Hospice Item Set (HIS) Quarterly Questions and Answers (Q+As) - April 2014

This document is intended to provide guidance on HIS-related questions that were received on the Hospice Quality Help Desk during the first quarter (January – March) of 2014. This document will not cover questions which resulted in updates made to V1.01 of the HIS Manual. Providers should review both this document and V1.01 of the HIS Manual and the relevant change table to ensure they have the most accurate information related to HIS data collection. Guidance contained in this document may be time-limited, and may be superseded by guidance published by CMS at a later date.

General HIS Questions

Question 1. How do we complete the HIS on patient transfers?

Answer 1. Since a HIS-Admission and a HIS-Discharge must be completed for each patient admission (not each patient admitted), if a patient transfers hospices, both hospices are responsible for completing and submitting a HIS-Admission and HIS-Discharge for that patient. If a patient transfers hospices, the first hospice agency should complete a HIS-Admission record within 14 days of the admission date and submit the record within 30 days of the admission date. The first hospice should also complete a HIS-Discharge record within 7 days of the date of discharge and submit the record within 30 days of discharge. The second hospice agency would also collect and submit a HIS-Admission and HIS-Discharge on the patient within the same timeframes mentioned above.

Question 2. What if a patient admission occurs before 7/1/2014 but that patient was discharged after 7/1/2014? Which HIS record(s) are we responsible for submitting for patient admissions with those admission and discharge dates – should we submit a HIS-Discharge only?

Answer 2. A HIS-Admission and HIS-Discharge are to be submitted for all patient admissions to a Medicare-certified hospice program on/after July 1, 2014. Hospices are not required to submit **any** HIS records for patient admissions prior to July 1, 2014, regardless of when the patient is discharged. In the example above, for patients admitted prior to 7/1/2014 but discharged after 7/1/2014, the hospice would not responsible for completing/submitting any HIS records, since the admission date is prior to 7/1/2014.

Question 3. We don't have an electronic medical record (EMR), do we have to have an EMR to submit HIS data?

Answer 3. Electronic submission of HIS records is required, but hospice providers can submit HIS data electronically without having an EMR system.

As noted on Page 48256 of the FY 2014 Final Rule, “Electronic data submission will be required for the FY 2015 payment determination and beyond; there will be no other data submission method available” (http://www.gpo.gov/fdsys/pkg/FR-2013-08-07/pdf/2013-18838.pdf). Therefore, no matter what type of clinical record a hospice organization uses (paper or otherwise), hospices are required to electronically submit HIS data that is abstracted from the clinical record. What this means is that while CMS does not require that a hospice have a clinical computerized system, hospices are required to submit HIS data electronically to CMS’ Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for all patient admissions beginning on or after July 1, 2014.

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/. Each hospice must decide which software they will use to format the hospice submission files. CMS offers free software (HART) which can be used to enter and store the data and format the submission files, or the provider can choose to install and use any other software that will create the files per the data specifications. The decision to use the HART software or to use vendor software is a provider decision. CMS does not rate or certify vendor software for QIES ASAP submission. All agreements and arrangements are strictly between the provider and the vendor of the software.

After the submission files are created by the chosen software, they must be submitted to CMS over the CMS virtual private network using the CMSnet Juniper software which is supplied by CMS and installed on the user’s workstation. Providers can contract with an entity to perform their submission, or providers can submit the files themselves. Should a provider contract with an entity to perform their submission, “scripting” or batch submissions are not allowed. In this situation, CMS is not involved in any arrangement between providers and other entities. There are no CMS-required procedures related to third party submissions. CMS does hold the provider fully accountable for the truthfulness, completeness and accuracy of their data, regardless of who the provider assigns to submit such data. Providers independently elect who is designated to submit their quality data to CMS, and third party submitters acting on behalf of providers are required to acknowledge they are duly authorized to submit the quality data at the time of submission. All data submission requirements, including deadlines for data submission, are applicable to third party submissions.

Recorded technical training modules will be available early May 2014 on the www.QTSO.com website. This training will cover the process of registration for user

IDs, submission of records, and the retrieval of final validation reports to ensure records were successfully submitted to the QIES ASAP system.

Question 4. What are the HIPAA implications with providing all patient admission information to CMS for the HIS reporting even though CMS may not be a pay source or involved in the patient's care?

Answer 4. By virtue of the regulation text, the described data disclosure is required by law, and therefore permitted under the HIPAA Privacy Rule. The delivery of high quality care in hospice is imperative. We believe that collecting quality data on all patients in the hospice setting supports CMS' mission to ensure quality care for Medicare beneficiaries. Collecting data on all patients provides the most robust and accurate reflection of the quality of care delivered to Medicare beneficiaries as compared with non-Medicare patients and ensures that all patients, regardless of payer, are receiving the same care.

Question 5. Can any portions of the HIS tool be electronically populated or auto-filled/auto-populated, such as demographics or any other items that could be mapped to the hospice clinical record?

Answer 5. If the entries to the HIS match the content of the clinical record and meet the requirements of the HIS as stipulated in the HIS Manual, then vendor software may complete the abstraction automatically based on information in the clinical record. The HIS Manual is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/HIS-Manual.pdf. The hospice is required to ensure the accuracy of all items on the HIS record no matter how they are entered or auto-populated in the HIS record. The record to be submitted must also meet the technical data submission specifications. This includes formatting each HIS record in XML per the data specifications and zipping one or more HIS XML records into a zipped file which then is submitted to CMS. CMS allows for various entities to submit; the provider, the corporation or a 3rd party such as a vendor. The technical data specifications are located at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html.

See Question 3 for more information on policies regarding vendor software and contracting with a vendor to perform HIS data submission.

Annual Payment Update (APU) Determinations

Question 6. What if we answer "no" to a gateway question to indicate that the clinical record contained no documentation that a care process took place (for example, we find no clinical record documentation indicating that the patient was screened for pain, so we answer "0, No" to J0900A) – will this affect our annual payment update (APU)?

Answer 6. The HQRP is currently a "pay-for-reporting" program, meaning that performance on quality metrics is not a factor in determining a hospice's APU at this time. This means that for the FY 2016 APU determination, criteria will be based on whether or not the hospice submits HIS records to CMS, not on the HIS data itself. The HIS is intended to capture whether or not care processes took place – if the clinical record contains no evidence that a care process took place, providers should answer "no" to gateway questions in the HIS, and then follow skip patterns as indicated in the HIS. Since APU determination is based on the act of submitting HIS data (not the "performance", or HIS data itself), hospices will not be penalized in their APU for answering "no" to gateway questions on the HIS.

Question 7. What if we fail to submit a HIS record? Will a single missed submission mean we are noncompliant with HQRP requirements?

Answer 7. As stated in the FY 2014 Final Rule: submission of the HIS on all patient admissions is expected. The requirement is that a HIS-Admission and HIS-Discharge must be submitted for each patient admission. Hospices should make every effort to make sure that HIS records are completed and submitted in a timely manner. More details about timeliness criteria for each record type can be found in sections 1.3 and 3.2 of V1.00.0 of the HIS Manual (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html). If a hospice realizes that it will not meet the timeliness criteria for any given record, it should still complete and submit that record, even if that means the completion/submission will be "late" for the record. As stated on Pages 1-3 and 1-4 of V1.00.0 of the HIS Manual, late completion and submission of HIS records will result in a non-fatal (warning) error. Records containing nonfatal errors can still be accepted by the QIES ASAP system. We encourage providers to regularly check the CMS HQRP website for additional information on the Hospice Quality Reporting Program.

Question 8. What if we submit an incomplete HIS record? Will this affect our APU/compliance with HQRP requirements?

Answer 8. It is not possible to successfully submit an incomplete HIS record to the QIES ASAP system. An "incomplete" HIS record would be a record in which a provider erroneously omitted a response to an item requiring a response, per skip pattern

requirements. (If an item is left blank because the skip pattern directed the provider *not* to complete that item, the record would not be considered an "incomplete" HIS record.) Leaving an item blank in violation of skip patterns would be considered a fatal error in the QIES ASAP system. Records with fatal errors are rejected by the QIES ASAP system so that incomplete submissions are not possible. If a provider receives a fatal error resulting in record rejection, the provider should correct the error and re-submit the record.

Question 9. Say we find an error in a record that has already been submitted and accepted into the QIES ASAP system and we need to either modify or inactivate the record to correct the error. If we modify/inactivate the record after the submission date (defined as no later than 30 calendar days after the admission or discharge date) will this make our submission "late?" Will it affect our APU?

Answer 9. The date a record is submitted and accepted into the QIES ASAP system is the submission date. Correcting an error after submission to the QIES ASAP system does not change the date on which the original record was submitted, so correcting an error after 30 days will not make a submission "late" (provided the original record was submitted/accepted to the QIES ASAP system prior to the submission deadline). Compliance with HQRP reporting requirements is associated with the *original* date on which the HIS record was submitted and accepted to the QIES ASAP system.

Section A: Administrative Information

Item A0600A. Social Security Number

Question 10. What if the patient refuses to provide their Social Security Number (SSN) or our hospice does not have access to the patient's SSN?

Answer 10. In rare instances, the SSN can be left blank if: (1) the patient does not have a SSN or (2) the hospice does not have access to the SSN. In this event, leaving the SSN blank will not cause a fatal error.

However, CMS strongly encourages hospices to gather the SSN and to report it on the HIS. If a hospice does not submit the SSN for a patient, the hospice may encounter problems when trying to modify or inactivate the HIS record. The SSN is used for tracking purposes, so if a patient does not have a SSN recorded, the system may not always be able to locate the original record. The SSN is also used for record matching, so without the SSN the system may consider a patient a "new person" when both a HIS-Admission and HIS-Discharge are submitted. Therefore, it is in the hospice's best interests to collect and report the SSN as part of the HIS.

A hospice provider may wish to explain the aforementioned reasons to any patients who are refusing to provide their SSN. The only reason a hospice should not submit a SSN is if the patient does not actually have a SSN.

See Question 4 for more information on HIPAA and the collection of HIS data.

Section F: Preferences

Question 11. Could you please further explain what acceptable forms of patient/responsible party/caregiver involvement are for items in Section F? Are patient/responsible party/caregiver signatures on POLST forms acceptable? What about checklists in the clinical record?

Answer 11. Checklists are acceptable documentation for the items in Section F as long as they indicate that the hospice discussed (or attempted to discuss) preferences with involvement form the patient/responsible party. For example, a checklist that says "patient DNR – yes/no" with no other evidence of involvement from the patient/responsible party would *not* be considered documentation that shows involvement of the patient/responsible party as described in the HIS manual (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html). If the checklist read "DNR status confirmed in discussion with patient/responsible party – yes/no", this would be considered acceptable documentation since it shows involvement from the patient/responsible party. In addition, the hospice can consider documentation contained in free text fields of electronic medical records, clinical notes, and/or signatures from the patient or responsible party on DNR orders or POLST or other equivalent forms when completing the HIS, provided the documentation clearly reflects patient/responsible party involvement.

Treatment initiation

Question 12. Can you please define "initiation" for the treatment items in Section J: Respiratory Status (Item J2040. Treatment for Shortness of Breath) and Section N: Medications (N0500. Scheduled Opioid, N0510. PRN Opioid, and N0520. Bowel Regimen)? Is initiation defined in the same manner for standing orders, treatments from previous care settings, and nonpharmacologic interventions?

Answer 12. For pharmacologic interventions/treatments "initiation" is defined as the date that the hospice received the order for the medication, irrespective of if/when the first dose was given. For the purposes of HIS item completion, standing orders are permissible. For "date treatment initiated" for standing orders, use the date on which the hospice received the order. For treatments the patient was using prior to admission to hospice, if the hospice/patient wish to continue the treatment, the hospice would have to

receive new orders to continue the treatment, after assuming responsibility for the care of the patient. For example, if a patient is on an opioid prior to hospice, should the hospice/patient wish to continue the treatment, the hospice would need to receive a new order to continue the opioid under hospice care. Do not include treatments from previous care settings unless the hospice has received orders to continue the treatment(s).

For nonpharmacologic interventions (for example, dietary interventions such as prune juice for the bowel regimen item or relaxation techniques or positioning for the shortness of breath item) orders may not be listed in the clinical record. For nonpharmacologic interventions, use the date the intervention (or education about the intervention) was delivered for “date treatment initiated.” Similar to the definition of “initiation” for pharmacologic interventions, “initiation” for nonpharmacologic interventions is defined as the date on which the patient/family was informed about the nonpharmacologic intervention, irrespective of if/when the intervention was implemented. For example, if on July 4, 2014 the nurse instructed the patient about relaxation techniques to ease shortness of breath, for purposes of HIS item completion, this intervention would be considered “initiated;” July 4, 2014 would be the date the treatment was initiated, irrespective of if/when the patient starting practicing relaxation techniques to ease shortness of breath.

Section Z: Record Administration

Question 13. Can electronic signatures be used for items in Section Z?

Answer 13. Hospices may use electronic signatures for the HIS when authorized by the hospice's policy. Hospices must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs. Although the use of electronic signatures for the HIS does not require that the entire record be maintained electronically, most facilities have the option to maintain a patient's record by computer rather than hard copy.