MLN Connects® National Provider Call Hospice Quality and Hospice Item Set (HIS) Manual V1.02 FAQs

This document is intended to cover frequently asked questions that were received prior to the June 17th, 2015 MLN connects National Provider Call. The MLN Connects Call was hosted to cover updates made to V1.02 of the HIS Manual.

Clarification of HIS Manual and HIS data submission specification versioning

1. Does V1.02 of the HIS Manual relate to V1.02.0 of the data submission specifications? The two documents have two different effective dates – V1.02 of the HIS Manual is effective 6/28/15 and V1.02.0 of the submission specifications is effective 4/1/16.

   Response: Changes to V1.02 of the HIS Manual do not correlate with changes in V1.02.0 of the data submission technical specifications. These two documents run on separate versioning schedules. **Changes in V1.02 of the HIS Manual correlate with changes that were in V1.01.0 of the data submission specifications, which were effective 6/28/15** (the same effective date as V1.02 of the HIS Manual).

   In the future, if providers would like to "map" or "crosswalk" versions of the HIS Manual with versions of the data submission specifications, **these materials should be matched based on the effective date listed on materials, not the version number(s) of the materials**.

   Changes outlined in V1.02.0 of the data submission specifications are not included in V1.02 of the HIS Manual. Changes outlined in V1.02.0 of the data submission specifications will be addressed by guidance released by CMS at a later date, closer to the implementation date of those specifications, which is 4/1/16.

Chapter 1

1.4 Applicable Facilities and Requirements for New Facilities

1. When does a new hospice agency need to begin submission of HIS data?

   Response: Current requirements are that if a provider receives their CCN notification letter on/after November 1, they are excluded from payment penalty for the relevant reporting year. Further details on reporting requirements for new agencies are addressed in this year's NPRM at the Federal Register: https://www.federalregister.gov/articles/2015/05/05/2015-10422/medicare-program-fy-2016-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting#h-61.

1.6 Record Types and Definitions

1. If a patient is admitted again after a discharge do I need to submit a new HIS admission record and subsequently a discharge record if the patient discharges or expires?

   Response: The answer to this question depends on whether or not there was an interruption in care/services when the patient was discharged/re-admitted. Please review Section 1.6 of V1.02 of the HIS manual for more information (pages 1-4 to 1-6) for more guidance on this topic.

2. If a patient is admitted and passes away the same day or during visit before all questions are answered, is HIS admission and discharge records both still required with some areas not yet addressed?

   Response: There is no length of stay exclusion for HIS reporting. Providers are required to submit HIS data on all patient admissions, regardless of length of stay. If the patient meets the definition for admission presented on Pages 1-4 to 1-5 of V1.02 of the HIS Manual, HIS reporting is required. If a care process was not completed, answer "no" to the gateway questions and follow skip patterns in the HIS.

3. If a patient is discharged and re-admitted to the same agency due to a payer change, what discharge reason should be used when completing the HIS?

   Response: This issue is addressed in updated guidance in V1.02 of the HIS Manual. Please review Section 1.6 of V1.02 of the HIS manual for more information (pages 1-4 to 1-6). In general, as long as there is no interruption in care/services, an HIS-DC and new HIS-admission is not required for "administrative discharges" (such as change in patient payer source).

4. Will there be a short stay form for patients who die within five days?

   Response: No – there is no separate HIS form for patients who die within 5 days. Providers should complete a HIS-Admission and HIS-Discharge for all patient admissions, regardless of length of stay. If a care process was not completed, answer "no" to the gateway questions and follow skip patterns in the HIS.

5. Are you changing the requirement that Initial Comprehensive Assessments do not need to be signed in order to submit the HIS data? It is very common for us to have patients die well within the 5 day completion COP rule. HIS requiring a signature on the ICA contradicts the COP regulation.

   Response: The HIS requirement is separate from the comprehensive assessment requirement in the CoPs. If a patient dies within 5 days from admission, providers are still required to submit an HIS-Admission and HIS-Discharge record for that patient. Providers

can submit HIS data even if the nurse did not initiate or complete the comprehensive assessment; if a particular HIS care process was not completed, answer “no” to the gateway question and follow skip patterns in the HIS.

1.7 Timing and Sequence Policies

1. Why is the deadline for the creation of the Discharge HIS form (7 days) different from the deadline for Admission HIS form (14 days)? Having two timeframes to manage is very difficult and can easily lead to missed deadlines.

   Response: The completion timeframe is shorter for the HIS-Discharge record since there are fewer items on this record and thus CMS expects that this record takes less time to complete. CMS will consider updates to these deadlines in the future.

2. Are HIS records submitted on time still considered late if you have to go back in to fix a clerical error after the time deadline?

   Response: No – records that are corrected are not considered late.

   On a modification or inactivation record, the completion date (Z0500B) should remain the original completion date that was on the erroneous record.

   Submission warnings only appear on new records, so they will not appear on modified or inactivated records.

Chapter 2

Section A: Administrative Information

1. For A1802 Admitted From/A0205 Site of Service, question “immediately preceding this admission, where was the patient?” Do we check #5 "short stay acute hospital"? or #1 “Hospice in patient’s home/residence”? Or do we only consider the place of discharge if it is the SAME day as hospice start of care? What is the timeframe for "immediately preceding" admission? Example: Patient was discharged to home/private residence from acute short stay hospital one day before hospice start of care/admission.

   Response: In the situation presented in your example, the patient was in multiple settings prior to admission to hospice (home and short stay acute hospital). As stated in the HIS Manual, when a patient is in multiple settings prior to admission to hospice, choose the setting where the patient was at the time of **referral** to hospice.

2. We have a contract with dually licensed SNF/LTC facility to provide our GIP. What do we select as our location of patient at admission for those admitted directly to GIP?

   Response: This is addressed in V1.02 of the HIS Manual. For purposes of completing Item A0205, SNF is not synonymous with nursing facility. The response option for SNF is to be

used for patients in a SNF or patients in the SNF portion of a dually-certified nursing facility. If a beneficiary is in a nursing facility but doesn't meet the criteria above, do not use the response option for SNF; instead, use the response option for long-term care facility (also known as NF or nursing facility).

Section F: Preferences

1. For F3000. RN Clinicians are having the most difficulty with this question, can you give examples of documentation? Can patient's religion preference be included as this is an important piece of information?

   Response: V1.02 of the HIS Manual contains updated guidance, including examples for F3000. Please review Page 2F-13 of the V1.02 of the HIS Manual for additional examples of spiritual/existential discussions. As stated in the HIS Manual, brief statements or data in the clinical record denoting a patient's religious affiliation (such as "Baptist") is not sufficient to select "Yes" for F3000A.

2. Is it appropriate for a clinician such as a spiritual care coordinator, to complete the HIS measure - 'Spiritual and Existential Concerns' after having a phone conversation with the patient or family member that involved responses to this issue? (Most times the Spiritual Care Coordinators are not able to get an in person visit with the patient/family within the 5 days after admission to hospice.

   Response: Yes. This is permissible as long as the clinical documentation supports that discussion about these issues occurred. Documentation of a telephone call to the patient/patient's family does not suffice without additional information.

Section J: Pain

1. Can you clarify the intent of the pain screening question- "if the patient says no they are not in pain and later when a scale is used says something other than zero, are we to use the scaled response or the patient response, "no I am not in pain"- this is assuming both are patient reported.

   Response: J0900 should be completed on the highest severity rating report *at the time of the screening visit.* So if, within the same visit, the patient reports they are not in any pain, then later reports they are in pain using a 0-10 scale, report the higher rating.

2. Clarify what is different between patient visual" and "staff observation" for pain and "no standardized tool"."

   Response: The response option "no standardized tool used" is to be used when there is no documentation that the clinician used a standardized tool to screen the patient for pain. Examples of common patient visual and staff observation scales are listed on Page 2J-3 of

the HIS Manual. Your hospice policy and procedure related to pain assessment may dictate the scale that is used consistently.

3. I would like more clarification about how nurses can meet the criteria for a comprehensive assessment (using at least 5 measures) for non-communicative nonverbal patients. Thank you

   Response: Page 2J-8 of V1.02 of the HIS Manual contains guidance on completing pain assessments for non-responsive patients. In general, clinicians can use nonverbal indicators of pain, or the clinician can ask the caregiver about any of the 7 elements in J0910C. An attempt to gather the information from the caregiver is sufficient to check off elements in J0910C.

4. The answer to Question 2 in the HIS Q&As-April 2015 has confused our understanding about what constitutes a yes to characteristics of the comprehensive pain assessment in a nonverbal patient. In the HIS manual, the example on 2J-7 states '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, what location should be checked for J0910C as the clinician attempted to gather the information? Based on this statement our understanding has been that if the clinician documented severity by PAINAD (Pain Assessment in Advanced Dementia), then stated that they were unable by observation or caregiver report to determine the location duration frequency effect on quality of life then we should check in J0910C all the characteristics listed above as there was an attempt to assess the stated characteristics. Would you please clarify? "

   Response: Thorough comprehensive pain assessment for non-verbal hospice patients can start with the use of standardized tools such as the PAINAD. The PAINAD is one tool for assessing the presence and severity of pain; it does not address many other important aspects of comprehensive clinical pain assessment for nonverbal patients. Thus, to meet the intent of the items in section J, the clinician must ask and assess other aspects of pain — what makes it better or worse, its frequency, its effect on function — with direct observation and with questions to the caregiver. Through direct observation, of nonverbal indicators of pain, such as crying or whining, facial expressions, and protective body movements, such as guarding, rubbing, or clutching a body part, clinicians can determine elements of a comprehensive pain assessment listed in J0910C. Page 2J-8 of V1.02 of the HIS Manual includes detailed guidance on comprehensive pain assessments for nonverbal patients for all elements listed in J0910C. In addition to using direct observation, clinicians may gather information from caregivers about a patient's pain. If collecting information from a caregiver, when an aspect of pain assessment isn't known — such as when the caregiver really cannot identify the character of the pain or what makes it better or worse — then the corresponding item should be selected for

J0910C, provided the clinician made an attempt to gather the information from the caregiver.

5. Should Morphine Sulfate in the Comfort Care Pack be considered as active pain treatment if it was intended for future use?

   Response: Instructions for comfort packs is addressed in updated guidance in V1.02 of the HIS Manual. As stated in V1.02 of the manual, only include medications in a comfort pack as "initiated" if there is documentation that the hospice instructed the patient/family to begin use of the medication/treatment. Medications that are in the comfort pack and "on standby" for future use are not considered initiated.

Section J: Dyspnea

1. During the admission assessment if the patient is lying in bed with oxygen on and does not appear to be experiencing any SOB, would you say yes for SOB or no? If he were to get up and walk across the room and then demonstrate SOB then the answer would be yes? Many staff is under the impression that the snap shot picture of the patient as they are doing their assessment is what the nurse bases her answers on. What do you say about this?

   Response: As stated in the HIS Manual, providers should complete the SOB item based on whether SOB is an *active problem* for the patient. Providers should determine whether SOB is an active problem for the patient based on clinical judgment. A situation where a patient does not have SOB when lying down and using oxygen, but *does* experience SOB upon exertion, could be a situation where SOB is an active clinical problem for the patient.

2. Dyspnea is a subjective value. How can we capture severity and improvement with no validated tool? Without a tool or more specific directions from CMS as to how to measure this symptom, none of the data CMS is collecting will be useful or meaningful. How are we to meaningfully collect this data?

   Response: You are correct that there is no single standardized and universally accepted assessment instrument that establishes the presence and severity of dyspnea symptoms. Like many symptoms, dyspnea is subjective-but patients can self-report its presence and severity. For example, shortness of breath / dyspnea is rated on numerical scales within structured, validated instruments such as the Edmonton Symptom Assessment System (ESAS). Caregivers can use observation of signs of respiratory effort to evaluate this symptom in non-verbal patients, such as signs found in the Respiratory Distress Observational Scale (RDOS) http://www.ncbi.nlm.nih.gov/pubmed/20078243. Note that the HIS items ask ONLY whether or not such a screening was conducted using clinical questions and observation, with or without one of these structured tools, and whether treatment to address the symptom of dyspnea was initiated

Section N: Medications

1. How do you code N0500 when a comfort pack is used?

   Response: Instructions for completing N0500 in cases where a comfort pack is used is included in updated guidance in V1.02 of the HIS manual. Please see page 2N-2 and the new example (situation D) on Page 2N-9.

Section Z: Record Administration

1. What is the best way to track Z section completion if you are using an EMR?

   Response: Signatures in Section Z are not submitted to CMS as part of the QIES ASAP system. Providers can develop their own internal policies for completing these items.

Chapter 3

1. Is there going to be a way to correct the information before it is published? We discovered that a nurse was not documenting the 48 hour pain in the correct area in the chart so the information captured and sent is incorrect.

   Response: If an error or incorrect/missing data is detected, the hospice should correct the error using a modification or inactivation request, whichever is appropriate. For more guidance on correcting HIS records using a modification and inactivation request, please review Chapter 3 of the HIS Manual.

Issues addressed by this year's Notice of Proposed Rulemaking (NPRM)

Future QMs

1. The focus of the HIS seems to be the care provided the first few days of admission to hospice. Will there be changes to the HIS in the future that will measure/monitor the care provided further into the episode. Our clinicians and QAPI staff feel that ignoring the rest of the episode after start of care and only focusing on quality during the first few days is strange.

   Response: Stakeholder feedback is very important to CMS. Improvements to the Hospice Quality Reporting Program are ongoing and will be published in the NPRM each year.

2. Current HIS measures focus on process (assessment of pain/symptoms) not efficacy of interventions. Will we be moving to more clinical symptom management measures?

   Response: Future measure concepts under consideration by CMS are outlined in this year's NPRM. Providers should review the NPRM, which is published in the federal register (www.federalregister.gov).

CASPER Quality Reports/Public Reporting

1. Are we going to see any reports from HIS data coming from CMS in the future? Can we expect any ratings based on HIS data like the Star rating in Home Health?
2. How can we access a compilation of results of HIS data to use as benchmark?
3. How can we get a report of HIS for 2014 for our specific agency. (Outcomes reports). How can we read and correct Validation errors?
4. How can we view the data that has been submitted? How does CMS aggregate the data?
5. We would like to use the HART software to produce reports that allow us to measure our compliance with the indicators themselves (not just whether or not we entered them timely) - when will that functionality be availability?
6. When is the HIS data to be publicly reported?
7. Will the HIS measures be publicly reported?
8. When will Casper reports be available? What type of reports will be available to providers?

   Response: Timelines for public reporting and for quality reports are addressed in this year's NPRM. We recommend providers review the NPRM (available in the federal register) for more details on timelines for public reporting and provider-level quality reports in CASPER. For quality reports in CASPER, CMS expects these reports will be available sometime in 2015. Several Hospice Provider Reports are now available through the CASPER Reporting System. Three new reports are available in the Hospice Provider Reports category on the CASPER Reporting application which can be accessed here: https://mds.qiesnet.org/hospc/home.html. These reports highlight HIS Record Error Detail by Provider, total HIS records submitted during the selected timeframe and HIS records with each particular error message.