Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
Title Page, footers	N/A	**V 1.02** Effective **June 28, 2015**	Updated to reflect new version number and date
Table of Contents	i	Section J: Health **C**onditions	Grammatical edit
1	1-1	**1.1 Background and Statutory Authority**	Added subsection header
1	1-1	[In Chapter 1, after the first instance of "fiscal year," changed "fiscal year" to "FY."]	Grammatical edit
1, 2A, 2F, 2J	1-1,2A-3, 2A-6, 2A-12, 2F-1, 2F-4, 2F-8, 2F-11, 2F-14, 2J-4, 2J-8, 2J-11, 2J-14, 2J-15	[Throughout the document, changed "since" to "because."]	Grammatical edit
1	1-1	[In the first paragraph of Chap. 1, made the following changes.] A hospice is not required to obtain patient consent ~~in order~~ to collect data for quality measures for the **Hospice Quality Reporting Program (**HQRP**)** ~~since~~ **because** the Centers for Medicare & Medicaid **S**~~s~~ervices (CMS) ….CMS established ~~the Hospice Quality Reporting Program (HQRP)~~ in the FY 2012 Hospice Wage Index final rule (76 FR 47318-47324).	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
1	1-1	[At the end of the first paragraph of Chap. 1, made the following change.] 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. **Hospices will continue to collect and submit HIS data on all patient admissions; HIS data will be submitted to CMS on a regular and ongoing basis from July 1, 2014, onward.**~~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.~~	Additional text added to improve clarity
1	1-1	[In Table 1, made the following change.] Patients Treated with an Opioid **W**~~w~~ho **A**~~a~~re Given a Bowel Regimen	Grammatical edit
1.1	1-2	**1.2 Manual Overview**	Subsection number change
1.1	1-2	[In Section 1.2, deleted the following text.] ~~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.~~	Deleted text

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
1	Not applicable	[Added the following sections.] **1.3 HIS Requirements and Reporting Years** **Hospices shall submit two HIS records (a HIS-Admission record and a HIS-Discharge record) for each patient admission occurring on or after July 1, 2014. HIS reporting consists of three primary activities: HIS data collection, HIS record conversion, and HIS record submission. See _Figure 1_.** **Figure 1: Three primary phases of HIS reporting** **HIS Data Collection:** Completing the HIS items in conjunction with the patient assessment or by abstracting data from the clinical record → **HIS Record Conversion:** Converting HIS data into the proper electronic file format (XML), either using a vendor-designed software or HART (available at www.qtso.com) → **HIS Record Submission:** Zipping XML files into the .zip format and submitting to QIES ASAP system **HIS data collection consists of selecting responses to HIS items in conjunction with patient assessment activities or via abstraction from the patient's clinical record. HIS data may be collected on paper forms or using an electronic health record, but prior to submission, HIS data must be converted into the proper electronic file format (XML), which is necessary for successful submission. To convert HIS records into the proper XML file format, providers can use either the Hospice Abstraction Reporting Tool (HART) software, which is free to download and use, or a vendor-designed software. Once HIS records are converted, files are submitted to CMS via the**	Added two new subsections to reflect most recent CMS guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Records should be completed and submitted according to the time frames outlined in Section 1.7, Timing and Sequence Policies. Although this manual contains general HIS record completion and submission policies, it does not contain detailed information about conversion and submission software and procedures. Please see Chapter 3 for links to additional resources on HIS record conversion and submission. **Any hospice that does not comply with the data submission requirements for any given reporting year shall have its market basket update, also known as the Annual Payment Update (APU), reduced by 2 percentage points for the relevant FY.** **HIS reporting activities currently operate on a cycle of HIS data collection and submission, compliance determinations, and payment impact that spans 3 years. HQRP reporting years are referenced by the relevant FY APU affected. For example, the FY 2017 Reporting Year consists of data collection and submission in calendar year (CY) 2015, compliance determinations in 2016, and payment impact for the FY 2017 APU. See Figure 2, below.**	

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		Figure 2: FY 2017 Reporting Year Activities	

Figure 2: FY 2017 Reporting Year Activities

CY 2015	CY 2016	CY 2017
Data Collection and Submission: Collect and submit HIS data for all patient admissions occurring during CY 2015 (January 1, 2015 – December 31, 2015).	**Compliance Determinations:** In 2016, CMS makes compliance determinations based on HIS submissions for patient admissions occurring in 2015.	**Payment Impact:** Determinations of noncompliance made in 2016 will go into effect in FY 2017 (10/1/2016), reducing the FY 2017 APU by 2 percentage points.

For more information on criteria for compliance determinations, see Section 1.9, Compliance with HQRP Requirements and APU Determinations.

1.4   Applicable Facilities and Requirements for New Facilities

All Medicare-certified hospice providers are required to submit HIS data on all patient admissions on or after July 1, 2014, onward.

Reporting eligibility and requirements for new hospice providers is addressed by CMS through rulemaking. In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79, FR 50487), CMS finalized that any hospice that receives its CMS Certification Number (CCN) notification letter on or after November 1 of the preceding year involved is excluded from any payment penalty for quality reporting purposes for the APU determinations for that particular FY. For example, a new hospice that received its CCN

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		notification letter on November 2, 2015, would not be required to submit quality data on patient admissions occurring during CY 2015 (which would affect the FY 2017 APU). In this example, the hospice would begin HIS data collection and submission on patient admissions occurring on or after January 1, 2016, at the latest, and collect and submit data for all subsequent years. HIS data submitted on patient admissions for CY 2016 would affect the FY 2018 APU. **For more details on requirements for new facilities, see proposed and final rules published by CMS in the Federal Register: https://www.federalregister.gov/.**	
1.2	1-2	**1.5** **Applicable Patients**	Subsection number change
1.2	1-2	[Made the following changes to Section 1.5.] A HIS-Admission and a HIS-Discharge **record** are submitted for all patient admissions to a Medicare-certified hospice program on or after July 1, 2014**,** regardless of **the following**: • 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~~	Deleted text

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
1	Not applicable	[Added the following section.] **1.6 Record Types and Definitions** **Hospices are required to submit two HIS records for each patient admission to their organization: a HIS-Admission record and a HIS-Discharge record. HIS-Admission and HIS-Discharge completion is generally triggered by the patient's admission to or discharge from a Medicare-certified hospice.** **Admission: For the purposes of completing the HIS, a patient is considered admitted to a hospice if the following conditions are met:** 1. **There is a signed election statement (or other agreement for care for non-Medicare patients).** 2. **The patient did not expire before the effective date of the election or agreement for care.** 3. **The hospice made a visit in the setting where hospice services are to be initiated.** **All three criteria listed above must be met for the patient to be considered admitted for the purposes of HIS reporting (see Figure 3, below).**	Added new subsection to reflect most recent CMS guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		Figure 3: Flowchart for Patient Admission Determining Whether an HIS-Admission Record is Required Step 1: Is there a signed election statement (or other agreement for care)? — NO → HIS **NOT** REQUIRED ↓ YES Step 2: Did patient expire prior to effective date? — YES → HIS **NOT** REQUIRED ↓ NO Step 3: Was hospice visit made in the setting where hospice services will be initiated? — NO → HIS **NOT** REQUIRED ↓ YES HIS REQUIRED **Admission date: The date on which the hospice becomes responsible for the care of the patient. For Medicare patients, this is the effective date of the election or re-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.**	

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		Discharge: For the purposes of completing the HIS, a patient is considered discharged when the patient is no longer receiving services from the hospice or there is an interruption in care/services related to one of the reasons listed in Item A2115 (expired, revoked, no longer terminally ill, moved out of hospice service area, transferred to another hospice, discharged for cause). **Discharge date: The date the hospice discharged the patient. If the patient expired, the date of death is the discharge date. For live discharges, the date the patient revoked the benefit or the date the hospice discharged the patient is the discharge date.** **Special Circumstances** **Certain circumstances may not be considered an admission or discharge for the purposes of HIS completion. Special circumstances and the appropriate HIS record action are presented below.** **Patient transfers from a provider with one CCN to a provider with different CCN: HIS reporting is at the CCN level. If a hospice patient's care transfers or changes from one hospice to another, and the two hospices have different CCNs, each hospice should complete a HIS-Admission and a HIS-Discharge record for the care provided to the patient by their organization. When the transferring hospice completes its HIS-Discharge, response 05, "transferred to another hospice," should be selected for Item A2115—Reason for Discharge.**	

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		Change in patient payer source or other administrative discharges with no interruption in care: In some circumstances, a hospice's policy may be to administratively discharge a patient and re-admit them. Such circumstances might include the following:	
		• Change in patient's payer source: a private pay patient becomes eligible for Medicare during the course of hospice stay; hospice completes an "administrative" discharge and re-admission for the patient for billing purposes.	
		• Hospice fails to meet the face-to-face requirement: if a hospice fails to meet the face-to-face requirement, the hospice must administratively discharge the patient, but the patient remains on service.	
		• In general, as long as the patient remains under a hospice's care with no interruption in hospice service, completion of a HIS-Discharge is not required. In both of the situations listed above, because the patient remained under the hospice's care with no interruption in service, the hospice would not be required to submit a HIS-Discharge. Hospices should submit a HIS-Discharge once the patient is no longer receiving hospice service or there is an interruption in care related to one of the reasons for discharge listed in Item A2115.	
		Traveling patients: Hospice patients may on occasion travel outside of their "home hospice's" service area. In these circumstances, during the time the patient is outside of the home hospice's service area, the patient may receive services from a "host hospice." Per CMS regulations at 418.26, a	

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		hospice may discharge a patient if the patient moves out of the service area or transfers to another hospice. However, per the hospice regulations, a hospice may also enter into a written arrangement with another Medicare-certified hospice program for the provision of core services to supplement hospice employees/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include a patient temporarily traveling outside of the hospice's service area. In the case of a traveling patient, whether or not a hospice should submit a HIS-Discharge and new HIS-Admission depends on whether the home hospice discharged the patient and if the host hospice admitted the patient to hospice care and filed a notice of election (NOE) within the claims processing system. If there is no discharge by the home hospice, then the home hospice is not required to submit a HIS-Discharge when the patient travels out of the home hospice's service area. Relatedly, the host hospice would not need to submit a HIS-Admission or HIS-Discharge for a traveling patient whom they are providing services to under a written agreement with the home hospice.	
1.3	1-2	**1.7** **Timing and Sequence Policies**	Subsection number change
1.3	1-3	[In the "Admission Date (item A0220)" row of Table 2, added text.] **The date on which the hospice becomes responsible for the care of the patient.** ~~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 **(or re-election)**, which may be…election statement.	Added text to reflect most recent CMS guidance
1.3	1-3	[In the "Completion Deadline" row of Table 2, changed "an HIS record" to "a HIS record."]	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
1.3	1-3	[In the last cell of Table 2, made the following changes.] Defined as the latest possible date on which a provider **should** submit ~~an~~ HIS record.	Missing word
1.3	1-4	[In the "Completion Timing" subsection of Section 1.7, made the following changes.] For HIS-Admission records, the Completion Deadline is defined as the Admission Date + 14 calendar days. **This means** ~~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 ….Validation Reports, see Chapter 3. For HIS-Discharge records, the Completion Deadline is defined as the Discharge Date + 7 calendar days. **This means** ~~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 …. after the Discharge Date. The completion deadlines above ~~only~~ define **only** the latest possible date on which a hospice should complete each HIS record. To better align …. If a hospice chooses to complete ~~an~~ HIS-Admission record prior to the Completion Deadline…	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
1.3	1-4	[In the "Submission Timing" subsection of Section 1.7, made the following changes.] Admission Date, **but**~~or~~ no greater than 30 days later. The QIES ASAP …Admission Date. For HIS-Discharge records, the submission deadline is defined as the Discharge Date + 30 calendar days…. The **Submission**~~Completion~~ Date can be *equal* to the Discharge Date, **but**~~or~~ no greater than 30 days later. **The s**~~S~~ubmission **deadlines** ~~timing policies outlined~~above only define the latest possible date a hospice should submit each HIS record. For additional information…	Grammatical edit
All chapters		[Changed all instances of "2014" to "2015" except for historical references.]	Updated to improve clarity
1.3	1-5	[In the "Submission Date" column of Table 4, changed both instances of "2015" to "2016"]	Updated to improve clarity
1.3	Not applicable	[In the "Submission Timing" subsection of Section 1.7, added the following text.] **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 record would be late. Late completion and submission of HIS records will result in a nonfatal (warning) error. Records containing nonfatal errors can still be accepted by the QIES ASAP system.**	Additional explanation added to reflect most current CMS guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
1.3	1.5, 1.6	[In the "Submission Sequence" subsection of Section 1.7, made the following changes.] …examples include **the following:** • 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).	Grammatical edit
1.4	1-6	**1.8** **Maintenance of HIS Records**	Subsection number change
1.4	1-6	[In Section 1.8, made the following changes.] We recommend that hospices retain a copy of ~~the~~ HIS **records**, along with any corrected versions…. **Copies of HIS records can be maintained in electronic format.**	Additional text added to reflect most recent CMS guidance
1	Not applicable	[Added the following section.] **1.9** **Compliance with HQRP Requirements and APU Determinations** **The HQRP is currently a "pay-for-reporting" program, meaning that the act of submitting required HIS records determines compliance with program requirements. The performance rate on a specific quality measure is not a factor in determining compliance with HQRP requirements at this time. Providers who do not comply with reporting requirements for any given**	Added new subsection

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		reporting period will have their APU reduced by 2 percentage points for the corresponding FY's APU (see Section 1.3, HIS Requirements and Reporting Years). **Specific criteria for determining compliance with HQRP requirements is proposed and finalized through the federal rulemaking cycle. Providers can view proposed and final rules in the Federal Register: http://www.federalregister.gov.** **Beginning with the FY 2017 reporting year, hospices will also have to meet requirements for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey as part of general HQRP requirements. This means that, beginning with the FY 2017 reporting year, hospices will have to meet HIS and CAHPS requirements in order to avoid the 2 percentage-point reduction in their APU. For more information on CAHPS Hospice Survey requirements, please visit http://www.hospicecahpssurvey.org.**	
2.1	2-1	[In Section 2.1, added the following text.] For each HIS item, the general order of information presented in **Chapter 2** is **as follows**:	Grammatical edit
2.1, 2F, 2I, 2J, 2N	2-1, 2F-2, 2F-5, 2F-9, 2F-12, 2I-1, 2J-2, 2J-6, 2J-9, 2J-12, 2N-1, 2N-2, 2N-4	[In every instance of the phrase "item completion (coding)," removed "(coding)."]	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2.1	2-1	[In Section 2.1, wrote out the acronym CMS on its first appearance in the chapter.]	Text revised to improve clarity
2.2	2-2	[In Section 2.2, added the following text.] 2. To complete each HIS….Responses to items on the HIS **can be selected by the assessing clinician as part of the patient visit/assessment, or c**~~sh~~ould be based on ~~data~~ **information documented** in the clinical record ~~that were documented~~ **and abstracted on or** ~~prior to~~**before** the Completion Date (Item Z0500B). 3. All completed HIS records must be electronically submitted to the **Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP)** ~~QIES ASAP~~ system.	Text revised to improve clarity
2.2	2-2	[In Section 2.2, added the following text.] 6. A HIS-Admission and HIS-Discharge…complete. **Follow the gateway questions and skip patterns for item completion.**	Text revised to improve clarity
2.2	2-2	[In the "Who May Complete the HIS" subsection of Section 2.2, made the following changes.] The HIS may be completed by any hospice staff member, ~~which~~ includ**ing**~~es~~ volunteers~~,~~**,** contractors, and affiliates ….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.	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2.2	2-2	[In the "Acceptable Sources of Documentation" subsection of Section 2.2, made the following changes.] ~~Since the HIS is not a patient assessment, the~~**The** primary source**s** of information for completing the HIS ~~is~~ **include the following:** • **D**~~d~~ata collected through clinical care processes **as they are completed.**~~, and/or~~ • **Documentation in the hospice clinical record from which the HIS responses can be abstracted.** ~~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. • **In some instances, 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.** • 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.~~	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2.2	2-3	[In the "Relationship Between Care Processes and the HIS" subsection of Section 2.2, made the following changes.] **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 **Medicare Hospice** Conditions of Participation. Thus, completing the HIS-Admission record ~~sometime~~ after the comprehensive assessment period ends and ~~prior to~~**before** the completion deadline (defined as the Admission Date + 14 calendar days) meets the intent of the HIS. Completion timelines outlined above ~~do not capture~~**may not necessarily align with** 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~~ **Section** 1.7~~3~~ for additional information on timing and sequence policies.	Text revised to improve clarity
2A	2A-1	[In the item-specific instructions of A0050, changed all instances of "code" to "response"]	Text revised to improve clarity
2A	2A-1	[In the item-specific instructions of A0050, made the following changes to Response 1.] If there is an existing record for the same patient~~,~~ **in** the same hospice~~,~~ with the same reason for record~~,~~ and **with** 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.	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2A	2A-2	[In the item-specific instructions of A0050, made the following changes to Response 2.] • Selecting ~~code~~**response** 2 creates a **Modification Request,** ~~that~~ **which** is used when a HIS record has been previously submitted and accepted in the QIES ASAP system, but the record contains **clinical** ~~and/~~**or non-key demographic** 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.~~	Text revised to improve clarity
2A	2A-1, 2A-2	[In the item-specific instructions of A0050, made the following changes to Response 3.] • Selecting ~~code~~**response** 3 creates an **Inactivation Request,** ~~that~~ **which** is used when a HIS record has been previously submitted and accepted in the QIES ASAP system but **one of the following occurs:** – ~~p~~**Particular item values (for example, recent event identifiers or key patient identifiers) are inaccurate.**~~; or~~ – **T**~~t~~he corresponding event did not occur (for example, a HIS discharge record was submitted, but the patient was not discharged)**.**~~; or~~ – ~~particular item values (for example, recent event identifiers or key patient identifiers) are inaccurate.~~	Text revised to improve clarity
2A	2A-2	[In the item-specific instructions of A0050, made the following change.] For more details on Inactivation Requests, see **Chapter 3** of this manual**.**	Grammatical edit
2A	2A-3	[In the item-specific instructions for A0205, replaced every instance of "code" with "response."]	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2A	Not applicable	[In the item-specific tips section for Item A0205, added the following text.] • **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).**	Text added to reflect most recent CMS guidance
2A, 2F, 2J, 2N	2A-4, 2A-5, 2A-9, 2F-3, 2F-6, 2F-10, 2F-13, 2J-2, 2J-6, 2J-9, 2J-12, 2N-1, 2N-3, 2N-4	[In all item-specific instructions that requested a date, made the following changes.] Use the format~~:~~ Month-Day-Year: MM-DD-YYYY. Do not leave any spaces blank. If the month and/or day contain~~s~~ only a single digit, enter ~~a~~ "0" in the first box of the month and/or day.	Grammatical edit
2A	Not applicable	[In the item-specific instructions for A0245, at the beginning of the cell, added the following.] **For more information on what constitutes a patient admission for the purposes of HIS reporting, see Section 1.6, Record Types and Definitions.**	Text added to reflect most recent CMS guidance

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2A	Not applicable	[In the item-specific instructions for A0245, at the end of the cell, added the following bullet.] • **Item A0245 is intended to reflect the date on which the initial nursing assessment (as defined in the Medicare Hospice Conditions of Participation) was initiated. For patients that are discharged for any reason before the initial assessment is completed, enter the date on which the initial assessment was initiated, even if the entire initial assessment was not completed or was initiated in another care setting. If no initial assessment was initiated, enter a dash (-) for Item A0245.**	Text added to reflect most recent CMS guidance
2A	2A-5	[In the item-specific instructions for A0250, replaced every instance of "code" with "response."]	Text revised to improve clarity
2A	2A-5	[In the item-specific instructions for A0250, made the following change.] **A0250. Reason for ~~r~~Record**	Grammatical edit
2A	2A-5	[In the item-specific instructions for A0270, made the following revision.] *Complete only if A0250 = 09, Discharge.* **For more information on what constitutes a patient discharge for the purposes of HIS reporting, see Section 1.x Record Types and Definitions.**	Text added to reflect most recent CMS guidance
2A	2A-6	[In the item-specific instructions for A0500, made the following changes to the instructions for the last name.] This field has a limit of 18 characters**. T**~~t~~he hospice must be consistent when entering the patient's last name **because** 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.	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2A	2A-6	[In the item-specific tips for A0500, made the following changes.] Be sure to carefully check the spelling of the patient's name each time a HIS record is submitted**.** ~~since~~ **T**~~t~~ypographical 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.	Text revised to improve clarity
2A	2A-7	[In the item-specific instructions for part B of A0600, made the following changes.] – A Medicare number is an identifier assigned to an individual for participation in national health insurance program**(s)**…. SSN. **For example, many patients receive Medicare benefits based on a spouse's Medicare eligibility. The HIC number**~~, and~~ may contain both letters and numbers. ~~For example, many patients receive Medicare benefits based on a spouse's Medicare eligibility.~~	Text revised to improve clarity
2A	2A-7	[In the item-specific tips of A0600, made the following change.] *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.*	Grammatical edit
2A	2A-8	[In the item-specific instructions for A0700, added the following bullet to the end of the bulleted list.] – **If the patient refuses to supply his or her Medicaid number or the Medicaid number is unknown, leave A0700 blank.**	Text added to reflect most recent CMS guidance
2A	2A-8	[In the item-specific tips of A0700, made the following change.] 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.	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2A	2A-9	[In the item-specific instructions for A0800, replaced every instance of "code" with "response."]	Text revised to improve clarity
2A	2A-9	[In the item-specific instructions for A0900, deleted the following comma.] – If only the birth year is known, enter the year in the "year" boxes of A0900~~,~~ and leave the "month" and "day" boxes blank.	Grammatical edit
2A	2A-9. 2A-10	[In the item-specific instructions for A1000, made the following changes.] • **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. • **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."	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation

		• **Check E, Native Hawaiian or Other Pacific Islander,**~~:~~ if the patient is Native Hawaiian or **o**~~O~~ther 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 **w**~~W~~hite**.**
		   – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.	

2A	2A-10, 2A-11	[In the item-specific instructions for A1802, replaced every instance of "code" with "response."]	Text revised to improve clarity
2A	2A-11	[In the item-specific instructions for A1802, added the following text.] ~~Code~~**Response 02, Long-term care facility**~~:~~ **(also known as a Non-Skilled Nursing Facility or NF):**	Text revised to improve clarity
2A	2A-12	[In the item-specific tips for A1802, made the following changes.] • If the patient was in multiple settings prior to hospice admission, enter the ~~code~~**response that reflects** ~~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~~**response** "5, Short-stay acute hospital**,**" **because** 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 **response** "10, Hospice**,**" rather than ~~code~~**response** "01, Community residential setting."	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2A	Not applicable	[At the end of the item-specific tips for A1802, added the following bullet.] • **For purposes of completing Item A1802, 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).**	Text revised to reflect most recent CMS guidance
2A	2A-12	[In the item-specific instructions for A2115, changed every instance of "code" to "response."]	Text revised for clarity
2A	Not applicable	[In the item-specific instructions for A2115, under Response 06, Discharged for cause, added the following bullet.] **CMS defines discharge for cause as a discharge made because the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.**	Text revised to reflect most recent CMS guidance
2F	2F-1	[Made the following changes to the Rationale of Section F.] 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~~ **ensure** their needs are met.	Grammatical edit
2F	2F-2, 2F-3	[In the item-specific instructions for F2000, changed every instance of "code" to "response."]	Text revised for clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2F	2F-2	[In the first paragraph of the item-specific instructions for F2000, made the following change.] For this item, it is also permissible to consider care processes documented in the clinical record that ~~may have taken place at~~**took place during** pre-admission or educational visits.	Text revised for clarity
2F	2F-2	[In the item-specific instructions for F2000, F2000A, Response 0, made the following change.] This could happen if the patient ~~is~~ **was** unable to discuss and/or the responsible party was unavailable.	Grammatical edit
2F	2F-2	**[In the item-specific instructions for F2000, F2000A, Response 1, made the following changes.]** – ~~Code~~**Response** 1 applies to situations where there is documentation that the hospice brought up the topic of CPR use~~,~~ and **had**~~there was~~ a conversation with the patient~~and/or~~**, the** responsible party**, or both**. The conversation does not have to result in the patient stating a preference for or against the use of CPR to select ~~code~~**response** 1 for F2000A.	Grammatical edit
2F	2F-2, 2F-5, 2F-9, 2F-12	[In the item-specific instructions sections of F2000, F2100, F2200, and F3000, under Response 1, changed "For the purposes if" to "For the purposes of."]	Grammatical edit
2F	2F-2, 2F-6, 2F-9, 2F-13	[In the item-specific instructions for F2000, F2100, F2200, and F2300, made the following change.] "I'm only going to talk to my priest about this."~~.~~	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2F	2F-3	[In the item-specific instructions of F2000, F2000B, made the following changes.] • It is possible that at the time of HIS completion**,** ~~there will be~~ multiple discussions regarding the use of CPR **will be** 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~~**before** the Admission Date).	Grammatical edit
2F	2F-2, 2F-3	**[In the item-specific tips of F2000, made the following changes]** • In order to ~~code~~**report** "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…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~~**report** "Yes" for F2000A.	Text revised for clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		Evidence of a discussion…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~~**response** "1, Yes" for F2000A, *provided there is evidence of involvement from **the** 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." – If a patient…. record. Clinical record documentation, such as "discussed CPR preference during the admission visit with patient," is sufficient to select ~~code~~**response** "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~~**response** "0, No" for F2000A and skip to Item F2100.	
2	Throughout chapter	[In the examples sections, changed all instances of "shows:" before a quotation to "shows,"]	Grammatical edit
2	Throughout chapter	[In the examples sections of the HIS Item Completion Conventions, changed all "Coding" run-in headers to "HIS Response Selection."]	Text revised for clarity
2F	2F-4	[In the examples for F2000, changed all instances of "code" to "response."]	Text revised for clarity
2F	2F-4, 2F-8, 2F-11	[In the examples for F2000, F2100, and F2200, changed "most appropriate coding option" to "most appropriate response option."]	Text revised for clarity

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2F	2F-4	[In the examples for F2000, in the explanation for Situation A, made the following changes.] Although the patient later stated a preference regarding DNR **on** 08-05-~~2014~~**2015**, F2000 should be completed based on the *first* dated discussion in the clinical record. The most appropriate ~~coding~~ **response** option for F2000A is "1"	Missing word
2F	2F-5	[In the item-specific instructions for F2100, in the first paragraph, made the following change.] For this item, it is permissible to consider care processes documented in the clinical record that ~~may have taken place at~~**took place during** pre-admission or educational visits.	Text revised for clarity
2F	2F-5, 2F-6	[In the item-specific instructions for F2100, changed all instances of "code" to "response."]	Text revised for clarity
2F	2F-5	[In the item-specific instructions for F2100, under Response 0, made the following change.] This could happen if the patient ~~is~~ **was** unable to discuss and/or the responsible party was unavailable.	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2F	2F-6	[In the item-specific instructions for F2100, under F2100B, made the following changes.] • 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 **will be** 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~~**before** the Admission Date).	Grammatical edit

2F	2F-6, 2F-7	[In the item-specific tips for F2100, made the following changes.]
		
		• In order to ~~code~~**report** "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.
		
		F2100 is intended…. equivalent.
		
		• A discussion…IDG.
		
		• Orders alone, without evidence of discussion or involvement from patient/responsible party, are *not* sufficient to ~~code~~**report** "Yes" for F2100A.
		
		• There is no….(for example, ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, intravenous [IV] fluids) is sufficient to ~~code~~**select** either **of the following for F2100A:**~~:~~
		
		  – "1, Yes, and discussion occurred" ~~or~~
		
		  – "2, Yes, but patient/responsible party refused to discuss" ~~for F2100A.~~
			Text revised for clarity

<div align="right">(continued)</div>

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		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~~ **select** "1, Yes" for F2100A, *provided there is evidence of involvement from **the** 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 ....record. Clinical record documentation, such as "discussed life-sustaining treatment preferences during the admission visit with patient," is sufficient to select ~~code~~ **response** "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~~**response** "0, No" for F2100A and skip to Item F2200, Hospitalization Preference.	
2F	2F-7, 2F-8	[In the examples for F2100, changed all instances of "code" to "response."]	Text revised for clarity
2F	2F-9	[In the item-specific instructions for F2200, made the following change.] For this item, it is ~~also~~ permissible to consider care processes **(discussions)** documented in the clinical record that ~~may have taken place at~~**took place during** pre-admission or educational visits.	Text revised to improve clarity
2F	2F-9	[In the item-specific instructions for F2200, under Response 0, made the following change.] This could happen if the patient **wa**~~is~~ unable to discuss and/or the responsible party was unavailable.	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2F	2F-9	[In the item-specific instructions for F2200, under Response 1, made the following change.] – ~~Code~~**Response** 1 applies to situations where there is documentation that the hospice brought up the topic of hospitalization~~,~~ and **had** ~~there was~~ a conversation with the patient and/or responsible party.	Grammatical edit
2F	2F-10	[In the item-specific instructions for F2200, under F2200B, made the following changes.] • It is possible that at the time of HIS completion**,** ~~there will be~~ multiple discussions regarding hospitalization preferences **will be** documented in the clinical record. Complete HIS... • For this item, it is permissible to consider care processes documented in the clinical record at pre-admission or educational visits (~~prior to~~**before** the Admission Date).	Grammatical edit and text revised to improve clarity

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2F	2F-10, 2F-11	[In the item-specific tips for F2200, made the following changes.] • In order to ~~code~~**report** "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… • A discussion …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~~**report** "1, Yes" for F2200A, *provided there is evidence of involvement from **the** patient/responsible party*, such as **the** signature of the patient or responsible party on POLST forms, or clinical documentation, such as "hospitalization preference confirmed with responsible party." • If a patient is admitted ….record. Clinical record documentation, such as "discussed preference regarding hospitalization during the admission visit with patient," is sufficient to select ~~code~~ **response** "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~~**response** "0, No" for F2200A and skip to Item F3000, Spiritual/Existential Concerns.	Grammatical edit and text revised to improve clarity
2F	2F-11	[In the examples for F2200, changed all instances of "code" to "response."]	Text revised to improve clarity

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2F	2F-11	[In the examples for F2200, in Situation B, made the following change.] **F2200A: Was the patient/responsible party asked about preference regarding** ~~the use of re-admission to hospital~~**hospitalization**?	Text edited to correct error
2F	2F-12	[In the item-specific instructions for F3000, in the first paragraph, added the following text.] **For this item, it is permissible to consider care processes documented in the clinical record that took place during pre-admission or educational visits.**	Text added to reflect most current CMS guidance
2F	2F-12, 2F-13	[In the item-specific instructions for F3000, changed all instances of "code" to "response."]	Text revised to improve clarity
2F	2F-12	[In the item-specific instructions for F3000, under Response 0, made the following changes.] This could happen if the patient ~~is~~ **was** unable to discuss and/or the ~~responsible party~~**caregiver** was unavailable.	Grammatical edit, word choice
2F	2F-13	[In the item-specific instructions for F3000, under F3000B, made the following change.] It is possible that at the time of HIS completion**,** ~~there will be~~ multiple discussions regarding spiritual/existential concerns **will be** documented in the clinical record.	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2F	2F-13, 2F-14	[In the item-specific tips for F3000, made the following changes.] • There is no comprehensive list of spiritual/existential concerns. Examples **of a discussion regarding spiritual/existential concerns might include, but are not limited to, asking the patient/caregiver about need for spiritual or religious support, asking questions about the cause or meaning of illness or death, having a discussion about a higher power related to illness, or offering a spiritual resource (such as a chaplain).** 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~~**select** either **of the following for F3000A**: – "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~~**select** "Yes" for F3000A. • If clinical record documentation is ambiguous as to whether discussion about spiritual/existential concerns was attempted, ~~code~~**select response** "0, No" for F3000A and skip to Item I0010, Principal Diagnosis.	Text added to reflect most recent CMS guidance
2F	2F-14	[In the examples for F3000, changed all instances of "code" to "response."]	Text revised to improve clarity
2I	2I-1	[In the first paragraph of Section I, made the following change.] Items in this section of the Hospice Item Set (HIS) pertain to principal diagnosis of the patient**. This section has**~~there is~~ only one item ~~in this section~~, I0010, Principal Diagnosis.	Grammatical edit.
2I	2I-1	[In the item-specific instructions for I0010, changed all instances of "code" to "response."]	Text revised to improve clarity

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2I	2I-1	[In the item-specific instructions for I0010, changed "disease/condition" to "disease or condition"]	Grammatical edit
2I	2I-1	[In the item-specific tips for I0010, changed "six months or less" to "6 months or less."]	Grammatical edit
2J	2J-2, 2J-3	[In the item-specific instructions for J0900, changed all instances of "code" to "response."]	Text revised to improve clarity
2J	2J-2	[In the item-specific instructions for J0900, under J0900B, made the following change.] It is possible that at the time of HIS completion**,** ~~there will be~~ multiple pain screenings **will be** documented in the clinical record.	Grammatical edit
2J	2J-2	[In the item-specific instructions for J0900, under J0900C, made the following change.] • ~~Code~~**Response** 2, Moderate: Select ~~code~~**response** 2 if the patient's pain severity score was moderate. This would include a score of 4 ~~7~~**6** on a 10-point numeric scale *or* equivalent on verbal, visual, other numeric, or staff observation scale. • ~~Code~~**Response** 3, Severe: Select ~~code~~**response** 3 if the patient's pain severity score was severe. This would include a score of ~~8~~**7**–10 on a 10-point numeric scale *or* equivalent on verbal, visual, other numeric, or staff observation scale.	Moderate and severe pain scores changed to reflect clinical guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation

2J	2J-3	[In the item-specific instructions for J0900, under J0900D, made the following changes.]
		
		 • ~~Code~~**Response** 1, Numeric: Select ~~code~~**response** 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, **the** Symptom Distress Scale (McCorkle), **the** Memorial Symptom Assessment Scale (MSAS), and **the** Edmonton Symptom Assessment System (ESAS).
		
		 • ~~Code~~**Response** 2, Verbal descriptor: Select ~~code~~**response** 2 if a verbal descriptor scale was used to conduct pain screening.
		    – examples of standardized verbal descriptor scales include, but are not limited to**,**~~:~~ **the** Brief Pain Inventory, **the** McGill pain questionnaire, **and the** 6-~~P~~**p**oint Verbal Pain Scale.
		
		 • ~~Code~~**Response** 3, Patient visual: Select ~~code~~**response** 3 if a patient visual scale was used to conduct pain screening.
		    – examples of standardized patient visual scales include, but are not limited to**,**~~:~~ **the** Wong-Baker FACES Pain Scale, **a** visual analog scale, **and a** distress thermometer.
			Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation

		• ~~Code~~**Response** 4, Staff observation: Select ~~code~~**response** 4 if a staff observational scale was used to conduct pain screening. Select ~~code~~**response** 4 only if a standardized staff observational scale was used.
		  – examples of standardized staff observation scales include, but are not limited to**, the** Critical Care Pain Observation Tool (CPOT), **the** Checklist of Nonverbal Pain Indicators (CNPI), **the** Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC), and Pain Assessment in Advanced Dementia (PAIN-AD).
		  – ~~Code~~**Response** 9, No standardized tool used: Select ~~code~~**response** 9 if no standardized scale was used to screen for the presence and severity of pain.	

2J	2J-3, 2J-4	[In the item-specific tips for J0900, made the following changes.] 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~~**response** 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~~**report** the highest level of severity ~~recorded~~**experienced during the visit**.	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		• If a non-numeric scale was used to screen the patient for pain, ~~code~~ **select** 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~~**response** "1, Yes" for J0900A, enter the date for J0900B, select ~~code~~**response** "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 **and** 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~~**response** "1, Yes" for J0900A, enter the date for J0900B, and select ~~code~~**response** "9" for J0900C and J0900D.	
2J	2J-4, 2J-5	[In the examples for J0900, changed all instances of "code" to "response" *except* in the explanation for Situations A and B.] • The correct course of action is to ~~code~~**complete** J0900A-C, skipping J0900D	Text revised to improve clarity
2J	2J-5	[In the examples for J0900, made the following change to the explanation for Situation D.] It is evident **that** the patient was in pain, and that the clinician evaluated the patient's pain and noted pain severity.	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	Not applicable	[At the end of the examples of J0900, added the following text] **Situation E – Patient's clinical record contains the following information:** **Initial assessment form dated 08-14-2015 shows, "patient reports he has recently taken a dose of his pain medication, and throughout the visit his pain is reported as 0/10. Patient states he has a history of pain, at its worst pain is 6/10 and is a dull, aching pain in lower abdomen. Historically, pain is worse when patient walks and pain is better when lying down."** • **HIS Response Selection:** **J0900A: Was the patient screened for pain? Select response "1, Yes."** **J0900B: Date of first screening for pain: Enter "08-14-2015."** **J0900C: The patient's pain severity was: Select response "0, None" and skip to Item J2030, Screening for Shortness of Breath (Dyspnea).** • **Explanation: Selecting a response for Item J0900 should be based on the patient's pain status *at the time of the screening.* This means that although the patient reported a history of pain, because the patient rated his pain as a 0/10 throughout the visit, Item J0900 should be completed based on the patient's report that he was not in any pain. Although there is clinical record documentation that the nurse further assessed the patient's pain (historical rating, location, character, what makes pain better/worse), because the patient's pain rating at the time of the screening was "0, None," providers should follow skip patterns as indicated on the HIS, skipping J0900D and J0910. In this situation, because the patient has a history of pain, it is clinically appropriate for the clinician to have further assessed the patient's pain; this information is not reported on the HIS, however.**	Example added to reflect most recent CMS guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	2J-6	[In the item-specific instructions for J0910, changed all instances of "code" to "response."]	Text revised to improve clarity
2J	2J-6	[In the item-specific instructions for J0910, under J0910B, made the following change.] It is possible that at the time of HIS completion**,** ~~there will be~~ multiple comprehensive pain assessments **will be** documented in the clinical record.	Grammatical edit
2J	2J-6	[In the item-specific instructions for J0910, under J0910C, changed all colons after the option name into commas.]	Grammatical edit
2J	2J-6	[In the item-specific instructions for J0910, under J0910C, made the following change.] **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.	Grammatical edit
2J	Not applicable	[At the beginning of the item-specific tips for J0910, added the following text.] **A comprehensive pain assessment should address multiple aspects of pain, beyond a determination of the presence of pain and its severity.**	Text added to reflect most recent CMS guidance

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and <u>underlined</u>** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	2J-7	[In the second bullet of the item-specific tips for J0910, made the following changes.] • Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimac**<u>ing</u>**~~es~~ and clench**<u>ing</u>**~~ed~~ jaw**<u>s</u>**; 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 **<u>and</u>** ~~/~~shouted when clinician touched their right leg" or other documentation denoting patient exhibiting nonverbal cues of pain *for a specific location on the body*.	Grammatical edit
2J	2J-7	[In the last paragraph of the item-specific tips for J0910, made the following changes.] For any of the seven characteristics included in the pain assessment, ~~coding can be~~**<u>select response options</u>** 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~~ **<u>because</u>** the clinician *attempted* to gather the information.	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	2J-8	[In the examples of J0910, in Situation A, made the following change.] **J0910C: Comprehensive pain assessment included**: Check "1, Location" (clutching lower abdomen); **c**~~C~~heck "2, Severity" (loudly moaning/grimacing); **c**~~C~~heck "4, Duration" (patient had been moaning all morning); **c**~~C~~heck "5, Frequency" (rarely looked comfortable); **c**~~C~~heck "6, What relieves/worsens pain" (family uncertain); **and C**~~C~~heck "7, Effect on function or quality of life" (unable to move because of distress). • **Explanation:** ~~Since~~ **Because** at least one of the seven characteristics of a comprehensive pain assessment were clearly documented in the patient's clinical record, select ~~code~~**response** "1, Yes" for J0910A and continue to J0910B-J0910C, ~~coding~~ **selecting responses** based on documentation in the clinical record. Even though **the** family stated they were not sure what made the pain better or worse, "6, What relieves/worsens pain" can still be checked ~~since~~ **because** there was documentation that the clinician asked about what relieves or worsens pain.	Grammatical edit, clarity
2J	2J-8	[In the examples of J0910, in Situation B, made the following change.] Current **p**~~P~~ain **i**~~I~~ntensity: moderate;	Grammatical edit
2J	2J-8	[In the examples of J0910, in Situation B, made the following changes.] • **Explanation:** ~~Since~~ **Because** at least one of the seven characteristics of a comprehensive pain assessment were clearly documented, select ~~code~~**response** "1, Yes" for J0910A and continue to J0910B-J0910C, ~~coding using~~**selecting responses based on** documentation found in the clinical record.	Clarity

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	2J-9	[In Section J, Respiratory Status: Rationale, made the following changes.] • Screening for shortness of breath is necessary to determine its presence and severity, and **screening** forms the basis for treatment decision making. Shortness of breath ... • Effective treatment.. • Treatment… • Treatment for shortness of breath will vary ~~with its~~**in** severity and etiology, and with patient and caregiver preferences.	Grammatical edit
2J	2J-9, 2J-10	[In the item-specific instructions of J02030, changed all instances of "code" to "response."]	Text revised to improve clarity
2J	2J-10	[In the item-specific instructions of J02030, under J2030B, made the following change.] • It is possible that at the time of HIS completion**,** ~~there will have been~~ multiple screenings for shortness of breath ~~that were~~**will be** documented in the clinical record.	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation

2J	2J-10	[In the item-specific tips of J02030, made the following revisions.]
		
		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 **that** the patient was screened for presence/absence of shortness of breath**,** *and,* if the patient …severity).
		
		   • If documentation… J2030A.
		
		Evidence of a "positive" screen for shortness of breath should consider **whether shortness of breath was an active problem for the patient at the time of the screening clinical encounter. In determining whether shortness of breath was an active problem for the patient, providers may need to consider historical report of patient's shortness of breath, documentation of** patient's self-report of distress, and observed clinical signs of shortness of breath *~~can be used to determine whether shortness of breath was an active problem for the patient~~* at the time of the visit in which the screening was conducted. ~~Based on~~**On the basis of reports of recent symptoms, current treatment, and so on, the assessing clinician may determine that shortness of breath is an active problem, even if shortness of breath does not occur during the assessment visit.** 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.~~**or at other times**; patient/caregiver report …life.
			Grammatical edit, text updated to reflect most recent CMS guidance

<div align="right">(continued)</div>

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	2J-10, 2J-11	[In the examples of J2030, Situations A and B, changed all instances of "code" to "response."]	Text revised to improve clarity
2J	2J-11	[In the examples of J2030, Situation B, made the following change.] • **Explanation**: The documentation in Situation B gives evidence that breathing was screened or assessed. J2030C is ~~code~~**reported as**~~d~~ "0, No" ~~since~~ **because** the screening indicated that although the patient was breathing shallowly, there were no signs of distress or concerns from patient/family.	Text revised to improve clarity, grammatical edit
2J	2J-11	[In the examples of J2030, Situations C and D, changed all instances of "code" to "response" *except* the following.] • **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~~**response** "1, Yes" for J2030A, and continue to J2030B-J2030C, using evidence in the clinical record to ~~code~~**report** date and presence or absence of shortness of breath.	Text revised to improve clarity
2J	2J-11	[In the examples of J2030, Situations C and D, deleted the following text.] ~~**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."~~	Text revised to improve clarity

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	Not applicable	[In the examples of J2030, added Situation E.] **Situation E - Patient's clinical record contains the following information:** **Clinical note dated 08-15-2015 reads, "patient reports he is currently not experiencing any shortness of breath. Patient reports that he does become short of breath when walking from the bed to the bathroom. Patient reports that when he is short of breath, shortness of breath is mild to moderate, depending on activity level."** • **HIS Response Selection:** **J2030A: Was the patient screened for shortness of breath? Select response"1, Yes."** **J2030B: Date of first screening for shortness of breath: Enter "08-15-2015."** **J2030C: Did the screening indicate the patient had shortness of breath? Select response "1, Yes."** • **Explanation: In Situation E, it is evident the clinician evaluated the patient for presence and severity of shortness of breath. Thus, select response "1, Yes" for J2030A and continue to J2030B, entering the date of the screening. J2030C should be completed based on whether documentation in the clinical record demonstrates that shortness of breath was an active problem for the patient. Although the patient was not experiencing shortness of breath at the time of the screening, clinical record documentation shows that shortness of breath is a current, active problem for the patient when engaging in certain activities. Thus, select response"1, Yes" for J2030C.**	New example added to reflect most current CMS guidance

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	2J-12, 2J-13	[In the item-specific instructions of J2040, changed all instances of "code" to "response."]	Text revised to improve clarity
2J	2J-13	[In the item-specific instructions of J2040, made the following change.] An order may be verbal (when permitted) or written; ~~coding~~ **responses** for this item should be based on whichever was used to determine the start of treatment.	Text revised to improve clarity
2J	2J-13	[In the item-specific instructions of J2040, made the following changes.] – For ~~standing orders~~**comfort kits or pre-printed admission orders, treatment is considered** "initiati~~on~~**ed**" **when** ~~is defined as the date the order was received by~~ the hospice **has received the order _and_ there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment for the relevant symptom. If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, "date treatment initiated" would be the later date, when both conditions were met (hospice received order and instructed patient/caregiver to begin use). Proactive education on medications in a comfort kit in anticipation of symptoms is not considered "initiation."** • 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 or~~ **the date on which the hospice first discussed the intervention with the patient/caregiver**. • If the patient received…initiated.	Text updated to reflect most recent CMS guidance

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		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. ○ **Common examples of non-opioid medications that are frequently used for dyspnea include inhaled bronchodilators, steroids, diuretics, and benzodiazepines. Orders must indicate that the 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.	
2J	2J-13	[In the item-specific tips of J2040, made the following changes to the second bullet.] • Include ~~standing orders~~**comfort kits or pre-printed admission orders** only if the~~standing order is initiated~~ **hospice has received the order *and* the patient/caregiver has been instructed to begin use of the medication or treatment for the relevant symptom**.	Text updated to reflect most recent CMS guidance
2J	Not applicable	[At the end of the item-specific tips of J2040, added the following text.] **For J2040C, only include treatments that were initiated on the date listed in J2040B. If additional treatments for ~~SOB~~shortness of breath are initiated at a later date, the hospice should not update J2040C to reflect these additional treatments.**	Text updated to reflect most recent CMS guidance

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	2J-14, 2J-15	[In the examples for J2040, changed all instances of "code" to "response."]	Text revised to improve clarity
2J	2J-14	[In the examples for J2040, in the explanation for Situation A, made the following changes.] • **Explanation**: Documentation in the clinical record clearly indicates that the patient was short of breath and ~~there was~~**that** treatment **was** 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~~ **because** 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*" **o**~~O~~r "as needed *for shortness of breath* and pain**.**"~~.~~	Grammatical edit
2J	2J-14	[In the examples for J2040, in the explanation for Situation B, made the following changes.] **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 **was** initiated for shortness of breath. The date that the *first* treatment for shortness of breath is initiated (09-15-~~2014~~**2015, education about positioning**) is the proper date to list in Item J2040B~~, since education about positioning was the first treatment initiated~~. **For J2040C, only list treatments that were initiated on the date listed in J2040B.**	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2J	2J-14, 2J-15	[In the examples for J2040, in Situation C, wrote out the acronym "SOB" as "shortness of breath."]	Text revised to improve clarity
2J	2J-15	[In the examples for J2040, in the explanation for Situation C, made the following change.] 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~~ **that** situation, the hospice would enter the date that the hospice received the order in J2040B.	Grammatical edit

2J	Not applicable	[At the end of the examples for J2040, added the following text.]
		
		Situation D - Patient's clinical record contains the following information:
		
		Clinical documentation dated 09-15-2015 shows, "comfort pack in patient's home and on stand-by." Documentation states, "patient and family were educated on what medications were in the comfort pack, what symptoms the medications might be used for (including shortness of breath), and where to store the pack until needed. Patient and family instructed not to use the medications in the comfort kit until specifically advised to do so."
		
		   • **HIS Response Selection:**
		     J2040A: Was treatment for shortness of breath initiated? Select response "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.
			Example added to reflect most recent CMS guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
		• **Explanation: Documentation in the clinical record indicates that the comfort pack included treatments that could be used for shortness of breath, and that the nurse provided proactive education to the patient/family about the availability of such treatments. However, documentation in the clinical record does not indicate that the nurse instructed the patient/family to begin using any of the treatments for shortness of breath. Thus, for the purposes of completing Item J2040, treatment for shortness of breath was _not_ initiated; in this situation, the hospice would enter "0, No" for J2040A and skip J2040B-C. Had the clinical record included an additional note stating "instructed patient/family to begin using morphine 2mg PO/SL PRN for shortness of breath," this would be sufficient evidence that treatment was initiated, and the hospice would enter "1, Yes" for J2040A. Date treatment initiated in this situation would be the date on which the nurse instructed the patient/family to begin using the treatments.**	
2N	2N-1, 2N-2	[In the item-specific instructions of N0500, changed all instances of "code" to "response."]	Text revised to improve clarity
2N	2N-2, 2N-3	[In the item-specific instructions of N0500 and N0510, made the following change.] An order may be verbal (when permitted) or written; ~~coding~~ **responses** should be based on whichever was used to determine the start of treatment.	Text revised to improve clarity
2N	2N-2, 2N-3, 2N-4	[In the item-specific instructions of N0500, N0510, and N0520, made the following change.] for which the _hospice_ has received orders. Do not include a ~~"~~continued~~"~~	Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2N	2N-2, 2N-3, 2N-4	[In the item-specific instructions of N0500, N0510, and N0520, removed the following text.] ~~For standing orders, "initiation" is defined as the date the order was received by the hospice.~~	Text deleted to reflect most recent CMS guidance
2N	Not applicable	[In the item-specific instructions of N0500 and N0510, added the following bullet.] – **For *comfort kits or pre-printed admission orders*, treatment is considered initiated when the hospice has received the order *and* there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment. If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, "date treatment initiated" would be the later date, when both conditions were met (hospice received order and instructed patient/caregiver to begin use). Proactive education on medications in a comfort kit in anticipation of symptoms is not considered initiation.**	Text added to reflect most recent CMS guidance
2N	Not applicable	[In the item-specific tips for N0500, added the following text.] • **For the purposes of completing Item N0500, an "opioid" includes Schedule II–Schedule IV opioids, including hydrocodone and tramadol, because of the side effect profile, which includes constipation.**	Text added to reflect most recent CMS guidance
2N	2N-2, 2N-3	[In the item-specific instructions for N0510, changed all instances of "code" to "response."]	Text revised to improve clarity
2N	2N-3	[In the item-specific tips for N0510, changed "code" to "response."]	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2N	Not applicable	[In the item-specific tips for N0510, added the following bullet.] • **For the purposes of completing Item N0510, an "opioid" includes Schedule II–Schedule IV opioids, including hydrocodone and tramadol, because of the side effect profile, which includes constipation.**	Text added to reflect most recent CMS guidance
2N	2N-4	[In the item-specific instructions for N0520, changed all instances of "code" to "response."]	Text revised to improve clarity
2N	Not applicable	[In the item-specific instructions for N0520, added the following bullet.] – **For *comfort kits or pre-printed admission orders*, treatment is considered initiated when the hospice has received the order *and* there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment for the relevant symptom. If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, "date treatment initiated" would be the later date, when both conditions were met (hospice received order and instructed patient/caregiver to begin use). Proactive education on medications in a comfort kit in anticipation of symptoms is not considered initiation.**	Text added to reflect most recent CMS guidance
2N	Not applicable	[At the end of the item-specific instructions for N05020, added the following text.] • **The bowel regimen order need not explicitly state it is for the management of opioid-induced constipation.**	Text added to reflect most recent CMS guidance

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2N	2N-5	[In the item-specific tips for N0520, made the following changes.] A bowel regimen may include, but is not limited to **the following:** • 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~~**response** "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 **the following:** • **B**~~b~~owel obstruction/ileus • **D**~~d~~iarrhea • **N**~~n~~o bowel function • **C**~~c~~olostomy/ileostomy • **N**~~n~~ausea/vomiting • **R**~~r~~ecent abdominal surgery • NPO/taking nothing by mouth Clinical record documentation indicating that any of the above clinical contraindications (or any other appropriate clinical contraindication) w**ere**~~as~~ present is sufficient to select ~~code~~**response** "1, No, but there is documentation of why a bowel regimen was not initiated or continued" for N0520A.	Grammatical edit
2N	2N-6	[In the examples for N0520, changed all instances of "code" to "response."]	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2N	2N-6	[In the examples for N0520, Situation A, made the following change] **Explanation**: Even though…(diarrhea). Thus, select **response** ~~code~~ "1" for N0520A and skip to Item Z0400.	Grammatical edit
2N	2N-6	[In the examples for N0520, made the following change in Situations B and C.] "Polyethylene glycol 17 g PO with full glass of water **once daily**."	Text updated to reflect most recent CMS guidance
2N	2N-7	[In the examples for N0520, made the following change in Situation C.] Even though the patient's clinical record shows that a bowel regimen was initiated, **because the patient is not on an opioid,** do not complete Item N0520 ~~since the patient is not on an opioid~~.	Grammatical edit
2N	2N-7	[In the examples for N0520, at the beginning of Situation D, made the following changes.] **Clinical documentation of initial assessment dated 07-23-2015 shows, "comfort pack in patient's home and on stand-by. Instructed patient and family on what medications are in the comfort pack, including pain medication."** ~~Standing order dated 07-23-2014 shows "Oxycodone 10 mg every 4 hours, PRN for pain;~~ **Order dated 07-23-2015 shows,** "Polyethylene glycol 17 g PO with full glass of water **once daily." Clinical note dated 07-25-2015 reads, "caregiver called and reported patient was in moderate pain. Instructed caregiver to open comfort pack and begin giving patient oxycodone 10 mg every 4 hours as needed for pain."**	Text updated to reflect most recent CMS guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2N	2N-7	[In the examples for N0520, Situation D, under HIS Response Selection, made the following change.] **N0510B: Date PRN opioid initiated or continued:** Enter "07-**25**~~2014~~**2015**."	Text revised to improve clarity
2N	2N-7	[In the examples for N0520, Situation D, made the following changes.] • **Explanation:** For Item N0500**A,** ~~since~~**because there is not scheduled opioid,** the ~~appropriate course of action is to select~~**response** "0, No" **should be selected.** ~~for N0500A~~**For N0510A, the hospice would select** ~~code~~**response "1, yes"** ~~since~~**because clinical record documentation shows there was a comfort kit including a PRN opioid (oxycodone) for pain and there is documentation that the nurse instructed the patient/caregiver to begin using the treatment. For N0510B, use the date on which the nurse instructed the patient/family to begin using the treatment, which was 07-25-2015.** ~~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.~~**For N0520A, select "1, Yes." For N0520B, enter the date of the order for polyethylene glycol.**	Text updated to reflect most recent CMS guidance
2Z	2Z-1	[In Section Z: Rationale, made the following changes.] • Section Z is to be used by the provider~~,~~ and should be retained **and archived** by the provider in accordance with provider policies and procedures related to patient information. • Item Z0400…. The signatures in Z0400 are used to certify that the information the individual(s) provided is accurate and that ~~he or she was~~**the signer was** authorized to collect the information ~~and~~ document**ed** on the HIS.	Text revised to improve clarity

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2Z	2Z-2	[In the item-specific instructions for Z0400, second paragraph, made the following change.] 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~~ **as well as** the date completed.	Grammatical edit
2Z	2Z-2	[In the item-specific instructions for Z0400, last paragraph, made the following change.] Persons signing Z0400 are certifying that the information in the HIS record, to the best of ~~his/her~~**their** knowledge, most accurately reflects documentation in the patient's clinical record.	Grammatical edit
2Z	2Z-2	[In the item-specific tips for Z0400, made the following addition to the first bullet.] • Z0400 is not submitted as part of the HIS record in the QIES ASAP system~~;~~ **it** ~~is at the discretion of the hospice to~~ **developing internal policies and procedures for completing and archiving Z0400 is up to the discretion of the hospice.**	Text added to reflect most recent CMS guidance
2Z	2Z-2	[In the item-specific instructions for Z0500, made the following changes.] 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 **in Z0500B** the date when he or she signs ~~Z0500B~~**Z0500A**. ~~Z0500B.~~	Text revised to improve clarity

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
2Z	Not applicable	[In the item-specific tips for Z0500, added the following bullets.] • **Z0500A is not submitted as part of the HIS record in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system; it is at the discretion of the hospice to develop internal policies and procedures for completing and archiving Z0500A.** • **In the case of a Modification or Inactivation Request, Z0500B should contain the original date on which the record was completed. Do not change Z0500B unless the date in Z0500B in the original record was incorrect and the modification request is to correct the date in Z0500B.**	Text added to reflect most recent CMS guidance
3.1	3-1	[In the first paragraph of Section 3.1, made the following changes.] Hospices must complete and submit required HIS records to **the Centers for Medicare & Medicaid Services' (**CMS's**)** Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Each provider …HQRP website at **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html**~~http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/.~~	Text revised to improve clarity, more direct link
3.1	3-1	[In the third paragraph of Section 3.1, made the following changes.] Other information**,** such as user's guides and bulletins**,** may also be found on the hospice welcome page.	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
3.2	3-2	[In Section 3.2, made the following changes.] • Completion **t**~~T~~iming 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,…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, …7 days. • Submission **t**~~T~~iming 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 **the Event Date** 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, …30 days. – For HIS-Discharge records (A0250 = 2)**,** the Submission Date may be no later than 30 days from the Discharge Date (A0270). Therefore,… 30 days.	Grammatical edit
3.3	3-2, 3-3	[In section 3.3, under "Fatal File Errors," made the following changes.] • …Examples of fatal file errors include **the following**: – The file is not a ZIP file**.** – The records in the ZIP file cannot be extracted**.** – The file cannot be read**.**	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
3.3	3-3	[In section 3.3, under "Fatal Record Errors," made the following change.] – Out-of-range responses (for example, the valid ~~codes~~**responses** for the item are 1, 2, **and** 3**,** and the submitted value is 6).	Grammatical edit

3.3	3-3	[In section 3.3, under "Warnings (Non-fatal Errors)," made the following changes.]
		
		  • …Examples of warnings include **the following**:
		
		   – 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~~
			Grammatical edit

3.3	3-4	[In Section 3.3, deleted the following text.] 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.qtso.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/.~~	Text updated to reflect most recent CMS guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
3.4	3-4	[In the last bullet of Section 3.4, made the following change.] • If an error is discovered in a record that has been accepted by the QIES ASAP system, **m**~~M~~odification or **i**~~I~~nactivation procedures must be implemented by the provider to ensure that the QIES ASAP system information is corrected.	Grammatical edit
3.6	3-5	[In the second paragraph of Section 3.6, made the following change.] 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~~**response selection** errors, or other errors.	Text revised to improve clarity
3.6	3-5	[In Section 3.6, above the "Modification Requests" subsection, made the following change.] In addition, it is suggested that the hospice keep a copy of inactivated records. **Copies of HIS records can be maintained in electronic format.** For more details on maintenance of HIS records, see **Chapter 1**.	Text updated to reflect most recent CMS guidance
3.6	3-6	[In Section 3.6, in the "Modification Requests" subsection, made the following changes to Record Event Identifiers.] • A0220**:** Admission Date (on a HIS-Admission record A0250 = 01)	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **<u>bold and underlined</u>** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
3.6	3-6	[In Section 3.6, in the "Modification Requests" subsection, made the following changes.] **<u>Note: In the case of a Modification or Inactivation Request, Z0500B should contain the original date on which the record was completed. Do not change Z0500B unless the date in Z0500B in the original record was incorrect and the modification request is to correct the date in Z0500B.</u>** Note: File creation software varies on how **<u>M</u>**~~m~~odification **<u>R</u>**~~r~~equest records are created. Please contact your software vendor for specific instructions.	Text updated to reflect most recent CMS guidance

3.6	3-6, 3-7	[In Section 3.6, in the "Modification Requests" subsection, made the following changes.]
		
		1. The system will attempt to locate the existing record in the QIES ASAP database for th**<u>e</u>**~~is~~ hospice using specific identifiers:
		
		  • **<u>L</u>**~~l~~ast name
		  • **<u>F</u>**~~f~~irst name
		  • SSN
		  • **<u>B</u>**~~b~~irth date
		  • **<u>G</u>**~~g~~ender
		  • **<u>F</u>**~~f~~acility identifier (facility and state code)
		  • **<u>E</u>**~~e~~vent identifiers (for example, the reason for record and admission or discharge date)
			Grammatical edit

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
3.6	3-7	[In Section 3.6, in the first paragraph of the "Inactivation Request" subsection, made the following change.] 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,…and when one or more of the event identifiers ~~and/~~or patient identifiers is found to be in error.	Grammatical edit
3.6	3-7	[In Section 3.6, in the "Inactivation Request" subsection, made the following change under Record Event Identifiers.] • A0220**:** Admission Date (on a HIS-Admission record A0250 = 01)	Grammatical edit
3.6	3-8	[In Section 3.6, in the "Inactivation Request" subsection, made the following changes.] Note: Any item in the previous list that was submitted as part of the original record must also be submitted as part of the **I**~~i~~nactivation **R**~~r~~equest and values for each item must match in the erroneous record and the inactivation record.	Grammatical edit

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation

3.6	3-8	[At the end of Section 3.6, made the following changes.]
		
		1. The system will attempt to locate the existing record in the QIES ASAP database for this hospice using specific identifiers:
		
		   • **L**~~l~~ast name
		
		   • **F**~~f~~irst name
		
		   • SSN
		
		   • **B**~~b~~irth date
		
		   • **G**~~g~~ender
		
		   • **F**~~f~~acility identifier (facility and state code)
		
		   • **E**~~e~~vent 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.
			Grammatical edit

3.7	3-9	[In the first paragraph of Section 3.7, made the following change.] These errors **most likely**~~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.	Text revised to improve clarity
A	Not applicable	[In Appendix A, in the "Acronyms" section, added the following acronym.] **HART— Hospice Abstraction Reporting Tool**	Acronym missing from list

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
A	A-1	[In Appendix A, in the "Acronyms" section, made changes to the following acronyms.] LTC—Long**-**Term Care LTCH—Long**-**Term Care Hospital PCA—Patient-**C**~~c~~ontrolled Analgesia	Grammatical edit
A	A-1	[In Appendix A, in the "Definitions" section, made the following changes.] ~~The admission date is the date the patient/family chooses hospice to begin~~ **The date on which the hospice becomes responsible for the care of the patient.** For Medicare patients, it is the same as the effective date of the hospice benefit **election (or re-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.	Added text to reflect most recent CMS guidance
A	A-2	[In Appendix A, in the "Definitions" section, made the following changes.] **Hospice Item Set (HIS): ….**National Quality Forum (NQF)**–**endorsed measures and one modified NQF measure. Hospices...	Grammatical edit
A	A-2	[In Appendix A, in the "Definitions" section, made the following changes.] **Bowel Regimen: ….M**~~m~~ilk of **M**~~m~~agnesia. A bowel regimen is specific for the patient. **Care Process Item: ….**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. **Comfort Kit (or pre-printed admission order): A set of medications or treatments reviewed and approved by medical staff and consistent with nationally recognized and evidence-based standards, routinely ordered for all patients upon admission to the hospice (also known as, comfort kits, comfort packs, emergency kits, E kits).**	Text updated to reflect most recent CMS guidance

(continued)

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
A	A-2, A-3	[In Appendix A, in the "Definitions" section, wrote out the acronyms CMS, QIES, and ASAP on their first appearance in the section.]	Text revised to improve clarity
A	A-3	[In Appendix A, in the "Definitions" section, made the following changes.] PRN **Order: An order prescribed on a patient-by-patient basis, for medication or treatment that is to be used on an "as needed" basis for specific signs and symptoms a patient is having or may have based on patient-specific conditions or assessment findings.** ~~Opioid: Opioids that are administered on an "as needed" (PRN) basis, providing more flexibility in dosage for the management of pain.~~ **Scheduled** Order: **An order prescribed on a patient-by-patient basis for medication or treatment that is to be used on a scheduled basis because of patient-specific conditions or assessment findings. Includes orders to start and to continue scheduled administration or treatment use.** ~~Opioid: Opioids that are administered on a regularly scheduled basis.~~	Text updated to reflect most recent CMS guidance
B	B-1	[In Appendix B, wrote out the acronyms CMS and ASAP on their first appearance.]	Text revised to improve clarity
B	B-1	[In Appendix B, under "Websites," made the following change.] 1. 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.	Grammatical edit
B	B-1	[In Appendix B, under "Help Desks," made the following change.] • E**-**mail: HospiceQualityQuestions@cms.hhs.gov	Grammatical edit

<div align="right">(continued)</div>

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
B	B-2	[In Appendix B, under "Listservs," made the following change.] Open Door Forum (ODF) listserv: CMS regularly holds Open Door Forums in which ~~CMS~~ **it** makes announcements pertinent to various programs/care settings.	Grammatical edit
B	B-2	[In Appendix B, under "Listservs," made the following change.] 2. **MLN Connects® Provider eNews** ~~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: **http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html** ~~https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819~~	Text updated to reflect most recent CMS guidance
C	C-1	[In Appendix C, wrote out the acronyms CMS and FY on their first appearance.]	Text revised to improve clarity
C	C-1	[In the first paragraph of Appendix C, made the following change.] Current…(NQF)**–**~~-~~endorsed measures and a modification of one NQF-endorsed measure.	Grammatical edit
C	C-3	[In Appendix C, in the measure specifications of NQF #1641, made the following change to the numerator time window.] (**[**F2000B **–** ~~-~~ A0220 ≤ 5**] and/or**~~;~~ **[**F2100B **–** ~~-~~ A0220 ≤ 5**] and/or**~~;~~ **[**F2200 **–** ~~-~~ A0220 ≤ 5**]**)	Text updated to reflect most recent CMS guidance
C	C-4	[In Appendix C, in the measure specifications of modified NQF #1647, made the following change to the numerator time window.] **Prior to admission or w**~~W~~ithin 5 days of the admission date (F3000B - A0220 ≤ 5).	Text updated to reflect most recent CMS guidance

Chapter and/or Section in V1.01	Page # in V1.01	Revised Text (added text appears in **bold and underlined** font, deleted text appears in ~~strike-through~~; for ease of reading, some sections of unchanged text are indicated by ellipses.)	Explanation
C	C-6	[In Appendix C, in the measure specifications of NQF #1637, made the following change to the numerator.] 2. The comprehensive pain assessment included *at least **five**~~5~~ of the* ...(**five**~~5~~ or more of J0910C boxes checked).	Grammatical edit
C	C-6	[In Appendix C, in the measure specifications of NQF #1637, made the following changes to the denominator exclusions.] 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 report~~ed~~ that they ha**ve**~~d~~ no pain during the initial nursing assessment (J0900C = 0).	Grammatical edit
C	C-8	[In Appendix C, in the measure specifications of NQF #1638, made the following change to the numerator time window.] Within 1 day …(J2040B **–** J2030B ≤ 1).	Grammatical edit
C	C-8	[In Appendix C, in the measure specifications of NQF #1638, made the following changes to the denominator exclusions.] 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 screen~~ed~~ negative for shortness of breath during the initial nursing assessment (J2030C = 0).	Grammatical edit
C	C-9	[In Appendix C, made the following changes to the name of NQF #1617.] Patients Treated with an Opioid **W**~~w~~ho **A**~~a~~re Given a Bowel Regimen	Grammatical edit