instructions (continued)**J0900D: Type of standardized pain tool used**

- **Code 1, Numeric:** Select code 1 if a numeric scale was used to conduct pain screening.
 - Examples of standardized numeric scales include, but are not limited to: 10-point scale, Symptom Distress Scale (McCorkle), Memorial Symptom Assessment Scale (MSAS), and Edmonton Symptom Assessment System (ESAS).
- **Code 2, Verbal descriptor:** Select code 2 if a verbal descriptor scale was used to conduct pain screening.
 - Examples of standardized verbal descriptor scales include, but are not limited to: Brief Pain Inventory, McGill pain questionnaire, 6-point Verbal Pain Scale.
- **Code 3, Patient visual:** Select code 3 if a patient visual scale was used to conduct pain screening.
 - Examples of standardized patient visual scales include, but are not limited to: Wong-Baker FACES Pain Scale, visual analog scale, distress thermometer.
- **Code 4, Staff observation:** Select code 4 if a staff observational scale was used to conduct pain screening. Select code 4 only if a *standardized* staff observational scale was used.
 - Examples of standardized staff observation scales include, but are not limited to Critical Care Pain Observation Tool (CPOT), Checklist of Nonverbal Pain Indicators (CNPI), Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC), and Pain Assessment in Advanced Dementia (PAIN-AD).
- **Code 9, No standardized tool used:** Select code 9 if no standardized scale was used to screen for the presence and severity of pain.

Item-Specific Tips

Pain screening includes evaluating the patient for presence of pain, and if pain is present, rating of its severity using a standardized tool. A standardized tool is one that (1) has been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, non-institutionalized adults with disabilities, etc.), and (2) includes a standard response scale (for example, a scale where patients rate pain from 0-10). The standardized tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond.

- Select the best code for pain severity based on the pain level at the time of the visit during which the screening was performed. If a range is provided, such as mild to moderate, code the highest level of severity recorded.

Item-Specific Tips (continued)

- If a non-numeric scale was used to screen the patient for pain, code the pain severity item based on the standard established for that scale. If no standard has been established for that scale, use clinician judgment to categorize severity.

If the screening indicated the patient was not in pain, the clinician may not have used a standardized pain tool to determine presence and severity of pain.

- If documentation in the patient's clinical record indicates the patient was assessed clinically and was found to have no pain, but no standardized pain tool was used to screen the patient, the best course of action is to select code "1, Yes" for J0900A, enter the date for J0900B, select code "0, None" for J0900C pain severity, and skip to Item J2030, Screening for Shortness of Breath (Dyspnea).

If documentation in the patient's clinical record indicates the patient has been clinically evaluated for pain, was found to be in pain, but it is ambiguous as to whether a screening was conducted using a *standardized* pain tool (with which severity of pain was also noted), the best course of action is to select code "1, Yes" for J0900A, enter the date for J0900B, and select code "9" for J0900C and J0900D.

Examples**Situations A and B - Patient's clinical record contains the following information:**

Situation A: Clinical note dated 08-12-2014 shows: "patient very drowsy; appears to be comfortable during visit. No nonverbal signs of pain observed during the visit" or

Situation B: Clinical note dated 08-12-2014 shows: "patient stated he was not in pain today; no complaints from patient or family"

- **Coding for Situations A and B:**

J0900A: Was the patient screened for pain? Select code "1, Yes."

J0900B: Date of first screening for pain: Enter "08-12-2014."

J0900C: The patient's pain severity was: Select code "0, None" and skip to Item J2030, Screening for Shortness of Breath (Dyspnea).

- **Explanation for Situations A and B:** Although there was no standardized pain tool used to screen the patient, it is evident the clinician evaluated the patient and determined the patient was not in any pain. The correct course of action is to code J0900A-C, skipping J0900D since the clinician determined the patient was not in any pain and thus did not use a standardized pain tool in their evaluation of the patient.

Situation C - Patient's clinical record contains the following information:

Clinical note dated 08-12-2014 shows: "patient reports 3/10 abdominal pain now; was 6/10 during past 24 hours."

- **Coding:**

J0900A: Was the patient screened for pain? Select code "1, Yes."

J0900B: Date of first screening for pain: Enter "08-12-2014."

Examples (continued)

J0900C: The patient's pain severity was: Select code "1, Mild."

J0900D: Type of standardized pain tool used: Select code "1, Numeric."

- **Explanation:** It is evident that the patient was in pain, and that the clinician evaluated the patient's pain using a standardized pain tool, noting pain severity. For J0900C, the correct course of action is to select code "1, Mild" based on the patient's pain severity rating **at the time of the visit**.

Situation D - Patient's clinical record contains the following information:

Clinical note dated 08-12-2014 shows: "patient unable to speak; observed during 20 minute evaluation; pain severity on nonverbal scale moderate to severe."

- **Coding:**

J0900A: Was the patient screened for pain? Select code "1, Yes."

J0900B: Date of first screening for pain: Enter "08-12-2014."

J0900C: The patient's pain severity was: Select code "3, Severe."

J0900D: Type of standardized pain tool used: Select code "4, Staff observation."

- **Explanation:** It is evident the patient was in pain, and that the clinician evaluated the patient's pain and noted pain severity. Although the clinical tool is not named, it is still evident that the clinician used a standardized approach or clinical protocol to screen the patient. For J0900C, the correct course of action is to select code "3, Severe," based on **the highest severity of pain at the time of the visit**.

J0910. Comprehensive Pain Assessment

Enter Code

☐
A. Was a comprehensive pain assessment done?

0. No → Skip to J2030, Screening for Shortness of Breath
1. Yes

B. Date of comprehensive pain assessment:

Month		Day		Year			

C. Comprehensive pain assessment included:

↓ Check all that apply

<input type="checkbox"/>	1. Location
<input type="checkbox"/>	2. Severity
<input type="checkbox"/>	3. Character
<input type="checkbox"/>	4. Duration
<input type="checkbox"/>	5. Frequency
<input type="checkbox"/>	6. What relieves/worsens pain
<input type="checkbox"/>	7. Effect on function or quality of life
<input type="checkbox"/>	9. None of the Above

Item-Specific Instructions

Review the clinical record for documentation of a comprehensive pain assessment. Pain assessment documentation includes a clinician's record of information about the location, severity, character, and other characteristics of a patient's pain. Pain assessment can be completed for verbal and nonverbal patients. Item completion (coding) should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

J0910A: Was a comprehensive pain assessment done?

- **Code 0, No:** Select code 0 if there is no documentation that a comprehensive pain assessment was done. Skip to Item J2030, Screening for Shortness of Breath (Dyspnea).
- **Code 1, Yes:** Select code 1 if there is documentation that a comprehensive pain assessment was done.

J0910B: Date of comprehensive pain assessment

- **Enter the date the hospice conducted the comprehensive pain assessment.** Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- It is possible that at the time of HIS completion there will be multiple comprehensive pain assessments documented in the clinical record. Complete HIS pain assessment items based on the *first* dated comprehensive pain assessment that appears in the clinical record.

J0910C: Comprehensive pain assessment included:

Check all that apply:

- **Check 1, Location:** if the **location** of the patient's pain was assessed.
- **Check 2, Severity:** if the **severity** of the patient's pain was assessed.
- **Check 3, Character:** if the **character** of the patient's pain was assessed.
- **Check 4, Duration:** if the **duration** of the patient's pain was assessed.
- **Check 5, Frequency:** if the **frequency** of the patient's pain was assessed.
- **Check 6, What relieves/worsens pain:** if **what relieves/worsens** the patient's pain was assessed.
- **Check 7, Effect on function or quality of life:** if the **pain's effect on the patient's function or quality of life** was assessed.
- **Check 9, None of the Above:** if there is no documentation that any of the above characteristics (1-7) were included in the pain assessment.

Item-Specific Tips

It is possible to include elements of the pain assessment listed in J0910C for nonverbal patients.

- A caregiver report about any of the above characteristics is acceptable. Clinical notes about assessment of nonverbal indicators of pain for any of the above characteristics are also acceptable.
- Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimaces and clenched jaw; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part. For example:
 - An assessment that included pain **location** for a nonverbal patient may include documentation, such as “patient grimaced/shouted when clinician touched their right leg” or other documentation denoting patient exhibiting nonverbal cues of pain **for a specific location on the body**.
 - An assessment that included pain **severity** for a nonverbal patient may include documentation about **intensity of nonverbal expressions of pain** (grimaces, wincing, and clenched teeth/jaw) or protective body movements (bracing, guarding, rubbing, clutching, or holding of a certain body part/area). It could also include documentation of severity using a nonverbal standardized rating scale.
 - An assessment that included pain **duration** for a nonverbal patient may include documentation about **how long a patient exhibits any nonverbal cues of pain**, such as “patient cradled right arm throughout entire visit.”
 - An assessment that included pain **frequency** for a nonverbal patient may include documentation about **how often a patient exhibits any nonverbal cues of pain**, such as most of the time, only at night, intermittently.
 - An assessment that included **what relieves/worsens pain** for a nonverbal patient may include documentation about **actions, activities, or positions that relieve/worsen pain**, such as “patient exhibits fewer nonverbal signs of pain when sitting up versus lying down.”
 - An assessment that included pain’s **effect on function or quality of life** for a nonverbal patient may include documentation about **change in patient activity**, such as “family caregiver reports that patient is no longer able to sit up in bed without moaning.”

For any of the seven characteristics included in the pain assessment, coding can be based on whether the clinician **made an attempt** to gather the information from the patient/caregiver.

- For example, if, for a nonverbal patient, the clinician asked the family/caregiver about pain location and the family/caregiver responded “I’m not sure” or “I don’t know,” “1, Location” should be checked for J0910C as the clinician **attempted** to gather the information.

Examples**Situation A - Patient's clinical record contains the following information:**

Clinical note dated 08-12-2014 shows: "patient unable to speak; noticed some loud moaning/grimacing during visit. Asked patient's family about how long patient had been in distress—family stated patient had been moaning all morning, and rarely looked comfortable. Family stated patient often clutches lower abdomen when touched. Unable to move patient because of signs of distress when turning or attempting to get up from bed. Family uncertain what makes pain worse or better."

- **Coding:**

J0910A: Was a comprehensive pain assessment done? Select code "1, Yes."

J0910B: Date of comprehensive pain assessment: Enter "08-12-2014."

J0910C: Comprehensive pain assessment included: Check "1, Location" (clutching lower abdomen); Check "2, Severity" (loudly moaning/grimacing); Check "4, Duration" (patient had been moaning all morning); Check "5, Frequency" (rarely looked comfortable); Check "6, What relieves/worsens pain" (family uncertain); Check "7, Effect on function or quality of life" (unable to move because of distress).

- **Explanation:** Since at least one of the seven characteristics of a comprehensive pain assessment were clearly documented in the patient's clinical record, select code "1, Yes" for J0910A and continue to J0910B-J0910C, coding based on documentation in the clinical record. Even though family stated they were not sure what made the pain better or worse, "6, What relieves/worsens pain" can still be checked since there was documentation that the clinician asked about what relieves or worsens pain.

Situation B - Patient's clinical record contains the following information:

Clinical documentation dated 08-12-2014 shows: "Current Pain Intensity: moderate; Rated by: patient; Frequency: intermittent; Type of pain: throbbing; What makes pain worse: movement; Pain affects patient's: appetite, emotions; Relief measures that work: heat, distraction, massage."

- **Coding:**

J0910A: Was a comprehensive pain assessment done? Select code "1, Yes."

J0910B: Date of comprehensive pain assessment: Enter "08-12-2014."

J0910C: Comprehensive pain assessment included: Check "2, Severity" (moderate); Check "3, Character" (throbbing); Check "5, Frequency" (intermittent); Check "6, What relieves/worsens pain" (heat, distraction, massage, movement); Check "7, Effect on function or quality of life" (appetite, emotions).

- **Explanation:** Since at least one of the seven characteristics of a comprehensive pain assessment were clearly documented, select code "1, Yes" for J0910A and continue to J0910B-J0910C, coding using documentation found in the clinical record.

SECTION J, RESPIRATORY STATUS: RATIONALE

Shortness of breath (dyspnea) is prevalent and often under-treated among patients nearing the end of life.

- Screening for shortness of breath is necessary to determine its presence and severity, and forms the basis for treatment decision making.

Shortness of breath can be functionally limiting and distressing to patients and their families/caregivers.

- Effective treatment is available to alleviate symptom distress.
- Treatment can include pharmacologic and non-pharmacologic interventions.
- Treatment for shortness of breath will vary with its severity and etiology, and with patient and caregiver preferences.

J2030. Screening for Shortness of Breath

Enter Code

☐
A. Was the patient screened for shortness of breath?

0. **No** → Skip to N0500, Scheduled Opioid
1. **Yes**

B. Date of first screening for shortness of breath:

Month

Day

Year

Enter Code

☐
C. Did the screening indicate the patient had shortness of breath?

0. **No** → Skip to N0500, Scheduled Opioid
1. **Yes**

Item-Specific Instructions

Review the clinical record for documentation of screening for shortness of breath. Item completion (coding) should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

J2030A: Was the patient screened for shortness of breath?

- **Code 0, No:** Select code 0 if there is no documentation that the patient was screened for shortness of breath. Skip to Item N0500, Scheduled Opioid.
- **Code 1, Yes:** Select code 1 if there is documentation that the patient was screened for shortness of breath.

J2030B: Date of first screening for shortness of breath

- **Enter the date the hospice first screened the patient for shortness of breath.** Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.

Item-Specific Instructions (continued)

- It is possible that at the time of HIS completion there will have been multiple screenings for shortness of breath that were documented in the clinical record. Complete HIS shortness of breath screening items based on the first shortness of breath screening that appears in the clinical record.

J2030C: Did the screening indicate the patient had shortness of breath?

- **Code 0, No:** Select code 0 if the screening indicated that the patient did not have shortness of breath. Skip to Item N0500, Scheduled Opioid.
- **Code 1, Yes:** Select code 1 if the screening indicated that the patient had shortness of breath.

Item-Specific Tips

A screening for shortness of breath must include evaluating the patient for presence/absence of shortness of breath, and if shortness of breath is present, rating of its severity. Structured clinical evaluation for shortness of breath is not well defined, therefore documentation found in the clinical record for screening of shortness of breath may vary and may not include use of a standardized tool for rating severity.

- To answer “yes” to J2030A, clinical record documentation must show the patient was screened for presence/absence of shortness of breath **and**, if the patient was found to be short of breath, there must also be evidence that severity was rated in any manner clinically appropriate for the patient (which may/may not have included the use of a standardized tool to rate severity).
- If documentation indicates the patient had shortness of breath, but severity was not evaluated in any manner, answer “no” to J2030A.

Evidence of a “positive” screen for shortness of breath should consider both patient’s self-report of distress and observed clinical signs of shortness of breath **at the time of the visit in which the screening was conducted**. The clinical record could include patient’s self-report of distress or “trouble breathing” from shortness of breath or dyspnea; documentation of shortness of breath or dyspnea at rest, upon exertion, etc.; patient/caregiver report of shortness of breath; observed clinical signs of distress from shortness of breath; and/or documentation that the symptom is distressing or limits patient function or quality of life.

Examples**Situation A - Patient’s clinical record contains the following information:**

Clinical note dated 08-12-2014 shows: “ patient very drowsy; appears to be comfortable during visit.”

- **Coding:**
J2030A: Was the patient screened for shortness of breath? Select code “0, No” and skip to Item N0500, Scheduled Opioid.
- **Explanation:** The documentation in Situation A provides no evidence that the patient was screened for shortness of breath. Thus, select code “0, No” for J2030A and skip to Item N0500.

Examples (continued)**Situation B - Patient's clinical record contains the following information:**

Clinical note dated 08-12-2014 shows: "patient reports no discomfort and is breathing shallowly but without signs of distress; no concerns about breathing from patient or family."

- **Coding:**

J2030A: Was the patient screened for shortness of breath? Select code "1, Yes."

J2030B: Date of first screening for shortness of breath: Enter "08-12-2014."

J2030C: Did the screening indicate the patient had shortness of breath? Select code "0, No" and skip to N0500, Scheduled Opioid.

- **Explanation:** The documentation in Situation B gives evidence that breathing was screened or assessed. J2030C is coded "0, No" since the screening indicated that although the patient was breathing shallowly, there were no signs of distress or concerns from patient/family.

Situations C and D - Patient's clinical record contains the following information:

Situation C: Clinical note dated 08-12-2014 shows: "patient reports great difficulty with breathing when walking to the bathroom; breathing is eased after resting and better if using oxygen when active."

- **Coding:**

J2030A: Was the patient screened for shortness of breath? Select code "1, Yes."

J2030B: Date of first screening for shortness of breath: Enter "08-12-2014."

J2030C: Did the screening indicate the patient had shortness of breath? Select code "1, Yes."

Situation D: Clinical note dated 08-12-2014 shows: "patient unable to speak; observed during 20-minute evaluation; respiratory rate 28 with intermittent use of abdominal breathing; some wheezing on exam but good air movement."

- **Coding for Situations C and D:**

J2030A: Was the patient screened for shortness of breath? Select code "1, Yes."

J2030B: Date of first screening for shortness of breath: Enter "08-12-2014."

J2030C: Did the screening indicate the patient had shortness of breath? Select code "1, Yes."

- **Explanation for Situations C and D:** In both Situations C and D it is evident that the clinician used careful questioning and observation to establish the presence and severity of shortness of breath. Thus, select code "1, Yes" for J2030A, and continue to J2030B-J2030C, using evidence in the clinical record to code date and presence or absence of shortness of breath.

J2040. Treatment for Shortness of Breath	
Enter Code <input type="checkbox"/>	<p>A. Was treatment for shortness of breath initiated? Select the most accurate response</p> <ol style="list-style-type: none"> 0. No → Skip to N0500, Scheduled Opioid 1. No, patient declined treatment → Skip to N0500, Scheduled Opioid 2. Yes <p>B. Date treatment for shortness of breath initiated:</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input type="text"/><input type="text"/> Month </div> <div style="text-align: center;"> <input type="text"/><input type="text"/> Day </div> <div style="text-align: center;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Year </div> </div> <p>C. Type(s) of treatment for shortness of breath initiated:</p>
↓ Check all that apply	
<input type="checkbox"/>	1. Opioids
<input type="checkbox"/>	2. Other medication
<input type="checkbox"/>	3. Oxygen
<input type="checkbox"/>	4. Non-medication
Item-Specific Instructions	
<p>Review the clinical record for information regarding treatment for shortness of breath. Item completion (coding) should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.</p> <p>J2040A: Was treatment for shortness of breath initiated?</p> <ul style="list-style-type: none"> Code 0, No: Select code 0 if there is no documentation that treatment for shortness of breath was initiated or offered. Skip to Item N0500, Scheduled Opioid. Code 1, No, patient declined treatment: Select code 1 if there is documentation that the hospice offered treatment for shortness of breath but the patient or responsible party declined. Skip to Item N0500, Scheduled Opioid. Code 2, Yes: Select code 2 if there is documentation that treatment for shortness of breath was initiated. <p>J2040B: Date treatment for shortness of breath initiated</p> <ul style="list-style-type: none"> Enter the date the hospice initiated treatment for shortness of breath. Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014. 	

Item-Specific Instructions (continued)

- For pharmacologic interventions, treatment initiation is defined as the date that an order was received to initiate or continue a treatment. An order may be verbal (when permitted) or written; coding for this item should be based on whichever was used to determine the start of treatment. Enter the date of the order, irrespective of if/when the first dose was given.
 - For orders continued from previous care settings, J2040 should be completed based on treatments for which the **hospice** has received orders. Do not include a “continued” treatment unless the hospice received a new order to continue the treatment. Once an order is received by the hospice to continue a treatment, use the date the hospice received the order in J2040B.
 - For standing orders, “initiation” is defined as the date the order was received by the hospice.
- For non-medication interventions (for example, fans, positioning, patient education efforts) there will not be any orders; in this case, use the date the interventions were delivered. If the patient received multiple types of treatment for shortness of breath (for example, oxygen and education about positioning), enter the date that the first treatment was initiated.

J2040C: Type(s) of treatment for shortness of breath initiated

Check all that apply:

- **Check 1, Opioids:** if the patient received opioids and there is documentation that opioids were initiated *for shortness of breath*.
- **Check 2, Other medication:** if a non-opioid medication was initiated for shortness of breath.
- **Check 3, Oxygen:** if the patient received oxygen.
- **Check 4, Non-medication:** if the patient received a non-medication intervention for shortness of breath, other than oxygen. This could include (but is not limited to) fans, positioning, and education about energy conservation techniques.

Item-Specific Tips

When reviewing the clinical record for treatments initiated for shortness of breath:

- Include both scheduled and PRN treatments for shortness of breath.
- Include standing orders only if the standing order is initiated.

Some treatments have multiple uses (for example, opioids can be used to treat pain or shortness of breath; relaxation techniques can be used to help with shortness of breath or anxiety).

- Only include such treatments in J2040 if the clinical record indicates that the intended purpose of the treatment is to address the patient’s shortness of breath.
- Orders that contain multiple purposes for the medication are acceptable as long as one of the stated purposes is to address shortness of breath.

Examples**Situation A - Patient's clinical record contains the following information:**

Clinical documentation dated 08-12-2014 shows: "dyspnea/shortness of breath at rest, clinical signs indicate patient is short of breath. Patient/family instructed on energy conservation techniques to alleviate shortness of breath." Order dated 08-12-2014 shows: "morphine 2-15 mg IV every 4 hours as needed."

- **Coding:**

J2040A: Was treatment for shortness of breath initiated? Select code "2, Yes."

J2040B: Date treatment for shortness of breath initiated: Enter "08-12-2014."

J2040C: Type(s) of treatment for shortness of breath initiated: Check "4, Non-medication" (energy conservation techniques).

- **Explanation:** Documentation in the clinical record clearly indicates that the patient was short of breath and there was treatment initiated for shortness of breath (energy conservation techniques). The morphine treatment listed in the order list **cannot** be deemed treatment for shortness of breath since there is no indication listed in the clinical record that the morphine was prescribed to treat shortness of breath. To be considered a treatment for shortness of breath, the order list would need to read "morphine 2-15 mg IV every 4 hours as needed *for shortness of breath*" Or "*as needed for shortness of breath and pain*".

Situation B - Patient's clinical record contains the following information:

Clinical documentation dated 09-15-2014 shows: "dyspnea/shortness of breath at rest. Instructed family to keep patient's head elevated on pillows while patient is in bed." Order dated 09-16-2014 shows: "oxygen ordered and scopolamine to dry respiratory secretions."

- **Coding:**

J2040A: Was treatment for shortness of breath initiated? Select code "2, Yes."

J2040B: Date treatment for shortness of breath initiated: Enter "09-15-14."

J2040C: Type(s) of treatment for shortness of breath initiated: Check "2, Other medication" (scopolamine), "3, Oxygen," and "4, Non-medication" (positioning with pillows).

- **Explanation:** Documentation in the clinical record clearly indicates that the patient was short of breath and that there was more than one treatment initiated for shortness of breath. The date that the **first** treatment for shortness of breath is initiated (09-15-2014) is the proper date to list in Item J2040B, since education about positioning was the first treatment initiated.

Situation C – Patient's clinical record contains the following information:

Clinical documentation dated 09-15-2014 shows: "patient reports SOB and is currently using oxygen and nebulizer ordered in previous care setting." No orders for oxygen or nebulizer found in the hospice record.

Examples (continued)

- **Coding:**
J2040A: Was treatment for shortness of breath initiated? Select code “0, No.” Skip to Item N0500, Scheduled Opioid.
J2040B: Date treatment for shortness of breath initiated: Do not complete.
J2040C: Type(s) of treatment for shortness of breath initiated: Do not complete.
- **Explanation:** Item J2040 should be completed based on treatments for which the hospice has received orders after assuming responsibility for the care of the patient. “Initiation” (or continuation) of a treatment from a previous care setting is defined as the date the hospice received new orders to continue the treatment. In Situation C, the nebulizer and oxygen cannot be listed as treatments for SOB in J2040 since there was no evidence in the clinical record that the **hospice** received orders to continue these treatments under hospice care. If new orders for the oxygen and nebulizer were listed in the hospice clinical record/order list, the treatments could be considered when completing J2040; in this situation, the hospice would enter the date that the hospice received the order in J2040B.

[This page intentionally left blank.]

SECTION N: MEDICATIONS

Items in this section of the Hospice Item Set (HIS) gather information on opioids and bowel regimens.

SECTION N: RATIONALE

Opioids are commonly used in the management of pain and other symptoms. Constipation is one of the most common opioid-related adverse effects. Most patients develop some degree of constipation after opioid initiation or dose increases, and reducing opioid-induced constipation has the potential to reduce patient discomfort and improve quality of life. Patients do not develop a tolerance to opioid-induced constipation; clinical guidelines recommend prophylactic bowel regimens.

N0500. Scheduled Opioid

Enter Code

☐
A. Was a scheduled opioid initiated or continued?

- 0. **No** → Skip to N0510, PRN Opioid
- 1. **Yes**

B. Date scheduled opioid initiated or continued:

Month

Day

Year

Item-Specific Instructions

Review the clinical record for information regarding medications and prescriptions. Item completion (coding) should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

N0500 A: Was a scheduled opioid initiated or continued?

- **Code 0, No:** Select code 0 if the clinical record indicates that a regularly scheduled opioid was neither initiated nor continued by the hospice and skip to Item N0510, PRN Opioid.
- **Code 1, Yes:** Select code 1 if the clinical record indicates that a regularly scheduled opioid was initiated or continued from the previous care setting.

N0500B: Date scheduled opioid initiated or continued:

- **Enter date scheduled opioid was initiated or continued.** Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.

Item-Specific Instructions (continued)

- This is the date that the hospice initiated or continued regularly scheduled opioids. Treatment initiation or continuation is defined as the date that an order was received. An order may be verbal (when permitted) or written; coding for this item should be based on whichever was used to determine the start of treatment. Enter the date of the order, irrespective of if/when the first dose was given.
 - For orders continued from previous care settings, N0500 should be completed based on scheduled opioids for which the **hospice** has received orders. Do not include a “continued” treatment unless the hospice received a new order to continue the treatment. Once an order is received by the hospice to continue a treatment, use the date the hospice received the order in N0500B.
 - For standing orders, “initiation” is defined as the date the order was received by the hospice.
- If the patient received different types of regularly scheduled opioids in sequence over time, enter the date that the first type of opioid treatment was initiated.

Item-Specific Tips

Select code “1, Yes” if the clinical record indicates that a regularly scheduled opioid was initiated for any reason, regardless of symptom.

N0510. PRN Opioid

Enter Code

☐
A. Was a PRN opioid initiated or continued?

0. **No** → Skip to N0520, Bowel Regimen
1. **Yes**

B. Date PRN opioid initiated or continued:

Month

Day

Year

Item-Specific Instructions

Review the clinical record for information regarding medications and prescriptions. Item completion (coding) should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

N0510A: Was a PRN opioid initiated or continued?

- **Code 0, No:** Select code 0 if the clinical record indicates that a PRN opioid was neither initiated nor continued from the previous care setting.
- **Code 1, Yes:** Select code 1 if the clinical record indicates that a PRN opioid was initiated or continued from the previous care setting.

Item-Specific Instructions (continued)**N0510B: Date PRN opioid initiated or continued.**

- **Enter the date PRN opioid was initiated or continued.** Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a “0” in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- This is the date that the hospice initiated or continued PRN opioids. Treatment initiation or continuation is defined as the date that an order was received. An order may be verbal (when permitted) or written; coding should be based on whichever was used to determine the start of treatment. Enter the date of the order, irrespective of if/when the first dose was given.
 - For orders continued from previous care settings, N0510 should be completed based on PRN opioids for which the **hospice** has received orders. Do not include a “continued” treatment unless the hospice received a new order to continue the treatment. Once an order is received by the hospice to continue a treatment, use the date the hospice received the order in N0510B.
 - For standing orders, “initiation” is defined as the date the order was received by the hospice.
- If the patient received different types of PRN opioids in sequence over time, enter the date that the first type of opioid treatment was initiated.

Item-Specific Tips

Select code “1, Yes” if the clinical record indicates that a PRN opioid was initiated for any reason, regardless of symptom.

N0520. Bowel Regimen

Complete only if N0500A or N0510A = 1

Enter Code

☐

A. Was a bowel regimen initiated or continued? Select the most accurate response.

0. **No** → Skip to Z0400, Signature(s) of Person(s) Completing the Record
1. **No, but there is documentation of why a bowel regimen was not initiated or continued** → Skip to Z0400, Signature(s) of Person(s) Completing the Record
2. **Yes**

B. Date bowel regimen initiated or continued:

Month

Day

Year

Item-Specific Instructions

Review the clinical record for information regarding medications and prescriptions. Item completion (coding) should be based on what is included in the clinical record. Do not use sources external to the clinical record. Review all response choices before making a selection.

N0520A: Was a bowel regimen initiated or continued?

Only complete N0520A if N0500A or N0510A = 1. Skip N0520A if the patient is not on any type of opioid.

- **Code 0, No:** Select code 0 if the clinical record does not include documentation that a bowel regimen was initiated or continued from the previous care setting. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record.
- **Code 1, No, but there is documentation of why a bowel regimen was not initiated or continued:** Select code 1 if the clinical record indicates that a bowel regimen was not initiated or continued, and includes a reason why it was not initiated or continued. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record.
 - Documentation why a bowel regimen was not initiated could include clinical contraindications to a bowel regimen or patient was offered a bowel regimen but refused treatment.
- **Code 2, Yes:** Select code 2 if the clinical record includes documentation that a bowel regimen was initiated or continued from the previous care setting.

N0520B: Date bowel regimen initiated or continued:

- **Enter date bowel regimen was initiated or continued.** Use the format: Month-Day-Year: MM-DD-YYYY. If the month and/or day contain only a single digit, enter a "0" in the first box of the month and/or day. For example, November 1, 2014, would be entered as 11-01-2014.
- This is the date that the hospice initiated or continued a bowel regimen. Treatment initiation or continuation is defined as the date that an order was received. An order may be verbal or written; coding should be based on whichever was used to determine the start of treatment. Enter the date of the order, irrespective of if/when the first dose was given.
 - For orders continued from previous care settings, N0520 should be completed based on bowel regimens for which the **hospice** has received orders. Do not include a "continued" bowel regimen unless the hospice received a new order to continue the bowel regimen. Once an order is received by the hospice to continue a bowel regimen, use the date the hospice received the order in N0520B.
 - For standing orders, "initiation" is defined as the date the order was received by the hospice.

Item-Specific Instructions (continued)

- For non-pharmacologic bowel regimens, such as prune juice or high fiber diet, there may not be any orders; in this case, use the date the hospice nurse or clinician instructed the patient/family about non-pharmacologic intervention(s).
- If multiple bowel regimens were ordered, enter the date that the first treatment was initiated.
- In certain instances the date the bowel regimen was initiated or continued (listed in N0520B) may precede the date an opioid (scheduled or PRN) was initiated (listed in N0500B and/or N0510B). This is permissible.

Item-Specific Tips

A bowel regimen may include, but is not limited to

- Laxatives or stool softeners
- High fiber supplements
- Enemas
- Suppositories
- Dietary interventions, such as prune juice or high fiber diet

Clinical record documentation indicating that any of the above bowel regimens were initiated is sufficient to select code “2, Yes” for N0520A. Orders may be for regularly scheduled use or for PRN use.

Documentation for why a bowel regimen was not initiated could include clinical contraindication, including but not limited to

- bowel obstruction/ileus
- diarrhea
- no bowel function
- colostomy/ileostomy
- nausea/vomiting
- recent abdominal surgery
- NPO/taking nothing by mouth
- patient offered bowel regimen but refused treatment

Clinical record documentation indicating that any of the above clinical contraindications (or any other appropriate clinical contraindication) was present is sufficient to select code “1, No, but there is documentation of why a bowel regimen was not initiated or continued” for N0520A.

A bowel regimen—or any clinical contraindication to a bowel regimen—may appear in the patient clinical record as any reference to avoiding constipation, which may not be linked to opioid prescription.

- In practical terms, this means completing Item N0520 may require review of other portions of the clinical record (for example, gastrointestinal assessment, elimination status, bowel function) to find evidence about bowel regimen or clinical contraindications to bowel regimen.

Examples**Situation A - Patient's clinical record contains the following information:**

Order dated 08-13-2014 shows: "Oxycodone 10 mg PO every 4 hours, PRN for pain." Clinical documentation dated 08-13-2014 shows: "Patient has diarrhea."

- **Coding:**
N0500A: Was a scheduled opioid initiated or continued? Select code "0, No." Skip to N0510, PRN Opioid.
N0510A: Was a PRN opioid initiated or continued? Select code "1, Yes."
N0510B: Date PRN opioid initiated or continued: Enter "08-13-2014."
N0520A: Was a bowel regimen initiated or continued? Select code "1, No, but there is documentation of why a bowel regimen was not initiated or continued." Skip to Item Z0400, Signature(s) of Person(s) Completing the Record.
- **Explanation:** Even though the patient is on a PRN opioid, the clinical record clearly indicates that the patient also has a clinical contraindication (diarrhea). Thus, select code "1" for N0520A and skip to Item Z0400.

Situation B - Patient's clinical record contains the following information:

Order dated 07-23-2014 shows: "Morphine 4 mg per hour IV continuous with 2 mg IV PCA every 15 minutes PRN breakthrough pain." Clinical documentation dated 07-23-2014 shows: "Last bowel movement 5 days ago. Patient complaining of abdominal discomfort." Order dated 07-24-2014 shows: "Polyethylene glycol 17 g PO with full glass of water."

- **Coding:**
N0500A: Was a scheduled opioid initiated or continued? Select code "1, Yes."
N0500B: Date scheduled opioid initiated or continued: Enter "07-23-2014."
N0510A: Was PRN opioid initiated or continued? Select code "1, Yes."
N0510B: Date PRN opioid initiated or continued: Enter "07-23-2014."
N0520A: Was a bowel regimen initiated or continued? Select code "2, Yes."
N0520B: Date bowel regimen initiated or continued: Enter "07-24-2014."
- **Explanation:** Clinical record documentation clearly indicates the patient was on an opioid (Morphine) and that a bowel regimen was initiated (Polyethylene glycol).

Situation C - Patient's clinical record contains the following information:

Clinical documentation dated 08-13-2014 shows: "Last bowel movement 5 days ago. Patient complaining of abdominal discomfort." Order dated 08-13-2014 shows: "Polyethylene glycol 17 g PO with full glass of water."

- **Coding:**
N0500A: Was a scheduled opioid initiated or continued? Select code "0, No." Skip to N0510, PRN Opioid.

Examples (continued)

N0510A: Was PRN opioid initiated or continued? Select code “0, No.” Skip to N0520, Bowel Regimen.

N0520A: Was a bowel regimen initiated or continued? Do not complete. Skip to Item Z0400, Signature(s) of Person(s) Completing the Record.

- **Explanation:** Even though the patient’s clinical record shows that a bowel regimen was initiated, do not complete Item N0520 since the patient is not on an opioid. Skip to Item Z0400, Signature(s) of Person(s) Completing the Record.

Situation D – Patient’s clinical record contains the following information:

Standing order dated 07-23-2014 shows “Oxycodone 10 mg every 4 hours, PRN for pain; Polyethylene glycol 17 g PO with full glass of water.”

- **Coding:**

N0500A: Was a scheduled opioid initiated or continued? Select code “0, No.” Skip to N0510, PRN opioid.

N0500B: Date scheduled opioid initiated or continued: Do not complete.

N0510A: Was PRN opioid initiated or continued? Select code “1, Yes.”

N0510B: Date PRN opioid initiated or continued: Enter “07-23-2014.”

N0520A: Was a bowel regimen initiated or continued? Select code “2, Yes.”

N0520B: Date bowel regimen initiated or continued: Enter “07-23-2014.”

- **Explanation:** For Items N0500-N0520, the appropriate course of action is to select “Yes” for N0510A and N0520A. The dates listed in N0510B and N0520B should reflect the date the standing order was received by the hospice, irrespective of if/when the first dose was given.

[This page intentionally left blank.]

SECTION Z: RECORD ADMINISTRATION

Items in this section contain signatures of individuals completing the Hospice Item Set (HIS) and the signature of the individual verifying HIS record completion.

SECTION Z: RATIONALE

It is the responsibility of the hospice to ensure the completeness of the HIS.

- Section Z is to be used by the provider, and should be retained by the provider in accordance with provider policies and procedures related to patient information.
- Item Z0400 provides a tracking log for the abstracted information contained in the HIS. The signatures in Z0400 are used to certify that the information the individual(s) provided is accurate and that he or she was authorized to collect the information and document on the HIS.
- Item Z0500 is used to document the individual responsible for ensuring the HIS is completed in a timely manner.

Z0400: Signature(s) of Person(s) Completing the Record

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Item-Specific Instructions

Signatures in Z0400 should reflect those hospice staff members who completed the HIS, which may or may not be the clinician who completed care processes documented in the clinical record. Signatures may be electronic.

All staff who complete any part of the HIS record shall enter their signature, title, section, or portion(s) of a section(s) they completed, and the date completed.

- If an individual completes multiple sections of the HIS, that individual can sign once in Z0400 and indicate which sections they completed in the “Sections” portion of Z0400.
- One or more staff members can complete items within the same section of the HIS record. When filling in the information for Z0400, any staff member who has completed a portion of a section should identify which item(s) he or she completed within that section.
- If a staff member cannot sign and date Z0400 on the same day that he or she completed a section or portion of a section of the HIS record, that staff member should enter the original date of HIS record completion when signing Z0400.
- The hospice is responsible for the accuracy of all items on the HIS, irrespective of how they are completed or auto-populated in the HIS record.

Read the Attestation Statement carefully. Persons signing Z0400 are certifying that the information in the HIS record, to the best of his/her knowledge, most accurately reflects documentation in the patient’s clinical record.

Item-Specific Tips

- Z0400 is not submitted as part of the HIS record in the QIES ASAP system.
- This signature-block section (Z0400) is provided for use by the hospice, and it is suggested that it be retained at the hospice in accordance with policies and procedures related to patient information.

Z0500. Signature of Person Verifying Record Completion**A. Signature:**

B. Date:

--	--

Month

--	--

Day

--	--	--	--

Year

Item-Specific Instructions

Sign and date Z0500 after verifying that all items on the record are complete and that Item Z0400, Signature(s) of Person(s) Completing the Record, contains attestation for all HIS sections.

- If for some reason the person verifying record completion is unable to sign Z0500A on the date the HIS is completed, the staff member should enter the date when he or she signs Z0500B.

Item-Specific Tips

The signature in Z0500A certifies only that all sections are complete. Persons completing Z0500 are not certifying the accuracy of portions of the HIS record that were completed by other hospice staff members.

CHAPTER 3: SUBMISSION AND CORRECTION OF HOSPICE ITEM SET RECORDS

This chapter details the submission and correction process for Hospice Item Set (HIS) records and requirements for data submission by hospices for the Hospice Quality Reporting Program (HQRP) starting July 1, 2014.

3.1 Submitting HIS Records

Hospices must complete and submit required HIS records to CMS's Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Each provider must create electronic HIS records and submission files using software that creates files that meet the requirements detailed in the current HIS Data Submission Specifications, available on the CMS HQRP website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/>.

Providers must establish communication with the QIES ASAP system to submit a file. This is accomplished by using specialized communications software installed on their computer to access the CMS secure wide area network (WAN). Details about how to obtain WAN software and access are available on the QIES Technical Support Office (QTSO) website at <https://www.qtso.com>.

Once communication is established with the QIES ASAP system via the CMS WAN, the provider can access the hospice welcome page in the QIES ASAP system. This site allows providers to register for QIES user IDs to submit HIS records and access reports. Other information such as user's guides and bulletins may also be found on the hospice welcome page. The technical user guide for HIS submission, the *Hospice Item Set (HIS) Submission User's Guide*, is located on the hospice welcome page and provides more detailed information about the QIES ASAP system. The technical user guide is also available on the QTSO website at <https://www.qtso.com/hospicetrain.html>.

When the submission file is received by the QIES ASAP system, the system performs a series of validation checks to evaluate whether the data submitted meet the required data specifications. HIS records are edited to verify that clinical responses are within valid ranges and are consistent with other items in the record, dates are reasonable, and the submitted record is in the proper order with regard to the records that were previously accepted by the QIES ASAP system for the same patient. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in Section 5 of the *Hospice Item Set (HIS) Submission User's Guide*.

3.2 Timeliness Criteria

HIS completion and submission timing requirements have been defined by CMS. The timing requirements in place encourage appropriate record completion and file submission for timely quality reporting. Providers are notified when the timing criteria have not been met by warnings that appear on the Final Validation Reports.

- **Completion Timing for HIS records:**
 - For HIS-Admission records (A0250 = 1) the Completion Date (Z0500B) may be no later than **14 days** from the Admission Date (A0220). Therefore, Z0500B (Completion Date) minus A0220 (Admission Date) should be less than or equal to 14 days.
 - For HIS-Discharge records (A0250 = 2) the Completion Date (Z0500B) may be no later than **7 days** from the Discharge Date (A0270). Therefore, Z0500B (Completion Date) minus A0270 (Discharge Date) should be less than or equal to 7 days.
- **Submission Timing for HIS records:** All HIS records should be submitted electronically to the QIES ASAP system within 30 days of the Event Date. The Event Date for a HIS-Admission record is the Admission Date (A0220) and for a HIS-Discharge record is the Discharge Date (A0270).
 - For HIS-Admission records (A0250 = 1) the Submission Date may be no later than 30 days from the Admission Date (A0220). Therefore, the Submission Date minus the Admission Date (A0220) should be less than or equal to 30 days.
 - For HIS-Discharge records (A0250 = 2) the Submission Date may be no later than 30 days from the Discharge Date (A0270). Therefore, the Submission Date minus the Discharge Date (A0270) should be less than or equal to 30 days.

3.3 Validation of Records and Files

The QIES ASAP system validation edits are designed to monitor the timeliness and ensure that the submitted records conform to the HIS Data Submission Specifications. If submitted HIS records do not meet the edit requirements, the system will provide fatal error and/or warning messages on the Final Validation Report. The following describes the validation, storage, and reporting of records in a submission file.

1. **Initial Submission Confirmation.** For each file submitted, the submitter will receive an online confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation information includes the file submission number, as well as the date and time the file was received for processing. Providers should print and maintain a copy of this confirmation.
2. **Validation and Editing.** Each time a user submits a HIS file to the QIES ASAP system, three types of validation are performed:
 - **Fatal File Errors.** The file structure is validated to ensure it follows the requirements outlined in the HIS Data Submission Specifications provided by CMS. The file is rejected by the QIES ASAP system if the file structure does not meet these requirements. Examples of fatal file errors include:
 - The file is not a ZIP file

- The records in the ZIP file cannot be extracted
- The file cannot be read
- The Submitter Final Validation Report will list any fatal file error(s). Files that are rejected must be corrected and resubmitted.
- **Fatal Record Errors.** If the file structure is acceptable, then each HIS record in the file is validated individually for fatal record errors. These errors include, but are not limited to, the following:
 - Out-of-range responses (for example, the valid codes for the item are 1, 2, 3 and the submitted value is 6).
 - Inconsistent relationships between items. For example, an inconsistent date pattern, such as the Patient's Birth Date (Item A0900) is later than the Admission Date (Item A0220).
- Fatal record errors result in rejection of individual records by the QIES ASAP system. The provider is informed of fatal record error(s) on the Final Validation Report. Rejected records must be corrected and resubmitted.
 - **Warnings (Non-fatal Errors).** The record is also validated for warnings (non-fatal errors). Warnings include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature.
- Examples of warnings include:
 - Timing errors
 - Submission date is more than 30 days after the Admission Date (A0220) when A0250 = 01 or
 - Completion Date (Z0500B) is more than 14 days after the Admission Date (A0220) when A0250 = 01
 - Record sequencing errors
 - A HIS-Admission record is submitted after a previous HIS-Admission record and there was no HIS-Discharge record submitted in between or
 - A record is submitted for a patient after a HIS-Discharge record with a Reason for Discharge (A2115) equal to Expired (01) has been submitted.

All warnings (nonfatal errors) are reported to the provider in the Final Validation Report. The provider must evaluate each warning to identify necessary corrective actions.

3. **Storage to the QIES ASAP System.** If there are any fatal record errors, the record will be rejected and not stored in the QIES ASAP system. If there are no fatal record errors, the record is stored in the QIES ASAP system, even if the record has warnings (non-fatal errors).

Detailed information on the validation error and warning messages is available in the *Hospice Item Set (HIS) Submission User's Guide*, which is available on the hospice welcome page and on the QTSO website at <https://www.qtsso.com/hospicetrain.html>. Information on the edits is also found in the HIS Data Submission Specifications, located on the CMS HQRP website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/>.

3.4 HIS Record Correction Policy

The HIS record should be accurate when submitted and accepted into the QIES ASAP system. When a provider determines that one or more data elements in an accepted record are inaccurate, the provider must take the necessary steps to correct the erroneous record (see *Section 3.6*).

Changes made to the provider's copy of the HIS record *after* the record is accepted into the QIES ASAP system will not be recognized. It is the provider's responsibility to correct any errors that exist in a submitted HIS record according to the HIS Record Correction Policy. This ensures that the information in the QIES ASAP system accurately reflects the patient's hospice record. A correction can be submitted for any accepted record, even if there has been a submission and acceptance of subsequent records for the patient. Furthermore, it is the provider's responsibility to ensure the record is complete and accurate prior to submission to the QIES ASAP system.

Several processes have been put in place to ensure that HIS records are accurate both at the provider level and in the QIES ASAP system:

- Software used by the provider to create electronic HIS record files must run all standard edits as defined in the HIS Data Submission Specifications released by CMS.
- Record rejection standards have been implemented in the QIES ASAP system whereby if a HIS record contains responses that are out of range (for example, a 4 is entered when only 0–3 are allowable responses for an item), or item responses are inconsistent (for example, a skip pattern is not observed), the record is rejected. Rejected records are not stored in the QIES ASAP database.
- If an error is discovered in a record that has been accepted by the QIES ASAP system, Modification or Inactivation procedures must be implemented by the provider to ensure that the QIES ASAP system information is corrected.

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

3.5 Correcting Errors in HIS Records That Have Not Yet Been Accepted into the QIES ASAP System

If a HIS record is found to have errors that incorrectly reflect the patient's information within the respective record period as established by CMS, then that record must be corrected. The correction process will depend on the type of error. HIS records that have not yet been accepted in the QIES ASAP system include records that have been submitted and rejected, or records that have not been submitted at all. Records that have been submitted and rejected can usually be corrected and resubmitted without any special correction procedures because they were never accepted by the QIES ASAP system. Hospices are responsible for correcting any errors to the record prior to submission or re-submission of the record to the QIES ASAP system.

3.6 Correcting Errors in HIS Records That Have Been Accepted into the QIES ASAP System

Hospices should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the patient's hospice record. Inaccurate information in the QIES ASAP system may affect hospice quality reporting results. A HIS record may be corrected even if subsequent records have been accepted for the patient.

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

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

Completion of a *Modification Request* record will archive the inaccurate HIS record within the QIES ASAP system and replace the record with the new, corrected record. Completion of an *Inactivation Request* will also archive an inaccurate HIS record within the QIES ASAP system, but will not replace the record with the new record.

We recommend that hospices retain a copy of the HIS, along with any corrected versions, to track what was modified. In addition, it is suggested that the hospice keep a copy of inactivated records. For more details on maintenance of HIS records, see **Chapter 1**.

Modification Requests

A Modification Request record (A0050 = 2) is used when a HIS record is accepted into the QIES ASAP system, but the information in the record contains clinical or non-key demographic errors.

The Modification Request record (A0050 = 2) is used to correct HIS record items that are erroneous. However, there are items that cannot be corrected with a Modification Request; rather, the invalid record must be inactivated with an Inactivation Request record or manually deleted and a new record submitted to the QIES ASAP system.

Items that **cannot be corrected** with a Modification Request are:

Record Event Identifiers:

- A0220 Admission Date (on a HIS-Admission record A0250 = 01)
- A0250: Reason for Record
- A0270: Discharge Date (on a HIS-Discharge record A0250 = 09)

Patient Identifier:

- A0500A: First Name
- A0500C: Last Name
- A0600: Social Security Number (SSN)
- A0800: Gender
- A0900: Birth Date

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

When an error is discovered (except for those items listed in the preceding bullets) in a HIS record, the provider must submit a Modification Request record (A0050 = 2) to the QIES ASAP system. When completing a Modification Request record, the Modification Request record must contain correct values for **all** items. This means if A0050 = 2, the provider should proceed to A0100, Facility Provider Numbers, and complete all items in all other HIS record sections.

Note: File creation software varies on how modification request records are created. Please contact your software vendor for specific instructions.

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

1. The system will attempt to locate the existing record in the QIES ASAP database for this hospice using specific identifiers:
 - last name
 - first name
 - SSN

- birth date
 - gender
 - facility identifier (facility and state code)
 - event identifiers (for example, the reason for record and admission or discharge date).
2. If the existing record is not found, the submitted Modification Request record will be rejected and not accepted in the QIES ASAP system. A fatal error will be reported to the hospice on the Final Validation Report.
 3. If the existing record is found, then the system performs a series of validation edits to evaluate whether the data submitted meets the required data specifications. HIS records are edited to verify that clinical responses are within valid ranges and are consistent with other items in the record, dates are reasonable, and the submitted record is in the proper order with regard to the records that were previously accepted by the QIES ASAP system for the same patient. If there are any fatal errors, the Modification Request record will be rejected and not accepted in the QIES ASAP system. The fatal error(s) will be reported to the hospice on the Final Validation Report.
 4. If the Modification Request record passes all the edits, it will replace the prior erroneous record in the QIES ASAP database. The prior erroneous record will be stored in an archive file within the QIES ASAP database.

Inactivation Requests

An Inactivation Request record (A0050 = 3) must be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur, (for example, a HIS-Discharge record was submitted for a patient, but there was no actual discharge) and when one or more of the event identifiers and/or patient identifiers is found to be in error.

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

Record Event Identifiers:

- A0220 Admission Date (on a HIS-Admission record A0250 = 01)
- A0250: Reason for Record
- A0270: Discharge Date (on a HIS-Discharge record A0250 = 09)

Patient Identifier:

- A0500A: First Name
- A0500C: Last Name

- A0600: Social Security Number (SSN)
- A0800: Gender
- A0900: Birth Date

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

If an Admission Date (A0220), Reason for Record (A0250), or Discharge Date (A0270) is incorrect, or if one or more patient identifiers are found to be in error, the provider must inactivate the record in the QIES ASAP system, and then complete and submit a new HIS record with the correct event and/or patient identifiers and ensure that the clinical information is accurate.

Note: For an inactivation of a HIS-Admission record, the Discharge Date (A0270) will be blank.

When an Inactivation Request record (A0050 = 3) is submitted, the QIES ASAP system will process the record as follows:

1. The system will attempt to locate the existing record in the QIES ASAP database for this hospice using specific identifiers:
 - last name
 - first name
 - SSN
 - birth date
 - gender
 - facility identifier (facility and state code)
 - event identifiers (for example, the reason for record and admission or discharge date).
2. If the existing record is not found in the QIES ASAP database, the submitted Inactivation Request record will be rejected and a fatal error will be reported to the hospice on the Final Validation Report.
3. If the existing record is found, the erroneous record will be removed from the active records in the QIES ASAP database and stored in an archive file within the QIES ASAP database.

3.7 Special Manual Record Deletion Request

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

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

In the event that this error has occurred, the provider must contact the QTSO Help Desk at help@qtso.com or 1-877-201-4721 to obtain the Manual Hospice Item Set Record Correction form. The provider is responsible for completing the form. The provider must submit the completed form to the QTSO Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The QTSO Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the QTSO Help Desk will work through the request with the provider.

[This page intentionally left blank.]

APPENDIX A: ACRONYMS AND GLOSSARY

Acronyms

ACA—Patient Protection and Affordable Care Act
CAH—Critical Access Hospital
CCN—CMS Certification Number (also known as Medicare Provider Number)
CMS—Centers for Medicare & Medicaid Services
CNPI—Checklist of Non-verbal Pain Indicators
CPOT—Critical Care Pain Observation Tool
CPR—Cardiopulmonary resuscitation
DD—Developmental Disability
DNI—Do Not Intubate
DNR—Do Not Resuscitate
ESAS—Edmonton Symptom Assessment System
FR—Final Rule
FY—Fiscal Year
HIC—Health Insurance Claim
HIS—Hospice Item Set
HQRP—Hospice Quality Reporting Program
ID—Intellectual Disability
IDG—Interdisciplinary Group (also known as Interdisciplinary Team, or IDT)
IRF—Inpatient Rehabilitation Facility or Unit
IV—Intravenous
LTC—Long Term Care
LTCH—Long Term Care Hospital
MSAS—Memorial Symptom Assessment Scale
NF—Non-Skilled Nursing Facility
NOS—Not Otherwise Specified
NPI—National Provider Identifier
NPO- Nothing by mouth, “Nil per os”
NQF—National Quality Forum
PACSLAC—Pain Assessment Checklist for Seniors with Limited Ability to Communicate
PAIN-AD—Pain Assessment in Advanced Dementia
PCA—Patient-controlled Analgesia
PO—By mouth, “Per os”
POLST form—Physician Orders for Life-Sustaining Treatment form
PRN—As needed, “Pro re nata”
QIES ASAP system—Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system
QTSO—QIES Technical Support Office
RRB—Railroad Retirement Board

SNF—Skilled Nursing Facility
SSN—Social Security Number
USPS—United States Postal Service
WAN—Wide Area Network

Definitions

Hospice Item Set: A standardized set of items intended to capture patient-level data on each hospice patient admission. HIS items can be used to calculate six National Quality Forum (NQF) endorsed measures and one modified NQF measure. Hospices will submit a HIS-Admission and a HIS-Discharge for each patient admission on or after July 1, 2014.

Admission Date: The admission date is the date the patient/family chooses hospice to begin. For Medicare patients, it is the same as the effective date of the hospice benefit election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.

Bowel Regimen: If a patient does not have regular bowel movements or has constipation, a bowel regimen may be used to induce and control bowel movements. A bowel regimen may include such components as a diet, laxatives, stool softeners, and milk of magnesia. A bowel regimen is specific for the patient.

Care Process Item: Care process items appear in Sections F, J, and N of the HIS-Admission. In general, HIS care process items direct providers to abstract data from the hospice clinical record, capturing information about care processes that took place during the initial or comprehensive assessment periods. Specifically, HIS care process items capture data about: (1) whether or not a care process took place, (2) when the care process took place, and (3) in some instances, what the results of that care process were.

Completion Date: The date all required information has been collected and recorded and staff have signed and dated that the record is complete. This date should represent the date the completion of the item set record has been verified by the individual authorized to do so. This individual signs and dates Item Z0500.

Conditions of Participation: CMS develops Conditions of Participation (CoPs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. Hospice Conditions of Participation can be found on the cms.gov website.

Discharge Date: The date a patient leaves the hospice. If the patient has expired, it is the date of death. For live discharges, it is the date the patient revoked the hospice benefit or the date the hospice discharged the patient for one of the following reasons:

- Determined to be no longer terminally ill

- Moved out of the hospice service area
- Transferred to another hospice
- For cause

Inactivation Request: Used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur and when one or more of the event identifiers and/or patient identifiers is found to be in error.

Manual Deletion Request: Used when a HIS record has been previously submitted and accepted in the QIES ASAP system but the record was submitted for the wrong facility. This request will permanently delete all traces of a record from the QIES ASAP database.

Modification Request: Used when a HIS record has been previously submitted and accepted in the QIES ASAP system, but the information in the record contains clinical or non-key demographic errors.

PRN Opioid: Opioids that are administered on an “as needed” (PRN) basis, providing more flexibility in dosage for the management of pain.

Scheduled Opioid: Opioids that are administered on a regularly scheduled basis.

Submission Date: The date on which the completed record is submitted to the QIES ASAP system.

[This page intentionally left blank.]

APPENDIX B: CMS HOSPICE QUALITY REPORTING PROGRAM RESOURCES

Websites:

The following links provide more information about the Hospice Quality Reporting Program (HQRP), and the Hospice Item Set (HIS). The CMS HQRP website is the official source of information about HQRP requirements. Providers should bookmark this website and visit it on a regular basis to make sure they have the most current information pertinent to the HQRP.

1. CMS HQRP Main Page: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/>.
 - This website contains additional information about data collection and submission, HIS Quality Measures, and HIS technical requirements.
2. QIES Technical Support Office (QTSO): Vendors and software developers should familiarize themselves with this website and review it regularly for important technical information and updates: <https://www.qtso.com/>.
 - The HIS Submission User Guide provides more detailed information about the QIES ASAP system and is available at <https://www.qtso.com/hospicetrain.html>.
 - Vendors should register at <https://www.qtso.com/vendor.html> to receive important announcements.
3. National Quality Forum (NQF): To read more about the six NQF-endorsed measures and the one modified NQF-endorsed measure visit the NQF website: <http://www.qualityforum.org/Home.aspx>.

Help Desks:

1. Quality Help Desk: For assistance with questions related to reporting requirements, quality measures, and reporting deadlines.
 - Email: HospiceQualityQuestions@cms.hhs.gov
2. General QTSO Help Desk: For assistance regarding technical questions.
 - Phone: 1-877-201-4721
 - E-mail: help@qtso.com

Listservs:

1. Open Door Forum (ODF) listserv: CMS regularly holds Open Door Forums in which CMS makes announcements pertinent to various programs/care settings. Open Door Forums are also an opportunity for live dialogue between CMS and the provider community. The specific Open Door Forum pertinent to the HQRP is the "Home Health, Hospice, and Durable Medical Equipment Open Door Forum." Use the link to sign up:
https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_502
2. E-News Listserv: CMS sends out a weekly e-Newsletter, which contains information pertinent to various Medicare programs and care settings. Use the link to sign up:
https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

APPENDIX C: QUALITY MEASURE LOGICAL SPECIFICATIONS

CMS implemented the Hospice Item Set (HIS) as part of the Hospice Quality Reporting Program in the FY 2014 Hospice Wage Index final rule (78 FR 48234-48281). The HIS is a standardized set of items intended to capture patient-level data on each hospice patient admission. Current HIS items can be used to calculate six National Quality Forum (NQF) endorsed measures and a modification of one NQF-endorsed measure. This appendix provides basic information on how HIS items can be used to calculate these measures. For more information on the quality measures, please refer to the NQF website: <http://www.qualityforum.org/Home.aspx>.

[This page intentionally left blank.]

Treatment Preferences (NQF #1641)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
The percentage of hospice patients with chart documentation of preferences for life sustaining treatments.	<p><i>Numerator</i> Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (CPR) (F2000A = 1 or 2), and/or 2. The patient/responsible party was asked about preferences regarding life-sustaining treatments other than CPR (F2100A = 1 or 2), and/or 3. The patient/responsible party was asked about preference regarding hospitalization (F2200A = 1 or 2). <p><i>Numerator Time Window</i> Prior to admission or within 5 days of the admission date (F2000B – A0220 ≤ 5; F2100B – A0220 ≤ 5; F2200 – A0220 ≤ 5)</p> <p><i>Denominator</i> Patients 18 years of age and older enrolled in hospice for 7 or more days.</p> <p><i>Denominator Exclusions</i> Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

Beliefs/Values Addressed (if desired by the patient) (modified NQF #1647)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients with documentation of a discussion of spiritual/existential concerns or documentation that the patient and/or caregiver did not want to discuss.</p>	<p><i>Numerator</i> Patients are included in the numerator if they meet the following criterion during the numerator time window:</p> <ol style="list-style-type: none"> 1. Patient and/or caregiver was asked about spiritual/existential concerns (F3000A = 1 or 2). <p><i>Numerator Time Window</i> Within 5 days of the admission date (F3000B - A0220 ≤ 5).</p> <p><i>Denominator</i> Patients 18 years of age and older enrolled in hospice for 7 or more days.</p> <p><i>Denominator Exclusions</i> Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.</p>

¹ This is a modified version of a NQF-endorsed measure for use in the hospice and/or palliative care setting. The measure is considered modified because the NQF measure specifications indicate that the numerator condition can be met at any time during the patient's hospice episode of care. Instead, we have opted to include the relevant items for this measure on the HIS-Admission even though the NQF measure specifications permit the numerator condition to be met at any time during the hospice episode of care.

Pain Screening (NQF #1634)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients who were screened for pain during the initial nursing assessment.</p>	<p><i>Numerator</i> Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. Patient was screened for pain (J0900A = 1), and 2. Patient reported that they had no pain (J0900C = 0) <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 3. Patient was screened for pain (J0900A = 1), and 4. Patient's pain severity was rated mild, moderate, or severe (J0900C = 1, 2, or 3), and 5. A standardized pain tool was used (J0900D = 1, 2, 3, or 4). <p><i>Numerator Time Window</i> Within 2 days of the admission date (J0900B - A0220 ≤ 2).</p> <p><i>Denominator</i> Patients 18 years of age and older enrolled in hospice for 7 or more days.</p> <p><i>Denominator Exclusions</i> Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

Pain Assessment (NQF #1637)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients who screened positive for pain and who received a comprehensive assessment of pain within 1 day of screening.²</p>	<p><i>Numerator</i> Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. A comprehensive pain assessment was completed (J0910 = 1), and 2. The comprehensive pain assessment included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more of J0910C boxes checked). <p><i>Numerator Time Window</i> Within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B - J0900B ≤ 1 day).</p> <p><i>Denominator</i> Patients 18 years of age and older enrolled in hospice for 7 or more days and screened positive for pain during the initial nursing assessment (J0900C = 1, 2, or 3).</p> <p><i>Denominator Exclusions</i> Patients are excluded from the denominator if they are under 18 years of age, have a stay of less than 7 days in hospice, and/or reported that they had no pain during the initial nursing assessment (J0900C = 0).</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

² The pain screening took place during the initial nursing assessment.

Dyspnea Screening (NQF #1639)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
The percentage of hospice patients who were screened for dyspnea during the initial nursing assessment.	<p><i>Numerator</i> Patients are included in the numerator if they meet the following criterion during the numerator time window:</p> <ol style="list-style-type: none">1. Patient was screened for shortness of breath (J2030A = 1). <p><i>Numerator Time Window</i> Within 2 days of the admission date (J2030B - A0220 ≤ 2).</p> <p><i>Denominator</i> Patients 18 years of age and older enrolled in hospice for 7 or more days.</p> <p><i>Denominator Exclusions</i> Patients are excluded from the denominator if they are under 18 years of age and/or have a stay of less than 7 days in hospice.</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

Dyspnea Treatment (NQF #1638)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
<p>The percentage of hospice patients who screened positive for dyspnea who received treatment within 1 day of the screening.²</p>	<p><i>Numerator</i> Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. Treatment for shortness of breath was initiated (J2040A = 2), or 2. The patient declined treatment (J2040A = 1). <p><i>Numerator Time Window</i> Within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B ≤ 1).</p> <p><i>Denominator</i> Patients 18 years of age and older enrolled in hospice for 7 or more days and screened positive for shortness of breath during the initial nursing assessment (J2030C = 1).</p> <p><i>Denominator Exclusions</i> Patients are excluded from the denominator if they are under 18 years of age, have a stay of less than 7 days in hospice, and/or screened negative for shortness of breath during the initial nursing assessment (J2030C = 0).</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

² The dyspnea screening took place during the initial nursing assessment.

Patients Treated with an Opioid who are Given a Bowel Regimen (NQF #1617)¹

MEASURE DESCRIPTION	MEASURE SPECIFICATIONS
The percentage of vulnerable adults treated with an opioid that are offered/ prescribed a bowel regimen or documentation of why this was not needed.	<p><i>Numerator</i> Patients are included in the numerator if they meet the following criteria during the numerator time window:</p> <ol style="list-style-type: none"> 1. A bowel regimen was initiated or continued (N0520A = 2), or 2. There is documentation of why a bowel regimen was not initiated or continued (N0520A = 1). <p><i>Numerator Time Window</i> Within 1 day of the patient being prescribed a scheduled opioid (N0520B - N0500B ≤ 1).</p> <p><i>Denominator</i> Patients 18 years of age and older who are given a prescription for a scheduled opioid (N0500A = 1).</p> <p><i>Denominator Exclusions</i> Patients under 18 years of age.</p>

¹ This measure is NQF-endorsed for use in the hospice and/or palliative care setting.

[This page intentionally left blank.]

APPENDIX D: HOSPICE ITEM SET—ADMISSION

[This page intentionally left blank.]

Section A**Administrative Information****A0050. Type of Record**

Enter Code

☐

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

A0100. Facility Provider Numbers. Enter code in boxes provided.**A. National Provider Identifier (NPI):**

--	--	--	--	--	--	--	--	--	--

B. CMS Certification Number (CCN):

--	--	--	--	--	--	--	--	--	--	--	--

A0205. Site of Service at Admission

Enter Code

--	--

01. Hospice in patient's home/residence
02. Hospice in Assisted Living facility
03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)
04. Hospice provided in a Skilled Nursing Facility (SNF)
05. Hospice provided in Inpatient Hospital
06. Hospice provided in Inpatient Hospice Facility
07. Hospice provided in Long Term Care Hospital (LTCH)
08. Hospice in Inpatient Psychiatric Facility
09. Hospice provided in a place not otherwise specified (NOS)
10. Hospice home care provided in a hospice facility

A0220. Admission Date

--	--

Month

--	--

Day

--	--	--	--

Year

A0245. Date Initial Nursing Assessment Initiated

--	--

Month

--	--

Day

--	--	--	--

Year

A0250. Reason for Record

Enter Code

--	--

01. Admission
09. Discharge

Administrative Information

A. First name:

--	--	--	--	--	--	--	--	--	--	--	--	--

B. Middle initial:

--

C. Last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

D. Suffix:

--	--	--

[illegible][illegible]

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

	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year
--	-------------------------------	-----------------------------	------------------------------

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

Section A**Administrative Information****A1802. Admitted From.** Immediately preceding this admission, where was the patient?

Enter Code

--	--

- 01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
- 02. Long-term care facility
- 03. Skilled Nursing Facility (SNF)
- 04. Hospital emergency department
- 05. Short-stay acute hospital
- 06. Long-term care hospital (LTCH)
- 07. Inpatient rehabilitation facility or unit (IRF)
- 08. Psychiatric hospital or unit
- 09. ID/DD Facility
- 10. Hospice
- 99. None of the Above

Section F Preferences

F2000. CPR Preference

Enter Code

☐

A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? - Select the most accurate response

0. No → Skip to F2100, Other Life-Sustaining Treatment Preferences

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preference regarding the use of CPR:

Month

Day

Year

F2100. Other Life-Sustaining Treatment Preferences

Enter Code

☐

A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? - Select the most accurate response

0. No → Skip to F2200, Hospitalization Preference

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:

Month

Day

Year

F2200. Hospitalization Preference

Enter Code

☐

A. Was the patient/responsible party asked about preference regarding hospitalization? - Select the most accurate response

0. No → Skip to F3000, Spiritual/Existential Concerns

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preference regarding hospitalization:

Month

Day

Year

F3000. Spiritual/Existential Concerns

Enter Code

☐

A. Was the patient and/or caregiver asked about spiritual/existential concerns? - Select the most accurate response

0. No → Skip to I0010, Principal Diagnosis

1. Yes, and discussion occurred

2. Yes, but the patient and/or caregiver refused to discuss

B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:

Month

Day

Year

Section I		Active Diagnoses
I0010. Principal Diagnosis		
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	01. Cancer 02. Dementia/Alzheimer's 99. None of the above	

Section J	Health Conditions
------------------	--------------------------

Pain
J0900. Pain Screening

Enter Code

☐
A. Was the patient screened for pain?

0. No → Skip to J2030, Screening for Shortness of Breath
 1. Yes

B. Date of first screening for pain:

Month

Day

Year

Enter Code

☐
C. The patient's pain severity was:

0. None → Skip to J2030, Screening for Shortness of Breath
 1. Mild
 2. Moderate
 3. Severe
 9. Pain not rated

Enter Code

☐
D. Type of standardized pain tool used:

1. Numeric
 2. Verbal descriptor
 3. Patient visual
 4. Staff observation
 9. No standardized tool used

J0910. Comprehensive Pain Assessment

Enter Code

☐
A. Was a comprehensive pain assessment done?

0. No → Skip to J2030, Screening for Shortness of Breath
 1. Yes

B. Date of comprehensive pain assessment:

Month

Day

Year

C. Comprehensive pain assessment included:

↓ Check all that apply

☐

1. Location

☐

2. Severity

☐

3. Character

☐

4. Duration

☐

5. Frequency

☐

6. What relieves/worsens pain

☐

7. Effect on function or quality of life

☐

9. None of the above

Section J**Health Conditions****Respiratory Status****J2030. Screening for Shortness of Breath**

Enter Code

☐**A. Was the patient screened for shortness of breath?**

0. No → Skip to N0500, Scheduled Opioid

1. Yes

B. Date of first screening for shortness of breath:

Month

Day

Year

Enter Code

☐**C. Did the screening indicate the patient had shortness of breath?**

0. No → Skip to N0500, Scheduled Opioid

1. Yes

J2040. Treatment for Shortness of Breath

Enter Code

☐**A. Was treatment for shortness of breath initiated? - Select the most accurate response**

0. No → Skip to N0500, Scheduled Opioid

1. No, patient declined treatment → Skip to N0500, Scheduled Opioid

2. Yes

B. Date treatment for shortness of breath initiated:

Month

Day

Year

C. Type(s) of treatment for shortness of breath initiated:

↓ Check all that apply

☐

1. Opioids

☐

2. Other medication

☐

3. Oxygen

☐

4. Non-medication

Section N**Medications****N0500. Scheduled Opioid**

Enter Code

☐**A. Was a scheduled opioid initiated or continued?**

0. No → Skip to N0510, PRN Opioid

1. Yes

B. Date scheduled opioid initiated or continued:

Month

Day

Year

N0510. PRN Opioid

Enter Code

☐**A. Was a PRN opioid initiated or continued?**

0. No → Skip to N0520, Bowel Regimen

1. Yes

B. Date PRN opioid initiated or continued:

Month

Day

Year

N0520. Bowel Regimen

Complete only if N0500A or N0510A = 1

Enter Code

☐**A. Was a bowel regimen initiated or continued? - Select the most accurate response**

0. No → Skip to Z0400, Signature(s) of Person(s) Completing the Record

1. No, but there is documentation of why a bowel regimen was not initiated or continued → Skip to Z0400, Signature(s) of Person(s) Completing the Record

2. Yes

B. Date bowel regimen initiated or continued:

Month

Day

Year

Section Z**Record Administration****Z0400. Signature(s) of Person(s) Completing the Record**

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion**A. Signature:****B. Date:**

--	--

Month

--	--

Day

--	--	--	--

Year

[This page intentionally left blank.]

APPENDIX D: HOSPICE ITEM SET—DISCHARGE

[This page intentionally left blank.]

Section A**Administrative Information****A0050. Type of Record**

Enter Code

☐

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

A0100. Facility Provider Numbers. Enter code in boxes provided.**A. National Provider Identifier (NPI):**

--	--	--	--	--	--	--	--	--	--

B. CMS Certification Number (CCN):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

A0220. Admission Date

--	--

Month

--	--

Day

--	--	--	--

Year

A0250. Reason for Record

Enter Code

--	--

01. Admission
09. Discharge

A0270. Discharge Date

--	--

Month

--	--

Day

--	--	--	--

Year

A0500. Legal Name of Patient**A. First name:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

B. Middle initial:

--

C. Last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

D. Suffix:

--	--	--

Section A**Administrative Information****A0600. Social Security and Medicare Numbers****A. Social Security Number:**

			-			-				
--	--	--	---	--	--	---	--	--	--	--

B. Medicare number (or comparable railroad insurance number):

--	--	--	--	--	--	--	--	--	--	--	--	--

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient

--	--	--	--	--	--	--	--	--	--	--	--	--	--

A0800. Gender

Enter Code

--

1. Male
2. Female

A0900. Birth Date

Month		Day		Year						

A2115. Reason for Discharge

Enter Code

--	--

01. Expired
02. Revoked
03. No longer terminally ill
04. Moved out of hospice service area
05. Transferred to another hospice
06. Discharged for cause

Section Z**Record Administration****Z0400. Signature(s) of Person(s) Completing the Record**

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion**A. Signature:**

B. Date:

--	--

Month

--	--

Day

--	--	--	--

Year

[This page intentionally left blank.]