CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Hospice

Quality Reporting Program Provider Training

Hospice Item Set (HIS) Submission Requirements

Please wait, the webinar will begin shortly.

March 3, 2020

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Hospice Item Set (HIS) Submission Requirements

Cindy Massuda, CMS
Joan Proctor, CMS
Brenda Karkos, Abt Associates

March 3, 2020

Today's Agenda

- Hospice Quality Reporting Program (HQRP)
- Hospice Item Set (HIS)
- HIS Assessment Submission Requirements
- Correcting HIS Records
- Case Examples
- Resources, Wrap-Up, and Questions

Today's Presenters

Cindy Massuda, J.D.
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Centers for Medicare & Medicaid Services

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Abt Associates

Today's Presenters (cont.)

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National Coordinator, Home Health Quality Reporting Program

Centers for Medicare & Medicaid Services

Acronyms in This Presentation

- APU – Annual Payment Update
- ASAP – Assessment Submission and Processing
- CAHPS® – Consumer Assessment of Healthcare Providers and Systems
- CASPER – Certification and Survey Provider Enhanced Reports
- CMS – Centers for Medicare & Medicaid Services
- FVR – Final Validation Report

Acronyms in This Presentation (cont.)

- HIS – Hospice Item Set
- HQRP – Hospice Quality Reporting Program
- QAPI – Quality Assurance and Performance Improvement
- QIES – Quality Improvement and Evaluation System
- QIES ASAP – Quality Improvement and Evaluation System Assessment Submission and Processing

Objectives

- Describe the elements of the HQRP.
- Provide an overview of HIS completion, submission, and reports.
- Differentiate between a modification and the inactivation of an HIS record.
- Describe some patient examples re: submission, modification, and inactivation.
- Locate at least two helpful resources for successfully completing the HIS.

Help During the Presentation

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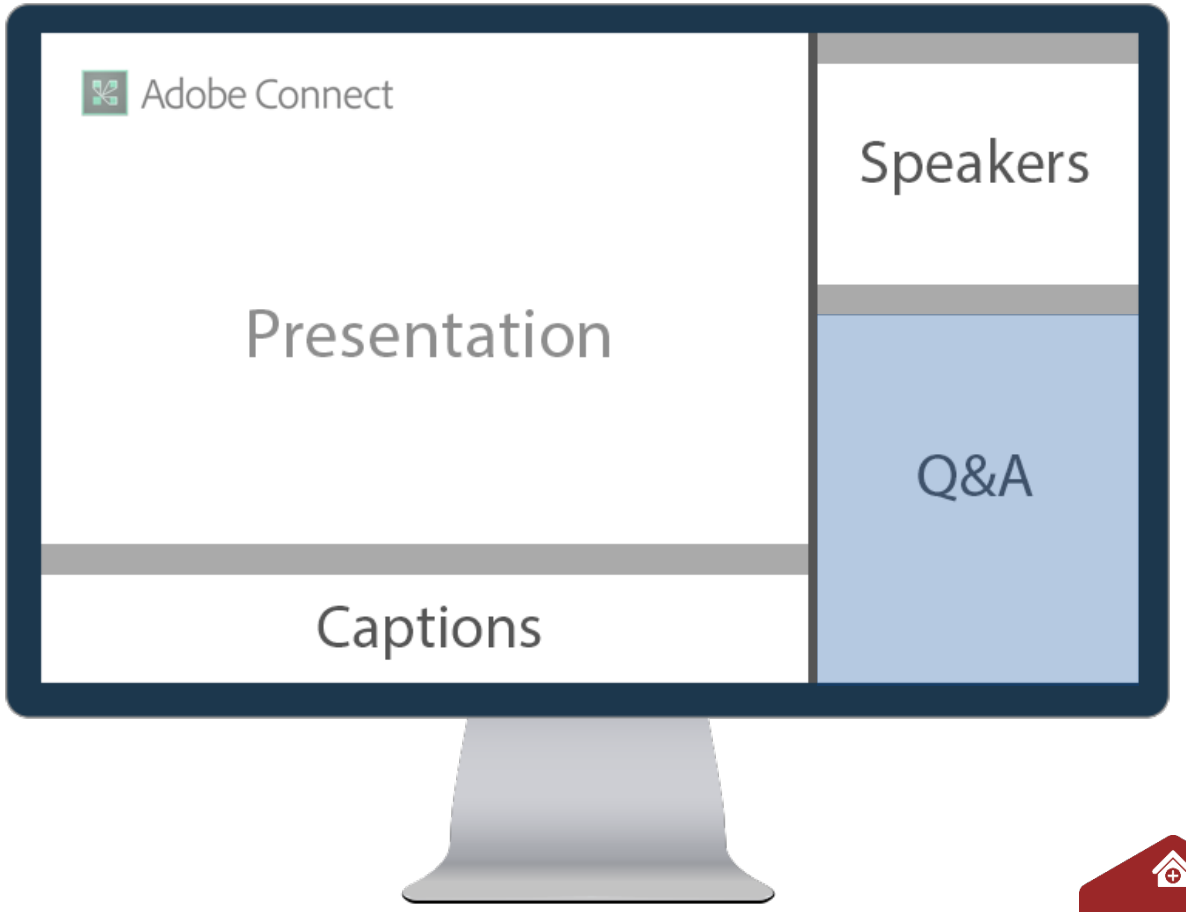

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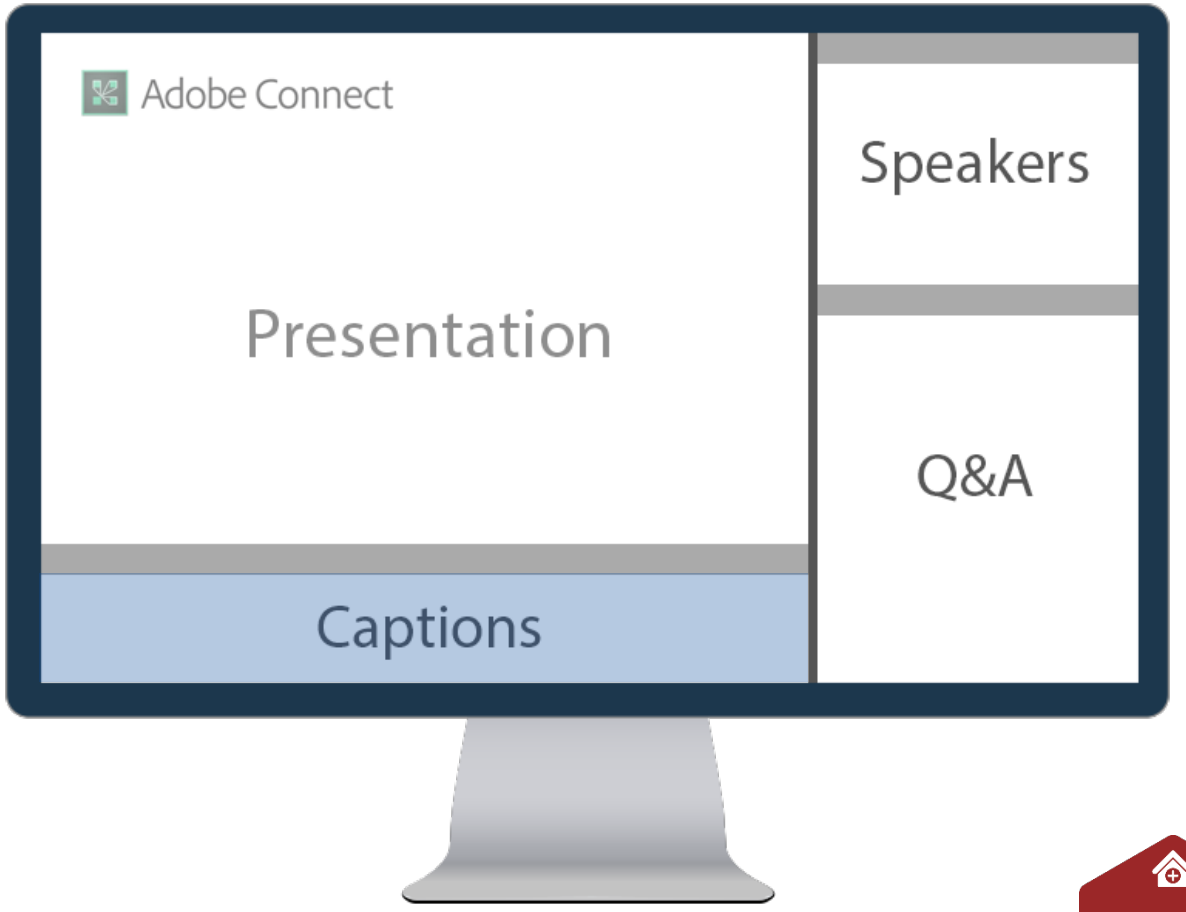

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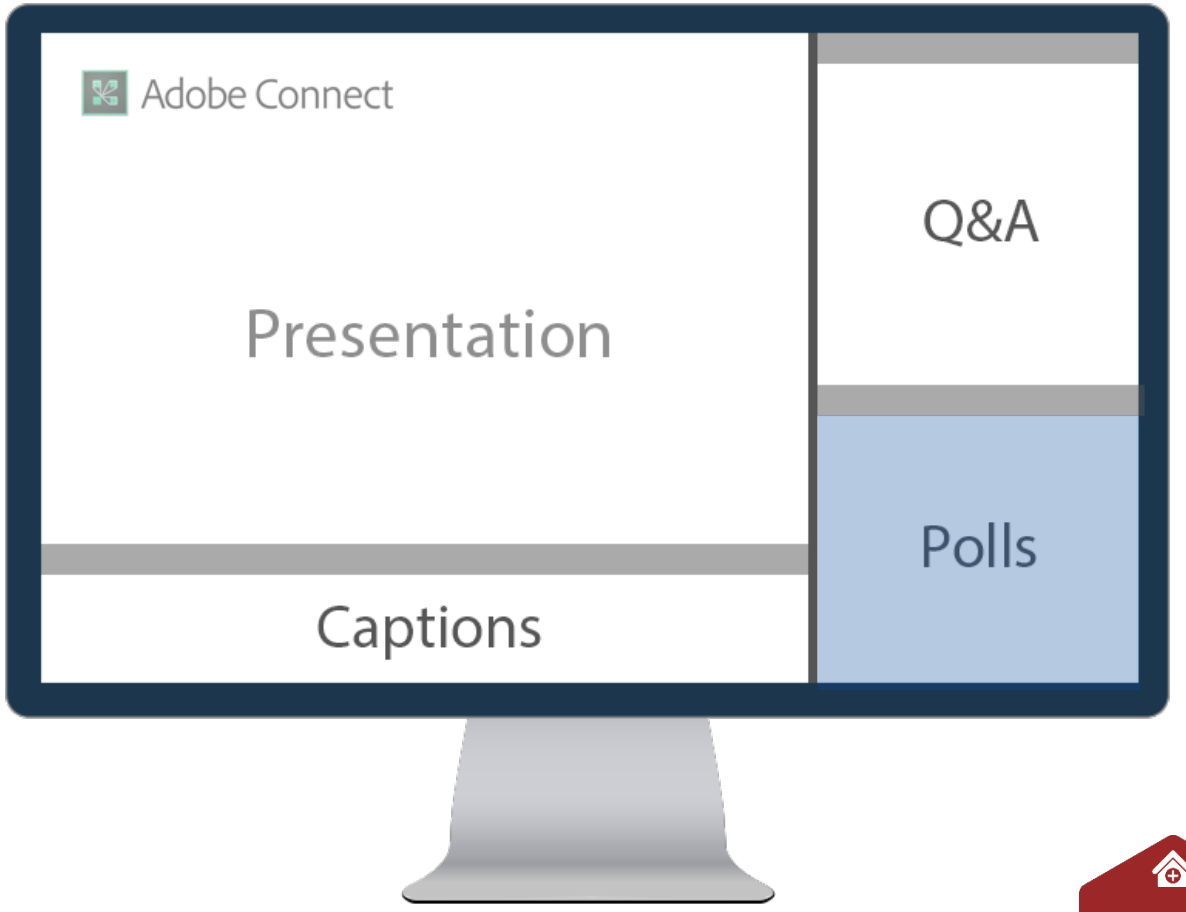


Q1 In which year did hospices first start HIS data collection for the HQRP?

A. 1979.

B. 1983.

C. 2014.

D. 2020.

Q1 In which year did hospices first start HIS data collection for the HQRP? (cont.)

A. 1979.

B. 1983.

C. 2014.

D. 2020.

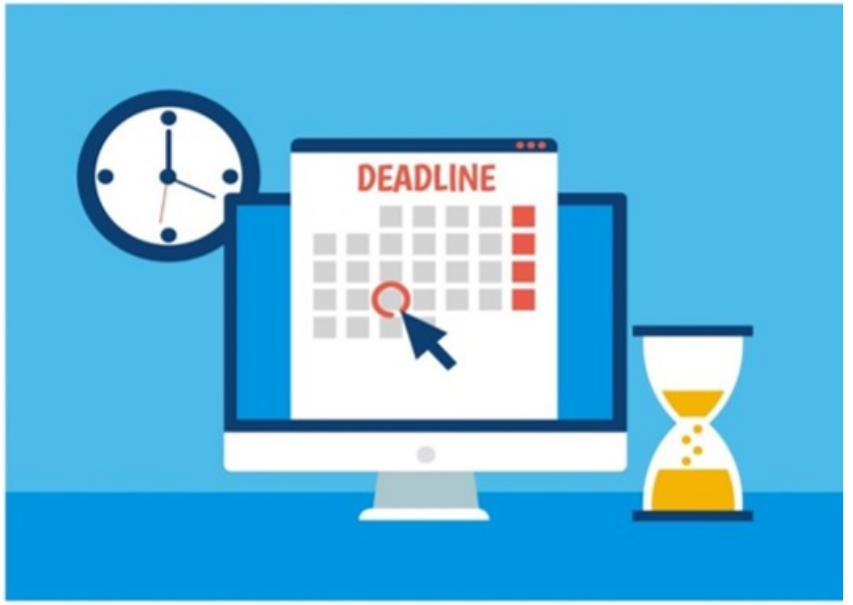
The HQRP

What is the HQRP?

- The HQRP promotes the delivery of person-centered, high-quality, and safe care by hospices.
- Hospice providers can use HQRP data as part of their Quality Assurance and Performance Improvement (QAPI) programs.
- Consumers can access publicly reported quality information via Hospice Compare - https://www.medicare.gov/hospicecompare/

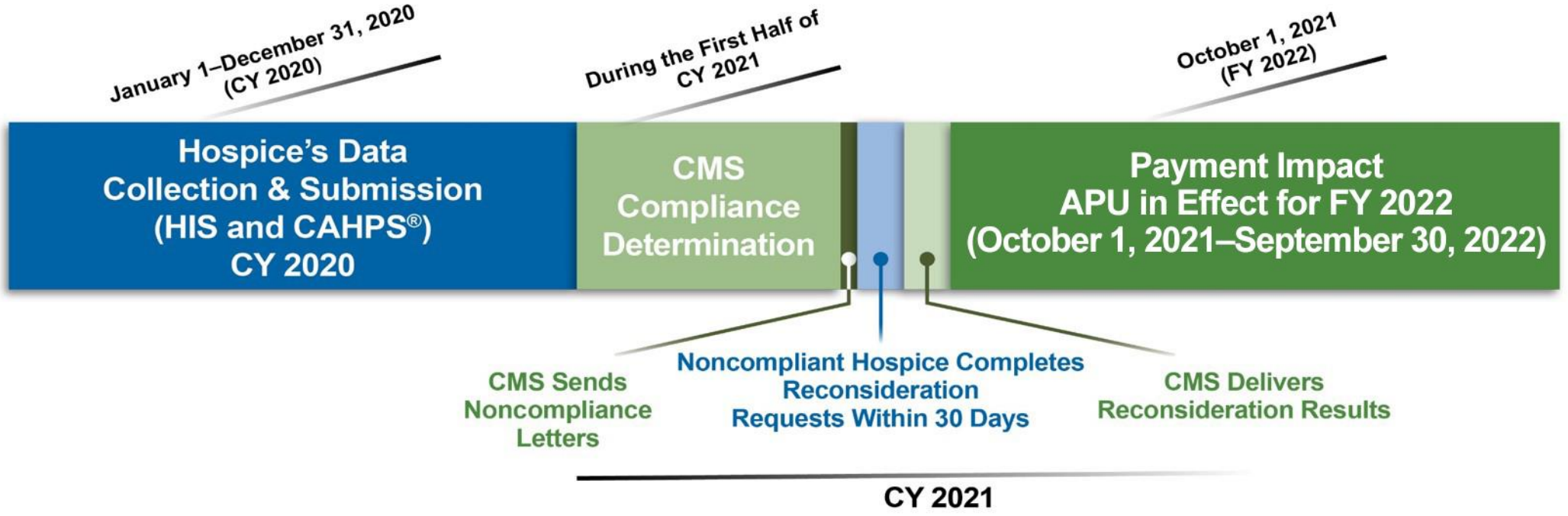
HQRP Requirements

- Currently, there are two requirements for HQRP:
  - HIS data collection and submission.
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey submission.
- All Medicare-certified hospice providers must comply with these two reporting requirements for all patients, regardless of payer.



The HQRP

The HQRP Life Cycle



- Annual Payment Update (APU) calculations:
  - Year 1: Data collection and submission.
  - Year 2: Compliance determinations.
  - Fiscal Year (FY): APU in effect.

HOSPICE QUALITY REPORTING PROGRAM

Completing the HIS

Basic Instructions

Common Questions About Completing the HIS

Where does the HIS data come from?

Who is allowed to complete the HIS?

Who makes the determination?

Who is responsible for the accuracy and completeness of the HIS?

Completing the HIS

- HIS data collection consists of selecting responses to HIS items in conjunction with patient assessment activities or via abstraction from the patient's clinical record.
- Any hospice staff member, including trained volunteers, contractors, and affiliates, may complete the HIS.
- The hospice is responsible for the accuracy and completeness of information in the HIS.
- It is at the discretion of the hospice to determine who can accurately complete the HIS.

Completing the HIS: Information Sources

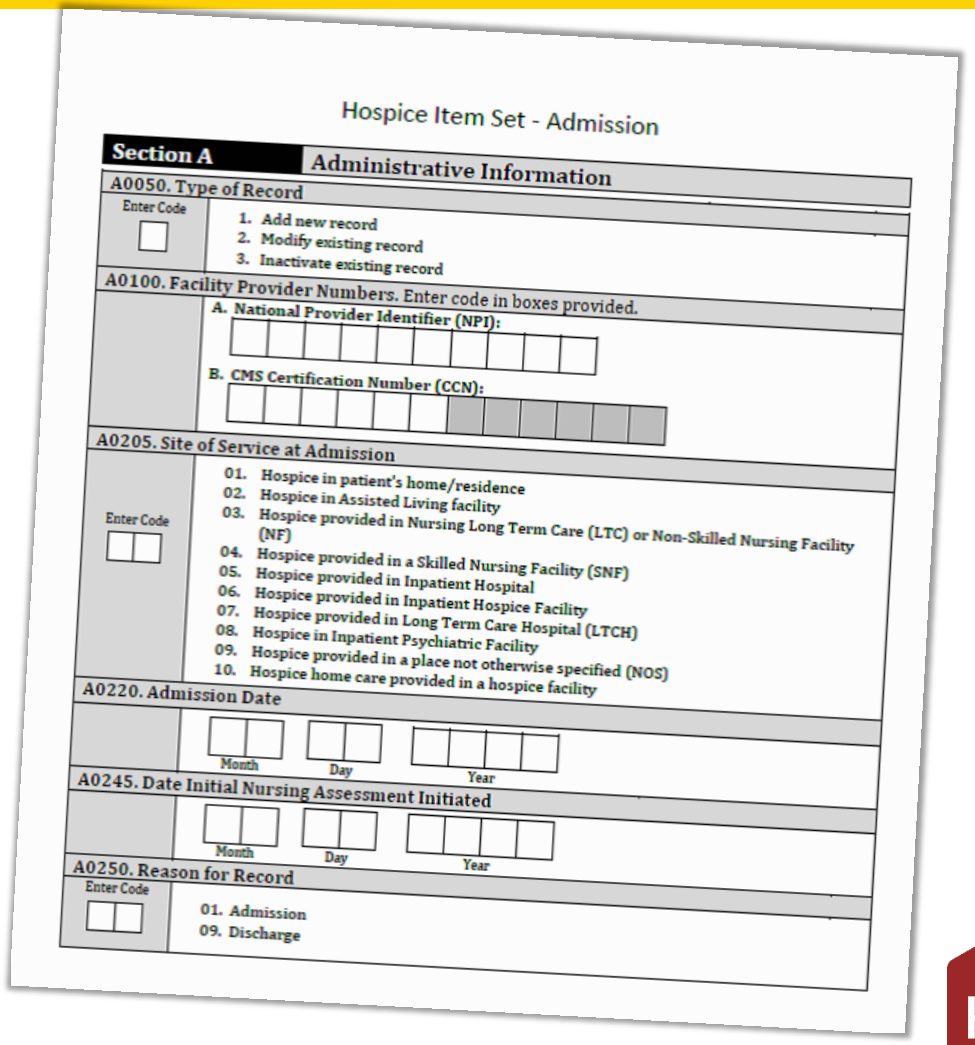
- Primary sources of information for completing the HIS:
  - Data collected through clinical care processes as they are completed.
  - Documentation in the hospice clinical record.

Completing the HIS: Information Sources (cont.)

- In general, sources external to the clinical record should not be used when completing the HIS.
  - In some instances, a provider may consult sources other than the hospice clinical record to complete HIS items.
  - For example, completion of Section A (Administrative Information) items may require review of claims or billing records.

Completing the HIS: Ensuring Accuracy

- HIS records should be fully and accurately completed on *all patient admissions.*
- Responses can be selected by the assessing clinician or can be based on information documented in the clinical record.
- If a particular HIS care process is not documented, the care process is considered not to have occurred.



Hospice Item Set - Admission

Section A Administrative Information

A0050. Type of Record

Enter Code ☐

1. Add new record
2. Modify existing record
3. Inactivate existing record

A0100. Facility Provider Numbers. Enter code in boxes provided.

A. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

B. CMS Certification Number (CCN): ☐☐☐☐☐☐☐☐☐☐☐☐

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

A0220. Admission Date

☐☐ Month ☐☐ Day ☐☐☐☐ Year

A0245. Date Initial Nursing Assessment Initiated

☐☐ Month ☐☐ Day ☐☐☐☐ Year

A0250. Reason for Record

Enter Code ☐☐

01. Admission
09. Discharge

Completing the HIS: Ensuring Accuracy (cont.)

- The HIS-Admission record and HIS-Discharge record should be submitted even if the patient revokes the hospice benefit or is discharged from hospice.
- If a patient is discharged before an HIS-related care process takes place, hospices should answer “no” to the gateway question and follow the skip patterns as indicated on the HIS.
- Hospices should not leave any items blank unless directed to do so by skip patterns.

J2030A Practice Coding Scenario

J2030. Screening for Shortness of Breath	
Enter Code ☐	**A. Was the patient screened for shortness of breath?** 0. **No** → Skip to N0500, Scheduled Opioid 1. **Yes** **B. Date of first screening for shortness of breath:**
Enter Code	**C. Did the screening indicate the patient had shortness of breath?** 0. **No** → Skip to N0500, Scheduled Opioid 1. **Yes**

J2030A Practice Coding Scenario (cont.)

While completing Mr. K's HIS-Admission, you are unable to find documentation of screening for shortness of breath.

How should you proceed with completing J2030A, Was the patient screened for shortness of breath?

J2030A Practice Coding Scenario (cont. 1)

- **Coding:**
  A. J2030A. Answer “0” indicating “no,” and follow the skip pattern outlined by the HIS.
  B. J2030A. Answer “1” indicating “yes,” because when you call the patient he confirms that the admitting nurse conducted the screen.
  C. J2030A. Answer “1” indicating “yes.” You can assume the screening was done as your hospice’s policy is to screen for shortness of breath with each nurse visit.

J2030A Practice Coding Scenario (cont. 2)

- **Coding:**
  - **A. J2030A. Answer "0" indicating "no," and follow the skip pattern outlined by the HIS**
  - B. J2030A. Answer "1" indicating "yes," because when you call the patient he confirms that the admitting nurse conducted the screen.
  - C. J2030A. Answer "1" indicating "yes." You can assume the screening was done as your hospice's policy is to screen for shortness of breath with each nurse visit.
- **Rationale:** If a particular HIS care process is not documented, the care process is considered not to have occurred.

Q2 True or False: HIS records need to be completed only on Medicare patients.

A. True

B. False

Q2 True or False: HIS records need to be completed only on Medicare patients. (cont.)

A. True

B. False: HIS records should be fully and accurately completed on all patient admissions regardless of payer.

HIS Submission Requirements

HIS Submission Requirements

- All Medicare-certified hospice providers are required to submit:
  - HIS-Admission records.
  - HIS-Discharge records.
- HIS data are collected and submitted on **all** patient admissions, regardless of the payer, patient's age, or location of the receipt of hospice services.
- The information captured includes items used in the calculation of nine HIS-based quality measures.

HIS Data: When to Submit Data?

- Hospice HIS-Admission and HIS-Discharge data must be submitted for all patients within 30 days of the event or target date.
- The act of **submission does not equal acceptance.**
- It is recommended that hospices submit data within 7–14 days to be sure of acceptance by the 30-day deadline.

Submit data within 30 days of the event or target date.

It is recommended that hospices submit data within **14 days** to ensure acceptance by the 30 day deadline.

HIS Data: Where Do You Submit Data?

- HIS records are submitted into the Centers for Medicare & Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) - Assessment Submission and Processing (ASAP) system.
- The **Hospice Submission User's Guide** is an important resource.
- Ensure that your submissions are in the correct format, contain the correct information, and will be accepted by the QIES ASAP system.

*All current QIES functions will be migrated to the new iQIES platform no sooner than CY 2021.

HIS Record Submission

Confirming Acceptance – Identifying Errors

Submission Validation

- After you submit the HIS, the system performs a validation of the data submitted. There are three types of validation checks performed by the QIES ASAP system:
  - Fatal File Errors.
  - Fatal Records Errors.
  - Nonfatal Errors, or Warnings.

Fatal File Errors

- Fatal File Errors: The submission file structure is checked against HIS Data Submission Specifications; if the file does not meet requirements, it is rejected.
  - Examples of Fatal File Errors include:
    - File is not a zip file.
    - File cannot be read.
- **Files that are rejected must be corrected and resubmitted.**

Fatal Records Errors

- Each HIS record within the file is checked for fatal record errors.
- Fatal record errors include, but are not limited to, the two following types:
  - Out-of-range responses
    - For example, the valid responses for an item are 1, 2, and 3, but the value submitted was 6.
  - Inconsistent relationships between items
    - For example, an inconsistent date pattern, such as the Patient's Birth Date (Item A0900) being later than the Admission Date (Item A0200), or not following a skip pattern correctly.

Fatal Records Errors (cont.)

- Records with fatal errors are rejected by the QIES ASAP system, and the record is not accepted.
- Rejected records are not saved in the QIES national repository.
- **Fatal records errors must be corrected and resubmitted** to ensure that data are accepted.

Nonfatal Errors, or Warnings

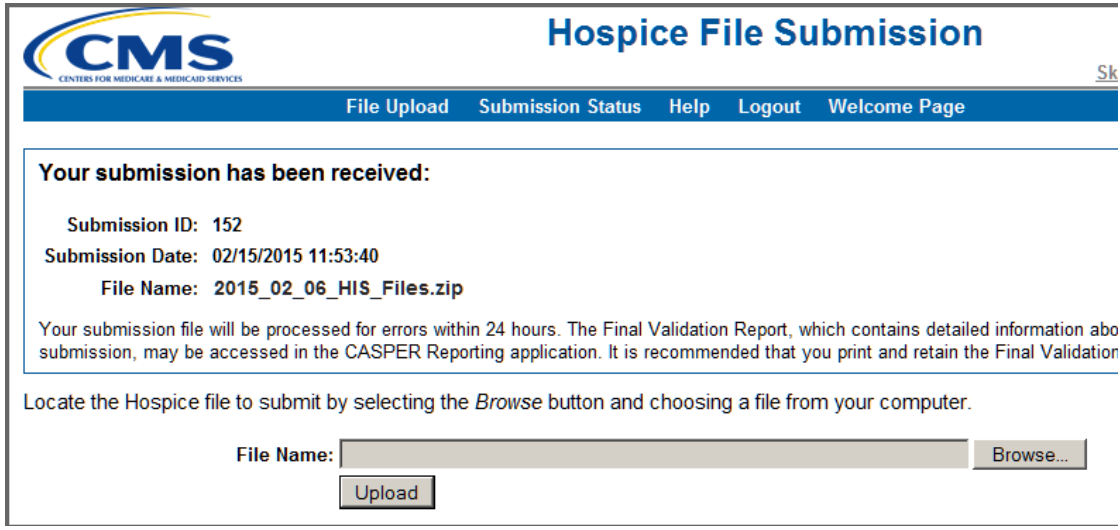
- Warnings and fatal record errors are displayed on the Final Validation Report (FVR).
- Late submission of HIS records will result in a nonfatal (warning) error.
- Records containing warnings, or nonfatal errors, can still be accepted by the QIES ASAP system.
- Any combination of fatal errors and nonfatal errors will be rejected and must be corrected.
- Warning messages alone do not cause an HIS record to be rejected by the QIES ASAP system.

Warning messages should be reviewed to see whether the information needs to be corrected and resubmitted.

The Hospice FVR

- The QIES ASAP system:
  - Confirms that the submission was received.
  - Includes the name of the file that you submitted.
- **Submission does not mean your data were accepted.**

The FVR is the only way to verify that submitted files were also accepted.



The Hospice FVR (cont.)

- The Hospice Final Validation Report (FVR) provides detailed information about the status of the submission files.
  - The FVR will verify acceptance or rejection of the HIS records.
    - Print and keep a copy of this confirmation. This is your proof of HIS Data Acceptance.
  - Details the fatal error and warning messages encountered.
  - Auto-generated for each submission and placed in your provider's Validation Report folder in Certification and Survey Provider Enhanced Reports (CASPER).
  - Automatically purged from the Validation Report folder after 60 days.
  - Can be user-generated upon request.

The Hospice FVR (cont. 1)

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CMS Submission Report
Hospice Final Validation Report

Run Date: 01/13/2020
Page 1 of 1

Submission Date/Time:	01/13/2020 10:04:43
Submission ID:	2684513
Submitter User ID:	HOSPC9999999
Submission File Name:	tdsdn3jgzxcaHISMeasureBatch.zip
Submission File Status:	Completed
Processing Completion Date/Time:	01/13/2020 10:09:06
FAC_ID:	1234567
Provider Name:	GREAT HOSPICE
Provider CCN:	123456
State Code:	NJ
# Records Processed:	2
# Records Accepted:	2
# Records Rejected:	0
# Duplicate Records:	0
# Records Submitted Without Provider Authority:	0
Total # of Messages:	0

Record: 1 — Accepted

Name (A0500C, A): DUCK, DONALD
SSN (A0600A): 111-11-1111
Medicare Num:(A0600B): 111111111A
Birth Date (A0900): 09/04/1935
Gender (A0800): M
Patient ID: 11111111

Target Date: 01/08/2020
HIS_ID: 17427085
XML File Name:
Type of Record (A0050): NEW RECORD
Reason for Record (A0250): 09
1097158.xml

Record: 2 — Accepted

Name (A0500C, A): BOOP, BETTY
SSN (A0600A): 999-99-9999
Medicare Num:(A0600B): 999999999A
Birth Date (A0900): 03/05/1925
Gender (A0800): F
Patient ID: 22222222

Target Date: 01/09/2020
HIS_ID: 17427084
XML File Name:
Type of Record (A0050): NEW RECORD
Reason for Record (A0250): 09
1100898.xml

This report may contain privacy protected data and should not be released to the public. Any alteration to this report is strictly prohibited.

The Hospice FVR (cont. 2)

CMS Submission Report
Hospice Final Validation Report

Run Date: 01/13/2020
Page 1 of 3

Submission Date/Time: 01/02/2020 10:21:27
Submission ID: 2673284

Submitter User ID: HOSPC9999999
Submission File Name: yknlxesxjgheHISMeasureBatch.zip
Submission File Status: Completed
Processing Completion Date/Time: 01/02/2020 10:24:07

FAC_ID: 1234567
Provider Name: GREAT HOSPICE
Provider CCN: 123456
State Code: NJ

 # Records Processed: 6
 # Records Accepted: 5
 # Records Rejected: 1
 # Duplicate Records: 0
 # Records Submitted Without Provider Authority: 0
Total # of Messages: 1

Record: 1 — Accepted

Name (A0500C, A): DUCK, DONALD
SSN (A0600A): 111-11-1111
Medicare Num:(A0600B): 111111111A

Birth Date (A0900): 09/04/1935
Gender (A0800): M
Patient ID: 11111111

Target Date: 12/30/2019
HIS_ID: 17322336
XML File Name:

Type of Record (A0050): NEW RECORD
Reason for Record (A0250): 09
1088745.xml

Record: 6 — Rejected

Name (A0500C, A): BOOP, BETTY
SSN (A0600A): 999-99-9999
Medicare Num:(A0600B): 999999999A

Birth Date (A0900): 03/05/1925
Gender (A0800): F
Patient ID: 22222222

Target Date: 01/02/2020
HIS_ID: 17322342
XML File Name:

Type of Record (A0050): NEW RECORD
Reason for Record (A0250): 09
1088790.xml

HIS Item(s): A0600B
Data Submitted: 00000
Message Number: -3079 FATAL
Message: Incorrect Medicare Beneficiary Identifier (MBI): The MBI format is invalid.

HIS Data: Impact on the Compliance Threshold

- Inaccurate information in the QIES ASAP system may affect hospice quality reporting results.
- Hospice must meet the 90 percent timeliness compliance threshold requirement to avoid the 2 percent reduction in their annual payment update (APU).

Threshold Compliance today pays off in the future.

HIS Records From	Submission Threshold	Reporting Year
CY 2019	90%	FY 2021
CY 2020	90%	FY 2022
CY 2021	90%	FY 2023

Other Valuable CASPER Reports

CASPER Reports

- CASPER has many other valuable reports with specific functions.
  - Select the CASPER Reporting link on the CMS QIES* for Providers webpage.
  - Locate hospice-specific reports in these categories in CASPER:
    - Hospice Provider.
    - Hospice Quality Reporting Program.
- The CASPER Reporting User's Guide For Hospice Providers is available at https://qtso.cms.gov/reference-and-manuals/casper-hospice-reporting-users-guide.

*All current QIES functions will be migrated to the new iQIES platform no sooner than 2021.

Future Change to iQIES

- The QIES system will change to iQIES.
- Reports will then migrate to the new iQIES system and will no longer be referred to as CASPER reports.
- The change will be in effect no sooner than CY 2021.

Overview of Reports for Hospice Public Reporting

Report Title	Always includes a full year of data	Includes patient stay-level data	Includes hospice-level data	Affected by data correction deadlines	Underlying data can be changed	Run on-demand
Quality Measure Reports	No*	Yes	Yes	No	Yes	Yes
Review and Correct Reports	Yes	Yes	Yes	Yes	**	Yes
HIS Provider Preview Reports	Yes	No	Yes	Yes	No	No

* The report may include a full year of data if requested by the provider.

** If the data correction period is “open,” provider corrections to HIS records will appear in a future release of the Review and Correct Reports. If the data correction period is “closed,” provider corrections to HIS records will NOT appear in a future release.

Provider Preview Reports

System-generated CASPER reports (shared folder within CASPER).

Covers HIS data from specific time points.

Hospice Provider Preview report.

Issued at specific times for 30-day preview periods.

CAHPS® Hospice Survey Provider Preview report.

Allows providers to preview final QM results before public display on Hospice Compare.

Accessing and Using Reports

- Access your reports in CASPER to investigate measure results.
- Identify opportunities for data correction and/or initiating and updating your quality improvement strategies.
- If determined necessary, submit, modify, or inactivate HIS records in CASPER.
- Access Review and Correct reports the following week to verify updates or corrections.

Q3 What is the best way to verify that HIS submissions have been accepted into the QIES ASAP system?

A. Cross your fingers that the records get accepted.

B. Review all of the reports in the CASPER system.

C. Check the Final Validation Report (FVR).

D. Access your Review and Correct reports regularly.

Q3 What is the best way to verify that HIS submissions have been accepted into the QIES ASAP system? (cont.)

A. Cross your fingers that the records get accepted.

B. Review all of the reports in the CASPER system.

C. Check the Final Validation Report (FVR).

D. Access your Review and Correct reports regularly.

Correcting HIS Records

Modification & Inactivation Requests

HIS Record Correction Policy

- The HIS record should be accurate when submitted and accepted into the QIES ASAP system.
- Inaccurate information in the QIES ASAP system may affect hospice quality reporting results.
- It is the provider's responsibility to correct any errors that exist in a submitted HIS record according to the HIS Record Correction Policy.

HIS Record Correction Policy (cont.)

- HIS records that have not yet been accepted in the QIES ASAP system include records that have been submitted and rejected, or records that have not been submitted at all.
- Records that have been submitted and rejected can usually be corrected and resubmitted without any special correction procedures because they were never accepted by the QIES ASAP system.

HIS Record Correction Policy (cont. 1)

- A correction can be submitted for any accepted record, even if there has been a submission and acceptance of subsequent records for the patient.
- The correction process will depend on the type of error.

When Should You Correct HIS Records?

- If one or more data elements in an accepted record are inaccurate, correct the erroneous record.
- Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item response selection errors, or other errors.

How Should You Correct HIS Records? (cont.)

- Two processes exist to correct HIS records that have been accepted into the QIES ASAP system:
  1. Modification.
  2. Inactivation.
- Corrections (modification or inactivation) should be made to HIS records containing HIS errors, even if that means the newly completed record (after an inactivation) would be late.

CMS Policy for HIS Record Submission

- The date by which providers modify or inactivate HIS records affects what data is reported on Hospice Compare.
- Effective October 1, 2019, the CMS policy for HIS patient record submission was changed to 24 months from the target date (the event date).
- The policy change applies to new, modified, and inactivated records.
- HIS submission after 24 months will be rejected.

Correcting HIS Records: Modifications

- A Modification Request is used to correct an HIS record that was accepted into the QIES ASAP system with clinical or non-key demographic errors.
- The Modification Request archives the inaccurate HIS record within the QIES ASAP system and replaces it with the new, corrected record.
- The Modification Request must contain correct values for all items, not just those that require correction.

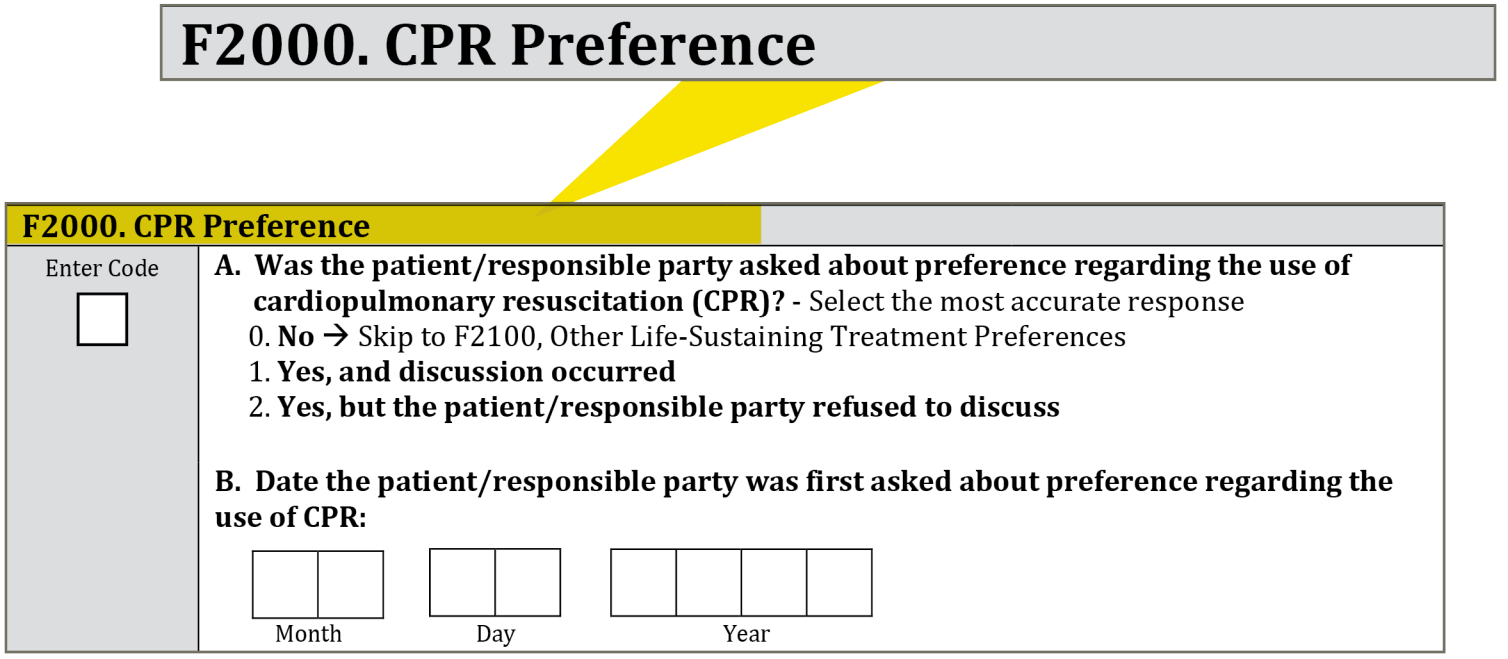
Correcting HIS Records: Modifications (cont.)

- After a Modification Request is submitted, the QIES ASAP system will attempt to locate the existing record.
- If the system does not find the record, the Modification Request will be rejected and a fatal error be reported on the FVR.
- If the system finds the record, then the prior erroneous record will be replaced within QIES with the corrected record, and the prior erroneous record will be stored in an archive file.

Correcting HIS Records: Modifications (cont. 1)

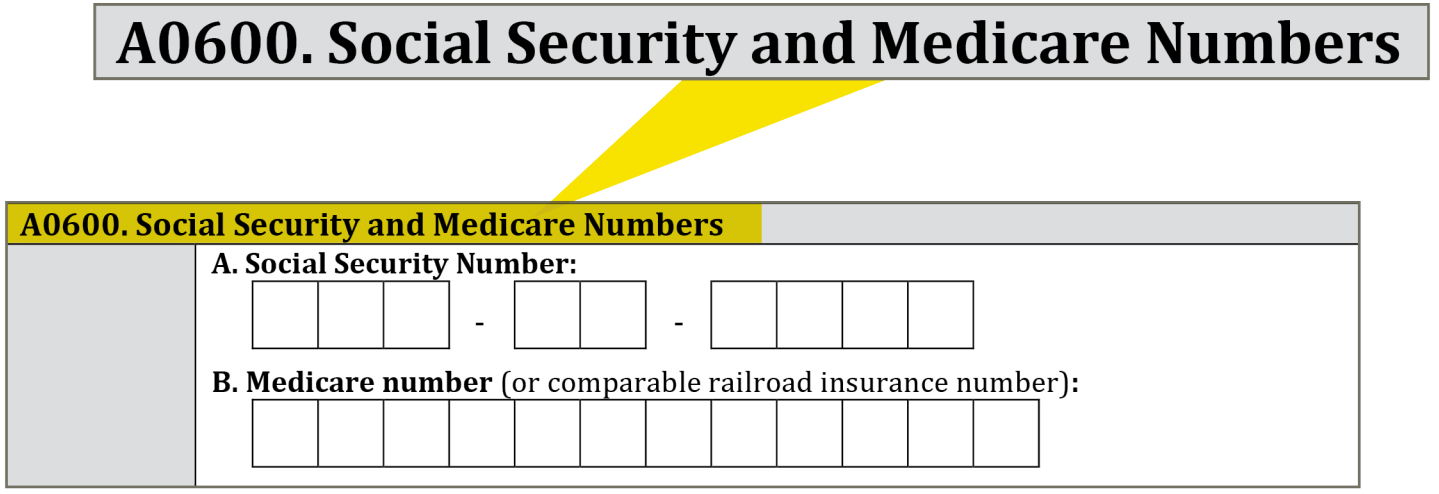
- Examples of when to modify.
  - Clinical errors in HIS responses, such as:
    - Whether the patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (CPR).
    - Whether or not the comprehensive pain assessment was completed.
  - Non-key demographic errors:
    - Site of service at admission.
    - Date the initial nursing assessment was initiated.

Correcting HIS Records: Modifications (cont. 2)



Correcting HIS Records: Inactivation

- Inactivation Requests must be used ***when a record has been accepted*** into the QIES ASAP system but:
  - The event did not occur.
  - One or more Event or Patient Identifiers is erroneous.



Correcting HIS Records: Inactivation (cont.)

- **Record Event Identifiers:**
  - Item A0220: Admission Date (on an HIS-Admission record).
  - Item A0250: Reason for Record.
  - Item A0270: Discharge Date (on an HIS-Discharge record).
- **Patient Identifiers:**
  - Item A0500A: First Name.
  - Item A0500C: Last Name.
  - Item A0600: Social Security. Number (SSN).
  - Item A0800: Gender.
  - Item A0900: Birth Date.

Correcting HIS Records: Inactivation (cont. 1)

- Record Identifiers or Patient Identifiers submitted as part of the original record must also be submitted as part of the Inactivation Request.
- In order for the system to find the record, ***the values for each item must match in the erroneous record and the inactivation record.***
- Once inactivated, the new information can be resubmitted by replacing the record with a new one with the correct information.

Correcting HIS Records: Inactivation (cont. 2)

- After an Inactivation Request is submitted, the QIES ASAP system uses patient identifiers to locate the existing record.
- If the system does not find the record, the Inactivation Request will be rejected and a fatal error is reported on the FVR.
- If the system finds the record, the prior erroneous record will be removed from the active QIES records and stored in an archive file within QIES.
- If necessary, create and submit a new record with the correct information.

Q4 How many months from the target date does a hospice have to complete the HIS patient record submission?

A. 30 days.

B. Submission must occur on the day of the event.

C. 24 months.

D. 36 months.

Q4 How many months from the target date does a hospice have to complete the HIS patient record submission? (cont.)

A. 30 days.

B. Submission must occur on the day of the event.

C. 24 months.

D. 36 months.

Submit, Modify, or Inactivate?

Case Examples

HIS Modification– Inactivation Scenario 1

- In auditing HIS submissions, the hospice's (QAPI) nurse found an error in the discharge reason on the HIS for Mrs. Jones.
- The HIS record has already been submitted and accepted.
- Does the hospice need to correct this?

Q5 Do you correct the discharge reason for an HIS record that has already been accepted?

A. No, this is not necessary since the patient died several months ago.

B. Yes, complete a modification.

C. Yes, an inactivation is required.

D. None of the above.

Q5 Do you correct the discharge reason for an HIS record that has already been accepted? (cont.)

A. No, this is not necessary since the patient died several months ago.

B. Yes, complete a modification.

C. Yes, an inactivation is required.

D. None of the above.

HIS Modification–Inactivation Scenario 2

- Mr. Green was discharged from a hospital on **February 26, 2020**. The hospice election paperwork was signed on that day. When the RN arrived for her assessment visit the next morning, the family was on the phone with their primary care practitioner and notified the RN that the patient had just died.
- Is an HIS record required?

Q6

Is an HIS record required?

A. Yes, because the RN is in the home and needs to complete the necessary paperwork.

B. Yes, because the election form was already signed.

C. No, the patient died before the RN arrived, so the services were never initiated.

Q6 Is an HIS record required? (cont.)

A. Yes, because the RN is in the home and needs to complete the necessary paperwork.

B. Yes, because the election form was already signed.

C. No, the patient died before the RN arrived, so the services were never initiated.

HIS Modification–Inactivation Scenario 2

- What if Mr. Green died while the nurse was in the home in the midst of the assessment?
- Is an HIS record required?

Q7 Is an HIS record required?

A. Yes, all the necessary conditions regarding admission were met.

B. The hospice QAPI nurse will make the final decision.

C. No, the patient died before the RN assessment was complete.

Q7 Is an HIS record required? (cont.)

A. Yes, all the necessary conditions regarding admission were met.

B. The hospice QAPI nurse will make the final decision.

C. No, the patient died before the RN assessment was complete.

HIS Modification–Inactivation Scenario 3

Mr. H. was admitted to Hospice on **January 28, 2020.** The HIS was submitted on Friday, **February 14.** When reviewing charts for the Interdisciplinary Group meeting on Thursday, **February 20,** the nurse manager finds a note in the chart from the initial hospice consult. It describes the patient/family conversation with the hospice liaison about all of his preferences noted just *two days prior to admission.*

HIS Modification–Inactivation Scenario 3 (cont.)

- The nurse manager knows that the hospice submitted the January HIS records on February 18 and that the submission for this patient did not reflect the completion of the care processes found in the note.
- Should the nurse manager make a correction? If so, how?

Note Re: Preferences	Admission Visit	HIS Submission	Note Found
January 26	**January 28**	**February 14**	**February 20**
2 days prior to admission	Target Date	Target date + 17	Target date + 23

Q8 Should the nurse manager make a correction in the HIS patient record submission?

A. Yes, the record should be corrected by modification, even though it will not change anything.

B. Yes, the record should be corrected by modification and will have an impact on the hospice's quality measure results.

C. No, it is too much trouble to do this.

D. No, the submission has already been accepted in the QIES ASAP system.

Q8 Should the nurse manager make a correction in the HIS patient record submission? (cont.)

A. Yes, the record should be corrected by modification, even though it will not change anything.

B. Yes, the record should be corrected by modification and will have an impact on the hospice's quality measure results.

C. No, it is too much trouble to do this.

D. No, the submission has already been accepted in the QIES ASAP system.

HIS Modification–Inactivation Scenario 4

- When discharging Mrs. S. after her death, the nurse noted that the first name of the patient was wrong in her electronic health record. Although the entire family referred to her as Mary, the patient's actual first name was Elizabeth. Mary was her middle name.
- What needs to be done to correct the HIS?

Q9 How would the hospice correct the HIS record?

A. There is no need. Just submit the accurate information on the discharge HIS.

B. A modification of the Admission HIS record is needed.

C. An inactivation of the Admission HIS is required. The data includes a patient identifier and the Admission HIS has already been accepted by the QIES ASAP system.

Q9 How would the hospice correct the HIS record? (cont.)

A. There is no need. Just submit the accurate information on the discharge HIS.

B. A modification of the Admission HIS record is needed.

C. An inactivation of the Admission HIS is required. The data includes a patient identifier and the Admission HIS has already been accepted by the QIES ASAP system.

Summary and Resources

Summary

- Described the elements of the HQRP.
- Provided an overview of HIS completion, submission and reports.
- Differentiated between a ***modification*** and the ***inactivation*** of an HIS record.
- Reviewed examples of HIS submission, modification, and inactivation.
- Provided a list of helpful resources for successfully completing the HIS.

Resources

- HIS Manual V2.01: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/HIS_Manual_V201.pdf.
- Hospice User Guides and Training page on the QIES Technical Support Office website at https://qtso.cms.gov/providers/hospice-providers/training.
- Hospice Submission User's Guide: https://qtso.cms.gov/reference-and-manuals/hospice-submission-users-guide.
- HQRP Training and Education Library web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training-Training-and-Education-Library.

Resources (cont.)

- The HQRP web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.
- HIS web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html.
- CMS Hospice CAHPS® Survey web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/CAHPS%C2%AE-Hospice-Survey.
- The official Hospice CAHPS ® Survey website: http://www.hospicecahpssurvey.org.

Help Desk Assistance

- Quality Help Desk: HospiceQualityQuestions@cms.hhs.gov.
  - For questions about quality reporting requirements, quality measures, and reporting deadlines.
- QIES Help Desk: Help@qtso.com or 1 (877) 201-4721.
  - For questions about HIS submission reports and CASPER reports.
- CAHPS® Hospice Project Survey Team: HospiceCAHPSSurvey@hcqis.org.
  - For questions about CAHPS® information and technical assistance.
- Hospice Compare: https://www.medicare.gov/hospicecompare/


Questions?