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

This document is intended to provide guidance on HIS-related questions that were received on the Hospice Quality Help Desk during the second quarter (April – June) of 2014. Guidance contained in this document may be time-limited, and may be superseded by guidance published by CMS at a later date.

General HIS Questions

Question 1. If a patient is discharged (for any reason) prior to the end of the initial or comprehensive assessment periods, how should we respond to items on the HIS? In some cases, the patient may not have been screened for pain, dyspnea, etc.?

Answer 1. If the patient is admitted to the hospice organization, the hospice must submit a HIS-Admission and HIS-Discharge record, regardless of the length of stay. If a patient is discharged before a HIS-related care process takes place, answer "no" to the gateway question (part A of each care process item, e.g., F2000A) and then follow skip patterns as indicated on the HIS. For example, if the patient was discharged before a discussion about CPR occurred, answer "0, No" to F2000A. Skip patterns in then HIS then direct providers to skip over F2000B and continue to Item F2100. Do not leave items blank unless directed to do so by skip patterns on the HIS.

Question 2. With respect to completing the HIS-Admission and HIS-Discharge, what processes are hospices to follow when a patient is transferred from one CCN number to another? For example, what if the patient is admitted to our hospice under home care, but moves to our inpatient unit? In this situation, the patient is still under the care of our organization, but has moved from one CCN (CMS Certification Number) to another. How should we complete the HIS?

Answer 2. HIS reporting is at the CCN level. If the patient moves from one CCN to another, the first CCN should complete a HIS-Admission and Discharge, as should the second CCN.

Question 3. We are undergoing the Medicare survey and certification process. We have received our certification, but have not yet received our CCN (CMS Certification Number). While we await receipt of our CCN, how and when should we submit HIS data? We cannot register for the User IDs needed to submit HIS data until we have our CCN. Additionally, on what patients are we responsible for submitting HIS data during this time period?

Answer 3. As of July 1, 2014, hospices are required to submit a HIS-Admission and HIS-Discharge for all patient admissions on or after the effective date of hospice's

Medicare certification. This means hospices who experience a lapse between Medicare certification and receipt of their actual CCN should submit HIS data for all patient admissions to their hospice on or after the effective date of Medicare certification.

Since hospices cannot submit data to the QIES ASAP system without a valid CCN, if a hospice has been certified but has not yet received their CCN, that hospice may have to hold HIS record submission until their CCN is received. CMS realizes that this may require hospices to submit some HIS records past the specified submission deadlines (which is Admission Date + 30 calendar days for the HIS-Admission and Discharge Date + 30 calendar days for the HIS-Discharge). This is permissible. Submitting a HIS record past the submission deadline is a nonfatal (warning) error in the QIES ASAP system. Once the CCN is received, the hospice should submit HIS records for all patient admissions on/after the effective date of their Medicare certification.

Question 4. When am I required to submit an HIS-Discharge? Am I required to submit an HIS-Discharge in the following situations?:

- **<u>Hospice fails to meet face-to-face requirement:</u> When the hospice fails to meet the face-to-face requirement, the patient must be "discharged." These discharges are a "paper discharge" as the hospice continues to service the patient. Do we submit an HIS-Discharge record for this "paper" discharge?**
- **<u>Patient's payer source changes:</u> The current practice for when a patient becomes Medicare eligible during the course of care is to do an "administrative" or "paper" discharge and admission so that there is a new start of care date for the Medicare billing, with a new benefit election and certification statement. Do we submit an HIS-Discharge record for this "paper" discharge?**
- **<u>Patient revokes Medicare benefit, then re-elects Medicare benefit:</u> For example, a cancer patient wishes to start an experimental treatment, not covered under the Medicare Hospice Benefit. The patient remains on service at our hospice, but revokes and then re-elects the Medicare Hospice benefit.**

Answer 4. In general, a HIS-Discharge is not required for patients that remain under a hospice's care with no interruption in hospice service. In all of the situations listed above, since the patient remained under the hospice's care with no interruption in service, the hospice would not be required to submit a HIS-Discharge because of a missed face-to-face encounter, a change in payer source, or revocation and re-election of the Medicare hospice benefit. 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.

Treatment Initiation

Question 5. Could you please clarify how "treatment initiation" is defined for Items J2040, N0500, N0510, and N0520 in the case of standing orders and/or comfort packs? The Quarter 1 Q+A document states: "For the purposes of HIS item completion, standing orders are permissible. For 'date treatment initiated' for standing orders, use the date on which the hospice received the order." Could you provider further detail on this guidance? Does "when the order is received", mean when the order was signed or when the nurse instructed the patient to begin using the drug/doctor was notified of the implementation of the drug? For example:

- **We have standing orders for all patients that include Morphine and oxygen to treat shortness of breath whenever it is indicated. We order a comfort kit at the time of admission that includes morphine for all patients. The morphine is in the home but we may not use it for a few months. So, the morphine is ordered, in the home, and on standby. Is the morphine considered "initiated" since it was ordered, delivered to the home, and on standby? In other words, does the morphine being delivered to the home meet the definition of "initiated" or only if the patient will start actually using the morphine? We also have oxygen on the standing orders and do not order the oxygen until needed. Do we consider the oxygen as "initiated" since it was not delivered to the home yet?**
- **There are standing orders on the chart for Morphine 2 mg PO/SL PRN pain/dyspnea. An order can be on a patient's chart but not initiated until it is needed (meaning we do not actually have the morphine in the patient's home until it is needed). How do we define "initiation" in this situation?**
- **May we count comfort kits that are placed in the home for eventual management of symptoms as initiation of treatment for dyspnea and/or opioids with bowel regimen? For example, patients may receive a symptom management kit and/or a bowel management kit in their homes but similar to standing orders, the meds are not initiated until a symptom issue is present. If we receive an order for these kits, does this count as "initiation" even if there is no other documentation about education or instructions to begin using the medication?**

Answer 5. For date treatment initiated, in the case of standing orders or comfort packs, you should consider the order initiated when: 1) the hospice has received the order 2) the patient and / or caregiver has access to the treatment 3) there is documentation that the patient and/or caregiver has been instructed to use the treatment for the relevant symptom.

In the situations listed above, treatments that are delivered to the patient's home and are "on standby" are not considered initiated until the hospice instructs the patient/family to begin using the treatment for the relevant symptom.

Note: this Q+A amends Question #12 in the April 2014 Quarterly Q+A document. Providers should consider this Q+A an addendum to the April 2014 Question #12.

Section Z: Record Administration

Question 6. Could you clarify the policies for completing Z0400 and Z0500?

Since Z0400 and Z0500A are not submitted to the QIES ASAP system as part of the HIS record, hospices can develop their own internal policies for completing these items. Z0500B is submitted as part of the HIS record. Thus, for Z0500B, hospices should ensure valid response values for this item are used. Providers should review the final technical specifications for valid item values. The technical specifications can be found here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html.