Hospice Quality Reporting Program (HQRP)

Hospice Item Set (HIS)
Questions and Answers (Q+A)
and Quarterly Updates

July 2015

*This document is intended to provide guidance on HIS-related questions that were received by the Hospice Quality Help Desk during the 2nd quarter (April – June) of 2015 (**Section 1**). This document also contains quarterly updates and events from the 2nd quarter (**Section 2**), as well as upcoming updates for the next quarter (**Section 3**). Guidance contained in this document may be time-limited, and may be superseded by guidance published by CMS at a later date.*

Section 1:
HIS Quarterly Questions and Answers

Section A: Administrative Information (Items A0205, A2115, and A1802)

Question 1: I'm seeking clarification for SNF versus NF/LTC as it relates to A0205 and A1802.   Are the following scenarios and HIS item response selections correct?

- **If a patient is in a dually-certified nursing facility and is in the NF portion of the facility (receiving unskilled care), we would answer NF/LTC on the HIS record.**

- **If a patient is in a dually-certified nursing facility and is in the SNF portion of the facility (receiving skilled care), we would answer SNF on the HIS record.**

   Answer 1: This item is clarified in V1.02 of the HIS Manual and the Q&A October 2014 that can be found here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html. For purposes of completing Items A1802 and A0205, SNF is not synonymous with nursing facility. The response option for SNF is to be used for patients in a skilled nursing facility (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 response option for SNF; instead, use the response option for long-term care facility (also known as NF or nursing facility). You would answer based on the level of care the patient is receiving. So based on the scenarios presented in your question, if the patient is in the NF portion of a dually-certified facility receiving unskilled care, you would select the response option for NF on the HIS. If the patient is in the SNF portion of a dually-certified facility receiving skilled care, you would select SNF on the HIS.

Question 2: A patient is being discharged from hospice because she/he wants to pursue curative and/or aggressive treatment. I believe that the reason for discharge (A2115. Reason for Discharge) in the HIS record should be "2.Revoked" even if Medicare is not the payer but there are some disagreements about it. Could you clarify?

> **Answer 2:** For the purposes of HIS reporting, revoked can be used in these circumstances where the patient/family revokes "hospice care", not the Medicare Benefit. So if a patient/family choses to pursue aggressive or curative treatment, the correct response for item A2115 should be "02" revoked. This means they are revoking hospice care, not the Medicare Hospice Benefit.

Section F: Preferences (Item F3000)

Question 3: Many times the spiritual counselors are not able to make an in person visit within the specified timeframe (within 5 days of the admission) but they are able to speak with the patient and family by phone after the patient is admitted to hospice. During their conversation via the phone they are able to discuss a number of issues and could also get information that would address the spiritual/existential concerns of the patient.

> **Answer 3:** While these conversations are best held face-to-face, phone conversations with patients/families about spiritual/existential issues can be used to answer yes to item #F3000 as long as the clinical documentation supports that a **discussion** (as defined in the HIS Manual) was had with the patient and/or caregiver.

Section J: Pain (Item J0900)

Question 4: What is the effective date of the change in pain severity guidance that is included in V1.02 of the HIS Manual? (The change that states that moderate pain is 4-6 on a 10-point numeric scale and severe pain is 7-10 on a 10-point numeric scale. If the change is effective according to the date listed on V1.02 of the HIS Manual (June 28, 2015) this leaves little time for vendors to update our software systems.

> **Answer 4:** The change in how moderate and severe pain is defined is included in V1.02 of the HIS Manual, meaning this change will be effective 6/28/15. This change in severity guidance does not impact the data submission specifications, thus, this change in guidance for J0900C is not reflected in either version of the data submission specifications (either V1.01 or V1.02). The change in severity guidance did not require a change to the data submission specifications based on the following logic: J0900C response options include no "crosswalking" on the actual HIS data item. J0900C response options on the actual item read as follows: The patient's pain severity was: 0. None, 1.Mild, 2.Moderate, 3.Severe, or 9.Pain not rated. Thus, since the actual item does not include any crosswalking to severity scores, guidance in V1.02 of the HIS Manual was changed without requiring a change to data submission specifications. Providers should be able to comply with guidance in V1.02 without any vendor changes. Moreover, prior to the change in guidance for J0900C, "crosswalking" of mild/moderate/severe to a 10-point numeric rating that is provided in the HIS Manual has always been provided as **suggested** guidance. Since the implementation of the HIS on 7/1/14, the Quality Help Desk has instructed providers that their selection of mild/moderate/severe does not have to align with 1-10 point crosswalking provided in the Manual. Thus, if providers use a different cutoff for mild/moderate/severe based on the particular 10-point numeric scale used at their hospice, providers can select mild/moderate/severe based on other 10-point numeric scale equivalents.

Section J: Respiratory Status (Item J2040)

Question 5: Regarding Item-Specific Instructions and Tips for Item #J2040 Treatment for SOB. It indicates that inhaled bronchodilators order should indicate that these are intended to address the patient's shortness of breath. We currently are not doing this except for "PRN" medications. Is this something we should be doing or was this overlooked? My understanding is that inhaled bronchodilators are prescribed for shortness of breath.

> **Answer 5**: Inhaled bronchodilators or inhaled corticosteroids prescribed on a routine basis are considered used for SOB. In the case of scheduled bronchodilator use, there is no need to address the clinical indication. Any other medications, if given on a routine basis for SOB, would need to be designated for clinical use. For example, steroids, opioids, anxiolytics can all be used for different clinical indications. In these cases, the order should state what the clinical indication is for the prescription. Please note that for clinical best practice, a prn order should indicate a clinical indication.

Section N: Medications (Item N0510)

Question 6: Is proactive education on the use of a prn medication considered "initiating"? Updated guidance in V1.02 of the HIS Manual states it is not, however the example in Situation D on page 2N-9 of the HIS Manual states "the patient /family was instructed on what medications are in the comfort pack" and you select "yes" for N0510A in this example. The guidance seems conflicting since proactive education is not considered sufficient for treatment initiation, but in Situation D, proactive guidance is given and you select "yes" for N0510A to indicate a PRN opioid was initiated.

> **Answer 6**: Guidance in the HIS Manual indicates that proactive education **alone** is insufficient to consider a treatment "initiated". In the example in Situation D in the HIS Manual, the nurse provided proactive education to the patient/family about what medications are included in the comfort pack on 7/23. On 7/23, medications in the comfort pack would not be considered "initiated" since the hospices had provided proactive education **only.** In Situation D, you selected "1, Yes" based on the fact that on 7/25, the nurse instructed the patient/caregiver to begin using the oxycodone 10mg from the comfort pack every 4 hours as needed for pain. In this situation, it is not the proactive education that triggers "initiation", it is the instruction to begin use of the treatment on 7/25 that triggers initiation.

HIS Reporting Requirements

Question 7: Can you provide me with information on the quality reporting requirements for 2016?

> **Answer 7:** Currently (CY15), the Hospice Quality Reporting Program (HQRP) is a 'pay-for-reporting' program. Fulfillment of the HQRP requirements will be monitored and compliance will be determined based on completing a calendar year's submissions for patient admissions. No specific reporting rates or thresholds indicating HQRP compliance have been published by CMS. The 2 percentage point penalty for non-compliance with reporting is based on the hospice's overall payment rate. The hospice proposed rule, which includes HQRP requirements and updates (for CY16), was published in the Federal Register as of May 2015. Once the proposed rule is published, providers have 60 days to review the proposed rule and submit comments to CMS. CMS then reviews all public comments, responding to comments and finalizing requirements

in the final rule. Publication of the hospice proposed rule can be obtained in the Federal Register at: https://www.federalregister.gov/.

Please note that there are timeliness criteria highlighted in the proposed rule.

For general information on the rulemaking process, please visit the "Proposed Regulations" portion of the CMS website: http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html?redirect=/QuarterlyProviderUpdates/.

Question 8: According to the updated HIS manual: A patient is considered admitted for the purposes of the HIS if: 1) There is a signed election statement AND 2) The patient did not expire prior to the effective date of the election of hospice AND 3)The hospice made a visit in the setting where hospices services are to be initiated.

- **Scenario #1:** The patient signed an election statement on Monday with an effective date of Tuesday. The nurse went Tuesday afternoon and the patient had passed right before she walked in so she did a pronouncement visit. In this particular case was the patient admitted to hospice for the purposes of the HIS audit?

- **Scenario #2:** The consents were signed on the admission date, the nurse was **in the process** of a visit where the care was to be provided, but the patient died during the admission assessment.

- **Scenario #3:** A patient expires in the ambulance on his/her way to the inpatient hospice. The ambulance brings the body to the hospice and the body is brought inside the hospice to await the funeral home. Conditions 1 and 2 have been met. Does this patient need a HIS completed?'

Answer 8: As you have stated, for HIS purposes, there should be a signed election of hospice care, the patient did not expire prior to the effective date of the election of hospice care AND a visit was made in the home where hospice services were to be delivered.

- In Scenario #1, the hospice **would NOT** be required to submit an Admission or Discharge HIS for that patient. No part of the assessment had been completed.

- In Scenario #2, the hospice **would** be required to submit an Admission and Discharge HIS because the assessment had begun.

- In Scenario #3, the hospice **would NOT** be required to complete and submit a HIS record for this patient. The patient expired prior to the initiation of any assessment.

HIS Submission

Question 9: Is there a document that tells how to read the warnings on the Hospice Item Set Final Validation report? If so, where can it be accessed?

Answer 9: Error messages and warnings are detailed in the HIS Data Submission Specifications available here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html as well as in Section 5 of the HIS Submission User's Guide, which is available here: https://www.qtso.com/download/Guides/hospice/Users_Sec5.pdf. We recommend you follow-up with the QTSO HelpDesk if you have questions about information contained in either of these 2 documents. You can contact the QTSO HelpDesk by phone at (877) 201-4721 or by email at help@qtso.com.

Question 10: In the HIS Manual, Chapter 3, Section 3.6, it states that hospices should correct any errors necessary to ensure that the information in the QIES ASAP system is reflected accurately in the patient record. It says that inaccurate information entered into the QIES system may affect the hospice quality reporting results and that a HIS record may be corrected even if subsequent records had already been accepted. My question is how far back should the agency go to correct an error. Can a correction be made 31-60-90 days after submitting the HIS-Admission or HIS-discharge records?

> **Answer 10:** Hospice providers are urged to make corrections and/or submit inactivations or modifications as quickly as possible after errors are identified so the national data repository will be as current and accurate as possible for quality reporting purposes. Since the HIS is currently an abstraction tool, when clinical corrections are made to the HIS, clinical documentation and the plan of care should support that correction. The hospice should establish a policy and procedure to review the HIS validation reports upon receipt and correct HIS submissions as soon as possible.

Reconsideration Requests

Question 11: Our hospice organization received the letter from CMS in regards to the HIS data submission and the potential 2 percentage point reduction in payment for FY16. In the CMS notification we received we were instructed to send our letter to the following email address, however we are getting a rejection when attempting to send this letter: HospiceQRPReconsiderations@cms.gov.

> **Answer 11:** The correct email address is HospiceQRPReconsiderations@cms.hhs.gov. As a result of this error, CMS will accept Reconsiderations Requests through 7/24/15.

HIS Manual V1.02

Question 12: Can you explain the effective date of the HIS Manual V1.02 and how this correlates with the data submission specifications that are on the "HIS Technical Information" portion of the CMS HQRP website? V1.02 of the data submission specifications are effective April 1, 2016, but V1.02 of the HIS Manual is effective June 28, 2015.

> **Answer 12:** Changes to V1.02 of the HIS Manual do not correlate with changes in V1.02.0 of the data submission technical specifications. These two documents run on separate versioning schedules. **Changes in V1.02 of the HIS Manual correlate with changes that were in V1.01.0 of the data submission specifications, which were effective 6/28/15** (the same effective date as V1.02 of the HIS Manual).

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

Section 2:
What you may have missed from the 2nd Quarter of 2015

MLN Connects National Provider Call covered V1.02 of the HIS Manual

- V1.02 of the HIS Manual, along with a change table outlining changes from V1.01 to V1.02 was posted for provider download on the "Hospice Item Set (HIS)" portion of the CMS HQRP website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html. V1.02 of the HIS Manual provides clarifications of HIS item definitions and expectations for use.

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

- CMS hosted an HIS-focused MLN Connects National Provider Call on June 17th, 2015. This presentation covered updates that were made to the HIS Manual from V1.01 to V1.02.

- The MLN Connects Call was recorded and transcribed. The recording and transcription are available for provider download on the "MLN Connects National Provider Calls" portion of the CMS website: http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2015-06-17-Hospice.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending. CMS also developed a frequently asked questions (FAQs) document to address provider questions that were received prior to the MLN Connects National Provider Call. The FAQs document as well as presentation slides with speaker notes are available for provider download on the "Hospice Item Set (HIS)" portion of the CMS HQRP website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html.

Initial notices of noncompliance issued June 2015

- CMS issued initial notices of noncompliance in June 2015.

- To meet HQRP FY 2016 reporting requirements, hospices must have collected HIS data for patient admissions from July 1, 2014 through December 31, 2014. All quality data must have been submitted to CMS by the final deadline of April 1, 2015, after which CMS ran the Annual Payment Update (APU) report to determine those providers who were/were not compliant with the quality reporting requirements.

- Any hospice found not to have submitted their HIS data as required was found non-compliant with the HQRP reporting requirements and may have been subject to the 2 percentage point reduction in their APU.

- Any provider receiving an initial notification of noncompliance has the opportunity to submit a request for reconsideration to CMS within 30 days from the date the non-compliance notification letter was issued. CMS will continue to accept Reconsideration Requests through 7/24/15.

- Further details about submitting a request for reconsideration can be found on the "Reconsideration Requests" portion of the CMS HQRP website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html.

- Providers with questions about the reconsideration process should contact the Reconsideration HelpDesk at HospiceQRPReconsiderations@cms.hhs.gov.

Section 3:
What's coming up in 2015

Hospice final rule to be published late summer

- The FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements proposed rule, which includes HQRP requirements and updates, was published in May 2015 in the Federal Register at: https://www.federalregister.gov/articles/2015/05/05/2015-10422/medicare-program-fy-2016-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting. Providers had 60 days to comment on proposals in the proposed rule. The comment period for the hospice proposed rule ended June 29th, 2015 and the final rule will be published later this summer.

- Rulemaking is the process through which CMS proposes and finalizes any new requirement for the HQRP. Once the proposed rule is published, providers have 60 days to review the proposed rule and submit comments to CMS. CMS then reviews all public comments, responding to comments and finalizing requirements in the final rule.

- For general information on the rulemaking process, please visit the "Proposed Regulations" portion of the CMS website: http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html?redirect=/QuarterlyProviderUpdates/ or the Office of the Federal Register website: https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf