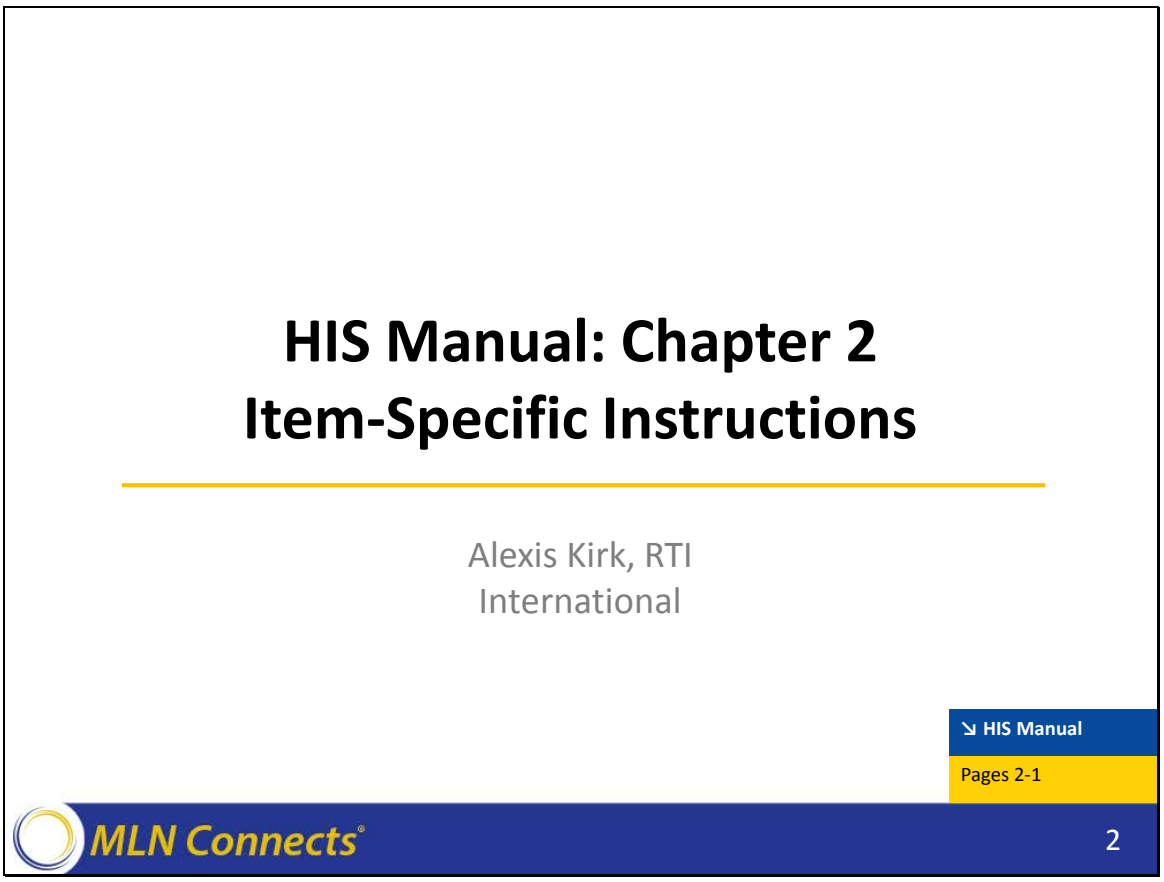
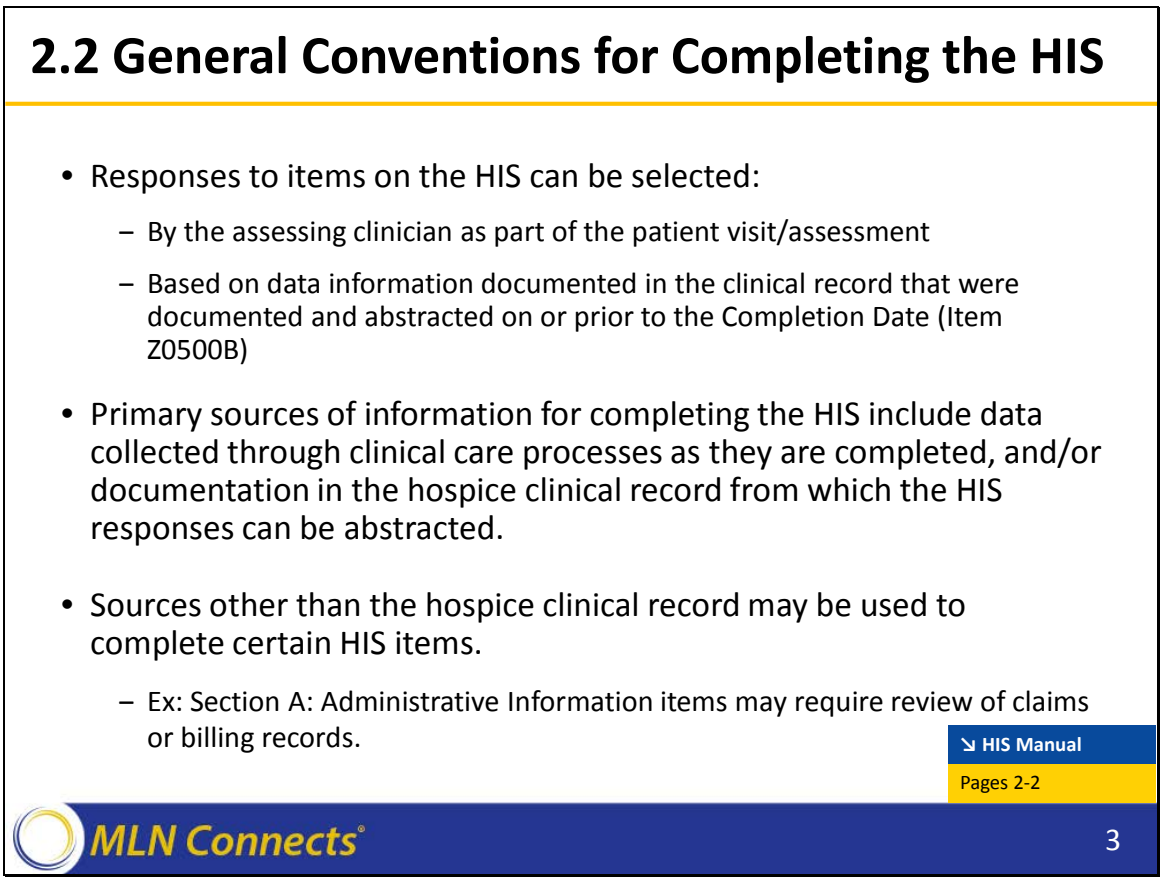
Welcome to the Centers for Medicare & Medicaid Services training presentation, “Updates to the Hospice Item Set Manual Version 1.02”.

This is the third of four modules. This module covers updates made to the Administrative Sections of Chapter 2 of V1.02 of the HIS Manual.



Now we'll move on to updates made to Chapter 2 of V1.02 of the HIS Manual. In this section of the presentation, we will begin to review Chapter 2 of the HIS Manual which contains general conventions for completing the HIS items, as well as detailed item-specific guidance.

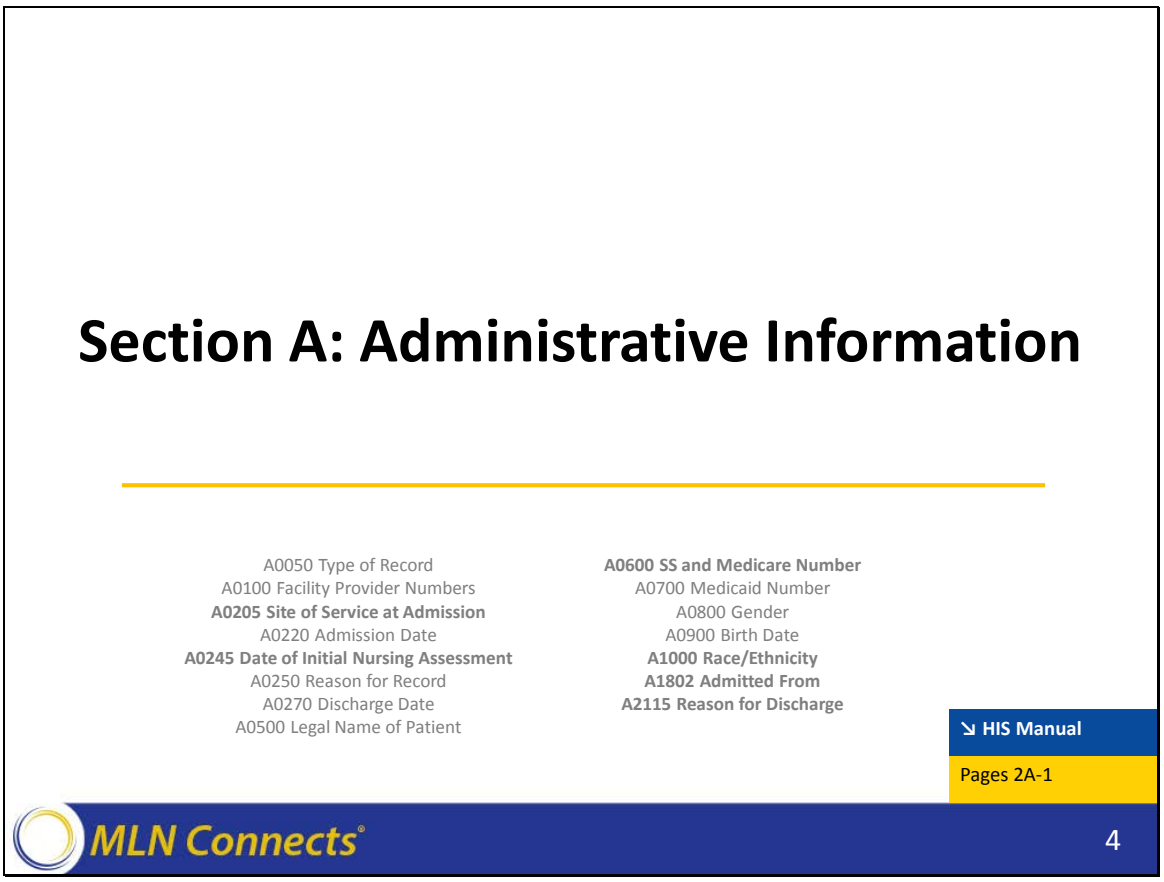


To complete each HIS item accurately and fully, hospice staff should understand what information and data each HIS item requires, and complete the item based only on what is being requested. Responses to items on the HIS can be selected by the assessing clinician as part of the patient visit and assessment, or could be based on information documented in the clinical record and abstracted on or prior to the Completion Date reported in Item Z0500B.

In general, sources external to the clinical record should not be used as documentation to complete HIS items.

However, there are some instances where the HIS data collector 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 Physician Order for Life-Sustaining Treatment (or POLST) forms, or other equivalent forms.

If the person completing the HIS does not find a care process documented in the hospice clinical record, the care process is considered not to have occurred. In these instances, complete the HIS items accordingly, following skip patterns outlined in the HIS.



We will now begin discussing in more detail the individual HIS items, and how they should be collected.

Remember that there are six sections in the hospice item set:

Three Administrative sections -- Sections A, I and Z -- that are primarily used for record-matching and identification; and three Care Process Sections -- Sections F, J and N -- which serve as the main data source for the quality measure calculations.

We will start by looking at the HIS items in Section A – Administrative Information.

Section A: Administrative Information starts on page 2A-1 of the manual and contains 15 HIS items that serve to uniquely identify each patient, the hospice from which he or she receives services, and the reason for the record. Since the focus of this training is to highlight new and refined guidance associated with the release of V1.02 of the HIS Manual, we will not be discussing every HIS item. Instead, we will focus on those items with new or updated guidance in V1.02 of the HIS Manual. Section A Items with new or updated guidance in V1.02 of the HIS Manual are listed in **bold** font on this slide.

Remember that the manual page numbers that correspond to the item or items we are discussing are listed in the bottom right corner of each slide. This may be particularly helpful for Section A, as we will be highlighting 6 of the 15 Section A items, and therefore will not be proceeding sequentially through the items.

A0205. Site of Service at Admission

A0205. Site of Service at Admission	
Enter Code ☐☐	01. Hospice in patient's home/residence 02. Hospice in Assisted Living facility 03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF) 04. Hospice provided in a Skilled Nursing Facility (SNF) 05. Hospice provided in Inpatient Hospital 06. Hospice provided in Inpatient Hospice Facility 07. Hospice provided in Long Term Care Hospital (LTCH) 08. Hospice in Inpatient Psychiatric Facility 09. Hospice provided in a place not otherwise specified (NOS) 10. Hospice home care provided in a hospice facility

- Clarification of SNF and NF presented on subsequent slide

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Pages 2A-2 – 2A-3

Instructions for completing Item A0205 begin on Page 2A-2 of the HIS Manual. Item A0205 reports the patient's site of service at admission.

When completing this item, read through the response options and definitions carefully to ensure you can differentiate the various sites of service.

We received many questions on the Quality Help Desk about the difference between response option 03 and 04 for this item, which are "Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)" and "Hospice provided in a Skilled Nursing Facility (SNF)".

We will discuss the difference between these two response options in an upcoming slide, since the distinction applies to both Item A0205 and Item A1802.

A1802. Admitted From

A1802. Admitted From. Immediately preceding this admission, where was the patient?	
Enter Code ☐☐	01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care) 02. Long-term care facility 03. Skilled Nursing Facility (SNF) 04. Hospital emergency department 05. Short-stay acute hospital 06. Long-term care hospital (LTCH) 07. Inpatient rehabilitation facility or unit (IRF) 08. Psychiatric hospital or unit 09. ID/DD Facility 10. Hospice 99. None of the above

- If the patient was in multiple settings prior to hospice admission, enter the response that reflects where the patient was at the time of referral to hospice.

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Item A1802 is on Page 2A-11 of the HIS Manual and reports where the patient was prior to the hospice admission. The response options for A1802 are very similar, but are not the same as the response options for Item A0205.

If the patient was in multiple settings prior to the admission to the hospice, choose the response option that reflect where the patient was at the **time of referral** to hospice.

For example, suppose there was a patient who was both in the hospital and at home in the week prior to admission to hospice. In this situation, the patient was in the hospital when they were referred to hospice, and were then discharged to the home 2 days prior to the start of hospice services. In this example, select response “5, Short-stay acute hospital” since the patient was in the hospital at the time of referral.

A0205 & A1802: Item-Specific Tips

- Skilled nursing facility (SNF) is not synonymous with nursing facility (NF, also known as a Long Term Care facility).
  - SNF should be used for patients in a SNF or patients in the SNF portion of a dually-certified nursing facility.
  - If patient is in a nursing facility but doesn't meet the criteria above, do not use SNF. Instead, use “NF” or “long-term care facility”

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Pages 2A-3, 2A-11

As mentioned previously, for items A0205 & A1802, a common question received on the HelpDesk is “how are Skilled Nursing Facilities (or ‘SNFs’) different from Nursing Facilities (also known as a ‘NFs’ or ‘Long Term Care facilities’)?”

For the purposes of completing Items A0205 and A1802, “SNF” is not synonymous with “NF”. To use the response option for SNF, the patient must be in a SNF, or in the SNF portion of a dually-certified nursing facility. Otherwise, choose the response option for “NF” or “long term care facility”.

A0245. Date Initial Nursing Assessment Initiated Item-Specific Instructions

- This is the date on which the initial nursing assessment (as defined in the Medicare Conditions of Participation) was initiated.
- If patient is discharged for any reason before the initial assessment is completed, enter the date on which the initial assessment was initiated.
- If no initial assessment was initiated, enter a dash ("-").

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Pages 2A-4

Item A0245 is on Page 2A-4 of the HIS Manual. This item is intended to reflect the date on which the initial nursing assessment --- as defined in the Medicare Hospice Conditions of Participation --- was initiated.

If a patient is admitted to the hospice, and an initial assessment is initiated, but the patient is discharged before it is completed, A0245 should report the date on which the initial assessment was initiated. You should report the date the initial assessment was initiated, even if the entire initial assessment was not completed, or was initiated in a site of service other than the site of service the patient is being discharged from.

However, if the patient was admitted to the hospice, but no initial assessment was initiated before the patient was discharged, new guidance in V1.02 of the HIS Manual instructs providers to enter a dash ("-") fo

Remember, HIS reporting is required for all patients meeting the 3 criteria for admission that were presented earlier. This means that if a patient meets the definition of "admitted," inability to initiate or complete an admission assessment does not eliminate the need for HIS submission for this patient. If there is a signed election statement, the patient did not expire prior to the effective date of hospice care, and a visit was made in the setting where hospice services will be initiated, the patient is considered admitted and HIS reporting is required.

A0700. Medicaid Number

A0700. Medicaid Number. Enter "+" if pending, "N" if not a Medicaid Recipient.

- If the patient refuses to supply his/her Medicaid number or the Medicaid number is unknown, leave A0700 blank.
- Enter “+” if pending, “N” if not a Medicaid recipient

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Pages 2A-9

A0700 is on Page 2A-9 of V1.02 of the HIS Manual. This item reports the patient’s Medicaid Number. For Item A0700, reporting of the patient’s Medicaid Number is used for patient identification purposes only, not for billing or payment. This means if the patient has a Medicaid number, you should enter it into Item A0700, even if Medicaid is not the payer, or if Medicaid is a secondary payer.

To complete A0700, confirm that the patient’s legal name on the HIS record matches the patient’s legal name on the Medicaid card.

Enter a “+” in the left-most box if the Medicaid number is pending.

If the patient is not a Medicaid recipient, enter an “N” in the left-most box.

New guidance in V1.02 of the HIS Manual states that if a patient refuses to supply his or her Medicaid Number, or the Medicaid Number is unknown, you should leave A0700 blank.

So now the the guidance for A0600A Medicare Number, A0600B Social Security Number, and A0700 Medicaid Number are aligned and consistent: if the number is unknown or the patient is unwilling to disclose, leave the item blank.

A1000. Race/Ethnicity

Response Option	OMB Definition
A. 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.
B. 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.
C. 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."
D. 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."
E. Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
F. White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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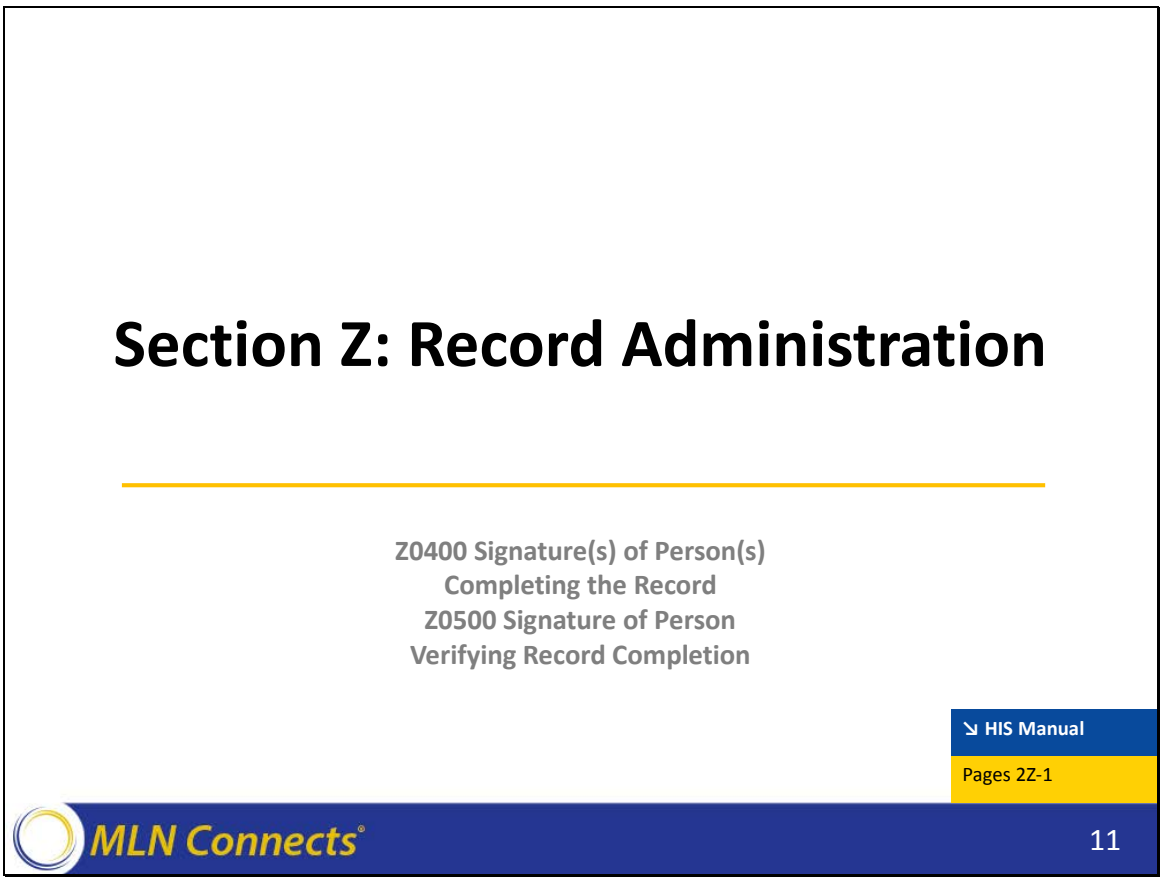
Pages 2A-10

A1000 Race/Ethnicity reports the race or ethnic categories that the patient uses to identify him or herself. This information is important to collect and provides data to assist CMS in achieving equitable care for hospice patients.

HIS data collection guidance for Item A1000 indicates that the preferred method of identifying race or ethnicity is by patient report. If the patient is unable to communicate this information, a family member or caregiver may provide the information. Lastly, observer identification can be used to complete this item if the patient is unable to respond and no family member, significant other, guardian, or legally authorized representative is available.

The question most often received on the Quality Help Desk about this Item is “What racial/ethnic categories are included in response option ‘F. White’?” As noted on the slide, response option “F. White” includes any person having origins in the original peoples of Europe, the Middle East, or North Africa. This slide shows the OMB guidance for each racial/ethnic category in Item A1000. Providers should review the OMB definitions for each response option prior to making a selection for Item A1000. OMB definitions for each response option are also included in the HIS Manual V1.02 on Pages 2A-10 and 2A-11.



The final administrative section of the HIS is Section Z. There are two items in Section Z:

Z0400, Signatures of Persons Completing Any Area of the Record, and

Z0500, Signature of Person Verifying Record Completion.

Instructions for completing these items begin on page 2Z-1 of the HIS Manual.

The signatures in Z0400 and Z0500A are for use and retention by the hospice. They indicate attestation that the abstracted information in the HIS record is complete and accurately reflects patient information. However, these signatures are not transmitted to CMS. The only thing that is transmitted to CMS through the QIES ASAP system in this section is **Z0500B**, which is the HIS Completion Date.

In practical terms, Section Z items allow hospices to do two things. The signatures in Z0400 allow the hospice to look back and see who was responsible for completing which sections. Item Z0500 allows the hospice to determine who verified that the HIS record was complete, and when completion occurred.

Let's take a closer look at the two Section Z items.

Z0400: Signature(s) of Person(s) Completing the Record Item-Specific Tips

Z0400: Signature(s) of Person(s) Completing the Record

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			

- Z0400 is not submitted as part of the HIS record in the QIES ASAP system.
- It is at the discretion of the hospice to develop internal policies and procedures for completing Z0400.

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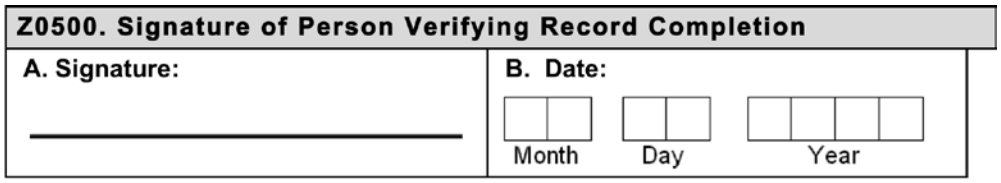
Pages 2Z-2

The intent of Z0400 is to capture signatures (electronic or physical) to reflect the person completing any item in any section of the HIS; in an electronic medical record, this may be accomplished electronically, which is perfectly acceptable.

Z0400 signatures and dates are not submitted to CMS as part of the HIS record. Thus, it is at the discretion of the hospice to develop internal policies and procedures for completing and retaining Z0400.

Z0500. Signature of Person Verifying Record Completion, and Date of Completion



- Z0500A is not submitted as part of the HIS record in the QIES ASAP system.
- In the case of a modification or inactivation request, Z0500B should contain the original date on which the record was completed.

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Pages 2Z-2

The intent of Item Z0500A is to reflect the signature of the individual who certifies that the entire HIS record, including all sections, is complete. This person is not certifying the accuracy of the HIS, just that it is complete.

This signature is not submitted to CMS as part of the HIS record, thus, it is at the discretion of the hospice to develop internal policies and procedures for completing and archiving Z0500A. Electronic signatures are acceptable.

Z0500B Completion Date is submitted to CMS as part of the HIS record. Z0500B is intended to reflect the date on which the person has verified the HIS record is complete.

When a hospice modifies an HIS record, the original Z0500B date should remain the same. Do not change the Z0500B date, unless the date in Z0500B in the original record was incorrect and the modification request is to correct the date in Z0500B. Using the original date prevents the modification/inactivation/correction record from being identified as “late.”

This concludes the portion of the presentation on updates to Administrative Items in V1.02 of the HIS Manual.