

HIS Manual: Revised Change Table from V1.00.0 to V1.01

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
Title Page	n/a	<u>V 1.01</u> Effective July 1, 2014	Updated to reflect new version number
Title Page	n/a	Expiration Date removed	Expiration date no longer current
Table of Contents	i	Section J: Health <u>C</u> onditions	Grammatical edit
1	1-1	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. <u>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).</u>	Text revised to improve clarity
1.2	1-2	on or after July 1, 2014 regardless of:	Grammatical edit
1.3	1-3	<i>Table 2 Timing Definitions, "Completion Date" definition modified to read:</i> <u>The actual date on which the hospice completes the record.</u> 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. <u>The completion date should be no later than the completion deadline.</u>	Text revised to improve clarity
1.3	1-3	<i>Table 2. Timing Definitions, new term added to appear in the row under "Completion Date"</i> <u>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.</u>	Additional text added to improve clarity

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
1.3	1-3	<p><i>Table 2 Timing Definitions, “Submission Date” definition modified to read:</i></p> <p><u>The actual date on which the hospice submits the completed record.</u> Defined as the date on which the completed record is submitted <u>and accepted</u> to the QIES ASAP system. <u>The submission date should be no later than the submission deadline.</u></p>	Text revised to improve clarity
1.3	1-3	<p><i>Table 2. Timing Definitions, new term added to appear in the row under “Submission Date”</i></p> <p><u>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.</u></p>	Additional text added to improve clarity
1.3	1-3 – 1-4	<p>Completion Timing</p> <p>For HIS-Admission records, <u>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.</u> The Completion Date can be <i>equal</i> to the Admission Date <u>or Completion Deadline.</u> 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. <u>For more information on Validation Reports, see Chapter 3.</u></p> <p>For HIS-Discharge records, <u>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.</u> The Completion Date can be <i>equal</i> to the Discharge Date, <u>or Completion Deadline.</u> 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.</p>	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
		<p>Completion Timing (continued)</p> <p><u>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.</u></p> <p><u>Completion timing policies above do not outline timing of care processes that are captured by HIS items for quality measure calculation purposes.</u> For additional information on timeliness criteria, see Chapter 3. For more information on timing for quality measure calculation purposes, please see Appendix C.</p>	
1.3	1-4	<p>Submission Timing</p> <p>For HIS-Admission records, <u>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.</u> The Submission Date can be <i>equal</i> 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.</p>	Additional text added to improve clarity

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
		<p>Submission Timing (continued)</p> <p><u>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.</u> The Completion Date can be <i>equal</i> 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.</p> <p>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.</p> <p>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.</p>	
1.3	1-5	<i>Subsection “General Conventions for Completing the HIS” moved to appear as the first subsection under “Section 2.2, HIS Item Completion Conventions”</i>	Text moved to improve clarity
1.3	1-5	<p><i>The following text was removed (point number two under “General Conventions for Completing the HIS”):</i></p> <p>2. The HIS may be completed by an hospice staff member. 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 Chapter 2.</p>	Text removed to improve clarity

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2.2	2-2	<p><i>Section 2.2 “HIS Item Completion Conventions” updated to include the following as a new sub-section:</i></p> <p><u>Who May Complete the HIS</u></p> <p><u>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.</u></p>	Additional text added to provide further instruction
2.2	2-2	<p>Relationship Between Care Processes and the HIS</p> <p>Most of the items in the HIS-Admission relate to care processes that align with the initial assessment or the comprehensive assessment period, <u>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.</u> See Appendix C for additional information on how timing of items in the HIS relates to quality measure calculation. <u>See Chapter 1.3 for additional information on timing and sequence policies.</u></p>	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2A	2A-4	<p>A0220. Admission Date</p> <p>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. <u>A day begins at 12:00 a.m. and ends at 11:59 p.m.</u></p> <p><u>The admission date specifies the date on which the hospice becomes responsible for the care of the patient.</u></p> <ul style="list-style-type: none"> ○ <u>For Medicare patients, this is the effective date of election or of re-election.</u> ○ <u>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.</u> 	Text revised to improve clarity
2A	2A-4	<p>Bullet point number two underneath "Item-Specific Instructions A0245. Date Initial Nursing Assessment Initiated" revised to read:</p> <p><u>Item A0245 refers to the initial assessment the registered nurse must complete, as defined in the Medicare Hospice Conditions of Participation.</u></p>	Text revised to improve clarity
2A	2A-6	If the patient does not have an SSN <u>or the SSN is unavailable</u> , the item may be left blank.	Text revised to improve clarity on how to respond to item if SSN is unavailable
2A	2A-6	<p>Added the following text to appear as a new section under "Item-Specific Instructions" for Item A0600</p> <p><u>Item-Specific Tips</u></p> <p><u>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.</u></p>	Text added to provide further instruction

(continued)

HIS Manual: Revised Change Table from V1.00.0 to V1.01

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2A	2A-7	A Medicare number is an identifier assigned to an individual for participation in national health insurance program. <u>The Medicare number may also be referred to as a Health Insurance Claim (HIC) number.</u> The Medicare Health Insurance <u>Claim (HIC)</u> 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.	Revised text to improve clarity
2A	2A-7	Item A0600B can only be a Medicare (HIC) number or an RRB number. <u>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.</u> <u>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.</u>	Additional text added to improve clarity
2A	2A-7	<i>The following text (first sub-bullet under Item-Specific Instructions for A0700. Medicaid Number) was removed.</i> Enter the Medicaid number (if available), even if Medicaid is a secondary payer.	Text deleted to improve clarity

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2A	2A-7	<p>To obtain the Medicaid number, check the patient's Medicaid card, admission or transfer records, or hospice clinical record.</p> <p><u>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.</u></p> <p><u>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.</u></p>	Additional text added to provide further instruction
2A	2A-9	<p>Check A, American Indian or Alaska Native: if the patient is American Indian or Alaska Native</p> <ul style="list-style-type: none"> ○ <u>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.</u> <p>Check B, Asian: if the patient is Asian</p> <ul style="list-style-type: none"> ○ <u>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.</u> <p>Check C, Black or African American: if the patient is Black or African American</p> <ul style="list-style-type: none"> ○ <u>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."</u> 	Additional descriptions added to further clarify racial/ethnic categories

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
		<p>Check D, Hispanic or Latino: if the patient is Hispanic or Latino</p> <ul style="list-style-type: none"> ○ <u>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."</u> <p>Check E, Native Hawaiian or Other Pacific Islander: if the patient is Native Hawaiian or Other Pacific Islander</p> <ul style="list-style-type: none"> ○ <u>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</u> <p>Check F, White: if the patient is White</p> <ul style="list-style-type: none"> ○ <u>A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.</u> 	
2A	2A-11	<p><i>The following text was added to appear as the first Item-Specific tip for Item A1802.</i></p> <p><u>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.</u></p> <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added to provide further instruction
2F	2F-2	<p>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.</p> <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added to provide further instruction

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2F	2F-2	<p>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.</p> <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added to provide further instruction
2F	2F-2	<p>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.</p> <ul style="list-style-type: none"> ○ <u>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.</u> ○ <u>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.</u> 	Additional text added to provide further instruction
2F	2F-2	<p><i>The following text was added to appear as the last bullet point under "Item-Specific Instructions" for Item F2000B.</i></p> <p><u>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.</u></p>	Additional text added to provide further instruction

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2F	2F-2	<p><i>The following text was added to appear as the first tip under “Item-Specific Tips” for Item F2000.</i></p> <p><u>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.</u></p> <ul style="list-style-type: none"> • <u>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.</u> 	Additional text added to provide further instruction
2F	2F-4	<p>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.</p> <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added to provide further instruction
2F	2F-5	<p>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.</p> <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added to provide further instruction

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2F	2F-5	<p>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.</p> <ul style="list-style-type: none"> ○ <u>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.</u> ○ <u>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.</u> 	Additional text added to provide further instruction
2F	2F-5	<p><i>The following text was added to appear as the last bullet point under “Item-Specific Instructions” for Item F2100B.</i></p> <p><u>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.</u></p>	Additional text added to provide further instruction
2F	2F-5	<p><i>The following text was added to appear as the first tip under “Item-Specific Tips” for Item F2100.</i></p> <p><u>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.</u></p> <ul style="list-style-type: none"> • <u>In order to code “Yes” to F2100A, if a party other than the patient was asked about preferences regarding the use of 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.</u> 	Additional text added to provide further instruction

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2F	2F-7	For the purposes of this item, “hospitalization” does not include hospice care <u>(such as general inpatient or respite level of care)</u> provided in contracted acute care settings <u>or hospital-based inpatient hospice units.</u>	Text revised to provide further clarification
2F	2F-7	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. <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added to provide further instruction
2F	2F-7	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. <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added for further clarification

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2F	2F-7	<p>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.</p> <ul style="list-style-type: none"> ○ <u>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.</u> ○ <u>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.</u> 	Additional text added to provide further instruction
2F	2F-8	<p><i>The following text was added to appear as the final bullet point under “Item-Specific Instructions” for Item F2200B.</i></p> <p><u>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.</u></p>	Additional text added to provide further clarification
2F	2F-8	<p><i>The following text was added to appear as the first tip under “Item-Specific Tips” for Item F2200.</i></p> <p><u>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.</u></p> <ul style="list-style-type: none"> • <u>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.</u> 	Additional text added to provide further clarification

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2F	2F-9	F2200A: Was the patient/responsible party asked about preference regarding the use of re-admission to hospital?	Edited to reflect proper item number
2F	2F-10	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. <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added to provide further instruction
2F	2F-10	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). <ul style="list-style-type: none"> ○ <u>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.</u> 	Additional text added to provide further clarification
2F	2F-10	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. <ul style="list-style-type: none"> ○ <u>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.</u> ○ <u>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.</u> 	Additional text added to provide further clarification

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2F	2F-10	<p><i>The following text was added to appear as the first tip under “Item-Specific Tips” for Item F3000.</i></p> <p><u>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.</u></p>	Additional text added to provide further instruction
2I	2I-1	Do not use sources external to the clinical record. Review all response choices before making a selection. <u>This item should be completed based on the patient’s principal diagnosis at the time of admission to hospice.</u>	Additional text added to provide further instruction
2J	2J-4	Situation A: Clinical note dated 08-12-2014 shows: “patient very drowsy; appears to be comfortable during visit. <u>No nonverbal signs of pain observed during the visit</u> ”	Text revised to provide clarification
2J	2J-7	<p><i>The following text under “Item-Specific Tips” for Item J0910 was removed.</i></p> <p>In order to code “1, Yes” to J0910A, there should be some evidence of at least one of the seven comprehensive pain assessment characteristics in the clinical record.</p> <p>If documentation in the clinical record is ambiguous as to whether the pain assessment included at least one of the seven characteristics, code “0, No” for J0910A. Skip to Item J2030, Screening for Shortness of Breath (Dyspnea).</p>	Text removed to provide clarification

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u></u> font)	Explanation
2J	2J-11	<p><u>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.</u> Structured clinical <u>evaluation</u> for shortness of breath is not well defined, <u>therefore</u> documentation found in the clinical record for screening of shortness of breath may vary and may not include use of a standardized <u>tool for rating severity.</u></p> <p><u>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).</u></p> <p><u>If documentation indicates the patient had shortness of breath, but severity was not evaluated in any manner, answer “no” to J2030A.</u></p> <p>Evidence of a “positive” screen for shortness of breath <u>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.</u> <u>The clinical record....”</u></p>	Text revised to provide clarification
2J	2J-14	<p><u>For pharmacologic interventions, t</u>reatment initiation is defined as the date that an order was received to initiate or continue a treatment. An order may be verbal (<u>when permitted</u>) or written; coding for this item should be based on whichever was used to determine the start of treatment. <u>Enter the date of the order, irrespective of if/when the first dose was given.</u></p> <ul style="list-style-type: none"> ○ <u>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.</u> ○ <u>For standing orders, “initiation” is defined as the date the order was received by the hospice.</u> 	Additional text added to provide further instruction

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	
2J	2J-14	<p><i>The following text was added to appear as the last bullet point under “Item-Specific Tips” for Item J2040.</i></p> <p><u>Orders that contain multiple purposes for the medication are acceptable as long as one of the stated purposes is to address shortness of breath.</u></p>	Additional text added to provide further instruction
2J	2J-15	<p>“...the order list would need to read “morphine 2-15 mg IV every 4 hours as needed for shortness of breath” <u>Or “as needed for shortness of breath and pain”.</u></p>	Text revised to provide clarification
2J	2J-15	<p><i>Additional example added to appear after “Situation B” under “Examples” for Item J2040.</i></p> <p><u>Situation C – Patient’s clinical record contains the following information:</u> <u>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.</u> <u>Coding:</u> <u>J2040A: Was treatment for shortness of breath initiated? Select code “0, No.” Skip to Item N0500, Scheduled Opioid.</u> <u>J2040B: Date treatment for shortness of breath initiated: Do not complete.</u> <u>J2040C: Type(s) of treatment for shortness of breath initiated: Do not complete.</u> <u>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.</u></p>	Example added to provide further instruction

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2N	2N-1	Code 0, No: Select code 0 if the clinical record indicates that a regularly scheduled opioid was neither initiated nor continued <u>by the hospice</u> and skip to Item N0510, PRN Opioid.	Text revised to provide clarification
2N	2N-1	<p>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 (<u>when permitted</u>) or written; coding <u>for this item</u> should be based on whichever was used to determine the start of treatment. <u>Enter the date of the order, irrespective of if/when the first dose was given.</u></p> <ul style="list-style-type: none"> ○ <u>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.</u> ○ <u>For standing orders, “initiation” is defined as the date the order was received by the hospice.</u> 	Additional text added to provide further instruction
2N	2N-2	<p>An order may be verbal (<u>when permitted</u>) or written; coding should be based on whichever was used to determine the start of treatment. <u>Enter the date of the order, irrespective of if/when the first dose was given.</u></p> <ul style="list-style-type: none"> ○ <u>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.</u> ○ <u>For standing orders, “initiation” is defined as the date the order was received by the hospice.</u> 	Additional text added to provide further clarification

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0		Explanation
2N	2N-4	<p>An order may be verbal or written; coding should be based on whichever was used to determine the start of treatment. <u>Enter the date of the order, irrespective of if/when the first dose was given.</u></p> <p><u>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.</u></p> <p><u>For standing orders, “initiation” is defined as the date the order was received by the hospice.</u></p> <p><u>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).</u></p> <p>If multiple bowel regimens were ordered, enter the date that the first treatment was initiated.</p> <p><u>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.</u></p>	Additional text added to provide further instruction
2N	2N-4	<p>A bowel regimen may include, but is not limited to</p> <ul style="list-style-type: none"> Laxatives or stool softeners High fiber supplements Enemas Suppositories <p><u>Dietary interventions, such as prune juice or high fiber diet</u></p>	Additional bowel regimen options included to provide further clarification

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
2N	2N-6	<p><i>Additional example added to appear after “Situation C” under “Examples”.</i></p> <p><u>Situation D – Patient’s clinical record contains the following information:</u> <u>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.”</u> <u>Coding:</u> <u>N0500A: Was a scheduled opioid initiated or continued? Select code “0, No.” Skip to N0510, PRN opioid.</u> <u>N0500B: Date scheduled opioid initiated or continued: Do not complete.</u> <u>N0510A: Was PRN opioid initiated or continued? Select code “1, Yes.”</u> <u>N0510B: Date PRN opioid initiated or continued: Enter “07-23-2014.”</u> <u>N0520A: Was a bowel regimen initiated or continued? Select code “2, Yes.”</u> <u>N0520B: Date bowel regimen initiated or continued: Enter “07-23-2014.”</u> <u>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.</u></p>	Additional example added to provide further instruction on how to account for standing orders in coding for Section N items
2Z	2Z-1	Items in this section contain signatures of individuals completing the Hospice Item Set (HIS) and the signature of the individual verifying <u>HIS record completion.</u>	Grammatical edit
2Z	2Z-1	Item Z0500 is used to document the individual responsible for ensuring the HIS is completed in a timely manner.	Revised text to provide further clarification
2Z	2Z-2	<p><i>The following text was added to appear as the final bullet point under “Item-Specific Instructions” for Item Z0400.</i></p> <p><u>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.</u></p>	Additional text added to provide further clarification

(continued)

Chapter and/or Section in V1.00.0	Page # in V1.00.0	Revised Text (appears in <u>bold and underlined</u> font)	Explanation
Appendix A	Appendix A-2	<p><i>The following definition was added to appear after “Bowel Regimen”</i></p> <p><u>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.</u></p>	Additional definition added to provide further instruction on what a care process item is
Appendix A	Appendix A-2	<p><i>The following definition was added to appear after “Completion Date”.</i></p> <p><u>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.</u></p>	Additional definition added to provide further instruction on what the Conditions of Participation are