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National Provider Call Transcript

Centers for Medicare & Medicaid Services
Hospice Quality and Hospice Item Set Manual V1.02
MLN Connects National Provider Call
Moderator: Amanda Barnes
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Contents

Operator: At this time, I'd like to welcome everyone to today's MLN Connects National Provider Call®. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If you have any objections, you may disconnect at this time.

I'll now turn the call over to Amanda Barnes. Thank you. You may begin.

Announcements and Introduction

Amanda Barnes: Thank you so much. And we're so sorry for the technical difficulties experienced at the beginning of this call. I'm Amanda Barnes from the Provider Communications Group here at CMS, and as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on Hospice Quality and Hospice Item Set Manual Version 1.02. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, CMS subject matter experts discuss the new Hospice Item Set (HIS) Manual Version 1.02. This call will focus on updates that will make the HIS Manual from Version 1.01 to Version 1.02 and provide clarifications of HIS definitions and expectations for use. Providers should have reviewed Version 1.02 on the HIS web page prior to the call.

Before we get started, there are a few items I would like to quickly cover. You should have received a link to the slide presentation for today's call in an email. If you have not seen the email, you can find today's presentation on the Call Details webpage, which can be found by visiting www.cms.gov/npc. Again, that URL is www.cms.gov/npc.

On the left side of that page, select National Provider Calls and Events, then select today's call by date from the list. The slide presentation is located there under the Call Materials section. And please note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Call Details webpage, and an announcement will be placed in the MLN Connects Provider eNews when they become available.

At this time, I would like to turn the call over to Michelle Brazil.

Presentation

Michelle Brazil: Thank you Amanda. Welcome to the Centers for Medicare & Medicaid Services, MLN Connects National Provider Call, Updates to the Hospice Item Set Manual Version 1.02. My name is Michelle Brazil, and I'm the lead for the — CMS lead for the Hospice Quality Reporting Program. Thank you for your attendance on today's MLN Connects National Provider Call.

Our objectives for today's presentation are intended to cover updates that were made to the Hospice Item Set Manual from Version 1.01 to Version 1.02. This presentation will provide clarifications of HIS definitions and expectations for use. Updates to the HIS Manual were made based on frequently asked questions received on the Quality Help Desk.

Since the focus of this presentation is on highlighting the changes made to the Hospice Item Set Manual, providers may find it helpful to have a copy of Version 1.02 of the HIS Manual available to review during the presentation. Providers can download the updated HIS Manual from the Hospice Item Set portion of the CMS website, available at the web address listed on the Objectives slide.

Since this presentation includes only updates that were made to the HIS Manual from Version 1.01 to Version 1.02, this presentation is not intended to cover a comprehensive overview of HIS reporting. For a comprehensive training on HIS reporting, providers should review the data collection training for the Hospice Item Set on the Hospice Item Set portion of the CMS website at the web address listed on slide Objectives.

All content from the National Provider Call presentation today will be recorded and posted for provider viewing at a later date. Along with the content presented on this call, an additional module that was previously recorded will be made available at a later date. This previously recorded module provides a more in-depth overview and background of the Hospice Item Set and the Hospice Quality Reporting Program.

At this time, I will turn the presentation over to Alexis Kirk from RTI International. Thank you.

Chapter 1: Background and Overview of the Hospital Item Set Manual

Alexis Kirk: Thank you. My name is Alexis Kirk, and I'll be presenting this portion of the National Provider Call. In this section of the presentation, we will review information found in Chapter 1 of the Hospice Item Set, or HIS Manual. Chapter 1 provides an introduction of contextual information, timing and sequence policies, and general guidance related to implementation and use of the HIS.

Chapter 1 begins on page 1-1 of Version 1.02 of the HIS Manual. Since this presentation covers updates made to Version 1.02 of the HIS Manual, throughout the slides in this presentation, we have included relevant HIS Manual page numbers in the blue and yellow box at the bottom right-hand corner of the slide.

The Hospice Quality Reporting Program, or HQRP, was established by Section 3004 of the Affordable Care Act. The HIS is a patient-level data collection tool that all Medicare-certified hospice providers were required to begin using on July 1st, 2014. Hospice providers must submit two HIS records for each patient admission to their hospice: an HIS admission record and an HIS discharge record. Hospice providers submit

HIS records to CMS, and CMS uses HIS data to calculate facility-level scores on seven quality measures.

On the next slide, we'll cover content from Section 1.3 of the HIS Manual, which begins on page 1-2. Figure 1 on page 1-2 of the manual outlines the three primary phases of HIS reporting. As shown in Figure 1 on this slide, the process of collecting and reporting HIS data can be broken down into three primary steps:

- HIS data collection,
- HIS record conversion, and
- HIS record submission.

The first step, HIS data collection, consists of selecting responses to HIS items, in conjunction with patient assessment activities or through a process of abstracting information from the patient's clinical record. Responses to HIS items may be collected on a paper form or electronically using an electronic medical record.

The second step is HIS record conversion, where HIS data is converted into the proper electronic file format necessary for submission to CMS; XML is the required file format. To convert HIS records into XML, providers can use either a vendor-designed software, or providers can use the Hospice Abstraction Reporting Tool, or HART, software. HART software is free to use and can be downloaded from the QIES Technical Support Office website at www.qtso.com. Additional information about installing the HART software and a related user guide are also available at the qtso.com website.

The third and final step is HIS record submission. Once HIS records are converted, the files can be submitted to CMS using the Quality Improvement and Evaluation System Assessment and Processing, or QIES ASAP system. All hospice providers must use the QIES ASAP system to submit HIS data to CMS. Additional information related to HIS record conversion and submission are available in Chapter 3 of the HIS Manual.

It is helpful to understand the cycle or timing of HIS data reporting and corresponding payment impacts. The relationship between HIS reporting and reimbursement currently spans the 3-year cycle. In the first year of the cycle, the provider collects and submits HIS data. In the second year of the cycle, the provider's compliance is determined based on the first year's HIS submissions.

If it is determined that the provider was not compliant with HIS requirements, then the 2 percentage point APU payment reduction would occur in the third year of the cycle. Let's review that cycle again, using an example.

Suppose Hospice A does not report HIS data during January through December of 2015, the first year of the cycle. In 2016, the second year in the cycle, Hospice A's reporting status would be evaluated, and a determination of noncompliance would be made. If

upheld, this finding of noncompliance would reduce Hospice A's APU in the fiscal year 2017, the third year of the cycle.

As you can see based on this example, by the time the determination of noncompliance is made, and a hospice's APU is reduced, the opportunity to collect HIS data for that reporting period is over. HIS reporting year cycles are referenced by the payment year they impact. So, the 3-year cycle outlined on this slide is referred to as the fiscal year 2017 reporting year.

Requirements for New Facilities

On the next slide, we'll cover information from Section 1.4 and Version 1.02 of the HIS Manual. This section provides information about requirements for new facilities. All Medicare-certified hospice providers are required to submit HIS data on all patient admissions on or after July 1st, 2014.

Reporting eligibility and requirements for new hospice providers is addressed by CMS through rulemaking. In the fiscal year 2015 Hospice Wage Index and Payment Rate Update Final Rule, CMS finalized that any hospice that received its CMS certification number, or CCN, notification letter on or after November 1st is excluded from any payment penalty for quality reporting for the APU determinations for that particular reporting cycle. Under current requirements, a new hospice that received their CCN notification letter on November 2nd, 2015, would not be required to submit HIS data on patient admissions occurring during calendar year 2015, which would affect the fiscal year 2017 APU.

In this instance, at the latest, the hospice would begin HIS data collection and submission on patient admissions occurring on or after January 1st, 2016, and for all subsequent years. HIS data submitted on patient admissions for calendar year 2016 would affect the fiscal year 2018 APU. For more details on requirements for new facilities, see proposed and final rules published by CMS in the *Federal Register* at the web address listed on this slide.

Record Types and Definitions

On the next slide, we'll cover Section 1.6, Record Types and Definitions, which is a new section in Version 1.02 of the HIS Manual. This section provides information on the two record types, HIS-Admission and HIS-Discharge, along with relevant definitions for each record type. Section 1.6 begins on page 1-4 of the HIS Manual. Hospices are required to submit two HIS records for each patient admission to their organization: an HIS-Admission and an HIS-Discharge record. HIS-Admission and HIS-Discharge completion is generally triggered by the patient's admission or discharge to a Medicare-certified hospice.

For the purposes of completing the HIS admission, a patient is considered admitted to a hospice if the following three conditions have been met:

- First, there must be a signed election statement or other agreement for care for non-Medicare patients.

- Second, the patient must not have expired prior to the effective date of the election or agreement for care.

- Third, the hospice must make a visit in the setting where hospice services are to be initiated.

Once all three of these criteria are met, the patient is considered admitted to the hospice, and HIS reporting is required.

The criteria outlined on this slide are for determining admission status for HIS reporting purposes only. Admission status may be different for billing purposes, depending on the payer. A flowchart, which is presented as Figure 3 in Section 1.6 of the HIS Manual, is particularly helpful in determining whether or not a patient should be considered admitted to the hospice for purposes of determining if HIS reporting is required.

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 or services. The reasons why a patient might be discharged from a hospice are reported in Item A2115 and include: a patient expiring, a patient revoking the election of hospice care, determination that the patient is no longer terminally ill, a patient moving out of the hospice's service area, a patient transferring to another hospice provider, or a hospice discharging a patient for cause.

Patient discharge is the trigger event for completing the HIS discharge, meaning, hospices should complete an HIS discharge record once the patient is no longer receiving services from the hospice or there is an interruption in care or services.

The next several slides cover special circumstances for defining admission and discharge for the purposes of HIS reporting. These special circumstances are new to Version 1.02 of the HIS Manual and begin on page 1-5.

The first special circumstance will cover our patient transfers. Sometimes, due to patient preference or patient relocation, a patient will change hospice providers. These situations can involve two related hospices under common ownership who have the same CCN, or these situations can involve two unrelated hospices, each with their own CCN. In general, HIS reporting occurs at the CCN level. Thus, when a patient transfers from a provider with one CCN to a provider with a different CCN, each provider is independently responsible for compliance with HIS reporting.

In the situation where a patient transfers from one hospice to another and the two hospices have different CCNs, each hospice should complete an HIS-Admission and an HIS-Discharge record for the care provided to the patient by their organization. When the transferring hospice completes their HIS-Discharge record, Response 05 Transferred to Another Hospice should be selected for Item A2115 Reason for Discharge.

Completing HIS records according to these guidelines allows for HIS quality data to be captured and attributed to the portion of the care that each hospice provided. When a patient transfers between two providers with one common CCN, there is no need for the transferring hospice to complete an HIS-Discharge, or for the receiving hospice to complete an HIS-Admission record. In this situation, the transferring hospice would complete the HIS-Admission, and the receiving hospice would complete the HIS-discharge, both under the same CCN.

Let's go over an example: In this example, a patient initially receives hospice care from Hospice A. Hospice A completes an HIS admission record for that patient. Sometime later, the patient decides to change hospice providers to receive care from Hospice B. The patient is discharged from Hospice A, and Hospice A completes the HIS-Discharge record, listing Transfer as the Reason for Discharge in Item A2115. Hospice B then admits the patient, completing an HIS-Admission record. Hospice B would complete an HIS-Discharge record once the patient is no longer receiving services from Hospice B or there is an interruption in services or care.

On the next slide, we'll look at another special circumstance, which begins on page 1-6 of the HIS Manual. This special circumstance covers administrative discharges with no interruption in care. There may be circumstances where it is the hospice's policy to administratively discharge a patient and re-admit them without an interruption in care.

In general, as long as there is no interruption in hospice care, completion of an HIS-Discharge is not required. This slide lists two examples of situations where the hospice may administratively discharge the patient, but there is no interruption in care. One such circumstance is when a patient has a change in payer source. For example, a private pay patient might become eligible for the Medicare benefit during the course of hospice care. In this situation, it might be the hospice's policy to complete an administrative or paper discharge and then an immediate readmission to meet billing purposes.

Another situation might occur when a hospice fails to meet the face-to-face requirement. In this circumstance, the hospice must administratively discharge the patient, but there is no interruption in care, so no HIS-Discharge would be required.

In the case of administrative discharges with no interruption in care, such as the two examples listed on this slide, the hospice would submit an HIS-Discharge once the

patient is no longer receiving hospice service or there's an interruption in care related to one of the reasons for discharge listed in Item A2115.

Next, we'll talk about the final special circumstance. According to CMS regulations at 418.26, a 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 agreement with another Medicare-certified hospice program for the provision of core services to supplement hospice employees or staff to meet the needs of the patient.

In the case of a traveling patient, whether or not a hospice should submit an HIS-Discharge and a new HIS-Admission depends on whether the home hospice discharged the patient and whether the host hospice admitted the patient to hospice care and filed a notice of election within the claims processing system. If there is no discharge by the home hospice, then the home hospice is not required to submit an HIS-Discharge when the patient travels out of the home hospice's service area.

Relatedly, the host hospice would not need to submit an HIS-Admission or HIS-Discharge for a traveling patient that they are providing services for under a written agreement with the home hospice. This is because the host hospice is providing services as an agent of the home hospice. Thus, the home hospice would be responsible for submitting the HIS-Discharge once they discontinued providing hospice services either directly or under arrangement.

Policies on Timing and Sequence of HIS Records

On the next slide, we'll cover Section 1.7 of Version 1.02 of the HIS Manual. This section discusses policies related to the timing and sequence of HIS record completion and submission. In situations where 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 it means the record would be late. Late completion and submission of HIS records will result in a nonfatal or warning error. Records containing nonfatal errors can still be accepted by the QIES ASAP system.

Failure to comply with HQRP requirements can result in a 2 percentage point reduction in a hospice's APU for the relevant fiscal year. The HQRP is currently a pay-for- reporting program, meaning it is the act of submitting required HIS records that determines compliance with program requirements. This means that quality measure scores or performance are not a factor in determining compliance with HQRP requirements at this time.

Beginning with the fiscal year 2017 reporting year, in order to avoid the 2 percentage point reduction in their APU, hospices will also be required to meet requirements for the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, Hospice Survey as part of the general HQRP requirements. The CAHPS survey is part of the HQRP

but is separate from the HIS requirement. For more information on CAHPS Hospice Survey requirements, please visit the CAHPS website at the web address listed on this slide.

This concludes updates made to Chapter 1 of Version 1.02 of the HIS Manual.

Chapter 2: Instructions for Completing HIS Items

On the next slide, we'll move on to updates made to Chapter 2 of Version 1.02 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 it 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's 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 POST, 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.

On the next slide, we will 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'll start by looking at the HIS items in Section A: Administrative Information.

Section A: Administrative Information

Section A 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 received 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 Version 1.02 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 Version 1.02 of the HIS Manual. Section A items with new or updated guidance 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 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.

Instructions for completing Item A0205 begin on Page 2A-2 of the HIS Manual.
Item A0205 reports the patient 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 or Non-Skilled Nursing Facility, and Hospice Provided in a Skilled Nursing Facility. 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.

On the next slide, we'll look at Item A1802, which 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 hospice, choose the response option that reflects 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.

As mentioned previously, for Items A0205 and A1802, a common question received on the Help Desk is "How are skilled nursing facilities, or SNFs, different from nursing facilities, also known as NFs or long-term care facilities?" For the purposes of completing Items A0205 and A1802, SNF is not synonymous with NF. Use the response option for SNF — the patient must be in a SNF or in a SNF portion of a dually certified nursing facility. Otherwise, choose the response option for NF or Long-Term Care Facility.

On the next slide, we'll discuss Item A0245, which 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 assessment was not completed or was initiated in the 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 Version 1.02 of the HIS Manual instructs providers to enter a dash for Item A0245.

Remember, HIS reporting is required for all patients meeting the three 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.

Item A0700 is on Page 2A-9 of Version 1.02 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 a 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 plus 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 Version 1.02 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 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.

The next slide discusses Item A1000, which is the Race or Ethnicity item. This item 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 a legally authorized representative is available.

The question most often received on the Quality Help Desk about this item is, "What racial or ethnic categories are included in Response Option F White?" As noted on this 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 and 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 on Pages 2A-10 and 2A-11.

Section Z: Record Administration

The final administrative section that we'll cover 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 is 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.

The next slide presents information on Z0400. The intent of this item 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.

The final item is Z0500. 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 to 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, the 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 and activation and correction record from being identified as late.

This concludes the portion of the presentation on updates to administrative items in Version 1.02 of the HIS Manual. At this time, I'll turn the call back over to Amanda.

Amanda Barnes: Thank you Alexis.

At this time, we will pause for a few minutes to complete keypad polling so CMS has an accurate count of the number of participants on the line with us today. Please note there will be silence on the line while we tabulate the results. Salema, we're ready to start polling.

Keypad Polling

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Again, please continue to hold while we complete the polling.

Thank you for your participation. I'll now turn the call back over to Amanda Barnes.

Presentation Continued

Amanda Barnes: Thank you so much. We will now resume the presentation. Franzi?

Franzi Rokoske: Thank you. My name is Franzi Rokoske, and I'll be leading the last portion of this presentation, which will cover updates to the care process items in Version 1.02 of the Hospice Item Set, or HIS, Manual. This portion of the presentation will cover updates to guidance for completing HIS items in Sections F: Preferences, Section J: Pain and Dyspnea, and Section N: Medications.

Section F: Preferences

We'll begin with updates made to guidance in Section F of the HIS Manual. In your manual, that section begins on Page 2F-1. Preferences reflect one of the tenets of hospice care; it is important for the patient and caregiver to be involved in decisionmaking and establishing goals for care.

There are four items in Section F that relate to patients' preferences regarding life-sustaining treatments and spiritual care. In this presentation, we will focus on Item F3000 Spiritual and Existential Concerns, since Version 1.02 of the HIS Manual includes a significant change in data collection guidance related to Item F3000.

Item F3000 reports whether or not the patient and/or caregiver were asked about spiritual or existential concerns and, if so, the date that this discussion took place or was attempted. New guidance in the item-specific instructions for Item F3000 changes the date range providers can consider when completing Item F3000B, the date patient and/or caregiver was first asked about spiritual or existential concerns.

New guidance indicates that it is now permissible to consider discussions that took place prior to admission, either at pre-admission or educational visits. This means that when completing Item F3000B, providers can now list dates that precede the admission date. This newly refined guidance provides consistency across all Section F items. Now it is permissible to consider discussions that took place at pre-admission or educational visits for all three items in Section F: F2000, F2100, F2200, and now also F3000.

An example of a pre-admission discussion or spiritual or existential concerns could be that during an educational or pre-admission visit, the hospice clinician discusses treatment preferences and spiritual and existential concerns.

A discussion with the patient or caregiver about spiritual or existential concerns can be initiated by any member of the hospice staff or interdisciplinary group. There is no comprehensive list of spiritual or existential concerns, although new guidance in Version 1.02 of the HIS Manual lists some examples. Discussion of spiritual or existential concerns might include asking the family about needs for spiritual support, asking the patient about the meaning of death, or offering the patient a spiritual resource such as a chaplain.

Remember, the patient and family have the right to refuse to discuss these items. In these instances, the data collector would select Response Option 2 Yes, but the Patient and/or Caregiver Refuse to Discuss for Item F3000A.

Also, keep in mind that brief statements in the clinical record denoting a patient's religious affiliation are not sufficient to select response Yes for Item F3000A. Additional items in Section F, including clinical examples, can be found in the HIS Manual. Because

this presentation focuses on updated guidance only, we recommend providers review the complete HIS Manual for instructions on completing all HIS items.

Section J: Pain

On the next slide, we'll turn our attention to Section J. In your manual, that section begins on Page 2J-1. Items in Section J pertain to Physical Symptom Management for hospice patients. Specifically, Section J reports on two physical symptoms: pain and shortness of breath or dyspnea. Pain items include a Pain Screening and Comprehensive Assessment item, and the Shortness of Breath items include a Screening and Treatment item.

Pain and shortness of breath screening, assessment, and treatment are fundamental elements of hospice care. Patients and families frequently worry if they or their loved one will experience pain or shortness of breath, and managing physical symptoms is central to high quality hospice care.

First, we'll go over Section J: Pain items. Version 1.02 of the HIS Manual contains updated guidance for both of the Pain items.

On the next slide, you can see Item J0900. Item J0900 reports whether the patient was screened for pain, and if so, what the date of the first pain screen was, what the severity of the patient's pain was, and what type of standardized pain tool was used for screening.

Let's briefly review the item-specific instructions for J0900, highlighting some new guidance that appears in Version 1.02 of the HIS Manual. Item-specific instructions for J0900 begin on Page 2J-2 of the HIS Manual.

J0900A is the gateway question and asks whether or not the patient was screened for pain. J0900B is the Date item and reports the date on which the patient was first screened for pain. J0900C reports the severity of the patient's pain. Pain severity levels for J0900C have been modified in Version 1.02 of the HIS Manual to align with the National Comprehensive Cancer Network guidelines. This means that Response Option 2 Moderate now includes a pain severity score of four to six using a 10-point numeric scale. Response Option 3 Severe now includes a score of 7 to 10, using a 10-point numeric scale. J0900D reports the type of standardized evidence-based pain tool used to conduct the pain screen. The type of standardized tool used should be documented in the clinical record. If no description or detail regarding the type of pain tool used is found in the record, then providers should use Response Option 09 No Standardized Tool Used for J0900D — do not use a dash for this item.

On the next slide, we'll discuss an example. We often receive questions on the Quality Help Desk about what to do in situations where a patient does not report current pain at the time of screening, but the patient does have a history of pain, and pain is an

active problem for the patient. A new example, Situation E, was added to Version 1.02 of the HIS Manual to illustrate how to complete J0900 in this situation.

Situation E begins on page 2J-5 of Version 1.02 of the HIS Manual and reads, “Patient’s initial assessment form dated August 14, 2015 states, ‘the patient reports he has recently taken a dose of his pain medication, and his current pain is zero on a zero to 10 pain scale. Patient states he has a history of pain. At its worst, the pain is six out of 10, and is a dull, aching pain in the low abdomen. Historically, pain is worse when the patient walks, and pain is better when lying down.’” So this is a situation where the patient reports no pain at the time of the visit, but clinical record documentation clearly shows that pain is an active problem for the patient.

On the next slide, we’ll review how to complete Item J0900 in this situation. In this example, J0900A Was the Patient Screened for Pain? would be completed using Response Option 1, Yes. The date of the screening, August 14, 2015, would be reported in J0900B. For J0900C, the data collector should respond 0, None, since J0900C should be completed based on the patient’s pain severity at the time of the visit in which the screening for pain was conducted. Note that when you select 0 -None for J0900C, HIS instructions direct you to skip J0900D and skip Item J0910, which is the Comprehensive Pain Assessment item.

The question we most often receive on the Help Desk is about the skip pattern in the situation where a patient doesn’t report pain at the time of the visit, but it is clear that pain is an active problem for the patient. Providers ask why they must skip J0900D and J0910 in this situation, especially in instances like Situation E, where it is clear, based on the clinical record documentation, that the assessing clinician completed a more comprehensive assessment of the patient’s pain. Providers often write the Help Desk wondering why the HIS directs you to skip over J0910, the Comprehensive Pain Assessment items, since it is good clinical practice to conduct a Comprehensive Pain Assessment for patients, where pain is an active problem.

Item completion instructions 4J0900 reflect the current quality measure specifications for the corresponding quality measure, which is NQS Number 1634. That being said, HIS completion instructions and corresponding quality measure specifications should not replace or supersede clinical best practice. In an instance like Situation E, it is appropriate for the clinician to carry out whatever assessment is clinically appropriate for the patient’s situation.

Best practice indicates if a patient is screened and is found to be in pain, or if pain is an active clinical problem for the patient, a comprehensive assessment should be completed to determine pain location, severity, character, duration, frequency, effect on function or quality of life, and what relieves and/or worsens the patient’s pain. The assessing clinician can and should carry out this comprehensive assessment. However,

in situations like this example presented here, information about that comprehensive assessment would not be captured by the HIS in Item J0910.

Thus, in Situation E, although there is clinical record documentation that the nurse further assessed the patient's pain, including historical rating, location, character, what makes the pain better or worse, and so forth, since the patient's pain rating at the time of the screening was 0-None, providers should follow the skip patterns as indicated on the HIS, skipping J0900D and J0910. Skipping J0910 in these instances will not negatively affect hospices' scores on the pain quality measure. CMS is considering future changes to the HIS items and to the quality measures specifications. These changes would more closely align the HIS data collection and quality measure calculations with clinical practice in situations like Situation E.

We'll turn our attention now to Item J0910 on the next slide. Item J0910 reports whether a comprehensive pain assessment was done, the dates of the first comprehensive pain assessment, and which specific assessment elements were included in the comprehensive pain assessment.

J0910 begins on page 2J-6 of the HIS Manual.

By definition, a comprehensive pain assessment should address multiple aspects of pain beyond the presence of pain and its severity. There are seven characteristics of elements of a comprehensive pain assessment that are reportable in the HIS. These seven characteristics include pain location, severity, character, duration, frequency, what relieves or worsens the pain, and the pain's effect on function or quality of life.

A comprehensive pain assessment can be completed on patients that are unresponsive. For unresponsive patients, the hospice can elicit this information from staff observation and/or family and caregiver report. For instance, the assessing clinician might observe a patient demonstrating nonverbal indicators of pain when changing position. Or a caregiver might tell the clinician that the patient grimaces and pulls away when her arm is touched.

Documentation in the clinical record that states something to the effect of, "The location, severity, and character cannot be assessed due to patient's nonresponsiveness," does not qualify to report that a comprehensive pain assessment was completed. Additional details regarding assessing pain for nonresponsive patients are provided in the HIS Manual.

Amanda Barnes: I'm sorry, we're going to just pause for 1 second. We are going to go about 10 minutes over call time just to answer a few questions and get to those since we did have some technical difficulties. So, if you could stay on the line a little bit past 3, that would be great. We'll be getting to your questions shortly.

Thank you Franzi.

Section J: Respiratory Status

Franzi Rokoske: Sure. So now we'll focus on Section J: Respiratory Status, and we'll focus on the Shortness of Breath items.

There are two items in this section, J2030 and J2040. These items note whether the patient was screened for shortness of breath, and whether treatment for shortness of breath was initiated.

Dyspnea, or shortness of breath, can be a symptom of terminal disease, such as lung cancer, or as a terminal process. It can also be a symptom of underlying disease. Shortness of breath can be distressing, not only for the patient, but also to caregivers and families.

On the next slide, you can see that J2030 reports whether there was a screening for shortness of breath, the date of the screening, and whether the patient screened positive for shortness of breath.

On the following slide, we'll review new guidance for completing J2030C. This new guidance can be found on page 2J-11 of Version 1.02 of the HIS Manual. Item-specific tips for J2030 state that evidence of a positive screen for shortness of breath should consider whether at the time of screening, the shortness of breath was an active problem for the patient.

Based on reports of recent symptoms or current treatments, 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.

Documentation of current treatment for shortness of breath, like oxygen use, indicates that shortness of breath is an active problem, even if the patient does not report current shortness of breath during the visit.

The guidance for providers to consider whether shortness of breath was an active problem for the patient differs from the guidance for determining pain severity in J0900C. Remember that in J0900C, you do not consider historical report of pain or whether pain is an active problem for the patient.

On the next slide, we'll look at an example. This is a new example that has been added to Version 1.02 of the manual. This new scenario, Situation E, demonstrates an example of determining whether shortness of breath is an active problem for the patient.

In Situation E, the clinical note dated August 15th, 2015, reads, "Patient reports he is currently not experiencing any shortness of breath. Patient reports that he does become

— shortness — short of breath when walking from the bed to the bathroom. Patient reports that when he is short of breath, the shortness of breath is mild to moderate, depending on his activity level."

On the following slide, we'll work through selecting responses for J2030 based on the information presented in Situation E.

For J2030A, "Was the patient screened for shortness of breath?" select Response 1 Yes. For J2030B, "Date of the first screening for shortness of breath," enter August 15th, 2015. And for J2030C, "Did the screening indicate the patient had shortness of breath? select Response 1 Yes. In this scenario, it is evident that the clinician evaluated the patient for the presence and severity of shortness of breath. So you select Response 1 Yes for J2030A and continue to J2030B, entering the date of the screening.

J2030C should be completed based on whether 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. So again, you would select Response 1 Yes for J2030C to indicate that the patient screened positive for shortness of breath.

Again, remember that the guidance about determining whether shortness of breath is an active problem for the patient differs from the guidance about determining pain severity for J0900C. For J0900C, only consider the patient's pain severity at the time of screening.

On the next slide, you see Item J2040 Treatment for Shortness of Breath, which appears on page 2J-14 of Version 1.02 of the manual. This item reports whether treatment for shortness of breath was initiated, the dates of treatment initiation, and what types of treatment for shortness of breath were initiated, including opioids, other nonopioid medications, oxygen, or nonmedication treatments for shortness of breath.

New guidance in Version 1.02 of the manual provides additional clarification on the definition of treatment initiation for comfort kits or preprinted admission orders. Many hospices use comfort kits or preprinted admission orders, which are a set of medications or treatments reviewed and approved by medical staff and are routinely ordered for patients upon admission. Medications in the comfort kits or on preprinted orders are initiated once the symptom profile of the patient changes and the need for the treatment arises.

For comfort kits or preprinted admission orders, treatment is considered to be initiated when the hospice has received the order, and there is documentation that the patient or caregiver was instructed to begin use of the medication or the treatment for the relevant symptom of shortness of breath.

If the date the hospice received the order is different from the date that the hospice instructed the patient or caregiver to begin using that treatment or medication, then the date treatment initiated would be the later date when both conditions were met — the hospice received the order and instructed the patient or caregiver to begin its use. Proactive education on medications in a comfort kit in anticipation of symptoms is not considered treatment initiation.

For nonmedication interventions, like the use of fans, positioning, or patient education efforts, there may not be specific physician orders. In this case, use the date on which the hospice first discussed the intervention with the patient or the caregiver.

In reporting the types of treatment initiated for shortness of breath, J2040C includes the opportunity to report non-opioid medications in response Option 2. Version 1.02 of the HIS Manual provides examples of non-opioid medications that could be used for dyspnea, including inhaled bronchodilators, steroids, diuretics, and benzodiazepines. Some of these treatments, including steroids and diuretics, have multiple uses. Since these medications have multiple uses, the order must indicate that these treatments were initiated to address the patient's shortness of breath.

For J2040C, only report treatments for shortness of breath that were initiated on the date listed in J2040B. If additional treatments for shortness of breath were initiated at a later date, do not include those treatments in J2040C.

On the next slide, we'll address an example in the HIS Manual. The example presented in Situation B on page 2J-17 of Version 1.02 of the manual has been updated to reflect current guidance about treatments for shortness of breath that are initiated on different dates.

In Situation B, the patient's initial assessment shows that treatments for shortness of breath were initiated on two dates: on September 15th, 2015, and on September 16th, 2015. On September 15th, the hospice instructed the family to keep the patient's head elevated on pillows while the patient was in bed. On the following day, September 16th, the hospice ordered oxygen and scopolamine to dry respiratory secretion.

On the next slide, we'll work through selecting responses for J2040 based on the information presented in that Situation B. For J2040A, you would select Response Option 2 Yes to indicate that treatment for shortness of breath was initiated.

For J2040B, you would enter the first — sorry, you would enter the dates that the first treatment for shortness of breath was initiated, which was September 15th, 2015. For J2040C, select only those treatments that were initiated on the first date, September 15th. This means that although there were additional treatments initiated on

September 16th, we would not include those in J2040C. J2040C should reflect only the treatments initiated on the date listed in J2040B.

A new example for the Treatment for Shortness of Breath item was added to Version 1.02 of the HIS Manual. This new example, Situation D, begins on page 2J-18 of the HIS Manual. This example illustrates how to define treatment initiation for comfort packs. As stated in Situation B, documentation in the clinical record indicates that a comfort pack was in the patient's home and on standby. The comfort pack included treatments that could be used for shortness of breath and that the nurse provided proactive education to the patient and the caregiver about the availability of these treatments. Documentation also shows that the nurse instructed the patient and the family not to use the medications in the comfort kit until specifically advised to do so.

On the next slide, we'll review the proper HIS response selections for Situation D. In Situation D, the proper course of action is to select 0 or No for J2040A, which asks whether treatment for shortness of breath was initiated. In Situation D, although there is documentation that a comfort pack was in the patient's home and the nurse provided proactive education about treatments in the comfort pack, there is no documentation that the nurse instructed the patient or family to begin using any of the treatments for shortness of breath. So for the purposes of completing Item J2040, treatment for shortness of breath, should be considered as Not Initiated. In this example, you would respond 0, No to J2040A, and you would skip J2040B and C.

Section N: Medications

On the next slide, we'll start discussing Section N: Medications, which includes items for reporting initiation of opioids and bowel regimens. Section N includes three HIS items: N0500 Scheduled Opioids, N0510 PRN Opioids, and N0520 Bowel Regimens.

Version 1.02 of the HIS Manual contains updated guidance for all three of the items in Section N. Section N begins on page 2N-1 of Version 1.02 of the HIS Manual. Items N0500 and N0510 report whether and when scheduled and PRN opioids were initiated. For the purposes of completing Item N0500 and N0510, an opioid includes Schedule II through Schedule IV opioids, including hydrocodone and tramadol, based on the side effects profile, which includes constipation.

Remember, items in Section N are related to NQS Measure Number 1617, which reports the percentage of patients treated with an opioid who are also given a bowel regimen within 1 day. The intent of this quality measure is to prevent opioid-induced constipation; since the side effects profile of Schedule II through IV opioids includes constipation, reporting Schedule II though IV opioids in Items N0500 and N0510 meets the intent of the quality measure.

As with treatments for shortness of breath, hospices using comfort kits or preprinted admission orders should follow new guidance in Version 1.02 of the HIS Manual.

Guidance for defining treatment initiation in the case of comfort kits or preprinted admission orders can be found on pages 2N-2 and 2N-5 for these two HIS items. Remember that for comfort kits or preprinted admission orders, treatment is considered to be initiated when the hospice has received the order, and there is documentation that the patient or the caregiver are instructed to begin using that medication or treatment. Proactive education alone is not considered initiation.

On the next slide, you can see Item N0520. N0520 reports if a bowel regimen was initiated or continued, and if so, the dates the bowel regimen was initiated or continued. Remember — only complete N0520 if the patient receives an opioid. If the patient is not receiving any opioids, you skip N0520, even if the patient is on a bowel regimen. This skip pattern mirrors the intent of the related quality measure, the NQS Number 1617. This quality measure is about preventing opioid-induced constipation. So only complete N0520, the Bowel Regimen item, if the patient is receiving an opioid.

Let's discuss two item-specific tips for N0520. First, following the skip pattern discussed on the previous slide, Item N0520, is only completed if the patient is taking a PRN or scheduled opioid. That being said, in order to respond Yes to N0520A, the bowel regimen order in the clinical record does not need to explicitly state that it is for the management of opioid-induced constipation. So, for example, suppose there was an order in a patient's clinical record dated August 12th, 2015, for 30 ccs of Milk of Magnesium daily for constipation. The orders in the clinical record do not specifically state that the constipation is opioid-induced, meaning in the scenario on this slide, the HIS data collector could still respond Yes to N0520, even though the order in the patient's clinical record does not state that the Milk of Magnesia was specifically ordered to prevent opioid-induced constipation. The second item-specific tip for N0520 states that the date on which the bowel regimen was initiated can precede the date on which opioids were initiated.

To illustrate treatment initiation in the case of comfort packs and preprinted admission orders, a new example, Situation D, has been added to Section N of the HIS Manual. Situation D begins on page 2N-9 of the HIS Manual.

In Situation D, the patient's initial assessment contains documentation that on July 23rd a comfort pack was in the patient's home and on standby. The patient and family were instructed on what medications were available in the comfort pack, and documentation from July 23rd also shows there was an order for polyethylene glycol to prevent constipation. On July 25th, the caregiver called the hospice and reported the patient was experiencing moderate pain. The hospice staff instructed the patient to open the comfort pack and to begin to take oxycodone every 4 hours as needed for pain.

On the next slide, let's review the HIS response selections for Situation D. For the Scheduled Opioid Item N0500, since no scheduled opioid was initiated, select 0, No, for N0500A, skipping N0500B.

For N0500 — excuse me, for N0510A, the clinical record documentation shows that a PRN opioid, oxycodone, 10 milligrams, was initiated.

For N0510B, the date PRN opioid was initiated, review the clinical record documentation carefully, since the PRN opioid was part of a comfort pack. For date PRN opioid initiated, list the date the nurse instructed the patient or family to begin using the oxycodone from the comfort pack, and that date was July 25th.

For N0520, the Bowel Regimen item, list the date on which the bowel regimen was initiated. In this example, the bowel regimen initiated on July 23rd — preceded — excuse me — preceded the PRN opioid initiation on July 25th. This is acceptable. Also note that the bowel regimen order does not need to state that the bowel regimen was initiated specifically to prevent opioid-induced constipation.

Resources

Alexis Kirk: The last few slides present some resources hospice providers can use to stay up-to-date on HQRP and HIS requirements.

On the Staying Informed slide, you will see that providers should regularly check the CMS HQRP website for updates and announcements. CMS recommends providers bookmark this website and visit the web page regularly.

The Hospice Item Set, HIS, portion of the web page contains HIS-specific information. There are also two listservs providers can sign up for to stay informed of CMS requirements. Providers can sign up for the MLN Connects eNews Listserv at the second web address listed on this slide. Providers can also sign up for the Open Door Forum or ODF Listserv at the third web address listed on this slide. Finally, providers should review proposed and final rules that are published by CMS. These rules can be accessed at the *Federal Register* website listed on this slide.

The next slide presents contact information for three help desks that are available to hospice providers. Contact information for each of the three help desks is listed on this slide.

Additional Information

Amanda Barnes: Thank you so much Alexis. This is Amanda, and unfortunately, due to technical difficulties that we experienced at the beginning of the call, we will not have time for question and answers today. If you would like to send your questions to the QualityNet — excuse me, the Quality Help Desk, you can do so, and their web address is

listed on slide 62. That email address is hospicequalityquestions@cms.hhs.gov. We will compile a Frequently Asked Questions document, and we will post that on the Call Detail page, as well as email you when that does become available.

I'd like to thank our subject matter experts and all participants who joined us for today's MLN Connects Call. On slide 63, you will find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary, but we hope you all take a few moments to evaluate your MLN Connects Call experience.

Again, we apologize for the technical difficulties that we had at the beginning of the call. I hope that this is informative for your providers, and we'd like to hope you have a great day. Thank you.

Operator: Thank you for participating on today's conference call. You may now disconnect. Speakers, please hold.

-END-


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