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Hospice Outcomes and Patient Evaluation (HOPE) Guidance Manual v1.01

Effective October 1, 2025

Centers for Medicare & Medicaid Services

Hospice Quality Reporting Program

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CHAPTER 1: BACKGROUND AND OVERVIEW OF THE HOSPICE DATA SET MANUAL

1.1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) under section 1814(i)(5) of the Social Security Act authorizes the Health and Human Services Secretary to establish a quality reporting program for hospices and requires the Secretary to make data available to the public and ensure hospices can review that data before public reporting. The Centers for Medicare & Medicaid Services (CMS) introduced the HQRP in the Fiscal Year (FY) 2012 Hospice Wage Index Final Rule (76 FR 47318-47324) and finalized the requirement for the Hospice Item Set (HIS) as part of the HQRP in the FY 2014 Hospice Wage Index Final Rule (78 FR 48255-48262). Beginning with FY 2014 and for each subsequent FY, hospice programs submit data on quality measures to the Secretary. Hospice quality data is publicly reported through the Care Compare website. The CMS HQRP website is the official website for resources, including announcements and updates to the HQRP.

CMS developed a tool, Hospice Outcomes and Patient Evaluation (HOPE), to replace the HIS. The name HOPE was confirmed in the FY 2020 Hospice Final Rule, and CMS finalized the requirement for HOPE as part of the HQRP in the FY 2025 Hospice Final Rule (CMS-1801-F). HIS used data from retrospective chart abstraction at admission and discharge to determine if hospices performed care processes. HOPE items are designed to collect patient-specific data in real-time, based on interactions with the patient and family/caregiver, and with flexibility to accommodate patients with varying clinical needs. While HOPE contains some original HIS items, HOPE intends to help hospices better understand patient care needs and contribute to the patient's plan of care at additional timepoints, not just at admission and discharge. HOPE data collection considers the hospice workflow and the Medicare Hospice Conditions of Participation (CoPs).

The primary objectives of HOPE are to provide quality data for HQRP requirements through standardized data collection, support survey, and certification processes, and to inform future payment and quality improvement refinements. Data collected at baseline, along with status changes and outcomes at other timepoints, will contribute to the updates to the hospice plan of care and support providers' quality improvement efforts via Quality Assurance Performance Improvement (QAPI).

HOPE contains a standardized set of items to capture patient-level data on each hospice patient. Quality measures based on these items are described in the HQRP Quality Measures (QM) User Manual, available in the downloads section of the HQRP Current Measures page.

1.2. Manual Overview

The purpose of this Manual is to offer guidance on collecting and submitting HOPE data to CMS. The manual is divided into three chapters and appendices:

Chapter 1 – Provides an introduction, background information, data collection timepoints, requirements, and general guidance.

Chapter 2 – Contains item-specific guidance for completing all data elements.

Chapter 3 – Includes information on the submission of HOPE records and the correction processes.

Appendices – Includes the HOPE data sets for each assessment timepoint, glossary, and resources.

1.2.1. HOPE Tool

The HOPE tool contains a set of demographic, screening, and clinical data elements (also referred to as "items"), which contribute to a comprehensive assessment of all hospice patients. The data elements for each timepoint, can be found in Appendix C.

1.3. HOPE Timepoints and Definitions

Generally, hospices are required to submit up to four records for each patient admitted to their organization. This includes a minimum of a HOPE-Admission record, a HOPE-Discharge record, and up to two HOPE Update Visits (HUVs). Depending on the patient's length of stay (LOS), up to two HUV records may be required for every hospice admission, each at specified timeframes. HOPE data are collected during the hospice's routine clinical assessments and are based on unique patient assessment visits. However, not all HOPE items are completed at every timepoint.

While HOPE data elements contribute to the assessment, they do not replace a thorough and ongoing assessment of each patient[1], nor do they replace clinical practice and clinical judgment. HOPE timepoints with associated timeframes are defined in **Table 1** below and depicted in **Figure 1.**

[1] § 418.54 Condition of participation: Initial and comprehensive assessment of the patient; 42 CFR 418.54; https://www.ecfr.gov/current/title-42/section-418.54.

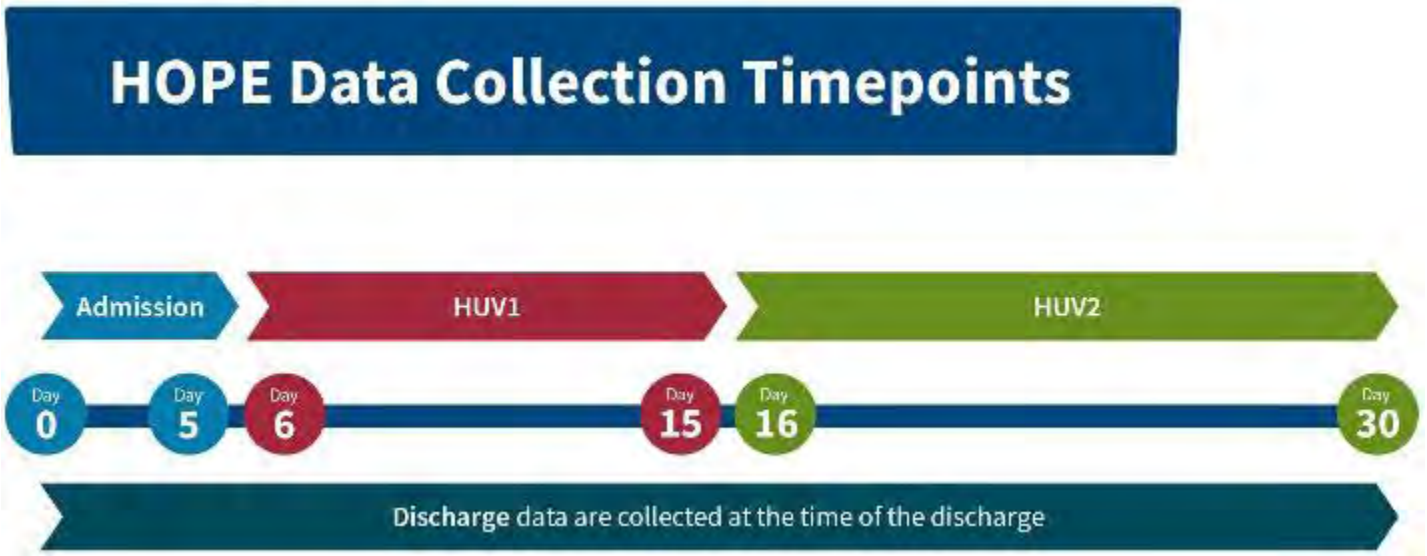
Table 1: HOPE Timepoint Definitions and Timeframes

Timepoint	Definition	Timeframe
Admission	The HOPE-Admission data are collected as part of the comprehensive assessment of the patient.	No later than five calendar days after the effective date of the hospice election.
HOPE Update Visit 1 (HUV1)	The data for HUV1 are collected via an in-person visit to inform updates to the plan of care.[2]	HUV1 is required on or between days six and 15 of the hospice stay and should ***not be conducted*** within the first five days after the hospice election. The date of the hospice election would be considered "Day 0."
HOPE Update Visit 2 (HUV2)	The data for HUV2 are collected via an in-person visit to inform updates to the plan of care.	HUV2 is required on or between days 16 and 30 after the hospice election.
Discharge	The data are collected at Discharge for any reason listed in A2115.	At the time of discharge.[3]

[2] § 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services; 42 CFR 418.56; https://www.ecfr.gov/current/title-42/section-418.56.

[3] § 418.104 Condition of participation: Clinical records.; 42 CFR 418.104(e); https://www.ecfr.gov/current/title-42/section-418.104.

Figure 1: HOPE Data Collection Timepoints



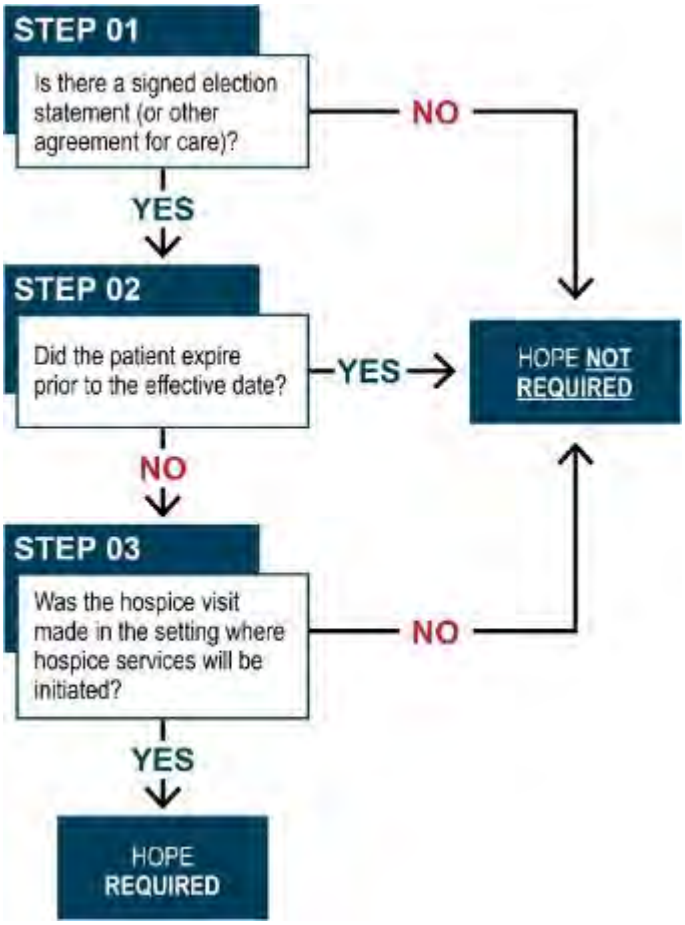
1.3.1. Admission

For the purposes of completing HOPE, a patient is considered admitted to a hospice if the following conditions are met:

- There is a signed election statement (or other agreement for care for non-Medicare patients).
- The patient did not expire before the effective date of the election or agreement for care.
- The hospice made a visit in the setting where hospice services are to be initiated.

All three criteria listed above must be met for the patient to be considered admitted for the purposes of HOPE reporting (see **Figure 2**, below).

Figure 2: HOPE-Admission Record Flow Chart



Examples for Patient Admission

Situation A

The patient signed an election statement on Monday with an effective date of Tuesday. The nurse went to the patient's home on Tuesday afternoon and the patient expired before the nurse arrived, so the nurse completed a visit with the grieving family.

Instructions

In this situation, the hospice is not required to submit the Admission or Discharge HOPE records. Although the patient signed the election statement and survived to the effective date of the election, the patient expired before the hospice visit could be made in the setting where the services were to be provided.

Situation B

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

Instructions

In this situation, since the assessment was in progress, the hospice nurse should complete the Admission and Discharge record with any HOPE data collected during the assessment visit. Due to the brief LOS, the HUV would not be required or expected.

Situation C

The patient was being transported for admission to an inpatient hospice facility. The admission process (including the election of the hospice benefit) was scheduled for that afternoon. The patient expired during transport, before arriving at the inpatient facility.

Instructions

In this situation, the hospice is not required to complete or submit HOPE data since the patient expired before electing the hospice benefit and before a visit could be made where the services were to be provided (the inpatient hospice facility).

1.3.2. HUV Timepoints

The HUV timepoints are designed to inform updates to the patient's written plan of care. Depending on the patient's LOS, up to two of these assessments are required. HUV1 should be conducted on or between days six and 15, but not within the first five days after the date of admission (A0220.Admission Date). HUV2 should be conducted on or between days 16 and 30. The date of the hospice election would be considered "Day 0."

If an HUV is missed or late for any reason (e.g., HUV1 conducted on day 17 or HUV2 conducted on day 33), conduct the visit as appropriate and submit the record once completed, including any SFV if applicable.

See **Table 2** for common HUV scenarios.

Table 2: Determining the Need to Conduct the HUV Timepoints

Scenario	If	Then	Rationale
Death/discharge day 0 to 5	The patient dies or is discharged within five days after the effective date of the hospice election (A0220 + 5).	HUV1 is not required.	No HUV is expected due to the short LOS.
Day 5 of hospice stay	It has been five days since the effective date of the hospice election (A0220 + 5).	The HUV1 is not required. It is too early to conduct HUV1.	HUV1 should not be conducted within the first five days after the effective date of the hospice election.
Day 15 of the hospice stay	The patient is still on service on day 15 (A0220 + 15) and beyond.	HUV1 is required and accepted.	Updates to the plan of care via HUV1 is required on or between days six and 15.
Day 30 of the hospice stay	The patient is still on service on day 30 (A0220 + 30) and beyond.	HUV2 is required and accepted.	Updates to the plan of care via both HUVs are required. (on or between days six and 15 for HUV1 and on or between days 16 and 30 for HUV2).
Death/discharge day 10	The patient dies or is discharged on day 10 (A0220 + 10).	HUV1 is not required. The HUV1 record would be accepted if submitted.	The hospice may not have had an opportunity to conduct HUV1 due to the death or discharge of the patient.
Death/discharge day 25	The patient dies or is discharged on day 25 (A0220 + 25).	HUV1 is required and accepted. HUV2 is not required. The HUV2 record will be accepted if it is submitted.	Updates to the plan of care via the HUV2 would be expected if the patient is on service for 30 days. With a discharge or death after day 15 and before day 30, the hospice may not have had an opportunity to conduct HUV2.

Examples for the HUV Timepoints

Situation A

Patient A elected hospice and was admitted on October 3. The hospice registered nurse (RN) completed the HOPE-Admission during the initial assessment visit (as defined in the Medicare Hospice Conditions of Participation). The HUV1 for this patient would be due sometime between October 9 and October 18, however, the patient declines rapidly and dies within one week of admission on October 10. *Is HUV1 required?* See **Figure 3** for the timeline in this example.

Figure 3: Hospice Discharge During the HUV1 Assessment Timeframe

Instructions for HUV completion: The HUV1 may or may not be completed.

Rationale: While there is time to conduct the HUV1 timepoint, it would not be required if the patient dies before the October 18 deadline.

Situation B

Patient B is admitted to hospice on November 1 and the RN conducts the initial assessment visit, completing the HOPE-Admission.

See **Figure 4** for the timeline of Situation B. *How soon should the nurse plan to conduct HUV1?*

Figure 4: HUV1 Assessment Timeframe

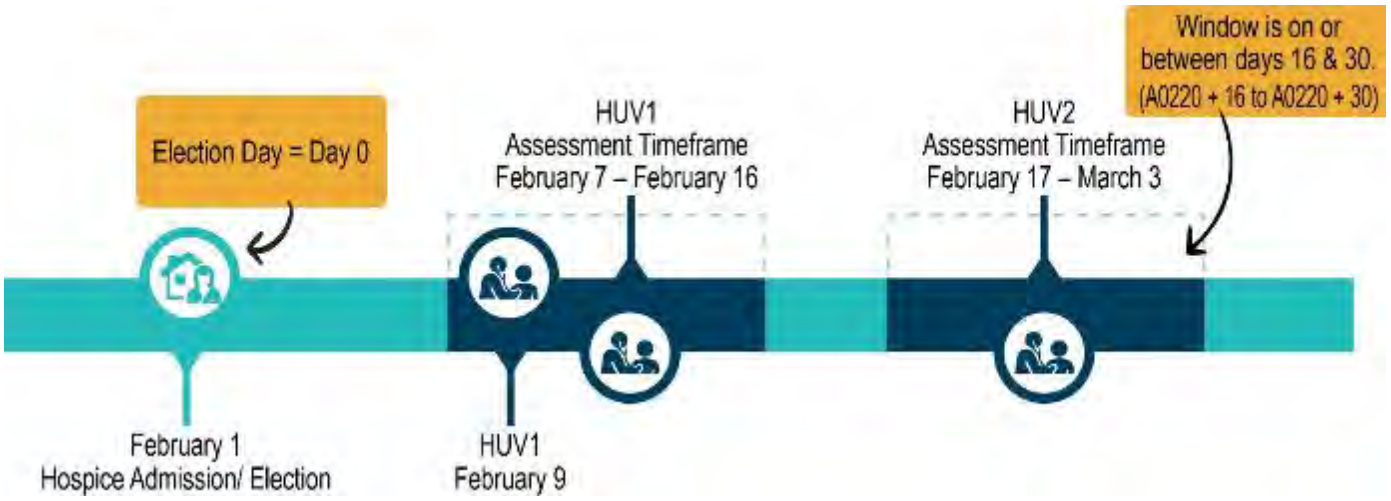
Instructions for HUV1 completion: The HUV1 is required starting on November 7.

Rationale: HUV1 should occur on or between days six and 15 after the hospice election. Therefore, in this situation, the HUV1 is due no sooner than November 7, and no later than November 16. Any visit to conduct HUV1 within this timeframe is acceptable.

Situation C

Patient C elected hospice on February 1. The patient remained on hospice throughout their illness and died on service 63 days later. HUV1 was conducted on February 9. See **Figure 5** for the timeline. *When should HUV2 be conducted?*

Figure 5: Both HUV Timepoints with HUV1 Conducted and HUV2 Pending



Instructions for HUV2 completion: HUV2 is due no sooner than February 17 and no later than March 3. Any visit within that timeframe is acceptable to conduct HUV2.

Rationale: Since the patient remained on service for 63 days, HUV2 is required on or between days 16 and 30, after the date of the hospice election.

1.3.3. Symptom Follow-up Visit (SFV)

During the Admission or HUV, data collected for the Symptom Impact item (J2051) may trigger the need for the Symptom Follow-up Visit (SFV).

The SFV is an **in-person visit** expected within two calendar days as a follow-up for any pain or non-pain symptom impact rated as *moderate* or *severe*. The SFV must be a separate visit from the Admission or HUV. It may occur anytime within two calendar days, or later on the same day as the assessment where the initial finding of a moderate or severe symptom was determined during the Admission or HUV. Depending upon timing and responses to J2051. Symptom Impact at Admission, or either of the two HUV timepoints, the SFV could stretch beyond the assessment timeframe. For the HUV timepoints, Z0350. Date Assessment was Completed would be the date the HUV was completed, including any SFV where applicable. Depending on the length of stay (LOS), up to three SFVs may be required over the course of the hospice stay (Admission, HUV1 and/or HUV2). See **Figure 6.** **Table 3** describes common situations for the SFV.

Figure 6: Example of a Symptom Follow-up Visit Triggered at the HUV1 Timepoint

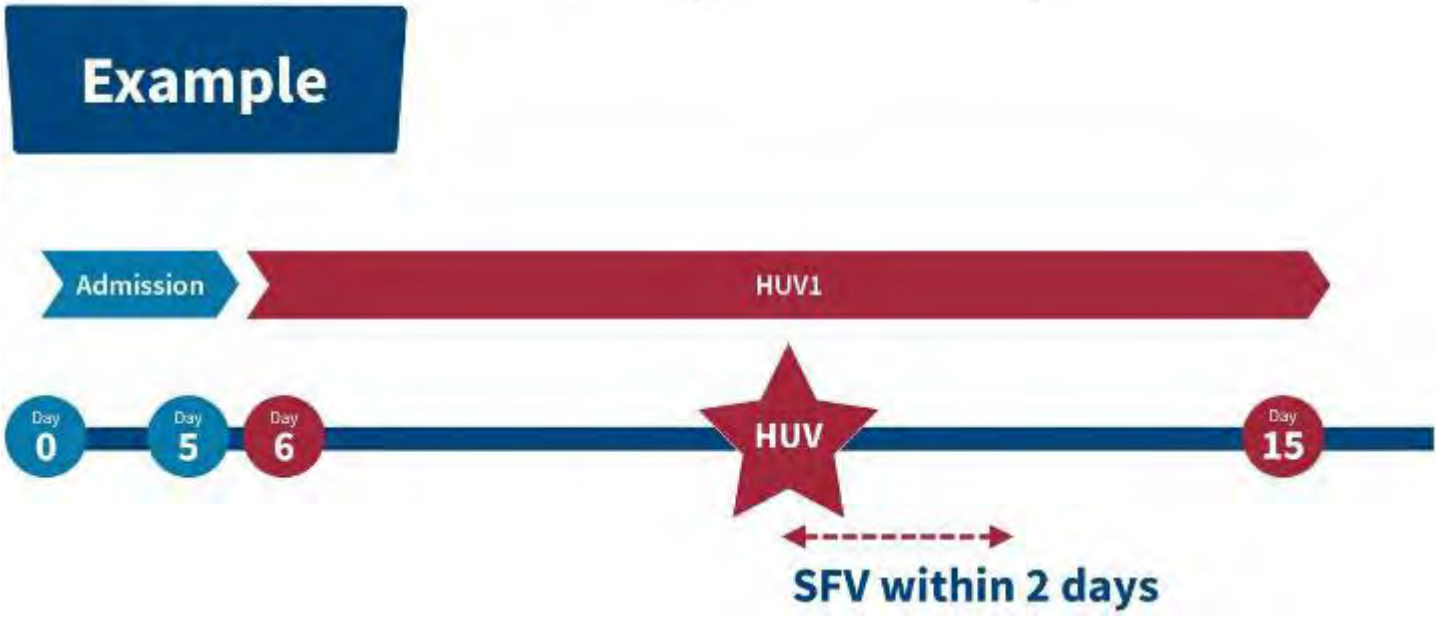


Table 3: Determining Whether the SFV is Required

Scenario	If	Then	Rationale
Moderate or severe symptoms documented at a HOPE timepoint visit	The HOPE-Admission or HOPE Update Visit (HUV) timepoint is conducted and at least one response to the Symptom Impact item (J2051) = moderate or severe (J2051A-H = 2 or 3).	Symptom Follow-up Visit (SFV) is required within two calendar days.	A HOPE-SFV is an in-person visit expected when any pain or non-pain symptom impact (J2051 A through H) is rated as **moderate or severe** when conducting the HOPE-Admission or HUV.

No moderate or severe symptoms were documented at a HOPE timepoint visit	The HOPE-Admission or HUV timepoint is conducted and no response to J2051 = moderate or severe (J2051A-H = 2 or 3).	SFV is not required.	A HOPE-SFV is only required when any pain or non-pain symptom (J2051 A through H) response is **moderate or severe** when completing J2051. Symptom Impact during a HOPE-Admission or HUV.

Examples for SFV

Situation A

During the admission visit, the nurse assesses the impact of pain as moderate and the impact of shortness of breath as severe. The nurse implements interventions for these symptoms and returns the next day to conduct an SFV. During the follow-up visit, the impact of pain is mild and the impact of shortness of breath is moderate.

Instructions for SFV: An additional SFV is not required for the purpose of the HQRP.

Rationale: If there is evidence of ongoing moderate or severe symptoms during an SFV, no additional SFV is required for HOPE. However, the hospice staff is expected to continue following up with the patient based on their clinical and symptom management needs.

Situation B

During the admission visit, the nurse assesses the impact of nausea as moderate, triggering the need for an SFV. The nurse returns within two days to conduct the SFV. Two weeks later, the nurse conducts the HUV1 and assesses the impact of constipation as severe, triggering the need for another SFV. The nurse returns within two days to conduct the SFV. On day 25, the HUV2 is conducted, and the impact of constipation is moderate. An SFV would be required to follow up on that symptom within two days.

Instructions for SFV: An SFV is required within two calendar days in each of these instances.

Rationale: An SFV should be conducted within two calendar days as a follow-up for **any moderate or severe pain or non-pain symptom impact** identified during an Admission or HUV timepoint. This may result in up to three SFVs per patient admission over the course of the hospice stay. Although multiple SFVs are not required for the purpose of the HQRP, it is expected that the hospice staff will continue to follow up with the patient based on their clinical and symptom management needs.

Situation C

During the admission visit, the RN assesses the impact of a symptom as moderate. Interventions are initiated to manage the symptoms, and the nurse (RN or LPN/LVN) returns in 2 days to follow up on the symptoms and conduct the SFV. HUV1 is then conducted on day 11 and no further symptoms are found to have a moderate or severe impact during that visit. The RN then conducts HUV2 on day 24 and the finding of a moderate to severe symptom impact triggers the need for another SFV. The LPN/LVN on the hospice team returns on day 25 to conduct the in-person SFV. Due to a decline in status, another nursing visit is conducted the next day. The patient dies on day 27 (A0220 + 27).

Instructions for HOPE Timepoint Completion: For the purposes of the HQRP, HOPE-Admission and HUVs are required based on the LOS. SFVs are only required when moderate or severe symptoms are documented at any Admission or HUV timepoint.

Rationale: Given the LOS for this patient, the HOPE-Admission and HUV1 are required to be completed and submitted. The submission of HUV2 is optional because the patient died before day 30. However, since the HUV2 is complete, if the HUV2 record is submitted, this record will be accepted and ultimately count favorably towards the HQRP QM because the SFV was conducted within two calendar days of the triggering HUV2 date.

Situation D

On day 30 after the hospice election, the primary nurse, just returning from vacation, realizes that HUV2 has not yet been conducted. A visit is able to be arranged for that day to ensure the agency meets the requirement of conducting an HUV2 on or between days 16 and 30. Upon visiting, the nurse hears from the patient and

caregiver that they have not been able to go out of the home recently, as the patient is experiencing diarrhea that is preventing them from doing any outside activities. Diet suggestions are provided by the nurse along with some medication adjustments, after consultation with the hospice physician. This symptom with moderate impact triggers the need for an SFV within two calendar days. The nurse revisits the home within 2 days (on day 32). The nurse determines the changes had a good effect and the impact is now slight. The nurse enters the date and result for **J2052. Symptom Follow-up Visit (SFV) and J2053. SFV Symptom Impact** and **Z0350. Date Assessment was Completed** to complete HUV2.

Rationale: An SFV should be conducted within two calendar days as a follow-up for **any moderate or severe pain or non-pain symptom impact** identified during an Admission or HUV timepoint. Based on the timing of the HUV2 (on or between days 16 and 30) and the results for **J2051. Symptom Impact,** the date of the SFV could stretch beyond the assessment timeframe. In this situation, **Z0350. Date Assessment was Completed** for this HUV2 would be when the SFV was conducted, which was two days after the HUV2 timeframe.

Figure 7: Example Calendar Depicting Completed HOPE-Admission, both HUV1 and HUV2, and SFVs when Triggered

1.3.4. Discharge Timepoint

For the purposes of completing HOPE, a patient is considered discharged when the patient is no longer receiving services from the hospice, or there is an interruption in care/services related to one of the reasons listed in Item A2115. Reason for Discharge (expired, revoked, no longer terminally ill, moved out of hospice service area, transferred to another hospice, discharged for cause).

1.4. Applicable Hospices/Agencies

All Medicare-certified hospice providers are required to submit data on all patient admissions.

CMS addresses reporting eligibility and requirements for new hospice providers through rulemaking. For more details on requirements for current and new hospices, refer to section 1.7.1 below and visit the Provider Toolkit documents and those located in the Downloads section on the HQRP Requirements and Best Practices webpage.

1.5. Applicable Patients

For all current patients with discharges occurring through September 30, 2025, completion and submission of both the HIS Admission and Discharge is required.
For patients admitted through September 30, 2025, but discharged on or after October 1, 2025, providers will:

- Complete and submit the HIS Admission.
- Not be required to administer the HUV assessment(s).
- Complete and submit a HOPE Discharge assessment.

For all patients admitted on or after October 1, 2025, only HOPE records will be accepted by CMS. These include

the HOPE-Admission, HOPE Update Visit(s), if applicable, and HOPE-Discharge records.

Completion of HOPE records (formerly HIS) applies to all patient admissions to a Medicare-certified hospice program regardless of the following:

- Payer source (Medicare, Medicaid, or private payer).
- Patient age.
- Where the patient receives hospice services, such as a private home, nursing home, assisted living, or hospice inpatient facility.
- Hospice LOS.

1.5.1. Special Circumstances Affecting HOPE

Patient transfers from one hospice provider to another provider with a different CMS Certification Number (CCN):

- Hospice quality reporting is at the CCN level.
- If a hospice patient's care transfers or changes from one hospice to another, and the two hospices have different CCNs, each hospice should complete a HOPE-Admission, HOPE Update Visit records (as applicable), and a HOPE-Discharge record for the care provided to the patient by their organization.
- When the transferring hospice completes its HOPE-Discharge, response 05, "transferred to another hospice," should be selected for Item A2115—Reason for Discharge.

In some circumstances, a hospice's policy may be to discharge a patient administratively and re-admit them. Such circumstances might include the following:

- Change in patient's payer source: a private pay patient becomes eligible for Medicare during the hospice stay; the hospice completes an "administrative" discharge and re-admits the patient for billing purposes.
- Hospice fails to meet the face-to-face requirement: if a hospice fails to meet the face-to-face requirement, the hospice must "administratively" discharge the patient, but the patient remains on service. This means that Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required (face-to-face) encounter occurs, enabling the hospice to re-establish Medicare eligibility.
- In general, if the patient remains under hospice care with no interruption in hospice service, completion of a HOPE discharge record is not required. In both situations listed above, the patient remained under the hospice's care without interruption in service. The hospice would not be required to submit a HOPE-Discharge. Hospices should submit a HOPE-Discharge record once the patient is no longer receiving hospice services or there is an interruption in care related to one of the reasons for discharge listed in Item A2115.

Traveling Patients

Hospice patients may, on occasion, travel outside of their "home hospice's" service area. In these circumstances, when the patient is outside of the home hospice's service area, the patient may receive services from a "host hospice." Per 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 arrangement with another Medicare-certified hospice program to provide core services to supplement hospice employees/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement to provide core services include a patient temporarily traveling outside of the hospice's service area.

In the case of a traveling patient, whether a hospice should submit a HOPE-Discharge record and new HOPE-Admission record depends on whether the home hospice discharged the patient and if the host hospice admitted the patient to hospice care and filed a notice of election (NOE) within the claims processing system. If there is no discharge by the home hospice, then the home hospice is not required to submit a HOPE-Discharge record when the patient travels out of the home hospice's service area. Relatedly, the host hospice would not need to submit a HOPE-Admission or HOPE-Discharge record for a traveling patient for whom they are providing services under a written agreement with the home hospice.

In rare circumstances where a newly admitted hospice patient travels during the first month of hospice service, the home hospice may request the host hospice to conduct and provide the documentation for HUV1 and/or HUV2.

1.6. General Conventions for Completing HOPE

1. To accurately and fully complete HOPE data, hospice staff should understand what information each item requires and complete the item based only on what is being requested. Responses to items in HOPE can be selected by the assessing clinician as part of the routine assessment during a patient visit or, for select items, can be based on information documented in the clinical record and abstracted on or before the Completion Date (Item Z0500B).
2. HOPE records should be submitted even if the patient revokes the hospice benefit or is discharged from hospice before all HOPE-related care processes are complete.
3. If a patient is discharged (for whatever reason) before a hospice care process takes place, hospices should answer "no" to any of the HOPE gateway questions and follow the skip patterns as indicated on the individual data elements. Hospices should not leave any items blank unless directed to do so by skip patterns.
4. HOPE includes several "date" items. All date items should be completed as follows:
    - Use the format Month-Day-Year: MM-DD-YYYY.
    - Do not leave any spaces blank.
    - If the month and/or day contains only a single digit, enter "0" in the first box of the month and/or day.
    - For example, November 1, 2025, would be entered as 11-01-2025.
    - The day begins at 12:00 a.m. and ends at 11:59 p.m.
5. All completed HOPE records must be electronically submitted to CMS.
6. HOPE record submission should follow the sequence outlined in Chapter 3, Section 3.3. Timing and Sequence Policies.
7. Policies outlined in Chapter 3 describe how to correct errors in a HOPE record that CMS has already accepted.

1.6.1. Who May Complete HOPE

HOPE contains a combination of existing HIS items and new items. Some of the data elements are to be collected during routine clinical assessment visits, while other data may be extracted from the clinical record by hospice staff, including volunteers, contractors, and affiliates. For example, staff could collect data from the quality division of the health system to which a hospice belongs. HOPE may be completed by any appropriate hospice staff member, based on the data being collected, such as the registered nurse (RN) for HOPE items requiring a skilled nursing assessment. The hospice is responsible for the accuracy and completeness of information in HOPE. Per the hospice CoPs, (See 418.114 Conditions of Participation), it is at the discretion of the hospice to determine who can accurately complete HOPE. Each person completing any portion of HOPE should provide a signature in Section Z, Record Administration, per the instructions provided in Section Z of Chapter 2.

1.6.2. Acceptable Sources of Documentation

The primary sources of information for completing HOPE include the following:

- Data collected through in-person visits and clinical care processes as they are conducted.
- Documentation in the hospice clinical record from which the responses to HOPE data elements can be obtained.

This means that, in general, sources external to the clinical record should not be used when completing the hospice data set.

- In some instances, a provider may consult sources other than the hospice clinical record to complete HOPE. For example, completion of Section A (Administrative Information) items may require review of claims or billing records, while Section F (Preferences) items may require review of physician orders for life-sustaining treatment (POLST) forms or other equivalent forms.
- If a particular HOPE care process is not documented in the hospice clinical record, the care process is considered not to have occurred. Complete each HOPE data element accordingly, following skip patterns outlined in the tool.

1.7. Compliance with HQRP Requirements and Annual Payment Update (APU) Determinations

HQRP activities operate on a cycle of data collection and submission, compliance determinations, and payment impact. Referred to as the HQRP FY reporting cycle, the data collected will impact hospice payments two years later. HOPE data collection consists of selecting responses to standardized items in conjunction with patient assessment activities and reporting the data to CMS. For example, HOPE data collected, submitted, and accepted on time during calendar year (CY) 2026 will be processed for compliance determinations in CY 2027. The impact on hospice payment will occur in FY 2028, which starts on October 1, 2027. See **Figure 8** for an example:

Figure 8: HQRP Compliance and Payment Impact

1.7.1. Compliance Criteria

- The HQRP is currently a "pay-for-reporting" program, meaning that the act of ***submitting and the acceptance*** of the required HOPE data determines compliance with HQRP requirements.
- Timely submission of HOPE data is a factor in determining a hospice's compliance with the HQRP requirements and APU determinations.
- To comply with the timeliness requirements providers must submit at least 90% of their HOPE records per the 30-day submission deadline throughout the calendar year, for each corresponding FY APU period.
- The HQRP includes data submitted by hospices through the HOPE tool, data from Medicare hospice claims, and an experience of care survey, the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey.
- All Medicare-certified hospice providers must comply with these reporting requirements.
- New providers are required to begin reporting data on the date noted in the letterhead of their CCN notification letter. However, if the CCN notification letterhead was dated on or after November 1st, they would not be subject to any financial penalty for failure to comply with HQRP requirements for the corresponding FY.
- Providers who do not comply with reporting requirements for any given reporting period will have their APU reduced by 4 percentage points for the corresponding FY.
- Specific criteria for determining compliance with HQRP requirements are proposed and finalized through the federal rulemaking cycle.

1.7.2. HQRP Resources

- For more information on HQRP requirements, refer to the HQRP Requirements and Best Practices | CMS webpage and the documents in the Provider Toolkit and the Downloads section.
- To obtain the latest regulations and notices, including proposed and final rules related to the HQRP, please visit CMS's Hospice Center web page.
- For more information on CAHPS requirements, refer to CAHPS Hospice Survey.

CHAPTER 2: ITEM SPECIFIC INSTRUCTIONS

2.1. Overview

This chapter presents each data element in HOPE and instructions for completing the item. Chapter 2 is organized to correspond with each section of HOPE:

- **Section A:** Administrative Information
- **Section F:** Preferences
- **Section I:** Active Diagnoses
- **Section J:** Health Conditions
- **Section M:** Skin Conditions
- **Section N:** Medications
- **Section Z:** Record Administration

The beginning of each section contains a description of the intent of all the HOPE data elements in the section. The rationale section that follows explains the purpose of items in each section.

For each HOPE item, the general order of information presented in Chapter 2 is as follows:

- **Item Display:** Provides a screenshot of each item as it appears on HOPE.
- **Time Point(s) Completed:** Lists when the information for the data element is to be collected during the patient's hospice stay.
- **Item Specific Instructions:** Outlines the proper method for completing each HOPE data element, including clarifying information for response options.
- **Coding Tips:** Any special situations, outliers, or uncommon scenarios; or any tips to clarify confusing or equivocal circumstances when coding each HOPE item.
- **Examples:** Illustrates examples of appropriate coding for several of the HOPE sections/items. Examples are designed to assist hospices in understanding the rationale for how to select the most accurate responses when completing HOPE. Examples do not represent the Centers for Medicare & Medicaid Services (CMS) endorsement of specific documentation language or products.

SECTION A: ADMINISTRATIVE INFORMATION

Section Intent

The intent of this section is to obtain key administrative information about the patient and hospice provider.

Section Rationale

This section obtains key information that uniquely identifies each patient, hospice, and potential patient care needs. Data collection in this section may be done by any of the assessing disciplines.

A0050. Type of Record

A0050. Type of Record	
Enter Code ☐	1. Add new record 2. Modify existing record 3. Inactivate existing record

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

- Indicate the record type being added.
- **Code 1, Add new record,** if this is a new record that has not been previously ***submitted and accepted.***
- **Code 2, Modify existing record,** if this is a request to modify items for a record that has already been ***submitted and accepted***.
  - Selecting response 2 creates a **Modification Request.**
- **Code 3, Inactivate existing record,** if this is a request to inactivate a record that has already been ***submitted and accepted***.
  - Selecting Code 3 creates an **Inactivation Request.**

DEFINITION

MODIFICATION REQUEST
A modification request is used when a HOPE record has been previously ***submitted and accepted*** in the system, but the record contains clinical or non-key demographic errors. See Chapter 3, for more information.

DEFINITION

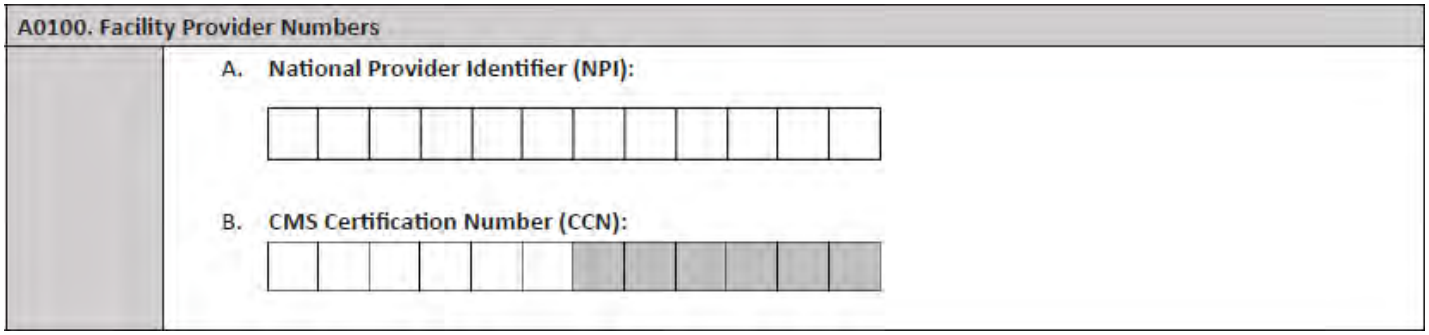
INACTIVATION REQUEST
An inactivation request is used when a record has been previously ***submitted and accepted*** in the system, but particular item values are inaccurate. See Chapter 3, for more information.

Coding Tips

- Corrections should be made to any record(s) that have errors to ensure that the information accurately reflects the patient's identification, location, and reason for the record.
- The current record would be a duplicate and not a new record if there is an existing record for the same patient in the same hospice with the same reason for record and with the same event date(s) (e.g., admission date or discharge date).
  - In this case, the system will reject the record when submitted, and a fatal error will be reported to the provider on the Final Validation Report (FVR).

- Further details on the FVR can be found in **Chapter 3**.
- Errors in most items on a record can be corrected with a Modification Request, with some exceptions.
- For more details on Modification Requests and Inactivation Requests, see **Chapter 3** of this manual.

A0100. Facility Provider Numbers



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

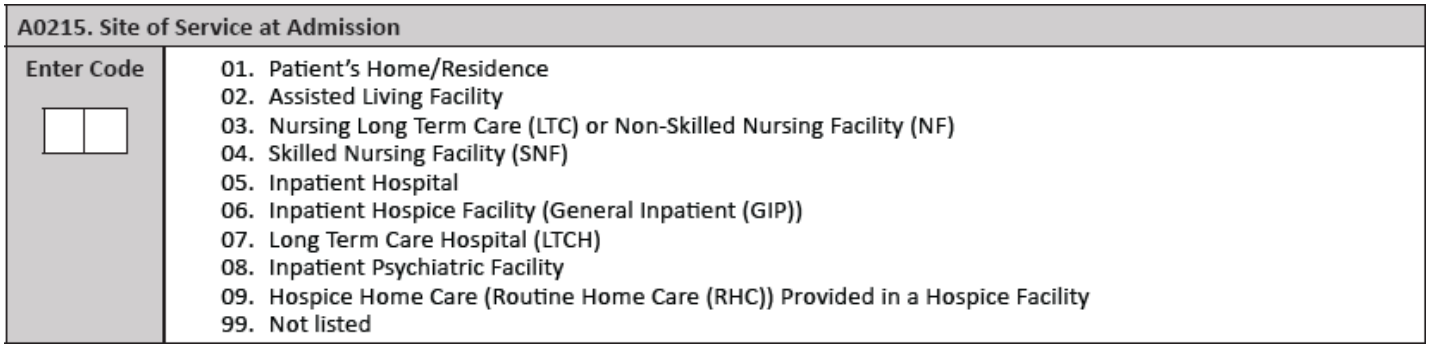
A: National Provider Identifier (NPI)

- **Enter the NPI.** The NPI is a unique federal number that identifies providers of health care services.

B: CMS Certification Number (CCN)

- **Enter the hospice's CCN**. The CCN, also known as the Medicare provider number, is a six-digit number, usually in the format xx-xxxx.

A0215. Site of Service at Admission



Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- **Code 01, Patient's Home/Residence,** if the patient received hospice care in their home/residence at

the time of admission.

  - This would include a patient receiving hospice care in the private home/residence of a family member or caregiver.

- **Code 02, Assisted Living Facility,** if the patient received hospice care in an ALF at the time of admission.
- **Code 03, Nursing Long-Term Care (LTC) or Non-Skilled Nursing Facility (NF),** if the patient received hospice care in a LTC or NF at the time of admission.
- **Code 04, Skilled Nursing Facility (SNF),** if the patient received hospice care in a SNF at the time of admission.
- **Code 05, Inpatient Hospital,** if the patient received hospice care in an Inpatient Hospital at the time of admission.
- **Code 06, Inpatient Hospice Facility (General Inpatient [GIP]),** if the patient received hospice care in an Inpatient Hospice Facility, e.g., GIP at the time of admission.

DEFINITION

SKILLED NURSING FACILITY (SNF, swing bed)
A nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services.

- **Code 07, Long Term Care Hospital (LTCH),** if the patient received hospice care in an LTCH at the time of admission.
- **Code 08, Inpatient Psychiatric Facility,** if the patient received hospice care in an Inpatient Psychiatric Facility at the time of admission.
- **Code 09, Hospice Home Care (Routine Home Care [RHC]) Provided in a Hospice Facility,** if the patient received hospice home care (Routine Hospice Care level or RHC) provided in a hospice residence or inpatient hospice facility at the time of admission.
- **Code 99, Not listed (none of the above),** if the patient received hospice care in a location not listed.

Coding Tips

- Codes for Item A0215 are structured to match sites of service found on Medicare claims.
  - Because the site of service must be identified on Medicare claims for the initial level of care billed, identifying the site of service the same way when completing this item can reduce the administrative burden for the hospice.
- For purposes of completing Item A0215, SNF is not synonymous with nursing facility.
- If a beneficiary is in a nursing facility but does not meet the SNF criteria above, use the code for nursing long-term care (LTC) (also known as NF or non-skilled nursing facility).

Examples

1. The patient was admitted to an inpatient hospice facility from the community for aggressive pain management and end-of-life care.

   Coding: Code 06, Inpatient Hospice Facility.

   Rationale: The patient was receiving hospice care in an Inpatient Hospice Facility at the GIP level of care at the time of admission.

2. A patient with late-stage pancreatic cancer was unable to return home due to no available caregiver. They were admitted from the hospital directly to an available bed at the local hospice house. At the time

of admission, the patient's condition is poor. Their symptoms are well managed, and they do not meet the GIP level of care requirements. They are placed on RHC level of care at the hospice house.

Coding: Code 09, Hospice Home Care (Routine Home Care (RHC)) Provided in a Hospice Facility.

Rationale: Although the patient resides in the hospice house, they are receiving hospice home care services (RHC level) at the time of the admission.

A0220. Admission Date

A0220. Admission Date	
	☐☐ ☐☐ ☐☐☐☐ Month Day Year

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

- **Enter the date of admission to this hospice**.

Coding Tips

- The admission date specifies the date on which the hospice becomes responsible for the patient's care.
  - For all patients, this is the effective date of the hospice election or re-election.
  - For patient transfers (regardless of payer source), this is the date the patient was transferred to your hospice from another hospice organization; specifically, the date your hospice became responsible for the patient's hospice care.

A0250. Reason for Record

A0250. Reason for Record	
Enter Code ☐	1. Admission (ADM) 2. HOPE Update Visit 1 (HUV1) 3. HOPE Update Visit 2 (HUV2) 9. Discharge (DC)

Timepoints Item(s) Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

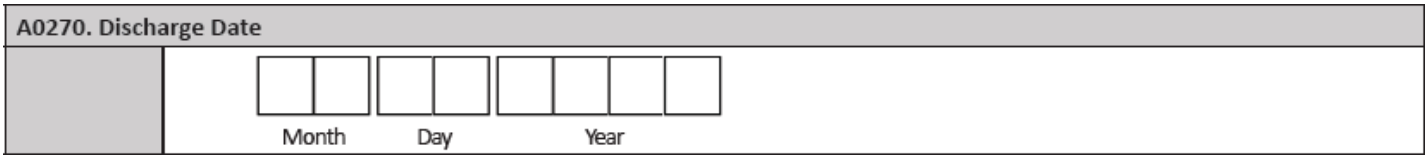
Item-Specific Instructions

- **Code 1, Admission,** for an Admission record.
- **Code 2, HOPE Update Visit 1,** for an HUV1 record.
- **Code 3, HOPE Update Visit 2,** for an HUV2 record.
- **Code 9, Discharge,** for a Discharge record.

Coding Tips

- An Admission and Discharge record must be completed for each patient admission.
- Depending on the patient's LOS, up to two HUV records are required for each hospice admission. More details regarding the HUV timepoints can be found in **Chapter 1**. **Section 1.3 HOPE Timepoints and Definitions**.
- Since the LOS for hospice patients varies, CMS understands that the number of HUV records will vary.

A0270. Discharge Date



Timepoint(s) Item Completed

Discharge (DC)

Item-Specific Instructions

Complete only if A0250 = 9, Discharge.

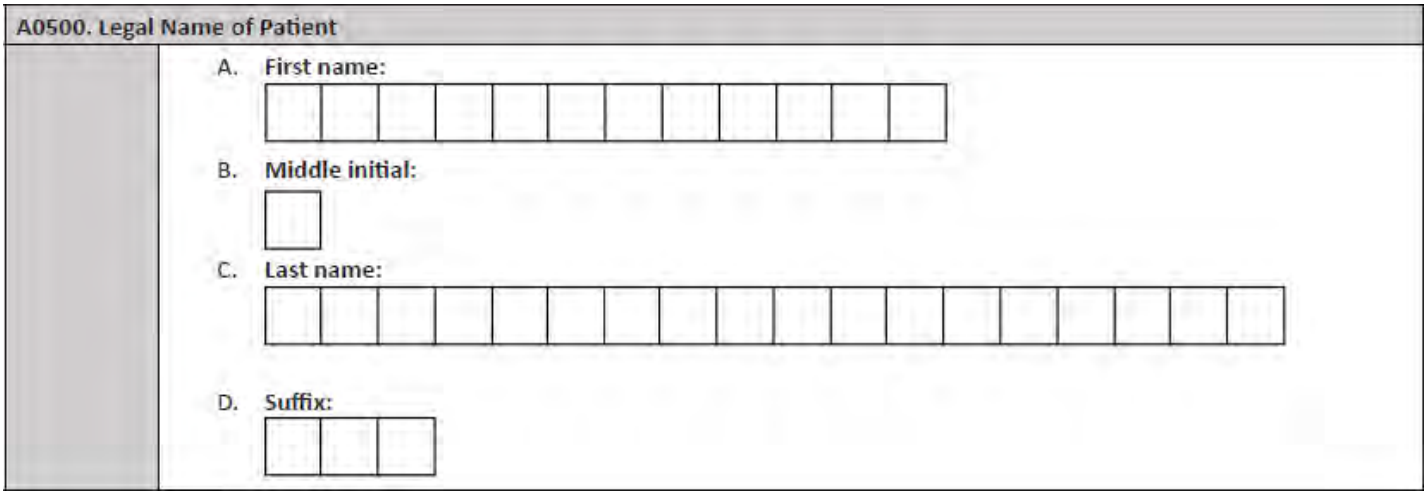
- Enter the date the patient was discharged from hospice (whether or not return is anticipated).
- Do not leave any spaces blank.
- If the patient expired, the date of death is the discharge date.
- For live discharges, the date the patient revoked the hospice benefit or the date the hospice discharged the patient is the discharge date.

DEFINITION

DISCHARGE

A patient is considered discharged when the patient is no longer receiving services from the hospice or there is an interruption in care/services related to one of the reasons listed in Item A2115 (expired, revoked, no longer terminally ill, moved out of hospice service area, transferred to another hospice, discharged for cause).

A0500. Legal Name of Patient



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

- The legal name is the patient's name as it appears on the Medicare card.
- If the patient is not enrolled in the Medicare program, use the patient's name as it appears on a Medicaid card or other government-issued document.

A. First name

- **Enter the patient's first name.**

B. Middle initial

- **Enter the patient's middle initial.**
  - If the patient has no middle initial, leave the item blank.
  - If the patient has two or more middle names, use the initial of the first middle name.

C. Last name

- **Enter the patient's last name.**

D. Suffix

- **Enter the** appropriate suffix **(e.g., Jr., Sr.), if any.**
  - If the patient has no suffix, leave the item blank.

Coding Tips

- Be sure to carefully check the spelling of the patient's name each time a record is submitted.
- Typographical errors in the patient's name item may cause a new record to be created for the same patient during submission.

A0550. Patient ZIP Code

A0550. Patient Zip Code	
	☐☐☐☐☐ – ☐☐☐☐

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- **Enter the ZIP Code,** for the address at which the patient is residing while receiving hospice services, even if this is not the patient's usual (or legal) residence.
  - If known, enter the "extended" ZIP Code (ZIP Code plus 4-digit code), starting with the left-most box, followed by one digit per box.
  - At a minimum, the five-digit ZIP Code must be entered.
    - If entering the five-digit ZIP Code only, start with the left-most box, leaving the last four boxes blank.
- The patient's ZIP Code is used for Care Compare to determine the location where your hospice provided services.

Coding Tips

- The ZIP Code in A0550 should reflect the ZIP Code where the patient will reside while receiving hospice services.

Examples

1. The patient lives in City A, but is currently receiving hospice care while staying at a daughter's home in City B.

   Coding: A0550 would be coded for City B.

   Rationale: City B is the location of the daughter's home where hospice services are being provided.

2. The patient's legal address is in City A, but they are residing and receiving hospice services in a facility (nursing facility, ALF, inpatient hospice facility) located in City B.

   Coding: A0550 would be coded for City B.

   Rationale: Enter the ZIP Code of the facility where the hospice services are provided, not the ZIP Code of the patient's permanent home/billing address.

3. A patient is admitted to hospice and initially receives hospice services in a GIP facility in City A, but with plans to move to a home at a future point in City B.

   Coding: A0550 would be coded for City A.

   Rationale: Enter the ZIP Code for the GIP facility where the initial hospice services are being provided.

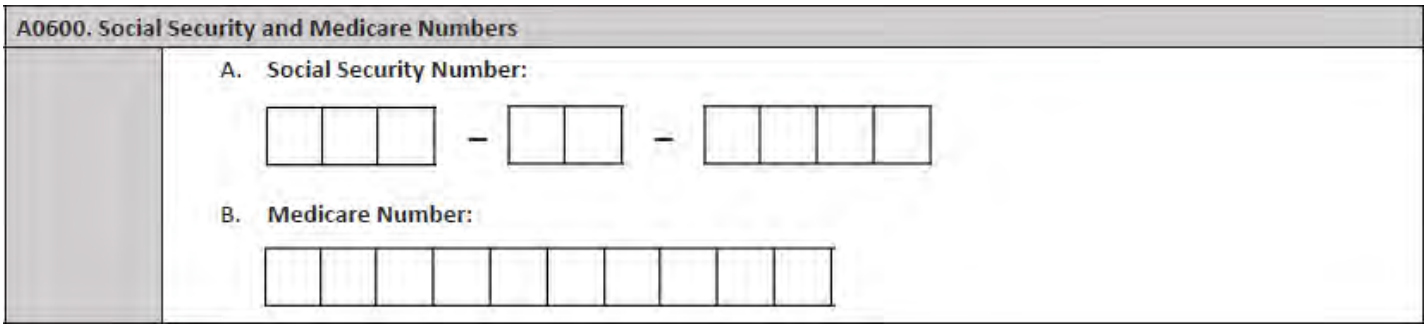
4. The first encounter between the hospice and the patient is in a facility in City A, which is not where the patient will be receiving hospice services. The patient will be going home to City B to receive

services, but the hospice made the initial visit in the hospital, pending the patient's discharge to home in City B.

Coding: A0550 would be coded for City B.

Rationale: Enter the ZIP Code of the address where the hospice services will be provided. In this example, the ZIP Code of the patient's home in City B.

A0600. Social Security and Medicare Numbers



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

A. Social Security Number

- **Enter the Social Security Number (SSN)**, one number per space, starting with the left-most space.
- If the patient's SSN is not available or the patient refuses to provide it, the item may be left blank.
- A valid SSN should be submitted whenever available so that record matching can be performed as accurately as possible.

DEFINITION

SOCIAL SECURITY NUMBER
A tracking number assigned to an individual by the U.S. federal government for taxation, benefits, and identification purposes.

B. Medicare Number

- **Enter the Medicare or MBI number,** exactly as it appears on the patient's Medicare card.
- A Medicare number is an identifier assigned to an individual for participation in national health insurance program(s).
- It is also referred to as the Medicare Beneficiary Identifier (MBI).
- In an effort to fight identity theft for Medicare beneficiaries, CMS replaced the SSN-based Health Insurance Claim Number (HICN) with the MBI.
- Confirm that the patient's name on the record matches the patient's name on the Medicare card.
- If the patient does not have a Medicare number, the item may be left blank.

Coding Tips

- To avoid inaccuracies in patient record matching, Item A0600 should only be left blank if the patient does not have an SSN or in rare instances where the SSN is unavailable.
- The Medicare number is not intended to reflect the patient's payer source.
- The Medicare number is only used for patient identification purposes.
- If the hospice is notified after the record has been submitted that the patient does have a Medicare number, include it on the next record.
    - For instance, if the Medicare number is received after submission of the Admission record, include the patient's Medicare number on the next HOPE record, such as HUV1, HUV2, or the Discharge (DC) record.
    - Including the Medicare number on the next record at a later date does not require a Modification Request to the original Admission record.

A0700. Medicaid Number

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

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

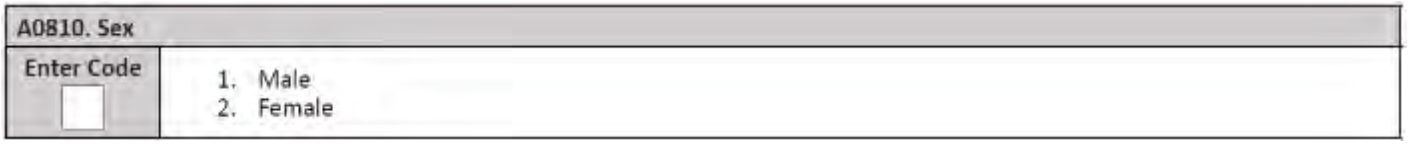
- **Enter the Medicaid number,** if the patient is a Medicaid recipient. Enter one number per box, beginning in the left-most box.
    - Enter a "+" in the left-most box if the Medicaid number is pending.
    - If the patient is not a Medicaid recipient, enter "N" in the left-most box.
    - Confirm that the patient's legal name on the record matches the patient's legal name on the Medicaid card.
    - If the patient refuses to supply his or her Medicaid number or the Medicaid number is unknown, leave A0700 blank.

Coding Tips

- Check the patient's Medicaid card, admission or transfer records, or hospice clinical record.
- The Medicaid Number entered in A0700 is not intended to reflect the patient's payer source. For the purposes of HOPE item completion, the Medicaid Number is used for patient identification purposes only.
- If the patient has a Medicaid Number, enter it in A0700, even if Medicaid is not a payer or is a secondary payer.

- If the hospice is notified after the record has been submitted that the patient does have a Medicaid number, include it on the next record.
    - Including the Medicaid number on the next HOPE record at a later date does not require a Modification Request to the original HOPE-Admission record.
    - For instance, if the Medicaid number is received after submission of the HOPE-Admission record, include the patient's Medicaid number on the next HOPE record, such as HUV1, HUV2, or the Discharge (DC) record.

A0810. Sex



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instruction

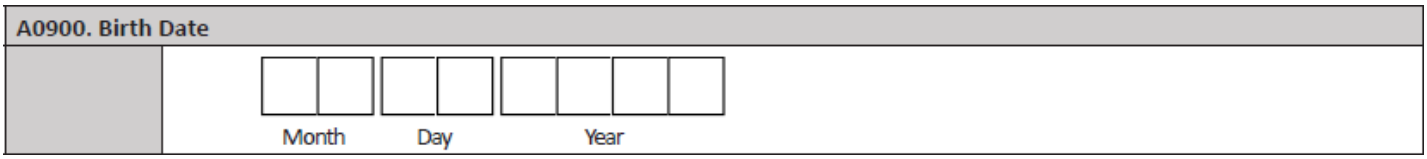
- **Code 1, Male,** if the patient is male.
- **Code 2, Female,** if the patient is female.

Coding Tips

- This item assists in correct identification.
- Provides demographic sex-specific health trend information.

Please Note: *Patient sex must match what is in the Social Security system.*

A0900. Birth Date



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

- **Enter the birth date of the patient.**
- If only the birth year or the birth year and birth month of the patient are known, handle each situation as follows:
  - If only the birth year is known, enter the year in the "year" boxes of A0900 and leave the "month" and "day" boxes blank.
  - If the birth year and birth month are known, but not the birthday, enter the year in the "year" boxes of A0900, enter the month in the "month" boxes, and leave the "day" boxes blank.

A1005. Ethnicity

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, Another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Ask the patient to select the category or categories that most closely correspond to the patient's ethnicity from the list in A1005.
- Respondents should be offered the option of selecting one or more ethnic categories.
- Ethnic category definitions are provided only if requested in order to answer the item.
- If a patient is **unable to respond**, a response from a caregiver and/or responsible party may be used.
- Only use medical record documentation to code A1005, Ethnicity if the patient is unable to respond and no caregiver and/or responsible party provides a response for this item.
- If a patient **declines** to respond, code Y, Patient declines to respond, and do not code based on other resources (caregiver, responsible party, or medical record documentation).
- If the patient can provide a response:
  - Check all that apply.
- Check the box(es) indicating the ethnic category or categories identified by the patient.
- **Code X, Patient unable to respond,** if the patient was unable to respond.
  - If the response(s) is/are determined via caregiver and/or responsible party input, and/or medical record documentation, check all boxes that apply, including Code "X, Patient unable to respond."
  - If the patient is unable to respond and no other resources (caregiver and/or responsible party or medical record documentation) provided the necessary information, code "X, Patient unable to respond," only.

- **Code Y, Patient declines to respond,** only if the patient declines to respond.
  - When the patient declines to respond, code only "Y, Patient declines to respond."
  - When the patient declines to respond do not code based on other resources (caregiver, responsible party, nor medical records). Complete as close to the time of admission as possible.

Coding Tips

- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple healthcare settings and is an important step in improving quality of care and health outcomes.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Examples

1. The patient had an acute cerebrovascular accident (CVA) with mental status changes. During the admission assessment, the patient is unable to respond to questions regarding their ethnicity. The patient's spouse informs the nurse that the patient is Cuban.

   Coding: A1005 would be coded as "D, Yes, Cuban," and "X, Patient unable to respond."

   Rationale: If a patient is unable to respond but the caregiver and/or responsible party provides the response, check all boxes that apply, including Code "X, Patient unable to respond."

2. Upon admission, the patient is asked about their ethnicity, but says they prefer to not answer the question.

   Coding: A1005 would be coded as Y. Patient declines to respond.

   Rationale: If a patient declines to respond to this item, code "Y, Patient declines to respond." Do not use other resources (caregiver and/or responsible party or medical record documentation) to complete this item when the patient declines to respond.

A1010. Race

A1010. Race What is your race?	
↓ Check all that apply	
☐	A. White
☐	B. Black or African American
☐	C. American Indian or Alaska Native
☐	D. Asian Indian
☐	E. Chinese
☐	F. Filipino
☐	G. Japanese
☐	H. Korean
☐	I. Vietnamese
☐	J. Other Asian
☐	K. Native Hawaiian
☐	L. Guamanian or Chamorro
☐	M. Samoan
☐	N. Other Pacific Islander
☐	X. Patient unable to respond
☐	Y. Patient declines to respond
☐	Z. None of the above

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010.
- Respondents should be offered the option of selecting one or more categories.
- If a patient is **unable** to respond, the assessor may ask a caregiver and/or responsible party.
- Only use medical record documentation to code A1010, Race if the patient is unable to respond and no caregiver and/or responsible party provides a response for this item.
- If the patient declines to respond, code Y, Patient declines to respond, and do not code based on responses from a caregiver and/or responsible party or medical record documentation.
- If the patient can provide a response, check the box(es) indicating the race category or categories identified by the patient.
- Complete as close to the time of admission as possible.
- **Code X, Patient unable to respond,** if the patient is unable to respond.
    - In the cases where the patient is unable to respond, and the response is from a caregiver and/or responsible party, check all boxes that apply, including "X, Patient unable to respond."
    - If the patient is unable to respond and no other resources (a caregiver and/or responsible party or

medical record documentation) provided the necessary information, code "X, Patient" unable to respond.

- **Code Y, Patient declines to respond,** if the patient declines to respond.
  - When the patient declines to respond, code only "Y, Patient declines to respond."
  - When the patient declines to respond do not code based on responses from a caregiver and/or responsible party or medical record documentation.
- **Code Z, None of the above,** if the patient reports or it is determined from a caregiver and/or responsible party, or medical record documentation that none of the listed races apply.

Coding Tips

- Standardizing self-reported data collection for race allows for the comparison of data within and across multiple healthcare settings and is an important step in improving quality of care and health outcomes.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Examples

1. The patient has severe dementia with agitation. During the admission assessment they are unable to provide their race. Their family member informs the nurse that the patient is Korean and African American.

   Coding: A1010 would be coded as "B, Black or African American," "H, Korean," and

   "X, Patient unable to respond."

   Rationale: If a patient is unable to respond but a caregiver and/or responsible party provides the response, code both the response from the caregiver and/or responsible party and "X, Patient unable to respond."

2. The patient declines to provide their race during the admission assessment stating, "I'd rather not answer."

   Coding: A1010, Race would be coded as "Y, Patient declines to respond."

   Rationale: If a patient declines to respond to this item, then code only "Y, Patient declines to respond." Do not make attempts to code A1010 when a patient declines to respond based on responses from a caregiver and/or responsible party or medical record documentation.

A1110. Language

A1110. Language	
Enter Code ☐	A. What is your preferred language? ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ B. Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes 9. Unable to determine

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Ask for the patient's preferred language.
- Ask if the patient needs or wants an interpreter to communicate with a doctor or health care staff.
- It is acceptable for a caregiver and/or responsible party to be the interpreter if the patient is comfortable with it and if the caregiver and/or responsible party will translate exactly what the patient says without providing their interpretation.
- If the patient, even with the assistance of an interpreter, is unable to respond, a caregiver and/or responsible party should be asked.
- If neither the patient nor caregiver and/or responsible party is able to provide a response to A1110A or A1110B medical record documentation may be used.
- Complete as close to the time of admission as possible.
- **Code 0, No,** if the patient, caregiver and/or responsible party, or medical record indicates no need or want of an interpreter to communicate with a doctor or health care staff.
- **Code 1, Yes,** if the patient, caregiver and/or responsible party, or medical record indicates the need or want of an interpreter to communicate with a doctor or health care staff.
    - Ensure that preferred language is indicated.
- **Code 9, Unable to determine,** if the patient is unable or declines to respond or any available source (caregiver and/or responsible party, or medical records) cannot or does not identify the need or want of an interpreter.

Coding Tips for A1110A

- Enter the preferred language the patient primarily speaks or understands.
- An organized system of signing, such as American Sign Language (ASL), can be reported as the preferred language if the patient needs or wants to communicate in this manner.

A1400. Payer Information

A1400. Payer Information	
↓ Check all existing payer sources that apply at the time of this assessment	
☐	A. Medicare (traditional fee-for-service)
☐	B. Medicare (managed care/Part C/Medicare Advantage)
☐	C. Medicaid (traditional fee-for-service)
☐	D. Medicaid (managed care)
☐	G. Other government (e.g., TRICARE, VA, etc.)
☐	H. Private Insurance/Medigap
☐	I. Private managed care
☐	J. Self-pay
☐	K. No payer source
☐	X. Unknown
☐	Y. Other

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Check the box(es) that best correspond(s) to the patient's current existing payment sources. Check all that apply.
  - This item is intended to identify **all** *current, existing payer sources* that the patient has, regardless of whether or not the payer is expected or likely to provide reimbursement for any services, supplies, medications, etc., that the patient may receive during the hospice stay.
  - *Pending* payer sources should **not** be included (i.e., do not report payment source(s) which have been applied for but not yet received).
  - Payer sources can be based on patient/caregiver report.
  - It is recommended that providers make efforts to validate existing payer sources (e.g., ask patients to present their Medicare card).
- **Code A, Medicare (traditional fee-for-service),** if the patient has traditional fee-for-service Medicare Parts A, B and/or D.
- **Code B, Medicare (managed care/Part C/Medicare Advantage),** if the patient has Medicare HMO/managed care, another Medicare Advantage Plan, or Medicare Part C.
  - If the patient had Medicare Advantage prior to enrolling in hospice, select response option B even though Medicare Advantage may not reimburse the hospice directly for any services.
  - If the patient had Part C/Medicare Advantage prior to enrolling in hospice, select the response options for BOTH part C and traditional fee-for-service Medicare or Medicaid, as applicable.
- **Code C, Medicaid (traditional fee-for-service),** if the patient has traditional fee-for-service Medicaid.
- **Code D, Medicaid (managed care),** if the patient has Medicaid managed care.

- **Code G, Other government (e.g., TRICARE, VA, etc.),** if the patient has a government plan besides Medicare and/or Medicaid. This would include other government insurance such as TRICARE, VA, etc.
- **Code H, Private Insurance/Medigap,** if the patient has any private insurance available.
    - Include commercial plans irrespective of how they were purchased (i.e., regardless of whether provided through an employer, purchased individually by the patient, or through a health insurance exchange, etc.).
    - Use this for prescription drug coverage from a private insurer in addition to/other than Medicare Part D coverage.
- **Code I, Private Managed Care,** if the patient has any private insurance available that is a managed care plan.
    - Include commercial or those privately purchased (e.g., commercial HMO or PPO plans) irrespective of how they were purchased (i.e., regardless of whether provided through an employer, purchased individually by the patient, or through a health insurance exchange, etc.).
- **Code J, Self-pay,** if the patient has any amount of personal funds available to contribute to healthcare expenses (services, supplies, medications, etc.) during the hospice stay.
    - Based on this definition of self-pay, for certain providers, a large majority of patients may be identified as self-pay; this is acceptable.
    - Self-Pay should be chosen even if the patient is not actively paying for anything but could pay for something or has the funds if needed.
    - The intent of the Self-Pay response option is not to assess patients' ability to self-pay, but rather to determine availability of funds to cover costs of care.
    - Selecting the Self-Pay response option obligates neither the hospice nor the patient to use those funds to pay for care, should a need to self-pay arise.
    - The collection of data to complete Item A1400 should not influence the delivery of hospice services based on the patient's ability to self-pay for care, or based on availability of other pay sources the patient may have.
- **Code K, No payer source,** if the patient does not have any of the payer sources in response options A-I available, nor do they have any personal funds available (response option J, Self-Pay) to contribute to healthcare expenses (services, supplies, medications, etc.) during the hospice stay.
- **Code X, Unknown,** if the patient is not confirmed to have any of the above payer sources in response options A-K available to contribute to healthcare expenses (services, supplies, medications, etc.) during the hospice stay.
- **Code Y, Other,** if the patient has available one or more payer sources that are not listed in responses options A-K above to contribute to healthcare expenses (services, supplies, medications, etc.) during the hospice stay.

Coding Tips

- Use "Code Y, Other" if the patient has a payer source available through a funded charity care program.
    - Patients are considered as "patients receiving charity" if they will receive funds from a funded charity care program and patients that have no other payer source available and are not part of a funded charity care program.

- Use “Code K, No payer source” if a patient neither has any of the payer sources listed in A-J available, nor are a part of a funded charity care program.
- For classifying individual commercial plans, providers should use their best judgement or follow-up with the appropriate commercial or private contact to classify individual commercial plans. For state-specific plans (other than traditional Medicaid) or other government plans (e.g., Tricare or other VA plans), providers should follow-up with the appropriate state or government contacts for advice on classifying these plans.

Example

1. The patient is a Medicare beneficiary and will be using traditional Medicare directly to access the Medicare Hospice Benefit. They also have private insurance available to them to help pay for prescriptions as needed, as well as some personal funds.

   Coding: A1400A, H, and J would all be checked.

   Rationale: This item is a “Check all that apply” item. Even though Medicare will be used to access the Medicare Hospice Benefit, the existence of a private insurance plan and personal funding should they be needed, are also coded as existing payment sources for A1400.

A1805. Admitted From

A1805. Admitted From	
Enter Code ☐☐	**Immediately preceding this admission, where was the patient?** 01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 99. Not Listed

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Enter the two-digit response that best describes the setting in which the patient was in immediately preceding this admission.
- **Code 99, Not listed (none of the above),** if the patient was admitted from other locations not listed.

Coding Tips

- If the patient was in multiple settings prior to hospice admission, enter the response that reflects where the patient was at the time of referral to hospice.
- The term "Admitted from" does not necessarily mean that the patient left the facility to be admitted to hospice.
    - The location immediately before admission may be the same as immediately after (e.g., a patient may be residing in a long-term care facility and remain there during and after hospice admission)
    - Or the two may be different (e.g., a patient may elect hospice while in an acute care hospital and begin receiving hospice services upon returning to their home).
- SNF is not synonymous with nursing facility (e.g., SNF is to be used for patients in a skilled nursing facility, SNF swing bed in a swing bed hospital, or the SNF portion of a dually certified nursing facility).
    - If the individual is in a nursing facility but does not meet the criteria above, do not use the response option for SNF; instead, code "02, Nursing Home (long-term care facility)."

Examples

1. A patient was referred to hospice while in the hospital in the week prior to admission to hospice and was discharged from the hospital to the home two days prior to the start of hospice services.

   Coding: Code 4, Short-Term General Hospital.

   Rationale: The patient was in the hospital at the time of referral.

2. The patient recently entered the SNF unit of a dually certified LTC facility post-hospitalization for an acute cardiac episode and has now taken a turn for the worse. The family is requesting hospice services and would like to bring the patient home for end-of-life care. The local hospice contracts with this facility and is able to admit the patient later that day.

   Coding: Code 03, Skilled Nursing Facility.

   Rationale: The patient was in the SNF unit of a dually certified long-term care facility and was receiving skilled nursing services prior to the referral to the hospice. Although the facility also has LTC residents, this patient was receiving care at the SNF level prior to going home on hospice.

3. The local oncology clinic referred a patient to hospice after her final visit to the clinic earlier this week. The disease has progressed to a point where treatment is no longer an option, and the oncologist suggested that care and comfort are the best options. The symptoms will require careful management, and the patient and family agreed to elect hospice. The patient lives in the community in an ALF. Her daughter lives nearby.

   Coding: Code 01, Home/Community.

   Rationale: Upon referral to hospice, the patient was living in an ALF, which is considered to be at home in the community.

A1905: Living Arrangements

A1905. Living Arrangements	
Enter Code ☐	**Identify the patient's living arrangement at the time of this admission.** 1. Alone (no other residents in the home) 2. With others in the home (e.g., family, friends, or paid caregiver) 3. Congregate home (e.g., assisted living or residential care home) 4. Inpatient facility (e.g., skilled nursing facility, nursing home, inpatient hospice, hospital) 5. Does not have a permanent home (e.g., has unstable housing or is experiencing homelessness)

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Patient and/or caregiver interview, clinical record, referral information, and observation can be used to code this item.
- Enter the code that best describes the patient's current living arrangements at the time of the assessment.
- **Code 1, Alone (no other residents in home),** if there are no other residents in the home at the time of the assessment. For example, the patient lives alone in a home, in their own apartment, or in their own room at a boarding house.
- **Code 2, With others in the home (e.g., family, friends, or paid caregiver),** if there are others such as family, friends or paid caregivers living with them in the home at the time of the assessment.
- **Code 3, Congregate home (e.g., assisted living or residential care home),** examples include ALF or residential care home.
- **Code 4, Inpatient facility (e.g., skilled nursing facility, nursing home, inpatient hospice, hospital),** examples include skilled nursing facility, nursing home, inpatient hospice, hospital.
- **Code 5, Does not have a permanent home,** examples include unstable housing, or the individual is experiencing homelessness.

DEFINITION

CONGREGATE HOME
A home in which assistance, supervision and/or oversight are provided as part of the living arrangement.

Coding Tips

- If more than one code applies, select the code with the greater numeric value. For example, if the patient lives with their spouse in an ALF, select Code 3, Person lives in a congregate home.

Examples

4. At the admission assessment, the nurse notes that the patient shares a room with their spouse in an ALF.

Coding: Code A1905, Living Arrangements = 3.

Rationale: The patient lives with their spouse in an ALF. An ALF is considered a congregate facility.

A1910. Availability of Assistance

A1910. Availability of Assistance	
Enter Code ☐	**Code the level of in-person assistance from available and willing caregiver(s), excluding hospice and facility staff, at the time of this admission.** 1. Around-the-clock (24 hours a day with few exceptions) 2. Regular daytime (all day every day with few exceptions) 3. Regular nighttime (all night every night with few exceptions) 4. Occasional (intermittent) 5. No assistance available

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Patient and/or caregiver interview can be used to code this item.
- In the event the patient cannot respond, and no caregiver is present, facility staff, clinical record, and referral information can be used to code the item.
- **Code 1, Around-the-clock,** if the patient receives assistance at the time of the assessment from someone other than hospice or facility staff 24 hours a day, with infrequent exceptions.
- **Code 2, Regular daytime,** if the patient receives assistance at the time of the assessment from someone other than hospice or facility staff all day, every day, with infrequent exceptions.
- **Code 3, Regular nighttime,** if the patient receives assistance at the time of the assessment from someone other than hospice or facility staff all night, every night, with infrequent exceptions.
- **Code 4, Occasional,** if there is only occasional or intermittent assistance with infrequent exceptions. Occasional assistance means someone, excluding hospice or facility staff, is available to provide in-person assistance only for a few hours a day or on an irregular basis or may be able to help occasionally.
- **Code 5, No assistance available,** if there is no one available to provide in-person assistance other than hospice or facility staff.

Examples

1. The patient resides in a senior citizen high rise and as included in the monthly rent, receives two hours of help every week. In addition, the patient has hired an aide four hours a day, six days per week, to assist with errands and meals.

   Coding: Code A1910, Availability of Assistance = 4. Occasional.

   Rationale: Although the patient has someone in the home to provide in-person assistance, this is not all day every day and therefore is coded as occasional.

2. At the admission assessment, the nurse determines that the patient's daughter has moved into the patient's home to care for the patient 24 hours per day, seven days per week.

   Coding: Code A1910, Availability of Assistance = 1. Around-the-clock.

   Rationale: The patient's daughter has moved into the patient's home to assist around-the-clock.

3. At the admission assessment, the nurse consults with long-term care facility staff and is informed that the patient has hired a private duty nurse's aide to care for them during daytime hours every day and the facility staff cares for the patient the rest of the time.

Coding: Code A1910, Availability of Assistance = 2. Regular daytime.

Rationale: The patient has a private duty nurse's aide during daytime hours every day. Although the facility staff are available the rest of the time, their availability is not considered when coding this item.

A2115. Reason for Discharge

A2115. Reason for Discharge	
Enter Code ☐	1. Expired 2. Revoked 3. No longer terminally ill 4. Moved out of hospice service area 5. Transferred to another hospice 6. Discharged for cause

Timepoint(s) Item Completed

Discharge (DC)

Item-Specific Instructions

Complete only if A0250 = 9, Discharge

- Review the clinical record, including the discharge plan and discharge order, for documentation of discharge reason.
- Code the response that corresponds to the patient's reason for discharge.
- **Code 1, Expired,** if the patient has died.
- **Code 2, Revoked,** if the beneficiary has chosen to revoke their hospice election.
  - Revoked is also used for non-Medicare/Medicaid patients who reject the hospice plan of care.
- **Code 3, No longer terminally ill,** for a discharge when the hospice determines the beneficiary is no longer terminally ill.
- **Code 4, Moved out of hospice service area,** for a discharge when the beneficiary moves out of the hospice's service area.
- **Code 5, Transferred to another hospice,** for a discharge when the beneficiary transfers to another hospice.
- **Code 6, Discharged for cause,** for a discharge for cause.

DEFINITION

DISCHARGE FOR CAUSE
A discharge made because the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

SECTION F: PREFERENCES

Section Intent

Items in this section pertain to the hospice patient's preferences regarding life-sustaining treatments and spiritual care. Preferences are best obtained directly from the patient, or the caregiver/responsible party, if the patient cannot self-report. The items in this section do not represent an exhaustive list of patient preferences that hospices should consider. Completing this section does not replace a thorough and ongoing discussion of patient preferences throughout the hospice stay.

Section Rationale

Seriously ill and dying patients who are allowed to express their preferences regarding life-sustaining treatment are more likely to receive care consistent with their values, improving patient and family outcomes, including greater satisfaction with care.

- Patients may come into hospice with documentation of preferences for life-sustaining treatment. However, pre-existing documentation may not reflect their current preferences because patient preferences may change, particularly as their condition changes.
- Care for spiritual needs is a critical element of quality of life at the end-of-life.

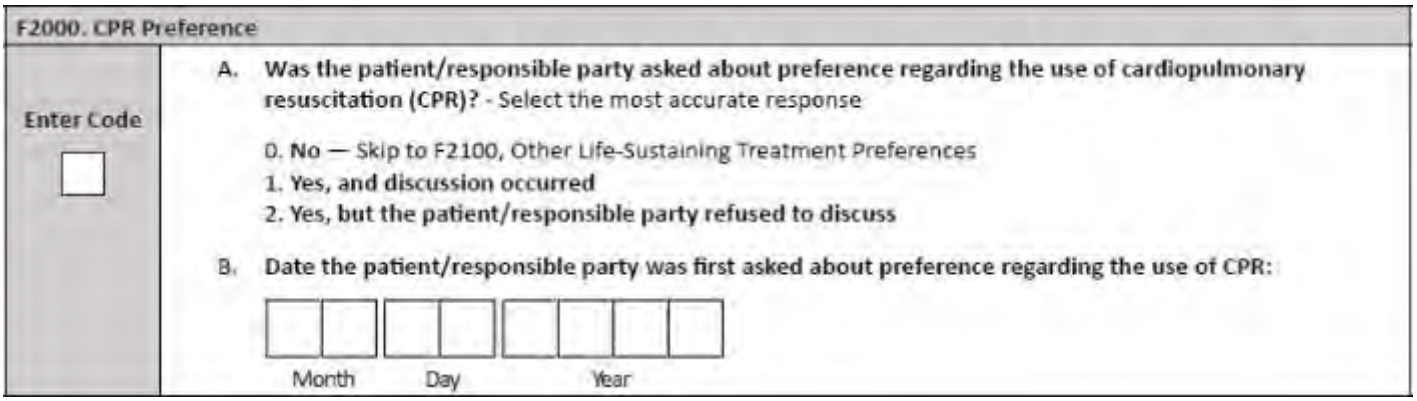
Patients and/or caregivers should be allowed to express their needs for spiritual care to help ensure their needs are met.

- One of the unique aspects of hospice care is its interdisciplinary approach to meeting the physical, psychosocial, and spiritual needs of the patient and caregiver(s). Discussing spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring these needs are met.

Items in this section are intended to capture the process of eliciting patient preferences; they are intended to *capture evidence of discussion and/or communication about patient preferences.*

- Orders alone, without evidence of discussion or involvement from the patient/responsible party, are not sufficient to code "Yes" for these preference items.

F2000: CPR Preference



Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Item completion should be based on what is included in the clinical record.
- Review the clinical record for information regarding discussion of patient preference for cardiopulmonary resuscitation (CPR).
- Consider care processes and discussions documented in the clinical record that took place during pre-admission or educational visits, as well as those during the admission assessment.
- Review all response choices before making a selection.
- Use the date on which the discussion *first* occurred.

A. Was the patient/responsible party asked about preference regarding the use of CPR?

- **Code 0, No,** if there is no documentation that the hospice discussed (or attempted to discuss) preference regarding the use of CPR with the patient or responsible party. Skip to Item F2100, Other Life-Sustaining Treatment Preferences.
    - This applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party. This could happen if the patient was unable to discuss and/or the responsible party was unavailable.
- **Code 1, Yes, and discussion occurred,** if there is documentation that the hospice discussed preference regarding the use of CPR with the patient or responsible party.
    - This applies to situations where there is documentation that the hospice brought up the topic of CPR use, engaged, and/or had a conversation with the patient, the responsible party, or both. The conversation does not have to result in the patient stating a preference for or against the use of CPR.
- **Code 2, Yes, but the patient/responsible party refused to discuss,** if there is documentation that the hospice asked about preference regarding the use of CPR, but the patient or responsible party refused to discuss or was unable to discuss. The hospice was not successful in engaging the patient and/or responsible party in a discussion.
    - This applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and responsible party, but both the patient and responsible party *explicitly refused* to discuss the topic with the hospice (e.g., “I don’t want to talk about this”) or the patient was unable to discuss because of their clinical status and the responsible party *explicitly refused* to discuss.

B. Date the patient/responsible party was *first* asked about preference regarding the use of CPR.

- Enter the date the hospice first discussed (or attempted to discuss) patient preference regarding the use of CPR.
- Multiple discussions regarding the use of CPR may be documented in the clinical record.
- Completion of this item is based on the first dated discussion about preference regarding the use of CPR that appears in the clinical record.

Coding Tips

- Documented evidence of a discussion or attempted discussion may be located in the clinical record or via a Do Not Resuscitate (DNR) order, POLST order, or the equivalent.
- A newly completed order or form that is completed after the admission to hospice or during a preadmission visit is sufficient provided there is evidence of involvement from the patient/responsible party (e.g., signature of the patient/ responsible party, or documentation that DNR preference was confirmed with patient/responsible party).
- Orders alone or short statements in the clinical record, such as "DNR/DNI" or "full code," without evidence of discussion or involvement from the patient/responsible party, are not sufficient to code "Yes" for F2000A.
- For pre-existing orders or forms signed in a prior care setting, the hospice should re-affirm the patient's preferences and document them in the clinical record.

Examples

1. Patient admitted on 11-05-2025. Clinical note dated 11-05-2025 shows, "talked with the patient about preference for CPR; patient states they are not sure. Requests time to think and wants to discuss later." Clinical note dated 11-10-2025 shows, "discussed patient's preference for CPR; patient stated preference for DNR. DNR order signed and in the clinical record."

   Coding: F2000A, Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? would be coded 1, Yes, and discussion occurred. F2000B, Date the patient/responsible party was *first* asked about preference regarding the use of CPR, would be coded "11-05-2025."

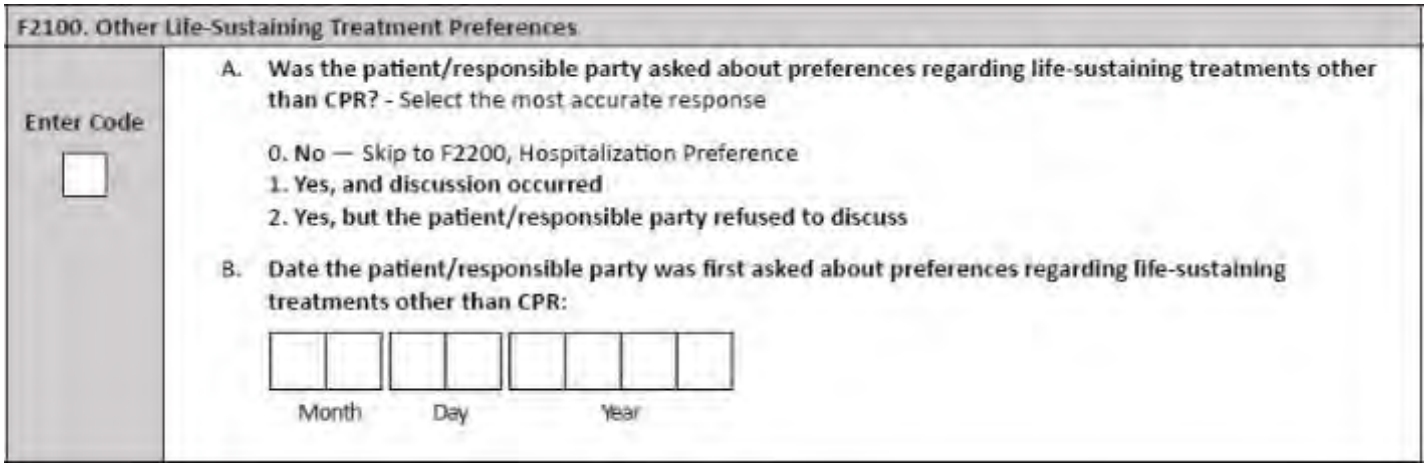
   Rationale: Although the patient later stated a preference regarding DNR, coding should be completed based on the *first* dated discussion. Although a clear preference was not expressed, a discussion did occur.

2. Patient admitted 11-01-2025. The clinical record for the patient includes a DNR order, signed in the prior care setting, which is dated 10-15-2025. There is no discussion documented in the clinical record on this topic.

   Coding: F2000A, Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? would be coded 0, No" Skip to Item F2100, Other Life-Sustaining Treatment Preferences.

   Rationale: Although the patient has a recently dated DNR order, it was signed in a prior care setting. There is no documentation in the clinical record to indicate that the hospice re-confirmed the patient's preferences. If a statement such as "DNR order confirmed with the responsible party, patient's daughter" was included, that would be sufficient to code 1, Yes, and discussion occurred.

F2100: Other Life-Sustaining Treatment Preferences


F2100. Other Life-Sustaining Treatment Preferences

Enter Code ☐

A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? - Select the most accurate response

0. No — Skip to F2200, Hospitalization Preference
1. Yes, and discussion occurred
2. Yes, but the patient/responsible party refused to discuss

B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:

☐☐ ☐☐ ☐☐☐☐
Month Day Year

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Item completion should be based on what is included in the clinical record.
- Review the clinical record for information regarding discussion of patient preference for life-sustaining treatment other than CPR.
- Consider care processes and discussions documented in the clinical record that took place during pre-admission or educational visits, as well as those during the admission assessment.
- Review all response choices before making a selection.
- Use the date on which the discussion *first* occurred.

A. Was the patient/responsible party asked about preferences regarding life-sustaining treatment other than CPR?

- **Code 0, No,** if there is no documentation that the hospice discussed (or attempted to discuss) preferences regarding life-sustaining treatment other than CPR with the patient or responsible party.
    - This applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party. This could happen if the patient was unable to discuss and/or the responsible party was unavailable.
- **Code 1, Yes, and discussion occurred,** if there is documentation that the hospice discussed preferences regarding life-sustaining treatment, other than CPR with the patient or responsible party.
    - This applies to situations where there is documentation that the hospice brought up the topic of life-sustaining treatment, other than CPR and engaged and/or had a conversation with the patient, the responsible party, or both. The conversation does not have to result in the patient stating a preference for or against the use of life-sustaining treatments, other than CPR.
- **Code 2, Yes, but the patient/responsible party refused to discuss,** if there is documentation that the hospice asked about preferences regarding life-sustaining treatments, other than CPR, but the patient or responsible party refused to discuss or was unable to discuss. The hospice was not successful in engaging the patient and/or responsible party in a discussion.
    - This applies to situations where there is documentation that the hospice attempted to have a

conversation with the patient and responsible party, but both the patient and responsible party *explicitly refused* to discuss the topic with the hospice (e.g., "I don't want to talk about this."), or the patient was unable to discuss because of their clinical status and the responsible party *explicitly refused* to discuss.

B. Date the patient/responsible party was *first* asked about preferences regarding life-sustaining treatments other than CPR.

- Enter the date the hospice *first* discussed (or attempted to discuss) patient preferences regarding life-sustaining treatment other than CPR.
- Multiple discussions regarding the use of life-sustaining treatments other than CPR may be documented in the clinical record.
- Completion of this item is based on the *first* dated discussion about preference regarding life-sustaining treatment other than CPR that appears in the clinical record.

Coding Tips

- There is no comprehensive list of life-sustaining treatments. Documentation in the clinical record indicating that a member of the hospice staff or interdisciplinary group (IDG) attempted to discuss preference for *any* life-sustaining treatment other than CPR (for example, ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, intravenous [IV] fluids) is sufficient to code either of the following for F2100A:
  - 1, Yes, and discussion occurred.
  - 2, Yes, but the patient/responsible party refused to discuss.
- Evidence of a discussion could be documented in the clinical record or via a POLST order or equivalent.
- A newly completed order or form that is completed after the admission to hospice or during a preadmission visit is sufficient provided there is evidence of involvement from the patient/responsible party (e.g., signature of the patient/ responsible party, or documentation that preference was confirmed with patient/responsible party).
- Orders alone, without evidence of discussion or involvement from the patient/responsible party, are not sufficient to code "Yes" for F2100A.
- For pre-existing orders or forms signed in a prior care setting, the hospice should re-affirm the patient's preferences and document them in the clinical record.

Examples

1. Patient admitted on 08-01-2025. Clinical note dated 08-01-2025 shows, "Had discussion with the patient about preference for use of prolonged IV fluids; the patient was hesitant and stated they weren't sure and wanted to discuss later. Told the patient we could discuss at a later date."

Coding: F2100A: Was the patient/responsible party asked about preference regarding the use of any life-sustaining treatment other than CPR? would be coded 1, Yes, and discussion occurred. F2100B: Date the patient/responsible party was *first* asked about preference regarding the use of any life-sustaining treatment other than CPR: Enter "08-01-2025."

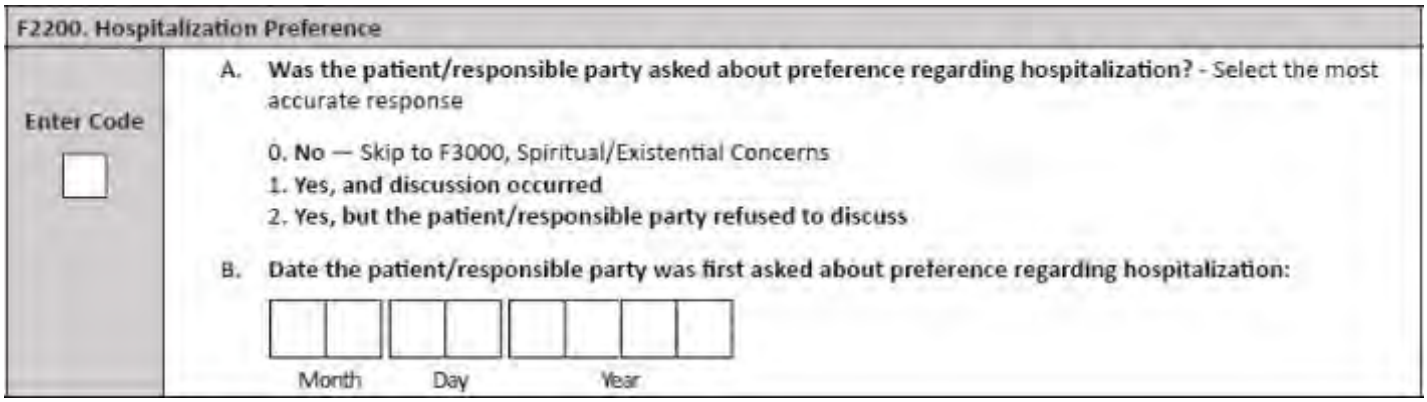
Rationale: The most appropriate response option is "1" because although the patient did not express a clear preference regarding the use of prolonged IV fluids, a discussion did occur.

2. Patient admitted 08-01-2025. The clinical record for the patient includes an order from the prior care setting, "no life-sustaining treatments desired," which is dated 07-15-2025. There is no discussion documented in the clinical record on this topic.

   Coding: F2100A: Was the patient/responsible party asked about preference regarding life-sustaining treatments other than CPR? would be coded 0, No. Skip to Item F2200, Hospitalization Preference.

   Rationale: Although the patient has a recently dated order regarding life-sustaining treatment preferences, it was signed in a prior care setting. There is no documentation in the hospice clinical record to indicate that the hospice re-confirmed the patient's preferences. If a statement such as "desire to avoid all forms of life-sustaining treatments confirmed with the responsible party, patient's daughter" was included, that would be sufficient to select response Code 1, Yes, and discussion occurred.

F2200: Hospitalization Preference


F2200. Hospitalization Preference

Enter Code ☐

A. **Was the patient/responsible party asked about preference regarding hospitalization?** - Select the most accurate response

0. No — Skip to F3000, Spiritual/Existential Concerns
1. Yes, and discussion occurred
2. Yes, but the patient/responsible party refused to discuss

B. **Date the patient/responsible party was first asked about preference regarding hospitalization:**

☐☐ ☐☐ ☐☐☐☐

Month Day Year

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Item completion should be based on what is included in the clinical record.
- Review the clinical record for information regarding patient preference for hospitalization.
- Consider care processes and discussions documented in the clinical record that took place during pre-admission or educational visits, as well as those during the admission assessment.
- Review all response choices before making a selection.
- Use the date on which the discussion *first* occurred.
- For the purposes of this item, "hospitalization" does not include hospice care (such as general inpatient or respite level of care) provided in contracted acute care settings or hospital-based inpatient hospice units.
  - This is not referring to the patient's choice of a particular facility, but rather if the patient/caregiver has a preference regarding hospitalization as a care option to consider.
  - Examples of discussions with the patient or family that could be considered include but are not limited to those where the patient and/or caregiver:
    - expressed the desire to keep the patient at home and not to be transferred/admitted to a hospital again.

- discussed specific situations in which they feel hospitalization would be the preferred location for their care.
- state that, at this time, they are unsure if being transferred/admitted to a hospital for care is something they would consider.

A. Was the patient/responsible party asked about preference regarding hospitalization?

- **Code 0, No,** if there is no documentation that the hospice discussed (or attempted to discuss) preference regarding hospitalization with the patient or responsible party. Skip to Item F3000, Spiritual/Existential Concerns.
  - This applies to situations where there is no documentation that a discussion occurred or was attempted with the patient or responsible party (e.g., the patient was unable to discuss and/or the responsible party was unavailable).
- **Code 1, Yes, and discussion occurred,** if there is documentation that the hospice discussed preference regarding hospitalization with the patient or responsible party.
  - This applies to situations where there is documentation that the hospice brought up the topic of hospitalization, engaged, and/or had a conversation with the patient, the responsible party, or both. The conversation does not have to result in the patient stating a preference for or against hospitalization.
- **Code 2, Yes, but the patient/responsible party refused to discuss,** if there is documentation that the hospice asked about preference regarding hospitalization, but the patient or responsible party refused to discuss or was unable to discuss. The hospice was not successful in engaging the patient and/or responsible party in a discussion.
  - This applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and responsible party, but both the patient *and* responsible party *explicitly refused* to discuss the topic with the hospice (e.g., "I don't want to talk about this") or the patient was unable to discuss because of their clinical status *and* the responsible party *explicitly refused* to discuss.

B. Date the patient/responsible party was first asked about preference regarding hospitalization.

- Enter the date the hospice *first* discussed (or attempted to discuss) patient preference regarding hospitalization.
- Multiple discussions regarding the use of CPR may be documented in the clinical record.
- Completion of this item is based on the first dated discussion about preference regarding the hospitalization that appears in the clinical record.

Coding Tips

- Evidence of a discussion could be documented in the clinical record or via a Do Not Hospitalize (DNH) order, or equivalent.
- A newly completed order or form that is completed after the admission to hospice or during a preadmission visit is sufficient provided there is evidence of involvement from the patient/responsible party (e.g., signature of the patient/ responsible party, or documentation that DNH preference was confirmed with patient/responsible party).
- Orders alone or short statements in the clinical record, such as "DNH", without evidence of discussion or involvement from the patient/responsible party, are not sufficient to code "Yes" for F2200A.

- For pre-existing orders or forms signed in a prior care setting, the hospice should re-affirm the patient's preferences and document them in the clinical record.

Examples

1. Patient admitted on 08-01-2025. Clinical note dated 08-01-2025 reads, "Talked with the patient about preference for readmission to hospital; the patient was hesitant and stated they weren't sure. Told the patient we could discuss at a later date."

   Coding: F2200A: Was the patient/responsible party asked about preference regarding hospitalization? would be coded "1, Yes, and discussion occurred." F2200B: Date the patient/responsible party was *first* asked about preference regarding hospitalization: Enter "08-01-2025."

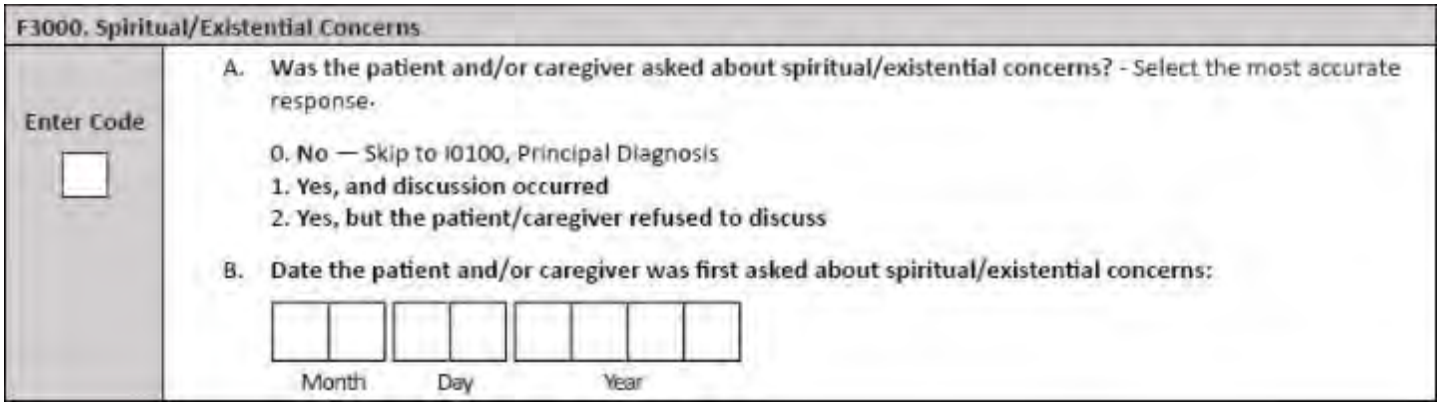
   Rationale: The most appropriate response option is "1" because although the patient did not express a clear preference regarding hospitalization, a discussion occurred.

2. Patient admitted 08-01-2025. The clinical record for the patient includes a POLST form completed in the prior care setting indicating the selection of comfort-oriented care, including a desire to avoid hospitalization, which is dated 07-15-2025. There is no discussion documented in the clinical record on this topic.

   Coding: F2200A: Was the patient/responsible party asked about preference regarding hospitalization? would be coded "0, No." Skip to Item F3000, Spiritual/Existential Concerns.

   Rationale: Although the patient has a recently dated POLST, it was signed in a prior care setting. There is no documentation in the clinical record to indicate that the hospice re-confirmed the patient's preferences for comfort-oriented care and avoidance of hospitalization. If a statement such as "All POLST treatment preferences confirmed with the responsible party, patient's daughter" was included, that would be sufficient to code "1, Yes."

F3000: Spiritual/Existential Concerns


F3000. Spiritual/Existential Concerns

Enter Code ☐

A. Was the patient and/or caregiver asked about spiritual/existential concerns? - Select the most accurate response.

0. No — Skip to I0100, Principal Diagnosis
1. Yes, and discussion occurred
2. Yes, but the patient/caregiver refused to discuss

B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:

☐☐ ☐☐ ☐☐☐☐
Month Day Year

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Item completion should be based on what is included in the clinical record.
- Review the clinical record for information regarding discussion of patient preference regarding

spiritual/existential concerns.

- Consider care processes and discussions documented in the clinical record that took place during pre-admission or educational visits, as well as those during the admission assessment.
- Review all response choices before making a selection.
- Use the date on which the discussion *first* occurred.

A. Was the patient and/or caregiver asked about spiritual/existential concerns?

- **Code 0, No,** if there is no documentation that the hospice discussed (or attempted to discuss) spiritual/existential concerns with the patient and/or caregiver(s). Skip to Item I0010, Principal Diagnosis.
    - This applies to situations where there is no documentation that a discussion occurred or was attempted with the patient and/or caregiver (e.g., the patient was unable to discuss and/or the caregiver was unavailable).
- **Code 1, Yes, and discussion occurred,** if there is documentation that the hospice discussed spiritual/existential concerns with the patient and/or caregiver(s).
    - This applies to situations where there is documentation that the hospice brought up the topic of spiritual/existential concerns and engaged or had a conversation with the patient and caregiver. The conversation does not have to result in the initiation of intervention(s) to address spiritual/existential concerns.
- **Code 2, Yes, but patient and/or caregiver refused to discuss,** if there is documentation that the hospice asked about spiritual/existential concerns, but the patient and/or caregiver(s) refused to discuss or were unable to discuss. The hospice was not successful in engaging the patient and/or caregiver in a discussion.
    - This applies to situations where there is documentation that the hospice attempted to have a conversation with the patient and caregiver, but both the patient and caregiver *explicitly refused* to discuss the topic with the hospice (e.g., "I don't want to talk about this" or "I'm only going to talk to my priest about this") or the patient was unable to discuss because of their clinical status and the caregiver *explicitly refused* to discuss.

B. Date the patient and/or caregiver was *first* asked about spiritual/existential concerns.

- Enter the date the hospice discussed (or attempted to discuss) spiritual/existential concerns.
- Multiple discussions regarding spiritual/existential concerns may be documented in the clinical record.
- Completion of this item is based on the *first* dated discussion about spiritual/existential concerns that appear in the clinical record.

Coding Tips

- For the purposes of completing this item, the "caregiver" does not have to be the legally authorized representative.
- There is no comprehensive list of spiritual/existential concerns.
    - Examples of a discussion regarding spiritual/existential concerns might include but are not limited to asking the patient/caregiver about the need for spiritual or religious support, having a discussion about a higher power related to illness, or offering a spiritual resource (such as a chaplain).
- Documentation in the clinical record indicating that a member of the hospice staff or IDG attempted to discuss spiritual/existential concerns is sufficient to select either of the following for F3000A:

- "1, Yes, and discussion occurred."
- "2, Yes, but the patient and/or caregiver refused to discuss."

- Brief statements or data in the clinical record denoting a patient's religious affiliation, or that denotes a spiritual visit was offered without documentation of a discussion is not sufficient to code "Yes" for F3000A.
- While these conversations are best held face-to-face, phone conversations with patients/families about spiritual/existential issues can be used to answer yes to F3000 as long as the clinical documentation supports that a discussion was had with the patient and/or caregiver.
- A discussion with the patient and/or caregiver(s) about spiritual/existential concerns can be initiated by any member of the hospice staff or IDG.

Examples

1. Social worker assessment dated 08-01-2025 shows, "Patient's spouse in a great deal of spiritual distress and would like to speak with a chaplain. Referral made."

   Coding: F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns? would be coded 1, Yes, and discussion occurred. F3000B: Date the patient and/or caregiver was *first* asked about spiritual/existential concerns. Enter "08-01-2025."

   Rationale: The completed assessment is strong evidence that the hospice engaged the patient and/or caregiver in a discussion regarding spiritual/existential concerns. Even though the clinical record does not contain documentation of a visit by the chaplain, code "1, Yes, and discussion occurred" because the intent of F3000 is to capture the initiation of a *discussion* about spiritual/existential concerns.

2. Patient's initial assessment shows, "patient identifies their religious affiliation as Baptist."

   Coding: F3000A: Was the patient and/or caregiver asked about spiritual/existential concerns? would be coded "0, No" and skip to Item I0010, Principal Diagnosis.

   Rationale: The intent of F3000 is to capture initiation of a discussion (or attempted discussion) about spiritual/existential concerns. Clinical record documentation showing only the patient's religious affiliation is not sufficient evidence that the hospice had (or attempted to have) a *discussion* regarding spiritual/existential concerns with the patient and/or caregiver.

SECTION I: ACTIVE DIAGNOSES

Section Intent

The item in this section pertains to the principal diagnosis of the patient and any co-morbidities.

Section Rationale

Disease processes and conditions can impact service delivery. This section includes the most common principal diagnoses among hospice patients, as well as comorbidities and co-existing conditions.

I0010. Principal Diagnosis

I0010. Principal Diagnosis	
Enter Code ☐☐	01. Cancer 02. Dementia (including Alzheimer's disease) 03. Neurological Condition (e.g., Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS)) 04. Stroke 05. Chronic Obstructive Pulmonary Disease (COPD) 06. Cardiovascular (excluding heart failure) 07. Heart Failure 08. Liver Disease 09. Renal Disease 99. None of the above
Comorbidities and Co-existing Conditions	
↓ Check all that apply	
	Cancer
☐	I0100. Cancer
	Heart/Circulation
☐	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	I0950. Cardiovascular (excluding heart failure)
	Gastrointestinal
☐	I1101. Liver disease (e.g., cirrhosis)
	Genitourinary
☐	I1510. Renal disease
	Infections
☐	I2102. Sepsis
	Metabolic
☐	I2900. Diabetes Mellitus (DM)
☐	I2910. Neuropathy
	Neurological
☐	I4501. Stroke
☐	I4801. Dementia (including Alzheimer's disease)
☐	I5150. Neurological Conditions (e.g., Parkinson's disease, multiple sclerosis, ALS)
	I5401. Seizure Disorder
	Pulmonary
☐	I6202. Chronic Obstructive Pulmonary Disease (COPD)
	Other
☐	I8005. Other Medical Condition

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- The principal diagnosis is defined as the condition established after reviewing all available information to be chiefly responsible for the patient's admission.
- For hospice patients, this is the diagnosis that most contributes to the patient's life expectancy of six months or less if the illness runs its normal course.
- This item should be completed based on the patient's principal diagnosis at the time of admission to hospice.
- Review the clinical record for information regarding the principal diagnosis.
- Item completion must be based on what is indicated in the clinical record.
  - Do not use sources external to the clinical record.
- Review all response choices before making a selection.
- **Code 99, None of the above,** if the patient's principal diagnosis is a disease or condition not listed.

Coding Tips

- Use Code 01. for all types of cancer, e.g., skin and blood cancers.
- Code 02 includes all types of dementia, e.g., Lewy body dementia and Pick's disease.
- Note that two principal diagnosis response codes are related to cardiac conditions. One is for cardiovascular conditions **excluding** heart failure (06) and the other is **specific** to heart failure (07).

Comorbidities and Coexisting Conditions

- Review the medical record for comorbidities and/or coexisting conditions at the time of admission to hospice.
- Check **all** comorbid and/or coexisting diseases or medical conditions that are addressed in the plan of care or that have the potential to impact the plan of care.
- Do not include the principal diagnosis, except if the patient has a secondary cancer.

DEFINITION

COMORBIDITIES

Refers to diseases or medical conditions that occur simultaneously with the principal diagnosis.

Example

During the admission assessment, the patient explains that she has a history of diabetes which is well controlled and also had breast cancer 25 years ago. She was treated for the breast cancer at that time and has scarring from a left breast mastectomy. At the time of the hospice admission the terminal diagnosis is stage four colon cancer.

Coding: I0010. Principal Diagnosis would be coded 01, Cancer, and I0100. Cancer, and I2900. Diabetes Mellitus (DM) would be checked for Comorbidities and Coexisting Conditions.

Rationale: Based upon the clinician's assessment and patient report, the nurse records Cancer for both the Principal Diagnosis and the Comorbidities and Coexisting Conditions category.

SECTION J: HEALTH CONDITIONS

Section Intent

Items in this section are intended to document the physical symptoms and the impact of pain and non-pain symptoms for hospice patients. The items in this section include an assessment of imminent death, screening for pain, a comprehensive pain assessment if warranted, and screening for dyspnea. The items are intended to incorporate information from the interview with the patient and family/caregiver, as well as the clinical assessment and judgment of the assessing nurse if the patient is unable to participate.

Section Rationale

Pain and non-pain symptoms (such as shortness of breath) are prevalent and undertreated for many populations of seriously ill patients, including those nearing the end of life.

Patients and family/caregivers rate pain management as a high priority when living with serious and life-limiting illnesses. Other non-pain symptoms can be functionally limiting and distressing to patients, as well as to their families/caregivers.

The consequences of inadequate screening, assessment, and treatment for these conditions can impact the patient by causing physical suffering, social withdrawal, depression, and functional decline.

Screening for pain and non-pain symptoms and their impact on the patient will assist the hospice team with care planning and is an essential step for effective symptom management and treatment.

Effective treatment is available to alleviate and lessen the impact of most pain and non-pain symptoms. Treatment may include pharmacologic and non-pharmacologic interventions and will vary based on patient and family/caregiver preferences.

Note: Examples combining items J0900, J0905, and J0910 can be found at the end of the item guidance for J0910.

J0050: Death is Imminent

J0050. Death is Imminent	
Enter Code ☐	**At the time of this assessment and based on your clinical assessment, does the patient appear to have a life expectancy of 3 days or less?** 0. **No** 1. **Yes**

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- **Code 0, No,** if clinical assessment and judgment determine the patient is expected to live longer than

three (3) days.

- **Code 1, Yes,** if clinical assessment and judgment determine the patient is expected to live three (3) days or less.
- Code this item based upon the clinician's assessment of the patient's status at the time of the visit.
- This response does not indicate a statement of the actual prognosis, but rather the likelihood that death may be imminent based on the symptoms the clinician is observing.
- In counting the number of days, the day of the assessment visit is day zero (0).

Examples

1. During the admission assessment, the nurse assessing the patient observes that his upper and lower extremities are mottled, cyanotic, and cold. The nurse also notes that the patient is accumulating secretions in his throat and appears unable to clear or swallow them.

   The nurse observes that the patient is not responding to verbal stimuli. The patient's family reports he is not waking nor trying to open his eyes when they talk to him. The family also reports that the patient has not urinated in more than 24 hours and does not respond when they ask if he needs to urinate.

   Coding: J0050. Death is Imminent would be coded 1, Yes.

   Rationale: Based upon the clinician's assessment and judgment, the patient presented with signs of imminent death, therefore the clinician determined the patient appeared to have a life expectancy of three (3) days or less.

2. During the HUV, the nurse assessing the patient observes that the patient is moderately short of breath, is able to ambulate from her bed to the bathroom using her walker and is alert and oriented throughout the visit. The family reports that the patient's activity level has not changed over the past week.

   Coding: J0050. Death is Imminent would be coded 0, No.

   Rationale: Based upon the clinician's assessment and judgment, the patient presented without signs of imminent death, and therefore the clinician determined the patient appeared to have a life expectancy of more than three (3) days.

J0900: Pain Screening

J0900. Pain Screening	
Enter Code ☐	A. Was the patient screened for pain? 0. No — Skip to J0905, Pain Active Problem 1. Yes B. Date of first screening for pain ☐☐ ☐☐ ☐☐☐☐ Month Day Year
Enter Code ☐	C. The patient's pain severity was: 0. None 1. Mild 2. Moderate 3. Severe 9. Pain not rated
Enter Code ☐	D. Type of standardized pain tool used: 1. Numeric 2. Verbal descriptor 3. Patient visual 4. Staff observation 9. No standardized tool used

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Assess the patient for the presence of pain.
- Item completion should be based on what is determined during the assessment visit and/or included in the clinical record. Do not use sources external to the clinical record.
- Review the clinical record for information regarding pain screening.
- Consider results of the standardized pain screening tool and any other screening approaches the clinician used that might include asking the patient about their pain comfort.
- Review all response choices before making a selection.

A. Was the patient screened for pain?

- **Code 0, No,** if the patient was not screened for pain, and/or there is no documentation that the patient was screened for pain. Skip to Item J0905, Pain Active Problem.
- **Code 1, Yes,** if the patient was screened for pain and/or there is documentation that the patient was screened for pain.

B. Date of first screening for pain

- Enter the date of the *fir*st screening for pain.
- It is possible that at the time of completion, multiple pain screenings will be documented in the clinical record.
- Complete pain screening items based on the *first* pain screening documented in the clinical record.

C. The patient's pain severity was:

Use **Table 4** below to assist with choosing pain severity.

Table 4: Pain Severity Ratings

Code	When to Use	Scale Equivalent Examples (Numeric, verbal, visual, staff observation, or other)
0, None	if the patient's pain severity score was none.	0 on a 10-point numeric scale.
1, Mild	if the patient's pain severity score was mild.	1–3 on a 10-point numeric scale.
2, Moderate	if the patient's pain severity score was moderate.	4–6 on a 10-point numeric scale.
3, Severe	if the patient's pain severity score was severe.	7–10 on a 10-point numeric scale.
9, Pain not rated	if the patient had pain, but the patient's pain severity was not assessed or documented.	

D. Type of standardized pain tool used: Use **Table 5** to determine the type of standardized pain tool used for the assessment.

Table 5: Standardized Tools for Pain Assessment

Type of Tool	When to Use	Scale Type Examples
1, Numeric	if a numeric scale was used to conduct pain screening.	e.g., 10-point scale, the Edmonton Symptom Assessment System (ESAS), and Symptom Distress Scale (McCorkle).
2, Verbal descriptor	if a verbal descriptor scale was used to conduct pain screening.	e.g., the Brief Pain Inventory, McGill pain questionnaire (MPQ), and the 6-Point Verbal Pain Scale.
3, Patient visual	if a patient visual scale was used to conduct pain screening.	e.g., Wong-Baker FACES Pain Scale, visual analog scale, and a distress thermometer.
4, Staff observation	if a staff observational scale was used to conduct pain screening.	Select only if a standardized staff observational scale was used. (e.g., Pain Assessment in Advanced Dementia (PAIN-AD), the FLACC scale, Critical Care Pain Observation Tool (CPOT) or Checklist of Nonverbal Pain Indicators (CNPI)).

Type of Tool	When to Use	Scale Type Examples
9, No standardized tool used	if no standardized scale was used to screen for the presence and severity of pain.	Not Applicable.

Coding Tips

- Select the best response for pain severity based on the pain level at the time of the visit during which the *first* screening was performed.
  - If a range is provided, such as mild to moderate, report the highest level of severity experienced during the visit.
- If a non-numeric scale was used to screen the patient for pain, select the pain severity item based on the standard established for that scale.
  - If no standard has been established for that scale, use clinician judgment to categorize severity.

J0905: Pain Active Problem

J0905. Pain Active Problem	
Enter Code ☐	**Is pain an active problem for the patient?** 0. **No** — Skip to J2030, Screening for Shortness of Breath 1. **Yes**

Time Points Item(s) Completed

Admission (ADM)

Item-Specific Instructions

- **Code 0, No,** if pain is not an active problem for the patient.
- **Code 1, Yes,** if pain is an active problem for the patient.

Coding Tips

- Code 1, Yes includes situations where the patient is not in pain at the time of screening, but pain is an active problem for the patient.
- The determination of whether or not pain is an active problem may be made by the assessing clinician based on patient-specific findings and/or conversations with family/caregivers.
- In determining whether pain is an active problem for the patient, clinicians may need to consider factors beyond pain severity at the time of the clinical encounter, such as historical report of pain, reports of recent symptoms, current treatment for pain (pharmacologic and/or non-pharmacologic), etc.
  - It is possible that the clinician may determine pain is an active problem for the patient, even if pain is not present during the clinical encounter.
- Generally, clinical documentation that the patient is currently taking pain medication is evidence that pain is an active problem for the patient.
- If documentation in the patient's clinical record indicates that pain is an active problem for the patient, then select 1, Yes to J0905, and continue to Item J0910, Comprehensive Pain Assessment and complete J0910 according to item completion instructions.

- If documentation in the patient's clinical record indicates that pain is not an active problem for the patient, then select 0, No to J0905, and skip item J0910.
- In instances where the patient is not in pain at the time of the screening, but pain is an active problem for the patient, complete Item J0910.

J0910: Comprehensive Pain Assessment

J0910. Comprehensive Pain Assessment	
Enter Code ☐	A. Was a comprehensive pain assessment done? 0. No — Skip to J2030, Screening for Shortness of Breath 1. Yes B. Date of Comprehensive pain assessment: ☐☐ ☐☐ ☐☐☐☐ Month Day Year C. Comprehensive pain assessment included:
↓ Check all that apply	
☐	1. Location
☐	2. Severity
☐	3. Character
☐	4. Duration
☐	5. Frequency
☐	6. What relieves/worsens pain
☐	7. Effect on function or quality of life
☐	9. None of the above

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- A comprehensive pain assessment should address multiple aspects of pain, beyond a determination of the pain presence and severity.
- For any of the seven characteristics included in the pain assessment, select response options based on whether the clinician made an attempt to gather the information from the patient/caregiver.
    - For example, if, for a nonverbal patient, the clinician asked the family/caregiver about pain location and the family/caregiver responded, "I'm not sure" or "I don't know," **01, Location** should be checked because the clinician attempted to gather the information.

Coding Tips

- It is possible to include elements of the pain assessment for nonverbal patients.
    - A caregiver report about any of the listed pain characteristics is acceptable.
    - Clinical notes about assessment of nonverbal indicators of pain for any of these characteristics are also acceptable.

Nonverbal Indicators

- Nonverbal indicators of pain include:

- Nonverbal sounds such as crying, whining, and groaning.
- Facial expressions, such as grimacing and clenching the jaw.
- Protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part.

Nonverbal Assessment Documentation

The table below, **Table 6,** provides examples of documentation for the various pain characteristics.

Table 6 : Nonverbal Pain Characteristics

Pain Characteristic	Examples
Location	An account of patient exhibiting nonverbal cues of pain for a *specific location on the body,* (e.g., "Patient grimaced and shouted when clinician touched their right leg.").
Severity	Description of the *intensity* of nonverbal expression, e.g., results of a nonverbal standardized rating scale.
Duration	Details about *how long* a patient exhibits any nonverbal cues, (e.g., "Patient cradled right arm through the entire visit.").
Frequency	A report of *how often* a patient exhibits any nonverbal cues of pain.
What relieves/worsens	Details of *actions, activities, positions that relieve/worsen pain, (e.g.,* "Patient exhibits fewer nonverbal signs of pain when sitting versus lying down.").
Effect on function or quality of life	Notes explaining a *change in patient activity, (e.g.,* "Family/caregiver reports that the patient is no longer able to sit up in bed without moaning").

Examples for J0900, J0905 and J0910

1. The clinical note dated 11-12-2025 indicates the patient reported no pain and there were no complaints from patient or family. The patient reported recently taking a dose of pain medication. Patient reported a history of dull, aching pain in the lower abdomen that comes and goes intermittently, and at its worst, pain is 6/10. Historically, pain is worse when the patient walks and pain is better when lying down.

   Coding: See **Table 7** for the coding answers to example 1.

Table 7: Example 1 Coding Answers

Data Element (or Item)	Detail	Correct Code or Response
J0900A	Was the patient screened for pain?	**1, Yes**
J0900B	Date of first screening for pain:	**Enter 11-12-2025**
J0900C	The patient's pain severity was:	**0, None**
J0900D	Type of Standardized pain tool used:	**9, No standardized tool used**
J0905	Pain Active Problem:	**1, Yes**
J0910A	Was a comprehensive pain assessment done?	**1, Yes**
J0910B	Date of comprehensive pain assessment:	**Enter 11-12-2025**
J0910C	Comprehensive pain assessment included:	**Check:** • 1, Location (lower abdomen) • 2, Severity (currently not in pain, but at its worst, pain is 6/10) • 3, Character (dull, aching pain) • 5, Frequency (intermittent) • 6, What relieves/worsens pain (worse when patient walks and pain is better when lying down)

Rationale:

Item J0900. Pain Screening should be completed based on the patient's pain status and assessment *at the time of the screening clinical encounter*. This means that, although the patient reported a history of pain, item J0900 should be completed based on the clinician's assessment that the patient was not in any pain *at the time of the visit*. Additionally, although there was no standardized pain tool used to screen the patient *at the time of the screening clinical encounter*, it is evident that the clinician evaluated the patient and determined the patient was not in any pain. The correct course of action is to complete J0900A-D.

Item J0905. Pain Active Problem considers factors *beyond pain severity at the time of the screening clinical encounter*, such as historical report of pain or report of recent symptoms. In this situation, because the patient has a history of pain, it is clinically appropriate for the clinician to consider pain to be an active problem for the patient, and code "1, Yes" for Item J0905. Pain Active Problem.

Since pain is an active problem for the patient, it is clinically appropriate for the clinician to complete a comprehensive pain assessment (even though the patient was not in pain at the time of the pain screening). Because at least one of the seven characteristics of a comprehensive pain assessment were clearly documented, code "1, Yes" for J0910A and continue to J0910B-J0910C, coding based on documentation found in the clinical record.

2. The clinical note dated 11-12-2025 indicates the patient is unable to speak, was observed during 20-minute evaluation, and had pain severity on a nonverbal scale of moderate to severe. The clinician interviewed the family about the patient's distress. The family stated the patient had been moaning all morning and rarely

looked comfortable. The family stated the patient often clutches the lower abdomen when touched. The family also reported they are unable to move the patient because of signs of distress when turning. The family was uncertain about factors that make pain better.

Coding: See **Table 8** for the coding answers to example 2.

Table 8: Example 2 Coding Answers

Data Element (or Item)	Detail	Correct Code or Response
J0900A	Was the patient screened for pain?	**1, Yes**
J0900B	Date of first screening for pain:	**Enter 11-12-2025**
J0900C	The patient's pain severity was:	**3, Severe**
J0900D	Type of Standardized pain tool used:	**4, Staff observation**
J0905	Pain Active Problem:	**1, Yes**
J0910A	Was a comprehensive pain assessment done?	**1, Yes**
J0910B	Date of comprehensive pain assessment:	**Enter 11-12-2025**
J0910C	Comprehensive pain assessment included:	**Check:** • 1, Location (clutching lower abdomen) • 2, Severity (pain severity on nonverbal scale moderate to severe) • 4, Duration (patient had been moaning all morning) • 5, Frequency (rarely looked comfortable) • 6, What relieves/worsens pain (family uncertain) • 7, Effect on function or quality of life (unable to move because of distress)

Rationale:

Item J0900. Pain Screening should be completed based on the patient's pain status and assessment *at the time of the screening clinical encounter*. It is evident that the patient was in pain, and that the clinician evaluated the patient's pain and noted pain severity. Although the clinical tool is not named, it is still evident that the clinician used a standardized approach or clinical protocol to screen the patient. For J0900C, the correct course of action is to code "3, Severe," based on the *highest severity of pain at the time of the visit*.

For Item J0905, clinical documentation that the patient was in pain at the time of the screening visit is evidence that pain is an active problem for the patient.

For Item J0910, because at least one of the seven characteristics of a comprehensive pain assessment were clearly documented in the patient's clinical record, code "1, Yes" for J0910A and continue to J0910B-J0910C, selecting responses based on documentation in the clinical record. Even though the family stated

they were not sure what made the pain better or worse, “6, What relieves/worsens pain” can still be checked because there was documentation that the clinician asked about what relieves or worsens pain.

3. Clinical documentation dated 11-14-2025 shows the patient is very drowsy but appears comfortable during the visit. No nonverbal signs of pain observed during the visit. However, the patient’s family reported that the patient is not allowing necessary dressing changes or incontinence/skin care because the patient cannot tolerate the pain that each intervention causes. The patient’s family explained to the clinician that the patient loudly moans/grimaces during weekly dressing changes and incontinence/skin care about six times per day and that now the patient won’t let them do any more dressing changes or skin care. The family explained sometimes it was helpful to play music and talk to the patient to try to distract them during dressing changes and skin care, and, once the dressing change/skin care has been completed, the patient no longer appears to be in pain. Family reports the patient has no other pain except that caused by dressing and/or incontinence/skin care interventions.

Coding: See **Table 9** for the coding answers to example 3.

Table 9: Example 3 Coding Answers

Data Element (or Item)	Detail	Correct Code or Response
J0900A	Was the patient screened for pain?	**1, Yes**
J0900B	Date of first screening for pain:	**Enter 11-14-2025**
J0900C	The patient’s pain severity was:	**0, None**
J0900D	Type of Standardized pain tool used:	**9, No standardized tool used**
J0905	Pain Active Problem:	**1, Yes**
J0910A	Was a comprehensive pain assessment done?	**1, Yes**
J0910B	Date of comprehensive pain assessment:	**Enter 11-14-2025**
J0910C	Comprehensive pain assessment included:	**Check:** • 2, Severity (loudly moans/grimaces) • 4, Duration (throughout dressing change/skin care and that once the dressing change/skin care is completed, the patient no longer appears to be in pain) • 5, Frequency (during weekly dressing changes and incontinence/skin care about six times per day) • 6, What relieves/worsens pain (dressing changes/skin care makes pain worse and playing music and distraction makes pain better) • 7, Effect on function or quality of life (patient no longer allowing dressing changes or skin care)

Rationale:

Item J0900. Pain Screening should be completed based on the patient's pain status *at the time of the screening clinical encounter*. This means, although the family reported the patient experiences pain during dressing changes/skin care, item J0900 should be completed based on the clinician's assessment that the patient was not in any pain *at the time of the screening clinical encounter*. Although there was no standardized pain tool used to screen the patient, it is evident the clinician evaluated the patient and determined the patient was not in any pain at the time of the screening.

For Item J0905, although the patient family reports no pain other than pain caused during dressing changes and/or incontinence/skin care, it is evident that pain is interfering with clinical care and potentially affecting the patient's quality of life. Thus, in this situation, pain is considered an active problem.

For Item J0910, since pain is an active problem for the patient, it is clinically appropriate for the clinician to complete a comprehensive pain assessment (even though the patient was not in pain at the time of the pain screening). Clinical documentation indicates a comprehensive pain assessment was performed using a standardized approach or clinical protocol including observation, clinical judgment, and care giver interview to identify the presence of at least one of the seven characteristics.

J0915. Neuropathic Pain

J0915. Neuropathic Pain	
Enter Code ☐	Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)? 0. No 1. Yes

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Assess the patient for signs and symptoms of neuropathic pain.
- Several data sources and resources can be used separately or collectively to respond to this item.
    - Patient and/or caregiver interview (including family and facility staff), observation, clinical assessment, and clinical judgment are acceptable.

DEFINITION

NEUROPATHIC PAIN
Pain caused by a lesion or disease of the somatosensory nervous system.

International Association for the Study of Pain: https://www.iasp-pain.org/resources/terminology/#Neuropathicpain

Coding Tips

- **Code 0, No,** if patient does not exhibit signs and symptoms of neuropathic pain at the time of the assessment.
- **Code 1, Yes,** if patient exhibits signs and symptoms of neuropathic pain at the time of the assessment.

Examples

1. During the hospice admission visit, the RN asks the patient about pain. The patient responds, "I don't know if you would call it pain, but I do have a burning and tingling feeling in my feet, especially at night which

makes it difficult for me to get a comfortable night's sleep. My physician has tried me on a few medications in the past, but nothing has really helped."

Coding: J0915. Neuropathic Pain = 1, Yes.

Rationale: At the time of the nursing admission visit, the patient reports symptoms consistent with neuropathic pain.

2. A resident of the local nursing home is being admitted to hospice with a diagnosis of advanced dementia and a long history of diabetes with diabetic ulcers on both feet. The resident is interactive, but unable to communicate in meaningful sentences. During the admission visit, the hospice nurse gathers information from the facility aide and nurse who has cared for the resident for many months. The aide reports the resident has hypersensitivity on her legs and "screams any time we touch them. Their daughter has told us that the resident complained of burning and numbness in both legs before coming to the nursing home." The nurse observes this behavior as the aide carefully attempts to bathe the resident and the facility documentation confirms this for the assessing nurse.

   Coding: J0915. Neuropathic Pain = 1, Yes.

   Rationale: The caregiver (facility staff) reported a history of pain characterized by hypersensitivity to touch. At the time of the assessment, the patient is exhibiting signs consistent with neuropathic pain. Based on the interview, clinical observation, and facility documentation, this item is coded 1, Yes.

J2030: Screening of Shortness of Breath

J2030. Screening for Shortness of Breath	
Enter Code ☐	A. **Was the patient screened for shortness of breath?** 0. **No** — Skip to J2050, Symptom Impact Screening 1. **Yes** B. **Date of first screening for shortness of breath:** ☐☐ ☐☐ ☐☐☐☐ Month Day Year
Enter Code ☐	C. **Did the screening indicate the patient had shortness of breath?** 0. **No** — Skip to J2050, Symptom Impact Screening 1. **Yes**

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Assess the patient for the presence of shortness of breath.
- Item completion should be based on what is determined during the assessment visit and/or included in the clinical record. Do not use sources external to the clinical record.
- Review the clinical record for documentation of screening for shortness of breath.
- A screening for shortness of breath must include evaluating the patient for presence/absence of shortness of breath **and**, if shortness of breath is present, rating its severity.

- Review all response choices before making a selection.

A. Was the patient screened for shortness of breath?

- **Code 0, No,** if the patient was not screened for shortness of breath, and/or there is no documentation that indicates the patient was screened for shortness of breath. Skip to Item J2050, Symptom Impact Screening.
- **Code 1, Yes,** if the patient was screened for shortness of breath or there is documentation that indicates the patient was screened for shortness of breath.

B. Date of first screening for shortness of breath

- Enter the date of the *first* screening for shortness of breath.
- It is possible that at the time of completion, multiple screenings for shortness of breath will be documented in the clinical record.
- Complete shortness of breath screening items based on the *first* shortness of breath screening documented in the clinical record.

C. Did the screening indicate the patient had shortness of breath?

- **Code 0, No,** if the screening indicated that the patient did not have shortness of breath. Skip to Item J2050, Symptom Impact Screening.
  - Use code 0, if the documentation indicates the presence of shortness but there is no documentation of severity.
- **Code 1, Yes,** if the screening indicated that the patient had shortness of breath.

Coding Tips

- Consider whether shortness of breath is an active problem at the time of the screening.
  - Indicators of shortness of breath as an active problem include, but are not limited to:
    - Patient's self-report or caregiver report of distress or "trouble breathing" from shortness of breath or dyspnea.
    - Documentation of dyspnea or shortness of breath at rest, upon exertion or other times.
    - Observed clinical signs of shortness of breath.
- On the basis of reports of recent symptoms, current treatment, and patient/family history, 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.
- There may be situations where an order for Oxygen as needed (PRN) exists, but the assessing clinician does not determine shortness of breath to be an active problem for the patient at the time of the screening.
  - In this situation, the skip pattern is maintained for J2030C to skip J2040, and the oxygen would not be reported as a treatment for J2040.

Examples

1. During the initial nursing visit, on 11-15-2025 the patient is very drowsy, but appears comfortable. The nurse does not ask about shortness of breath during the visit."

   Coding: J2030A: Was the patient screened for shortness of breath? would be coded 0, No and skip to Item J2050, Symptom Impact Screening.

   Rationale: The nurse does not screen for shortness of breath and the documentation provides no evidence that the patient was screened for shortness of breath. Thus, code 0, No for J2030A and skip to Item J2050.

2. The clinical note dated 11-12-2025 shows the patient reports no discomfort and is breathing shallowly without signs of distress. There are no concerns about breathing from the patient or family.

   Coding: J2030A: Was the patient screened for shortness of breath? Code 1, Yes; J2030B: Date of first screening for shortness of breath: Enter 11-12-25; J2030C: Did the screening indicate the patient had shortness of breath? Code 0, No and skip to J2050, Symptom Impact Screening.

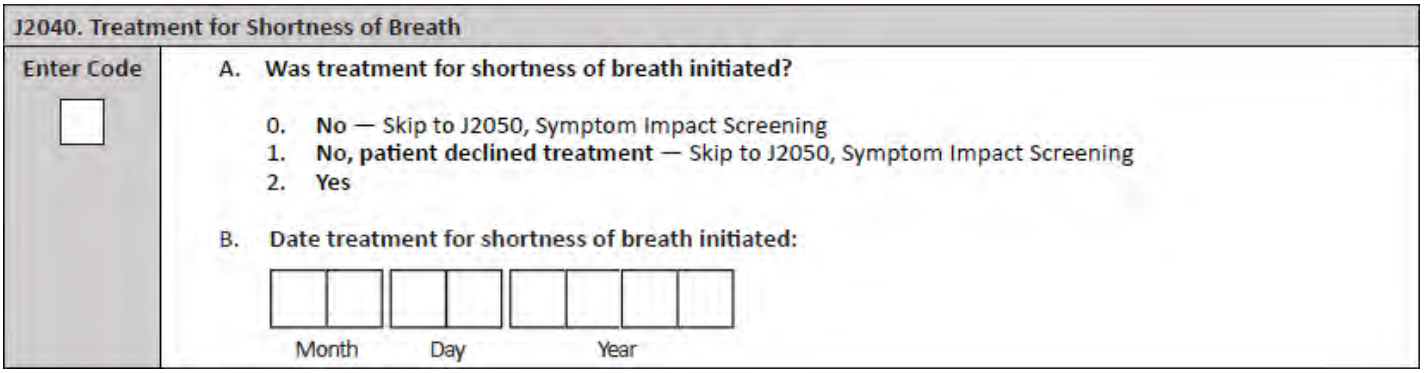
   Rationale: The documentation provides evidence that breathing was screened or assessed. J2030C is reported as 0, No because the screening indicated that although the patient was breathing shallowly, there were no signs of distress or concerns from patient/family.

3. During the admission visit, on 01-22-2026, the patient had great difficulty with breathing when walking to the bathroom and the nurse noted a respiration rate of 30. The patient's respiration rate decreased to 24 after resting for a few minutes. The nurse documents the findings in the hospice electronic health record (EHR).

   Coding: J2030A: Was the patient screened for shortness of breath? Code 1, Yes; J2030B: Date of *first* screening for shortness of breath: Enter 01-22-2026; J2030C: Did the screening indicate the patient had shortness of breath? Code 1, Yes.

   Rationale: The clinician used careful questioning and observation to establish the presence and severity of shortness of breath. Documentation confirmed the screening for shortness of breath. Thus, code 1, Yes for J2030A, and continue to J2030B-J2030C, using evidence in the clinical record to report date and presence or absence of shortness of breath.

J2040: Treatment for Shortness of Breath



J2040. Treatment for Shortness of Breath	
Enter Code ☐	A. **Was treatment for shortness of breath initiated?** 0. **No** — Skip to J2050, Symptom Impact Screening 1. **No, patient declined treatment** — Skip to J2050, Symptom Impact Screening 2. **Yes** B. **Date treatment for shortness of breath initiated:** ☐☐ ☐☐ ☐☐☐☐ Month Day Year

Timepoint(s) Item Completed

Admission (ADM)

Item-Specific Instructions

- Item completion should be based on what is determined during the assessment visit and/or included in the clinical record. Do not use sources external to the clinical record.
- Review the clinical record for information regarding treatment for shortness of breath.
- Review all response choices before making a selection.

A. Was treatment for shortness of breath initiated?

- **Code 0, No,** if treatment for shortness of breath was not initiated or offered and/or there is no documentation that treatment for shortness of breath was initiated or offered. Skip to J2050, Symptom Impact Screening.
- **Code 1, No, patient declined treatment,** if the patient declined treatment for shortness of breath that was offered and/or there is documentation that the hospice offered treatment for shortness of breath, but the patient or responsible party declined. Skip to J2050, Symptom Impact Screening.
- **Code 2, Yes,** if treatment for shortness of breath was initiated and/or there is documentation that treatment for shortness of breath was initiated.

B. Date treatment for shortness of breath initiated:

- Enter the date the hospice-initiated treatment for shortness of breath.
- For *non-medication interventions* (for example, fans, positioning, patient education efforts) there will not be any orders; in this case, use the date on which the hospice first discussed the intervention with the patient/caregiver.
- If the patient received multiple types of treatment for shortness of breath (for example, oxygen and education about positioning), enter the date that the first treatment was initiated.
- For *pharmacologic interventions*, treatment is considered initiated when the hospice has received the order and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment.
    - An order may be verbal (when permitted) or written.
    - Responses for this item should be based on whichever was used to determine the start of treatment.
        - Enter the date of the order, irrespective of if/when the first dose was given. For *orders continued from previous care settings*, the hospice must receive a new order to continue the treatment.
        - Once this order is received, the date the hospice received the order is entered in J2040B.
- For *comfort kits or pre-printed admission orders*,
    - *Proactive education on medications in a comfort kit in anticipation of symptoms is not considered initiation.*
    - Code based on when the *order* was both received **and** initiated.
    - If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, “date treatment initiated” would be the date, when **both** conditions were met (that is, the date the hospice received the order and instructed patient/caregiver to begin use).

Coding Tips

- When reviewing the clinical record for treatments initiated for shortness of breath:
    - Include both non-pharmacologic and pharmacologic treatment suggestions or measures.
    - Include both scheduled and PRN treatments for shortness of breath.
- Some treatments have multiple uses. For example, opioids can be used to treat pain or shortness of breath and relaxation techniques can be used to help with shortness of breath or anxiety.
    - Only include such treatments in J2040 if the clinical record indicates that the intended purpose of the treatment is to address the patient’s shortness of breath.
    - Orders that contain multiple purposes for the medication are acceptable as long as one of the stated purposes is to address shortness of breath.

Examples

1. Clinical documentation dated 10-06-2025 shows, “dyspnea/shortness of breath at rest, clinical signs indicate patient is short of breath. Patient/family instructed on energy conservation techniques to alleviate shortness of breath.” There is also an order dated 10-06-2025 showing, “morphine 10 mg PO every four hours as needed.”

   Coding: J2040A: Was treatment for shortness of breath initiated? Select response “2, Yes.” J2040B: Date treatment for shortness of breath initiated: Enter “10-06-2025.”

   Rationale: Documentation in the clinical record clearly indicates that the patient was short of breath and that treatment was initiated for shortness of breath (energy conservation techniques). The morphine listed in the order cannot be deemed treatment for shortness of breath because there is no indication listed in the clinical record that the morphine was prescribed to treat shortness of breath. To be considered a treatment for shortness of breath, the order would need to read “morphine 10 mg PO every four hours as needed *for shortness of breath.*”

2. Clinical documentation dated 10-15-2025 shows, “dyspnea/shortness of breath at rest. Instructed family to keep patient’s head elevated on pillows while patient is in bed.” Order dated 10-16-2025 shows, “oxygen ordered and scopolamine to dry respiratory secretions.”

   Coding: J2040A: Was treatment for shortness of breath initiated? Select response “2, Yes.” J2040B: Date treatment for shortness of breath initiated: Enter “10-15-2025.”

   Rationale: Documentation in the clinical record clearly indicates that the patient was short of breath and that more than one treatment was initiated for shortness of breath. The date that the *first* treatment for shortness of breath is initiated (10-15-2025, education about positioning) is the proper date to list in Item J2040B.

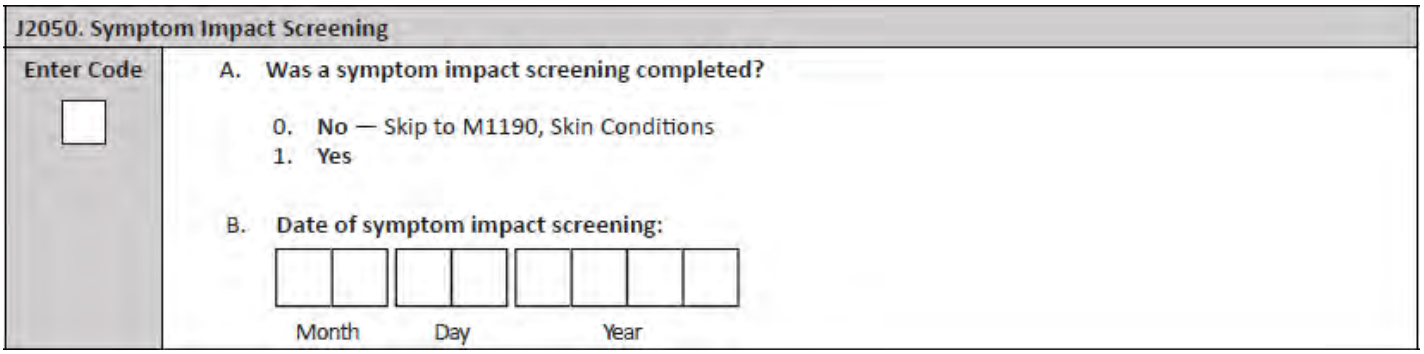
3. Clinical documentation dated 12-28-2025 shows, “comfort kit in patient’s home and on stand-by.” Documentation states, “patient and family were educated on what medications were in the comfort kit, what symptoms the medications might be used for (including shortness of breath), and where to store the kit until needed. Patient and family instructed not to use the medications in the comfort kit until specifically advised to do so.”

   Coding: J2040A: Was treatment for shortness of breath initiated? Select response “0, No.” Skip to Item J2050, Symptom Impact Screening. J2040B: Date treatment for shortness of breath initiated: Do not complete.

   Rationale: Documentation in the clinical record indicates that the comfort kit included treatments that could be used for shortness of breath, and that the nurse provided proactive education to the patient/family about the availability of such treatments.

   Documentation in the clinical record does not indicate that the nurse instructed the patient/family to begin using any of the treatments for shortness of breath. Thus, for the purposes of completing Item J2040, treatment for shortness of breath was *not* initiated.

J2050. Symptom Impact Screening



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Review all response choices before making a selection.
- Item completion should be based on what is determined during the assessment visit and/or included in the clinical record. Do not use sources external to the clinical record.

A. Was a symptom impact screening completed?

- **Code 0, No,** if the patient was not screened for symptom impact and Skip to Item M1190, Skin Conditions.
- **Code 1, Yes,** if the patient was screened for symptom impact.

B. Date of symptom impact screening

- Enter the date of the symptom impact screening was performed.

DEFINITION

SYMPTOM IMPACT
The effect of symptom(s) on the patient. Symptoms may impact a patient in multiple ways, (e.g., sleep, concentration, day to day activities).

J2051. Symptom Impact

J2051. Symptom Impact	
Over the past 2 days, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others. Coding: 0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment 1. Slight 2. Moderate 3. Severe 9. Not applicable (the patient is not experiencing the symptom)	
	Enter Code ↓
A. Pain	☐
B. Shortness of breath	☐
C. Anxiety	☐
D. Nausea	☐
E. Vomiting	☐
F. Diarrhea	☐
G. Constipation	☐
H. Agitation	☐

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Assess the patient for the impact of symptoms.
  - This is not an assessment of the severity, intensity, frequency, or other characteristics of the symptoms listed, but the impact these symptoms have on the patient.
- Item completion should be based on what is determined during the assessment visit and/or included in the clinical record. Do not use sources external to the clinical record.
- For Admission and at HUVs, this is an overall rating of how the patient is affected by their symptom(s) over the past two days.
- Based on the patient/caregiver interview, observation, clinical assessment, and clinical judgment, the assessing clinician decides the effect of each symptom on the patient.
- For each symptom, enter one code that best describes how the patient has been affected by the symptom.

Coding Tips

- Symptom impact is coded based on the clinician's assessment and judgment after considering all the information provided by the patient, family/caregiver, and/or facility staff in addition to their own

assessment.

Examples

1. During the patient's admission to hospice, the assessing nurse meets with the patient alone and hears their complaints that pain is severely impacting sleep. They report that in the past two days, pain interfered with their ability to rest/nap during the day and sleep well at night. The patient also reports being short of breath only when walking upstairs once or twice a day to go up to the bedroom or to get something from their closet. The shortness of breath has a slight impact on activities. The patient denies any experience/treatment for any of the other symptoms listed.

   Coding: Item J2051. Symptom Impact: a. Pain, 3. Severe; b. Shortness of breath, 1. Slight; Code all other symptoms, 9, Not applicable.

   Rationale: Based on assessment, observation, and interviewing the patient, the assessing nurse used clinical judgment to determine that pain has been severely affecting the patient. Shortness of breath is assessed as only slightly impacting the patient's activities. Since the patient reported they have not experienced/been treated for any other symptoms, code all other symptoms in J2051. Symptom Impact as 9. Not applicable.

2. During the patient's HUV, the nurse met with the patient and their spouse. The patient said that pain is no problem, but the spouse told the nurse that pain interferes with the patient's ability to sleep every night, rest during the day, and significantly impacts their tolerance of visits with friends, reading, or just watching TV. The nurse observes that the patient does not seem comfortable and is fidgety during the visit. Both patient and spouse agreed that anxiety does slightly interfere with activities and the ability to interact with others, especially when there is more than one person visiting. The patient and spouse deny any experience/treatment for any of the other symptoms listed.

   Coding: Item J2051. Symptom Impact: a. Pain, 3. Severe; c. Anxiety, 1. Slight; Code all other symptoms, 9, Not applicable.

   Rationale: Based on assessment, observation, and interviewing the patient and family, the assessing nurse used clinical judgment to determine that pain is severely impacting the patient's sleep and daily activities; anxiety had slight impact on the patient's ability to interact with others. The patient and the spouse deny any experience/treatment for the other symptoms listed.

J2052. Symptom Follow-up Visit (SFV)

J2052. Symptom Follow-up Visit (SFV) (complete only if any response to J2051 Symptom Impact = 2. Moderate or 3. Severe)	
Enter Code ☐	An in-person **Symptom Follow-up Visit (SFV)** should occur within 2 calendar days as a follow-up for any moderate or severe pain or non-pain symptom identified during Symptom Impact assessment at Admission or HOPE Update Visit (HUV). A. **Was an in-person SFV completed?** 0. **No** — Skip to J2052C, Reason SFV Not Completed. 1. **Yes** B. **Date of in-person SFV** — Complete and skip to J2053, SFV Symptom Impact. ☐☐ ☐☐ ☐☐☐☐ Month Day Year C. **Reason SFV not completed** — Skip to M1190, Skin Conditions. 1. Patient and/or caregiver declined an in-person visit. 2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired). 3. Attempts to contact patient and/or caregiver were unsuccessful. 9. None of the above
Enter Code ☐	

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Unlike the assessments, the SFV item for symptom follow-up may be conducted by either an RN or LPN/LVN.
- Conduct the SFV only if any response to J2051, Symptom Impact is coded as 2, Moderate, or 3, Severe on either the Admission or an HUV assessment.
- The in-person SFV should occur within two calendar days as a follow-up for any moderate or severe pain or non-pain symptom impact identified during an Admission or HUV.
- Since the clinician has two days to conduct the SFV, completion of this visit could stretch beyond the specified Admission or HUV assessment timeframes.
- An SFV cannot be conducted during the same visit as the initial assessment to conduct a HOPE Admission or HUV, but it can occur later in the same day, as a separate visit.

A. Was an in-person SFV completed?

- **Code 0, No,** if an in-person SFV was not completed. Skip to J2052C, Reason SFV not completed.
- **Code 1, Yes,** if an in-person SFV was completed.

B. Date of in-person SFV:

- Enter the date the in-person SFV was completed, skip to J2053.SFV Symptom Impact.

C. Reason SFV not completed

- Enter the code, then skip to M1190. Skin Conditions.
- **Code 1,** if the patient and/or caregiver declined an in-person visit.

- **Code 2,** if the patient was unavailable (e.g., in emergency department, hospital, traveled outside of the service area, expired).
- **Code 3,** if attempts to contact the patient and/or caregiver were unsuccessful.
- **Code 9, None of the above,** if none of the above reasons apply.

Coding Tips

- If a new symptom is identified during an SFV, another SFV **is not required**, yet clinicians should follow agency practice standards to address, promptly treat, and follow up on any newly identified symptoms.

J2053. SFV Symptom Impact

J2053. SFV Symptom Impact

Since the last Symptom Impact assessment was completed, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:

0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. Pain	☐
B. Shortness of breath	☐
C. Anxiety	☐
D. Nausea	☐
E. Vomiting	☐
F. Diarrhea	☐
G. Constipation	☐
H. Agitation	☐

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- SFV Symptom Impact item for follow up of symptoms identified in a HOPE Admission or HUV may be conducted by either an RN or LPN/LVN.
    - This is not an assessment of the severity, intensity, frequency, or other characteristics of the symptoms listed, but the impact these symptoms have on the patient.
- For each symptom listed, enter one code that best describes how the patient has been affected.
- The clinician, based on the patient/caregiver interview, observation, and clinical judgment, determines

how each symptom has affected the patient.

- **Code 0, Not at all,** if the patient is not affected by the symptom, including if the symptom(s) is well controlled with the current treatment.
- **Code 1, Slight,** if the patient is slightly affected by the symptom.
- **Code 2, Moderate,** if the patient is moderately affected by the symptom.
- **Code 3, Severe,** if the patient is severely affected by the symptom.
- **Code 9, Not applicable,** if the patient is not experiencing the symptom.

Coding Tips

- Symptom impact is coded based on the clinician's judgment after considering all the information provided by the patient, family/caregiver, and/or facility staff in addition to their own assessment.
- Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day-to-day activities, or ability to interact with others.

Examples

- During the hospice Admission assessment on October 18, 2025, the patient complained to the nurse of *severe* nausea. Medication orders were obtained by the hospice physician for Prochlorperazine, and this was delivered to the patient the same day as the admission visit. Telephone follow-up confirmed the delivery of the medication and instructions for its administration were reinforced by the on-call nurse that evening. The nurse returned for an SFV two days later on October 20, 2025. During the SFV, the patient reported no further episodes of nausea since beginning the new medication two days prior. However, the caregiver reported that the patient was now experiencing constipation and had no bowel movement for the last five days. The patient confirmed this information and reported discomfort over the past few days. Based on this information, the nurse judged constipation as being of moderate impact. The patient and caregiver deny any additional symptoms/treatment.

  Coding:

    - J2052A (Was an in-person SFV completed?): Code 1, Yes.
    - J2052B (Date of in-person SFV): Enter 10-20-2025.
    - J2052C (Reason in-person SFV not completed): Skip.
    - J2053 (Since last symptom impact assessment was completed how has the patient been affected by each of the following symptoms?): Code D (Nausea), 0. Not at all; G (Constipation), 2. Moderate. Code all other symptoms in J2053 as 9, Not applicable.

Rationale: Based on assessment, observation, and interviewing the patient and caregiver, the nurse determined at the SFV that the nausea was now well-controlled with the current medication and had no further effect on the patient. However, based on clinical judgment, the nurse determined that constipation was moderately affecting the patient. There were no other symptoms/treatments reported by the patient or caregiver at the SFV. Although no further SFV is required, the nurse obtained orders to address the constipation and to revisit the patient in one day.

SECTION M: SKIN CONDITIONS

Section Intent

The items in this section document the presence, type and current treatment of various skin conditions common in the hospice patient population. It is important to recognize and evaluate each patient for current or potential skin injury.

Section Rationale

Skin conditions, wounds, and lesions affect quality of life for patients because they may limit activity and be painful. This information identifies patients at risk for further complications or skin injury.

M1190. Skin Conditions

M1190. Skin Conditions	
Enter Code ☐	Does the patient have one or more skin conditions? 0. No - Skip to N0500, Scheduled Opioid 1. Yes

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Review the medical record.
- Ask the patient/caregiver about any current skin condition.
- Assess any ulcers, wounds, or skin problems if present.

M1195. Types of Skin Conditions

M1195. Types of Skin Conditions	
Indicate which following skin conditions were identified at the time of this assessment.	
↓ Check all that apply	
☐	A. Diabetic foot ulcer(s)
☐	B. Open lesion(s) other than ulcers, rash, or skin tear (cancer lesions)
☐	C. Pressure Ulcer(s)/Injuries
☐	D. Rash(es)
☐	E. Skin tear(s)
☐	F. Surgical wound(s)
☐	G. Ulcers other than diabetic or pressure ulcers (e.g., venous stasis ulcer, Kennedy ulcer)
☐	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
☐	Z. None of the above were present

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Review the medical record.
- Assess any ulcers, wounds, or skin problems to determine the type(s) present.

Coding Instructions

- Check all that apply at the time of assessment.

Coding Tips

- Diabetic foot ulcers are caused by the neuropathic and small blood vessel complications of diabetes.
    - Diabetic neuropathy affects the lower extremities of individuals with diabetes and places them at high risk for foot injury and contributes to a decreased awareness of pain in their feet along with dry, cracked skin.
- Open lesions include those that develop as part of a disease (e.g., boils, cysts, and vesicles).
- Skin tears are a result of shearing, friction, or trauma to the skin that causes a separation of the skin layers. Code all partial or full thickness skin tears in this item.
- For surgical wounds, do not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. Peripherally inserted central catheter (PICC), central line sites, and peripheral IV sites are not coded as surgical wounds.
- MASD is also referred to as maceration and includes incontinence-associated dermatitis, intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis.

DEFINITION

MOISTURE ASSOCIATED SKIN DAMAGE (MASD) is superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration.

- Moisture exposure and MASD are risk factors for pressure ulcer/injury development. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.

M1200. Skin and Ulcer/Injury Treatments

M1200. Skin and Ulcer/Injury Treatments	
Indicate the interventions or treatments in place at the time of this assessment.	
↓ Check all that apply	
☐	A. Pressure reducing device for chair
☐	B. Pressure reducing device for bed
☐	C. Turning/repositioning program
☐	D. Nutrition or hydration intervention to manage skin problems
☐	E. Pressure ulcer/injury care
☐	F. Surgical wound care
☐	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
☐	H. Application of ointments/medications other than to feet
☐	I. Application of dressings to feet (with or without topical medications)
☐	J. Incontinence Management
☐	Z. None of the above were provided

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Review the medical record, including treatment records and health care provider orders, for documented skin treatments.
- Ask the patient, caregiver, and responsible party about any wound treatments.
- For patients living in a facility, speak with direct-care staff and the treatment nurse to confirm conclusions from the medical record review.
- Some skin treatments can be determined by observation. For example, observation of the patient's wheelchair and bed will reveal if the patient is using pressure-reducing devices for the bed or wheelchair.

Coding Instructions

- Check all that apply at the time of assessment, including those initiated or continued.
- Treatment is considered initiated when the hospice has received the order and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment.

Coding Tips

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury.
- Turning/repositioning includes a consistent program for changing the patient's position and realigning the body.
- Dietary measures include those received by the patient for the purpose of preventing or treating specific

skin conditions (e.g., high calorie diet with added supplementation to prevent skin breakdown).

- Pressure ulcer care includes **any** intervention for treating pressure ulcers (e.g., topical dressings; enzymatic, debridement, wound irrigations, negative pressure wound therapy).
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound (e.g., topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type).
- Non-surgical dressings do not have to be applied daily in order to be coded in this item.
    - May include, but not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, compression bandages, etc.
    - Do **not** include adhesive bandages (e.g., BAND- AID® bandages, wound closure strips).
- Application of Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions. This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

Examples for Items M1190-M1200

1. The patient was admitted to hospice following discharge to home after an episode of acute respiratory distress from his end-stage lung cancer. During the initial nursing assessment, the nurse asked the patient and caregiver about any skin conditions. The patient explained that they had a skin tear on the right elbow and had a dressing over a wound on the buttocks. Upon examination, the nurse identified a Stage 2 pressure ulcer on the coccyx. The patient did not have any other wounds, lesions, or skin conditions. The patient is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. The patient's skin tear treatment consists of a nonadherent dressing with antimicrobial gel. The patient also has pressure-reducing devices on their bed and chair. The nurse recommended a frequent turning and repositioning schedule (every 1 ½ to 2 hours) as the caregiver is able and as tolerated by the patient.

Coding – Admission:

- M1190 (Skin Conditions): Code 1, Yes.
- M1195 (Types of Skin Conditions): Check C (Pressure Ulcer(s)/Injuries), E (Skin tear(s).
- M1200 (Skin and Ulcer/Injury Treatments): Check A (Pressure reducing device for chair), B (Pressure reducing device for bed), C (Turning/repositioning program), E (Pressure Ulcer/Injury care), and G (Application of nonsurgical dressings – with or without topical medications – other than to feet).

Rationale: The patient was admitted to hospice and was found to have a skin tear on the right elbow, and a coccygeal Stage 2 pressure ulcer. The hospice staff is providing both pressure ulcer and skin tear treatments with dressings. To aid in prevention of further skin ulcer/injury, the patient also has pressure reducing devices on their chair and bed, and a turning/repositioning schedule protocol was instituted.

2. A patient was admitted to hospice with late-stage Congestive Heart Failure (CHF) and cardiomyopathy. Upon admission, the hospice nurse found the patient to have no skin condition. However, when the nurse conducting the HOPE Update Visit (HUV1) arrived at the home on day eight, the patient was found to have a venous ulcer on the right leg. The nurse consulted with the hospice medical director and an order was received to begin a three-layer compression-bandaging

protocol, which after the first application, is to be reapplied every five days. The patient was also provided with a pressure-reducing pad for their mattress and another one for their wheelchair.

Coding – HUV1:

- M1190 (Skin Conditions): Code 1, Yes.
- M1195 (Types of Skin Conditions): Check G (Ulcers other than diabetic or pressure ulcers).
- M1200 (Skin and Ulcer/Injury Treatments): Check A (Pressure reducing device for chair), B (Pressure reducing device for bed), and G (Application of nonsurgical dressings – with or without topical medications – other than to feet).

Rationale: The HUV1 was conducted on day eight. The patient was noted to have a venous ulcer and had treatments ordered which included a pressure reducing pad (M1200A) for their wheelchair and mattress (M1200B) as well as application of a compression-bandaging system (M1200G) for the patient's venous ulcer.

SECTION N: MEDICATIONS

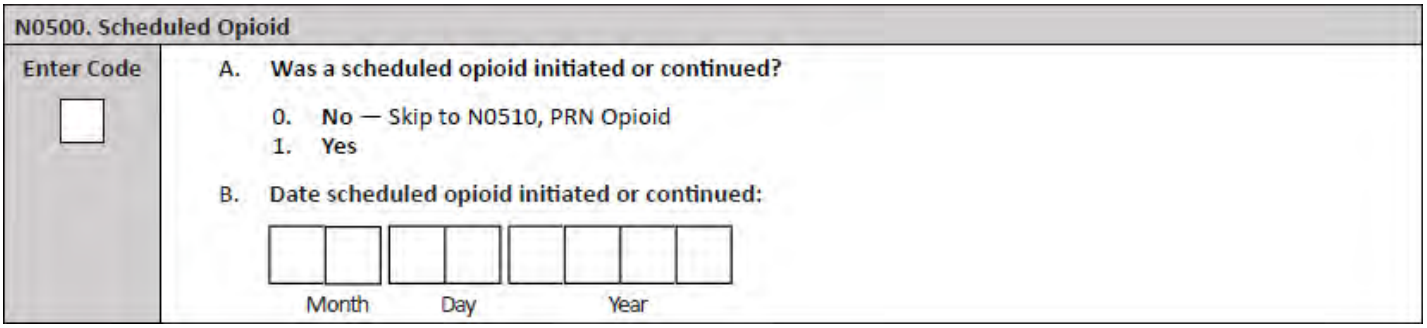
Section Intent

Items in this section of HOPE gather information on opioids and bowel regimens.

Section Rationale

Opioids are commonly used in the management of pain and other symptoms. Constipation is one of the most common opioid-related adverse side effects. Most patients develop some degree of constipation after opioid initiation or dose increases. Reducing opioid-induced constipation has the potential to reduce patient discomfort and improve quality of life. Patients do not develop a tolerance to opioid-induced constipation; clinical guidelines recommend prophylactic bowel regimens.

N0500. Scheduled Opioid



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Item completion should be based on what is determined during the assessment visit. and/or included in the clinical record. Do not use sources external to the clinical record.
- Review the clinical record for information regarding medications and prescriptions.
- Review all response choices before making a selection.

A. Was a scheduled opioid initiated or continued?

- **Code 0, No,** if a regularly scheduled opioid was neither initiated nor continued and/or the clinical record indicates that a scheduled opioid was neither initiated nor continued by the hospice and skip to Item N0510, PRN Opioid.
- **Code 1, Yes,** if a regularly scheduled opioid was initiated or continued and/or the clinical record indicates that a scheduled opioid was initiated or continued from the previous care setting.

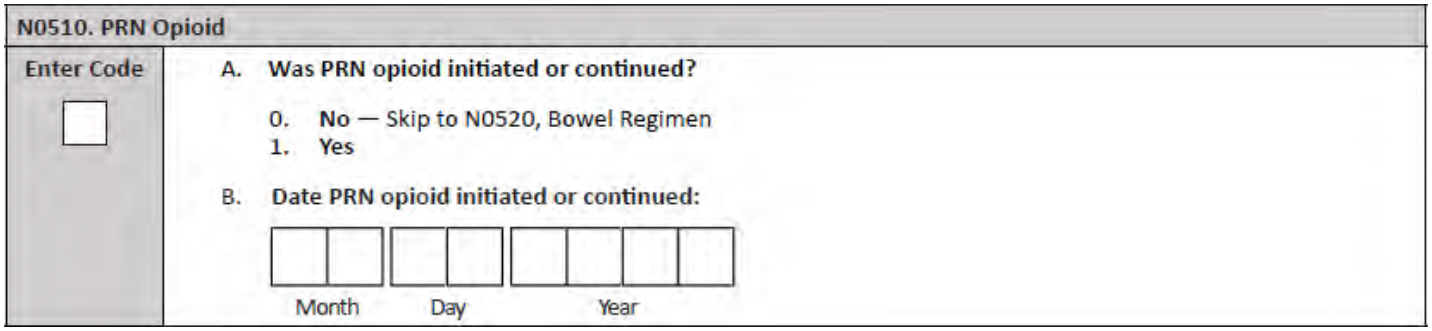
B. Date scheduled opioid initiated or continued

- Treatment is considered initiated when the hospice has received the order **and** there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment.
  - An order may be verbal (when permitted) or written.
  - Responses should be based on whichever was used to determine the start of treatment.
- Enter date the scheduled opioid order was received, irrespective of if/when the first dose was given.
  - If the patient received instructions for different types of regularly scheduled opioids in sequence over time, enter the date that the order for the first type of opioid treatment was received.
  - ***Note:*** In order to continue regularly scheduled opioids from a previous care setting, the hospice must receive a new order to continue the treatment. Once this order is received, the date the hospice received the order is entered in N0500B.
- For comfort kits or pre-printed admission orders:
  - *Proactive education on medications* in a comfort kit in anticipation of symptoms is *not* considered initiation.
  - Code based on when the order was both received and initiated.
  - If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, "date treatment initiated" would be the date when both conditions were met (that is, the date the hospice received the order and instructed patient/caregiver to begin use).

Coding Tips

- Code response 1, Yes if the clinical record indicates that a regularly scheduled opioid was initiated for any reason, regardless of symptom.
- For the purposes of completing Item N0500, an "opioid" includes Schedule II – Schedule IV opioids, including hydrocodone and tramadol, because of the side effect profile, which includes constipation.

N0510. PRN Opioid



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Item completion should be based on what is determined during the assessment visit and included in the clinical record. Do not use sources external to the clinical record.

- Review the clinical record for information regarding medications and prescriptions.
- Review all response choices before making a selection.

A. Was a PRN opioid initiated or continued?

- **Code 0, No,** if a PRN opioid was *neither* initiated *nor* continued and/or the clinical record indicates that a PRN opioid was *neither* initiated *nor* continued from the previous care setting.
- **Code 1, Yes,** if a PRN opioid was initiated or continued and/or the clinical record indicates that a PRN opioid was initiated or continued from the previous care setting.

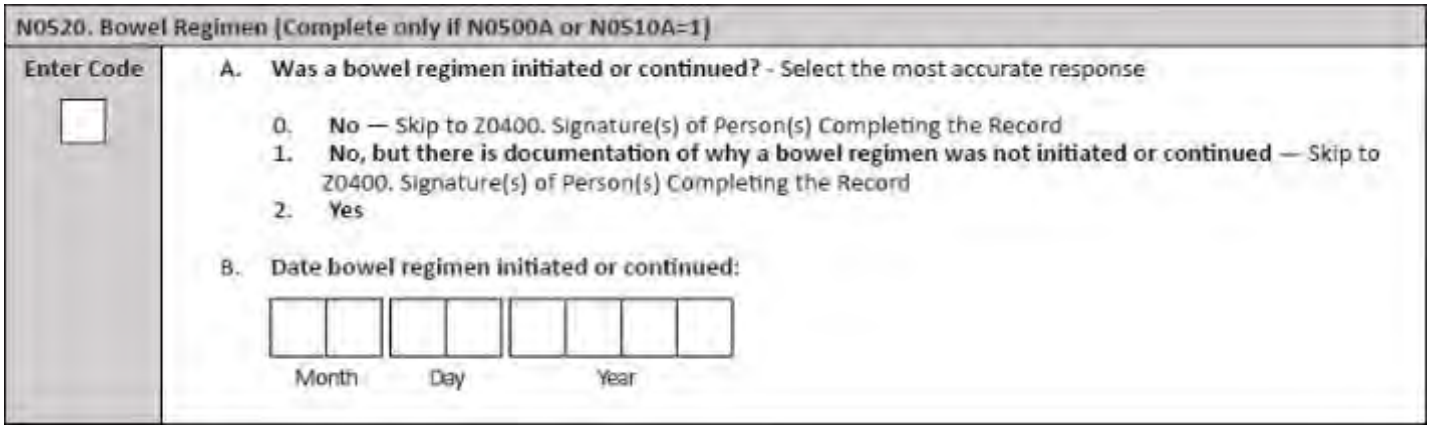
B. Date PRN opioid initiated or continued

- Treatment is considered initiated when the hospice has received the order **and** there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment.
  - An order may be verbal (when permitted) or written.
  - Responses should be based on whichever was used to determine the start of treatment.
- Enter date the PRN opioid order (whether hospice initiated or continued from prior care setting) was received, irrespective of if/when the first dose was given (assuming instructions have been provided to initiate).
  - If the patient received instructions for different types of PRN opioids in sequence over time, enter the date that the order for the *first* type of opioid treatment was received.
  - *Note:* In order to continue PRN opioids from a previous care setting, the hospice must receive a new order to continue the treatment. Once this order is received, the date the hospice received the order is entered in N0510B.
- For comfort kits or pre-printed admission orders:
  - *Proactive education on medications* in a comfort kit in anticipation of symptoms is *not* considered initiation.
  - Code based on when the order was <u>both received and initiated.</u>
  - If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, “date treatment initiated” would be the date, when both conditions were met (that is, the date the hospice received the order and instructed patient/caregiver to begin use).

Coding Tips

- Code 1, Yes, if the clinical record indicates that a PRN opioid was initiated for any reason, regardless of symptom.
- For the purposes of completing Item N0510, an “opioid” includes Schedule II– Schedule IV opioids, including hydrocodone and tramadol, because of the side effect profile, which includes constipation.

N0520. Bowel Regimen



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Item completion should be based on what is determined during the assessment visit and/or what is included in the clinical record. Do not use sources external to the clinical record.
- Review the clinical record for information regarding medications and prescriptions.
- Review all response choices before making a selection.

A. Was a bowel regimen initiated or continued?

Only complete N0520A if N0500A or N0510A = 1. Skip N0520A if the patient is not on any type of opioid.

- **Code 0, No,** if a bowel regimen was *neither* initiated *nor* continued and/or the clinical record does not include documentation that a bowel regimen was initiated or continued from the previous care setting. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record.
- **Code 1, No, but there is documentation of why a bowel regimen was not initiated or continued,** if the clinical record indicates that a bowel regimen was not initiated or continued and includes a reason why it was not initiated or continued. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record.
  - The documented reason why a bowel regimen was not initiated could include clinical contraindications to a bowel regimen or patient was offered a bowel regimen but refused treatment.
- **Code 2, Yes,** if a bowel regimen was initiated or continued and/or the clinical record includes documentation that a bowel regimen was initiated or continued from the previous care setting.

B. Date bowel regimen initiated or continued

- Treatment is considered initiated when the hospice has received the order **and** there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment.
  - An order may be verbal (when permitted) or written.
  - Responses should be based on whichever was used to determine the start of treatment.

- Enter date the bowel regimen order (whether hospice initiated or continued from prior care setting) was received, irrespective of if/when the first dose was given (assuming instructions have been provided to initiate).
    - Note: In order to continue a bowel regiment from a previous care setting, the hospice must receive a new order to continue the treatment.
        - Once this order is received, the date the hospice received the order is entered in N0520B.
- For comfort kits or pre-printed admission orders:
    - *Proactive education on medications* in a comfort kit in anticipation of symptoms is *not* considered initiation.
    - Code based on when the order was both received and initiated.
    - If the date the hospice received the order is different than the date the hospice instructed the patient/caregiver to begin using the treatment/medication, "date treatment initiated" would be the date, when both conditions were met (that is, the date the hospice received the order and instructed patient/caregiver to begin use).
- For non-pharmacologic bowel regimens, such as prune juice or high-fiber diet, there may not be any orders; in this case, use the date the hospice nurse or clinician instructed the patient/family about non-pharmacologic intervention(s).
- If multiple bowel regimens were ordered, enter the date that the first treatment was initiated.
- In certain instances, the date the bowel regimen was initiated or continued (listed in N0520B) may precede the date an opioid (scheduled or PRN) was initiated (listed in N0500B and/or N0510B). This is permissible.
- The bowel regimen order need not explicitly state it is for the management of opioid-induced constipation.

Coding Tips

- Clinical documentation sufficient to code 1 for why a bowel regimen was not initiated could include clinical contraindication, including but not limited to the following:
    - Bowel obstruction/ileus
    - Diarrhea
    - No bowel function
    - Colostomy/ileostomy
    - Nausea/vomiting
    - Recent abdominal surgery
    - NPO/taking nothing by mouth
- Clinical documentation sufficient to code 2 for a bowel regimen may include, but is not limited to the following:
    - Laxatives or stool softeners
    - High fiber supplements
    - Enemas
    - Suppositories
    - Dietary interventions, such as prune juice or high fiber diet
- A bowel regimen—or any clinical contraindication to a bowel regimen—may appear in the patient clinical record as any reference to avoiding constipation, which may not be linked to opioid prescription.

- In practical terms, this means completing Item N0520 may require review of other portions of the clinical record (for example, gastrointestinal assessment, elimination status, bowel function) to find evidence about bowel regimen or clinical contraindications to bowel regimen.

Examples

1. Order dated 10-13-2025 shows, Oxycodone 10 mg PO every four hours, PRN for pain. Clinical documentation dated 10-13-2025 indicates the patient has diarrhea.

   Coding: N0500A: Was a scheduled opioid initiated or continued? Code 0, No. Skip to N0510, PRN Opioid; N0510A: Was a PRN opioid initiated or continued? Code 1, Yes; N0510B: Date PRN opioid initiated or continued: Enter 10-13-2025; N0520A: Was a bowel regimen initiated or continued? Code 1, No, but there is documentation of why a bowel regimen was not initiated or continued. Skip to Item Z0400, Signature(s) of Person(s) Completing the Record.

   Rationale: Even though the patient is on a PRN opioid, the clinical record clearly indicates that the patient also has a clinical contraindication (diarrhea). Thus, code 1 for N0520A and skip to Item Z0400.

2. Order dated 10-23-2025 shows, Morphine 4 mg per hour IV continuous with 2 mg IV patient-controlled analgesia (PCA) every 15 minutes PRN breakthrough pain.

   a. Clinical documentation dated 10-23-2025 indicates the patient's last bowel movement was five days ago. The patient is also complaining of abdominal discomfort.

   b. Order dated 10-24-2025 shows Polyethylene glycol 17 g PO with full glass of water once daily.

   Coding: N0500A: Was a scheduled opioid initiated or continued? Code 1, Yes; N0500B: Date scheduled opioid initiated or continued: Enter 10-23-2025; N0510A: Was PRN opioid initiated or continued? Code 1, Yes; N0510B: Date PRN opioid initiated or continued: Enter 10-23-2025; N0520A: Was a bowel regimen initiated or continued? Code 2, Yes; N0520B: Date bowel regimen initiated or continued: Enter 10-24-2025.

   Rationale: Clinical record documentation clearly indicates the patient was on an opioid (Morphine) and that a bowel regimen was initiated (Polyethylene glycol).

3. Clinical documentation dated 11-13-2025 indicates the patient's last bowel movement was five days ago. The patient has complaints of abdominal discomfort.

   a. Order dated 11-13-2025 shows Sennosides 17.2 mg tablets, one to two tablets by mouth twice per day.

   b. There is no order for an opioid medication.

   Coding: N0500A: Was a scheduled opioid initiated or continued? Code 0, No. Skip to N0510, PRN Opioid; N0510A: Was PRN opioid initiated or continued? Code 0, No. Skip to N0520, Bowel Regimen; N0520A: Was a bowel regimen initiated or continued? Do not complete.

   Rationale: Even though the patient's clinical record shows that a bowel regimen was initiated because the patient is not on an opioid, do not complete Item N0520.

4. Clinical documentation of initial assessment dated 10-23-2025 shows comfort kit in patient's home and on stand-by. Instructed patient and family on what medications are in the comfort kit, including pain medication (oxycodone).

a. Order dated 10-23-2025 shows Sennosides 17.2 mg tablets, take one tablet by mouth twice per day. The patient is currently taking this medication.

b. Clinical note dated 10-25-2025 reads, “caregiver called and reported patient was in moderate pain. Instructed caregiver to open comfort kit and begin giving patient oxycodone 10 mg every four hours as needed for pain.”

Coding: N0500A: Was a scheduled opioid initiated or continued? Code 0, No. Skip to N0510, PRN opioid; N0500B: Date scheduled opioid initiated or continued: Do not complete; N0510A: Was PRN opioid initiated or continued? Code 1, Yes; N0510B: Date PRN opioid initiated or continued: Enter 10-25-2025; N0520A: Was a bowel regimen initiated or continued? Code 2, Yes; N0520B: Date bowel regimen initiated or continued: Enter 10-23-2025.

Rationale: For Item N0500A, because there is no scheduled opioid, code 0, No should be selected. For N0510A, the hospice would code 1, Yes, because clinical record documentation shows there was a comfort kit including a PRN opioid (oxycodone) for pain and there is documentation that the nurse instructed the patient/caregiver to begin using the treatment. For N0510B, use the date on which the nurse instructed the patient/family to begin using the treatment, which was 10-25-2025. For N0520A, code 1, Yes. For N0520B, enter the date of the order for sennosides.

SECTION Z: RECORD ADMINISTRATION

Section Intent

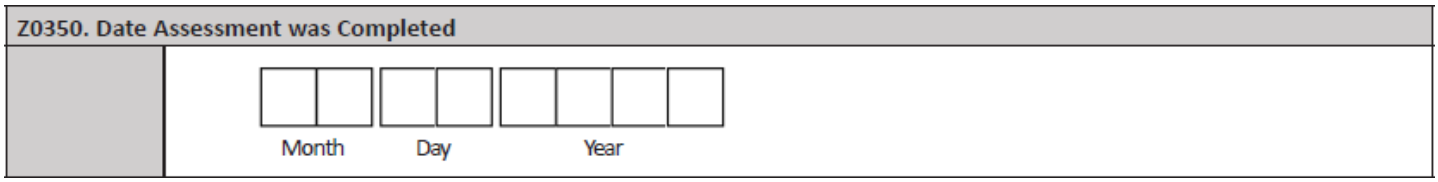
Items in this section contain signatures of individuals completing HOPE and the signature of the individual verifying HOPE record completion.

Section Rationale

It is the responsibility of the hospice to ensure that HOPE is completed.

- Section Z is to be used, retained, and archived by the provider in accordance with provider policies and procedures related to patient information.
- Item Z0400 provides a tracking log for the abstracted information contained in HOPE. The signatures in Z0400 are used to certify that the information the individual(s) provided is accurate and that the signer was authorized to collect the information documented on HOPE.
- Item Z0500 is used to document the individual responsible for ensuring HOPE is completed in a timely manner.

Z0350. Date Assessment was Completed



Timepoint(s) Item Completed

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Item-Specific Instructions

- Enter the date that information/responses were gathered for the HUV and documented by the assessing clinician including any follow-up visit data that was added for an SFV as applicable.
- This is the date that the entire HUV item set is complete including SFVs, if any.
- Submission of HUV timepoints is based on this date.
- In situations where there is an SFV, this date may extend beyond the HUV assessment timeframes.

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

Z0400. Signature(s) of Person(s) Completing the Record			
I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a payment reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.			
Signatures	**Title**	**Sections**	**Date Section Completed**
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

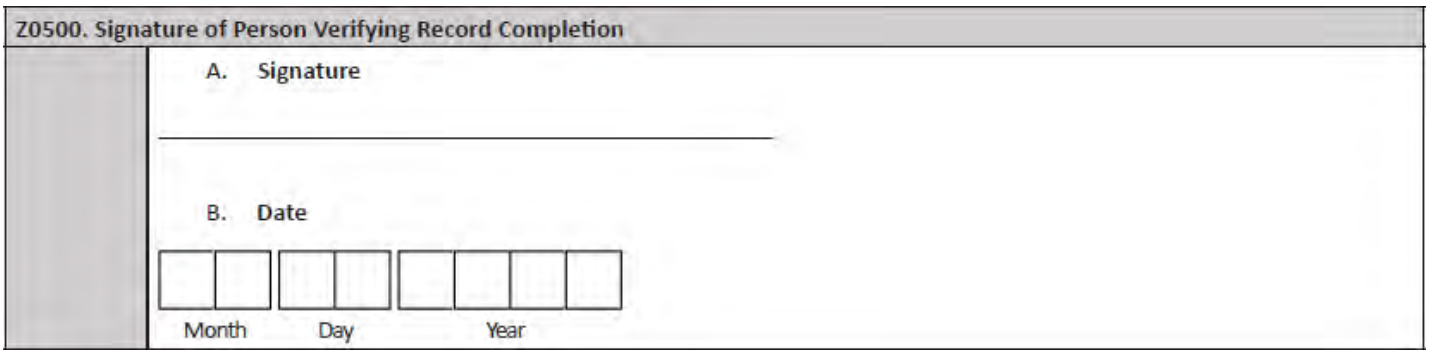
- Signatures in Z0400 should reflect those hospice staff members who completed HOPE, which may or may not be the clinician who completed care processes documented in the clinical record. Signatures may be electronic.
- All staff who complete any part of the HOPE record shall enter their signature, title, section, or portion(s) of a section(s) they completed, as well as the date completed.
    - If an individual completes multiple sections of HOPE, that individual can sign once in Z0400 and indicate which sections they completed in the "Sections" portion of Z0400.
    - One or more staff members can complete items within the same section of the HOPE record. When filling in the information for Z0400, any staff member who has completed a portion of a section should identify which item(s) he or she completed within that section.
    - If a staff member cannot sign and date Z0400 on the same day that he or she completed a section or portion of a section of the HOPE record, that staff member should enter the original date of HOPE record completion when signing Z0400.
    - The hospice is responsible for the accuracy of all items on HOPE, irrespective of how they are completed or auto-populated in the HOPE record.
- Read the Attestation Statement carefully. Persons signing Z0400 are certifying that the information in

the HOPE record, to the best of their knowledge, most accurately reflects documentation in the patient's clinical record.

Coding Tips

- Z0400 is not submitted as part of the HOPE record; developing internal policies and procedures for completing and archiving Z0400 is up to the discretion of the hospice.
- This signature-block section (Z0400) is provided for use by the hospice, and it is suggested that it be retained at the hospice in accordance with policies and procedures related to patient information.

Z0500. Signature of Person Verifying Record Completion



Timepoint(s) Item Completed

Admission (ADM)

HOPE Update Visit 1 (HUV1)

HOPE Update Visit 2 (HUV2)

Discharge (DC)

Item-Specific Instructions

- Sign and date Z0500 after verifying that all items on the record are complete and that Item Z0400, Signature(s) of Person(s) Completing the Record, contains attestation for all HOPE sections.
- If for some reason the person verifying record completion is unable to sign Z0500A on the date HOPE is completed, the staff member should enter the date in Z0500B when they sign Z0500A.

Coding Tips

- The signature in Z0500A certifies only that all sections are complete. Persons completing Z0500 are not certifying the accuracy of portions of the HOPE record that were completed by other hospice staff members.
- Z0500A is not submitted as part of the HOPE record; it is at the discretion of the hospice to develop internal policies and procedures for completing and archiving Z0500A.
- In the case of a Modification or Inactivation Request, Z0500B should contain the original date on which the record was completed. Do not change Z0500B unless the date in Z0500B in the original record was incorrect and the modification request is to correct the date in Z0500B.

CHAPTER 3: SUBMISSION AND CORRECTION OF HOPE RECORDS

This chapter details the submission and correction process for HOPE records and requirements for data submission by hospices for the HQRP starting October 1, 2025.

3.1. Submitting HOPE Records

Hospices must complete and submit required HOPE records to CMS. Each provider must create electronic HOPE records and submission files using software that creates files that meet the requirements detailed in the current HOPE Data Submission Specifications, available on the CMS HOPE Technical Information webpage.

Providers must register for an account in the CMS system and request a user role. Additional information about HOPE record submissions, associated reports, and error messages can be found on the QIES Technical Support Office (QTSO) website: Hospice Providers Reference & Manuals | QIES Technical Support Office. When the submission file is received by CMS, the system performs a series of validation checks to evaluate whether the data submitted meets the required data specifications. HOPE records are evaluated to verify that clinical responses are within valid ranges and consistent with other items in the record, dates are reasonable, and the submitted record is in the proper order with regard to the records that were previously accepted by CMS for the same patient. The provider is notified of the acceptance or rejection of records on a Final Validation Report (FVR).

3.2. Timeliness Criteria

CMS has defined HOPE completion and submission timing requirements. The timing requirements in place encourage appropriate record completion and file submission for timely quality reporting. Providers are notified when the timing criteria have not been met by warnings that appear on the FVRs.

3.3. Timing and Sequencing Policies

The HOPE tool contains several data elements calling for dates. There are also recommended completion and required submission dates. **Table 10** below defines the various dates associated with HOPE.

Table 10: Timing Definitions

Title / Date Name	Definition
Admission Date (A0220)	The date on which the hospice becomes responsible for the care of the patient. For Medicare patients, it is the same as the effective date of the hospice benefit election (or re-election), which may be the first day of hospice care or a later date but may be no earlier than the date of the election statement.[4]
Discharge Date (Item A0270)	The date a patient leaves the hospice. If the patient has expired, it is the date of death. For live discharges, it is the date the patient revoked the hospice benefit or the date the hospice discharged the patient.[5]
Date Assessment Completed (Z0350)	This is the date that the clinician enters once they have conducted their assessment visit, gathered information/responses for the HOPE Update Visit (HUV) as well as any SFV data if applicable.
Record Completion Date (Z0500B)	The actual date on which the hospice verifies the information to be submitted in the HOPE record is complete. Defined as the date all required information has been collected and documented, and staff have signed and dated that the record is complete.
Completion Goal	The latest possible date that a provider is encouraged to complete a HOPE record. The completion goal for the Admission record is no later than the Admission Date + 14 calendar days. The completion goal for HUV records is no later than Z0350. Date Assessment was Completed + 14 calendar days. The completion goal for the Discharge record is no later than the Discharge Date + 7 calendar days.
Submission Date	The submission date is defined as the date on which the completed record was ***submitted to*** CMS. The submission date should be no later than the submission deadline.
Submission Deadline	The submission deadline is defined as the latest possible date on which the HOPE record should be ***submitted to and accepted by*** CMS. The submission deadline for the Admission record is no later than the Admission date + 30 calendar days. The submission deadline for HUV records is no later than Z0350. Date Assessment was Completed + 30 calendar days. The submission deadline for the Discharge record is no later than the Discharge Date + 30 calendar days.

[4] "Hospice Care." 42 CFR 418.24 (2011).
[5] Centers for Medicare & Medicaid Services. *Medicare Claims Processing Manual.*

3.3.1. Completion Timing

Clinician in-person visits for HOPE timepoints should be completed within the assessment timeframes outlined in Chapter 1 (**Table 1**).

The following completion goals are the latest possible dates that providers are encouraged to complete HOPE records. Note that the Completion Date (Z0500B., the actual date on which the hospice completed the record) may occur later than the date the patient was assessed by the clinician (Z0350) because some HOPE data elements can be extracted from the patient record after the assessment date but prior to submission:

- For Admission records (A0250 = 1), the Completion Goal is no later than Admission Date + 14 calendar days. Therefore, Z0500B (Completion Date) minus A0220 (Admission Date) is recommended to be less than or equal to 14 days.
- For HOPE Update Visit (HUV) records (A0250 = 2 or 3), the Completion Goal is no later than Z0350. Date Assessment was Completed + 14 calendar days. Therefore, Z0500B (Completion Date) minus Z0350 is recommended to be less than or equal to 14 days.
- For Discharge records (A0250 = 9), the Completion Goal is no later than the Discharge Date + seven calendar days. Therefore, Z0500B (Completion Date) minus A0270 (Discharge Date) is recommended to be less than or equal to seven days.

The completion goals outlined above are CMS guidance only. Compliance with completion goals is not considered in APU determinations. Although it is at the discretion of the hospice to develop internal policies for completing HOPE records, CMS continues to recommend that providers complete and attempt to submit HOPE records early, prior to the submission deadline of 30 days. This allows ample time to address any technical issues encountered in the submission process, such as correcting fatal errors. Although a hospice may complete and submit a HOPE record prior to the completion goal/deadline, the data reported in HOPE must accurately reflect the patient's status at the time the data was collected during the clinician's visit.

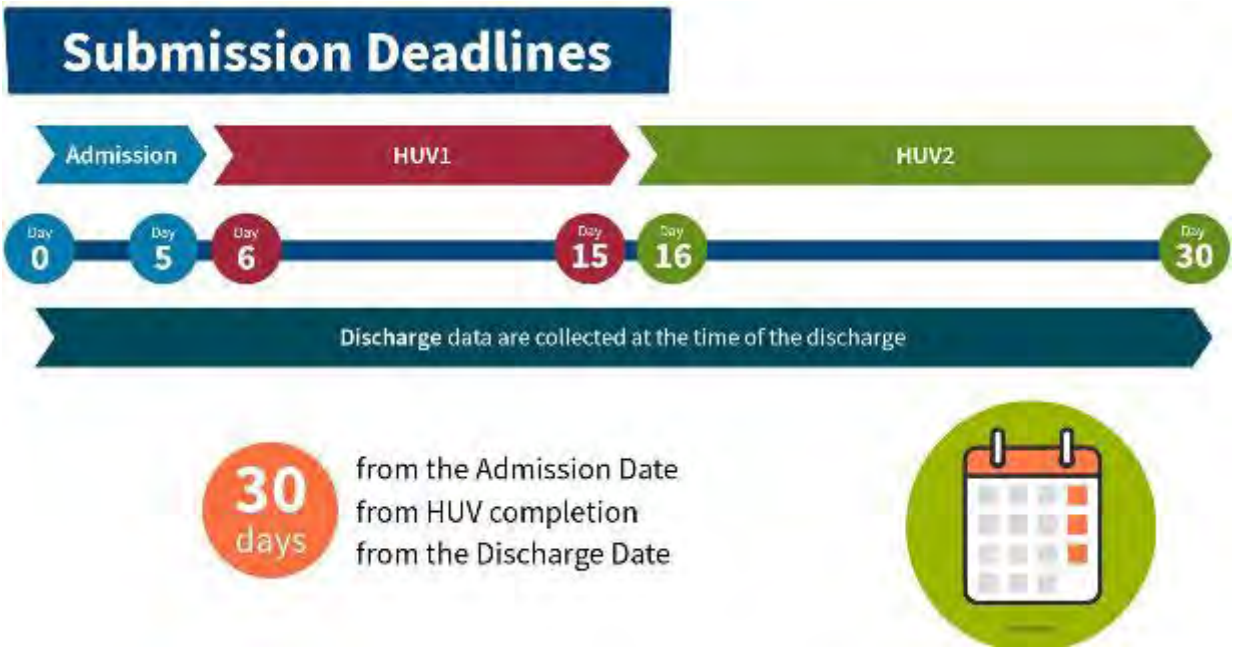
Completion timing policies above do not outline the timing of care processes captured by HOPE for quality measure calculation purposes. For more information on timing for quality measure calculation purposes, please see the HQRP QM User Manual, available in the Downloads section on the Current Measures page of the CMS HQRP website.

3.3.2. Submission Timing

All HOPE records should be ***submitted and accepted*** electronically within 30 days of completion as specified:

- For Admission records (A0250 = 1), the submission date may be no later than 30 days from the Admission Date (A0220). Therefore, the submission date minus the Admission Date (A0220) should be less than or equal to 30 days.
- For HOPE Update Visit (HUV) records (A0250 = 2 or 3), the submission date may be no later than 30 days from the Date Assessment was Completed (Z0350). Therefore, the submission date minus the Date Assessment was Completed (Z0350) should be less than or equal to 30 days.
- For Discharge records (A0250 = 9), the submission date may be no later than 30 days from the Discharge Date (A0270). Therefore, the submission date minus the Discharge Date (A0270) should be less than or equal to 30 days.
- See **Figure 9** for a summary of submission deadlines.

Figure 9: Submission Deadlines



The table below outlines one patient example with an Admission Date of November 11 and Discharge Date of December 22, 2025. Each assessment timeframe, record completion goal, and record submission deadline is depicted. See **Table 11** below.

Table 11: HOPE Completion and Submission Timing Example

HOPE Timepoint	Date	Assessment Timeframe	Record Completion Goal (Recommended)	Record Submission Deadline
Admission	Admission Date (A0220) = 11/11/2025	No later than 11/16/2025 (within five days of Admission Date)	No later than 11/25/2025 (within 14 days of Admission Date)	No later than 12/11/2025 (within 30 days of Admission Date)
HOPE Update Visit 1 (HUV1)	HUV1 Date Assessment was Completed (Z0350) = 11/24/2025	On or between day six and day 15 (should ***not*** occur within the first five days after the date of hospice election)	No later than 12/08/2025 (within 14 days of HUV1 Date)	No later than 12/24/2025 (within 30 days of the Date Assessment was Completed (Z0350) for HUV1)
HUV2	HUV2 Date Assessment was Completed (Z0350) = 12/10/2025	On or between day 16 and day 30	No later than 12/24/2025 (within 14 days of HUV2 Date)	No later than 01/09/2026 (within 30 days of the Date Assessment was Completed (Z0350) for HUV2)

Discharge Assessment	Discharge Date (A0270) = 12/22/2025	Completed at the time of discharge	No later than 12/29/2025 (within seven days of Discharge Date)	No later than 01/21/2026 (within 30 days of Discharge Date)

3.3.3. Submission Sequence

The submission system will issue a warning on the FVR when a HOPE record is submitted out of sequence. Examples include the following:

- Submission of an Admission record where the prior record submitted was also an Admission record and there was no Discharge record submitted in between.
- An Admission record submitted for a patient after the submission of a Discharge record indicating that the patient has expired (A2115 = 1).
- Submission of a HUV record before an Admission record.
- Submission of HUV2 before HUV1.
- A Discharge record where the Discharge Date (A0270) minus Admisison Date (A0220) indicates that an HUV1 or HUV2 record should be the prior record.

Admission and Discharge records may be completed and submitted on the same day when situations arise that warrant this; for example, when a patient is admitted and discharged or dies on the same day.

3.4. Validation of Records and Files

The submission system is designed to monitor timeliness and ensure that the uploaded records conform to the HOPE Data Submission Specifications. After uploading, the system will provide a success or failure notification to indicate if the upload was successful. The following describes the validation, storage, and reporting of records in a submission file.

3.4.1. Initial Submission Confirmation

After records are uploaded in a zip file, a success or failure notification will indicate if the upload was successful. This notification only indicates if the upload was successful, not whether the patient records have been processed. Upload failures can occur for several reasons, including an invalid zip file format, an empty zip file, a virus found, or if the file size is over five megabytes.

3.4.2. Validation and Editing Process

After the records have been successfully uploaded, the View Report link will be enabled after the zip file has been processed. The submitter can refresh their browser until the View Report link is enabled. The FVR is automatically generated in the CMS system within 24 hours of the submission of a file and will verify acceptance or rejection of records, as well as warnings and any fatal errors. Errors and warning messages detailed in the FVR are explained further in the *HOPE Error Message Reference Guide*. Each time a user submits a zip file of one or more HOPE records to CMS, three types of validation are performed:

- **Fatal File Errors.** The file structure is validated to ensure it follows the requirements outlined in the HOPE Data Submission Specifications provided by CMS. The file is rejected by the system if the file structure does not meet these requirements. Examples of fatal file errors include the following:

- The file is not a ZIP file.
- The records in the ZIP file cannot be extracted.
- The file cannot be read.

- The Submitter Final Validation Report will list any fatal file error(s). Files that are rejected must be corrected and resubmitted.
- **Fatal Record Errors.** If the file structure is acceptable, then each HOPE record in the file is validated individually for fatal record errors. These errors include, but are not limited to, the following:
  - Out-of-range responses (for example, the valid responses for the item are 1, 2, and 3, and the submitted value is 6).
  - Inconsistent relationships between items, e.g., an inconsistent date pattern, such as the Patient's Birth Date (Item A0900) is later than the Admission Date (Item A0220).
  - Duplicate records.
- Fatal record errors result in the rejection of individual records. The provider is informed of fatal record error(s) on the FVR. Rejected records must be corrected and resubmitted, if appropriate based upon the error displayed on the FVR (i.e., records that received the duplicate record error should not be resubmitted to the CMS system as the record already exists in the CMS database).
- **Warnings (Non-fatal Errors).** The record is also validated for warnings (non-fatal errors). Warnings include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. Examples of warnings include the following:
  - Timing errors:
    - Submission date is more than 30 days after the Admission Date (A0220) when A0250 = 1 (Admission).
  - Record sequencing errors:
    - An Admission record is submitted after a previous Admission record and there was no Discharge record submitted in between.
    - A record is submitted for a patient after a Discharge record with a Reason for Discharge (A2115) equal to Expired (1) has been submitted.
    - A HUV record is submitted before an Admission record.

All warnings (non-fatal errors) are reported to the provider in the FVR. The provider must evaluate each warning to identify necessary corrective actions.

3.4.3. Record Storage

If there are any fatal record errors, the record will be rejected and will not be stored in the CMS system. If there are no fatal record errors, the record is stored by CMS, even if the record has warnings (non-fatal errors).

3.5. HOPE Correction Policy

The HOPE record should be accurate when ***submitted to and accepted by*** CMS. When a provider determines that one or more data elements in an accepted record are inaccurate, the provider must take the necessary steps to correct the erroneous record (see Section 3.6).

Any corrections or changes made to the provider's copy of the HOPE record after the record is accepted by CMS will not be recognized by the system. The same corrections or changes must also be made to the electronic version of the HOPE record, and that record must be submitted to and accepted by the system. It is the provider's responsibility to correct any errors that exist in an accepted HOPE record according to the HOPE Record Correction Policy. This ensures that the information accurately reflects the patient's hospice record. A

correction can be submitted for any accepted record, up to 24 months from the Discharge Date, even if there has been a submission and acceptance of subsequent records for the patient. Furthermore, it is the provider's responsibility to ensure the record is complete and accurate prior to submission to CMS.

Several processes have been put in place to ensure that HOPE records are accurate both at the provider level and the CMS system.

- Software used by the provider to create electronic HOPE record files must run all standard edits as defined in the HOPE Data Submission Specifications released by CMS.
- Record rejection standards have been implemented whereby if a HOPE record contains responses that are out of range (for example, a 4 is entered when only 0–3 are allowable responses for an item), or item responses are inconsistent (for example, a skip pattern is not observed), the record is rejected. Rejected records are not stored in the CMS system.
- If an error is discovered in a record that has been accepted by CMS, modification or inactivation procedures must be implemented by the provider to ensure that submitted information is corrected.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps.

3.6. Correcting Errors in HOPE Records That Have Not Yet Been Accepted by CMS

HOPE records that have not yet been accepted by CMS 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 system. Hospices are responsible for correcting any errors to the record prior to submission or re-submission of the record to CMS.

3.7. Correcting Errors in HOPE Records That Have Been Accepted by CMS

Hospices should correct any errors necessary to ensure the information accurately reflects the patient's hospice record. Inaccurate information in the system may affect hospice quality reporting results. A HOPE record may be corrected even if subsequent records have been accepted for the patient.

An error identified in a HOPE record must be corrected. 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. The following two processes exist for correcting HOPE records that have been accepted into the CMS system:

- Modification Request
- Inactivation Request

Completion of a Modification Request record will archive the inaccurate HOPE record and replace the record with the new, corrected record. Completion of an Inactivation Request will also archive an inaccurate HOPE record but will not replace the record with the new record.

We recommend that hospices retain a copy of submitted HOPE records, along with any corrected versions, to track what was modified. In addition, it is suggested that the hospice keep a copy of inactivated records. Copies of HOPE records can be maintained in electronic format. For more details on maintenance of HOPE records, see Chapter 1.

3.7.1. Modification Requests

A Modification Request record (A0050 = 2) is used when a HOPE record is accepted by CMS but the information in the record contains clinical or non-key demographic errors. However, there are items that cannot be corrected with a Modification Request; rather, the invalid record must be inactivated with an Inactivation Request record or manually deleted, and a new record submitted to the CMS system.

Items that *cannot be corrected* with a Modification Request are:

Record Event Identifiers:

- A0220: Admission Date (on an Admission record A0250 = 1)
- A0250: Reason for Record
- A0270: Discharge Date (on a Discharge record A0250 = 9)
- Z0350: Date Assessment was Completed (for HUV records A0250 = 2 or 3)

Patient Identifier:

- A0500A: First Name
- A0500C: Last Name
- A0600A: Social Security Number (SSN)
- A0810: Sex
- A0900: Birth Date

Note: To make record event identifier and/or patient identifier corrections, you must complete an Inactivation Request record for the incorrect record and create a new record with the correct information. Refer to Inactivation Requests below.

When an error is discovered (except for those items listed in the preceding bullets) in a HOPE record, the provider must submit a Modification Request record (A0050 = 2) to CMS. When completing a Modification Request record, the Modification Request record must contain correct values for all items. This means if A0050 = 2, the provider should proceed to A0100, Facility Provider Numbers, and complete all items in all other HOPE record sections.

Note: In the case of a Modification or Inactivation Request, Z0500B should contain the original date on which the record was completed. Do not change Z0500B unless the date in Z0500B in the original record was incorrect and the modification request is to correct the date in Z0500B.

Note: File creation software varies on how Modification Request records are created. Please contact your software vendor for specific instructions.

When a Modification Request record (A0050 = 2) is submitted, CMS will process the record as follows:

1. The system will attempt to locate the existing record in the system's database for the hospice using specific identifiers:
    - Last name
    - First name
    - SSN
    - Birth date
    - Sex

- Facility identifier (facility and state code)
- Event identifiers (for example, the reason for record, and the admission, discharge, or HUV completion date)

2. If the existing record is not found, the submitted Modification Request record will be rejected and not accepted by CMS. A fatal error will be reported to the hospice on the FVR.
3. If the existing record is found, then the system performs a series of validation edits to evaluate whether the data submitted meets the required data specifications. HOPE records are edited to verify that clinical responses are within valid ranges and are consistent with other items in the record, dates are reasonable, and the submitted record is in the proper order with regard to the records that were previously accepted by CMS for the same patient. If there are any fatal errors, the Modification Request record will be rejected and not accepted. The fatal error(s) will be reported to the hospice on the FVR.
4. If the Modification Request record passes all the edits, it will replace the prior erroneous record in the CMS system. The prior erroneous record will be stored in an archive file within the CMS database.

3.7.2. Inactivation Requests

An Inactivation Request record (A0050 = 3) must be used when a record has been accepted but the corresponding event did not occur (for example, a Discharge record was submitted for a patient, but there was no actual discharge) or when an error is found with one or more of the event identifiers or patient identifiers.

An Inactivation Request (A0050 = 3) must be completed when any of the following items are inaccurate.

Record Event Identifiers:

- A0220: Admission Date (on an Admission record A0250 = 01)
- A0250: Reason for Record
- A0270: Discharge Date (on a Discharge record A0250 = 09)
- Z0350: Date Assessment was Completed (for HUV records A0250 = 2 or 3)

Patient Identifier:

- A0500A: First Name
- A0500C: Last Name
- A0600: Social Security Number (SSN)
- A0810: Sex
- A0900: Birth Date

Note: Any item in the previous list that was submitted as part of the original record must also be submitted as part of the Inactivation Request, and values for each item must match in the erroneous record and the inactivation record. For example, if A0600A, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record.

If an Admission Date (A0220), Reason for Record (A0250), Discharge Date (A0270), or HUV completion date (Z0350) is incorrect, or if one or more patient identifiers are found to be in error, the provider must inactivate the record, and then complete and submit a new HOPE record with the correct event and/or patient identifiers and ensure that the clinical information is accurate.

Note: For an inactivation of an Admission record, the Discharge Date (A0270) will be blank.

When an Inactivation Request record (A0050 = 3) is submitted, the system will process the record as follows:

1. The system will attempt to locate the existing record in the database for this hospice using specific identifiers:
    - Last name
    - First name
    - SSN
    - Birth date
    - Sex
    - Facility identifier (facility and state code)
    - Event identifiers (for example, the reason for record and admission, discharge, or HUV completion date)
2. If the existing record is not found in the database, the submitted Inactivation Request record will be rejected, and a fatal error will be reported to the hospice on the FVR.
3. If the existing record is found, the erroneous record will be removed from the active records in the database and stored in an archive file within the database.

3.8. Special Manual Record Deletion Request

A special Manual Record Deletion Request is only necessary when there has been an error in a record that has been accepted by CMS that cannot be corrected with a Modification or Inactivation Request record. There are only two items to which this applies. A Manual Record Deletion Request must be performed when the record has the wrong state code (STATE_CD) and/or facility ID (FAC_ID) in the control items. Control items are items created by the HOPE software. These errors most likely occurred at the time of software installation when initializing the software, and not during the routine entry of the patient's administrative or clinical data.

If a HOPE record has the wrong state code and/or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in the system. The record must be resubmitted with the correct STATE_CD and FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record.

In the event that this error has occurred, the provider must contact the iQIES Service Center by email (iQIES@cms.hhs.gov) or telephone (1-877-201-4721).

APPENDIX A: ACRONYMS AND GLOSSARY

Acronyms

ADM—Admission

APU—Annual Payment Update

CAHPS®—Consumer Assessment of Healthcare Providers and Systems

CCN—CMS Certification Number (also known as Medicare Provider Number)

CHF—Congestive Heart Failure

CMS—Centers for Medicare & Medicaid Services

CNPI—Checklist of Nonverbal Pain Indicators

CPOT—Critical Care Pain Observation Tool

CPR—Cardiopulmonary Resuscitation

DC—Discharge

DNI—Do Not Intubate

DNR—Do Not Resuscitate

ESAS—Edmonton Symptom Assessment System

FR—Final Rule

FVR—Final Validation Report

FY—Fiscal Year

GIP—General Inpatient

HICN—Health Insurance Claim Number

HIS—Hospice Item Set

HOPE—Hospice Outcomes and Patient Evaluation

HQRP—Hospice Quality Reporting Program

HUV—HOPE Update Visit

IDG—Interdisciplinary Group (also known as Interdisciplinary Team, or IDT)

iQIES—Internet Quality Improvement and Evaluation System

IV—Intravenous

LTC—Long-Term Care

LTCH—Long-Term Care Hospital

MASD—Moisture Associated Skin Damage

NF—Non-Skilled Nursing Facility

NPI—National Provider Identifier

NPO—Nothing by mouth, “Nil per os”

PAIN-AD—Pain Assessment in Advanced Dementia

PCA—Patient-Controlled Analgesia

POLST form—Physician Orders for Life-Sustaining Treatment form

PRN—As needed, “Pro re nata”

QTSO—QIES Technical Support Office

RHC—Routine Home Care

SNF—Skilled Nursing Facility

SFV—Symptom Follow-up Visit

SSN—Social Security Number

Glossary

Comfort Kit (or pre-printed admission order): A set of medications or treatments reviewed and approved by medical staff and consistent with nationally recognized and evidence-based standards, routinely ordered for all patients upon admission to the hospice (also known as comfort kits, comfort packs, emergency kits).

Conditions of Participation: The Centers for Medicare & Medicaid Services (CMS) develop Conditions of Participation (CoPs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs.

Hospice Item Set (HIS): A standardized set of data elements intended to capture patient-level data on each hospice patient admission at admission and discharge.

Hospice Outcomes and Patient Evaluation (HOPE): A new standardized set of data elements developed by CMS to replace the HIS. HOPE data elements are intended to capture patient-level data on each hospice patient at admission and other important timepoints.

Hospice Residence: A home-like residence that specializes in the care of terminally ill people. The patients are typically limited to hospice patients.

Manual Deletion Request: Used when a HOPE record has been previously ***submitted and accepted*** by CMS, but the record was submitted for the wrong agency/facility. This request will permanently delete all traces of a record from the CMS system.

PRN Order: An order prescribed on a patient-by-patient basis for medication or treatment that is to be used on an “as needed” basis for specific signs and symptoms a patient is having or may have based on patient-specific conditions or assessment findings.

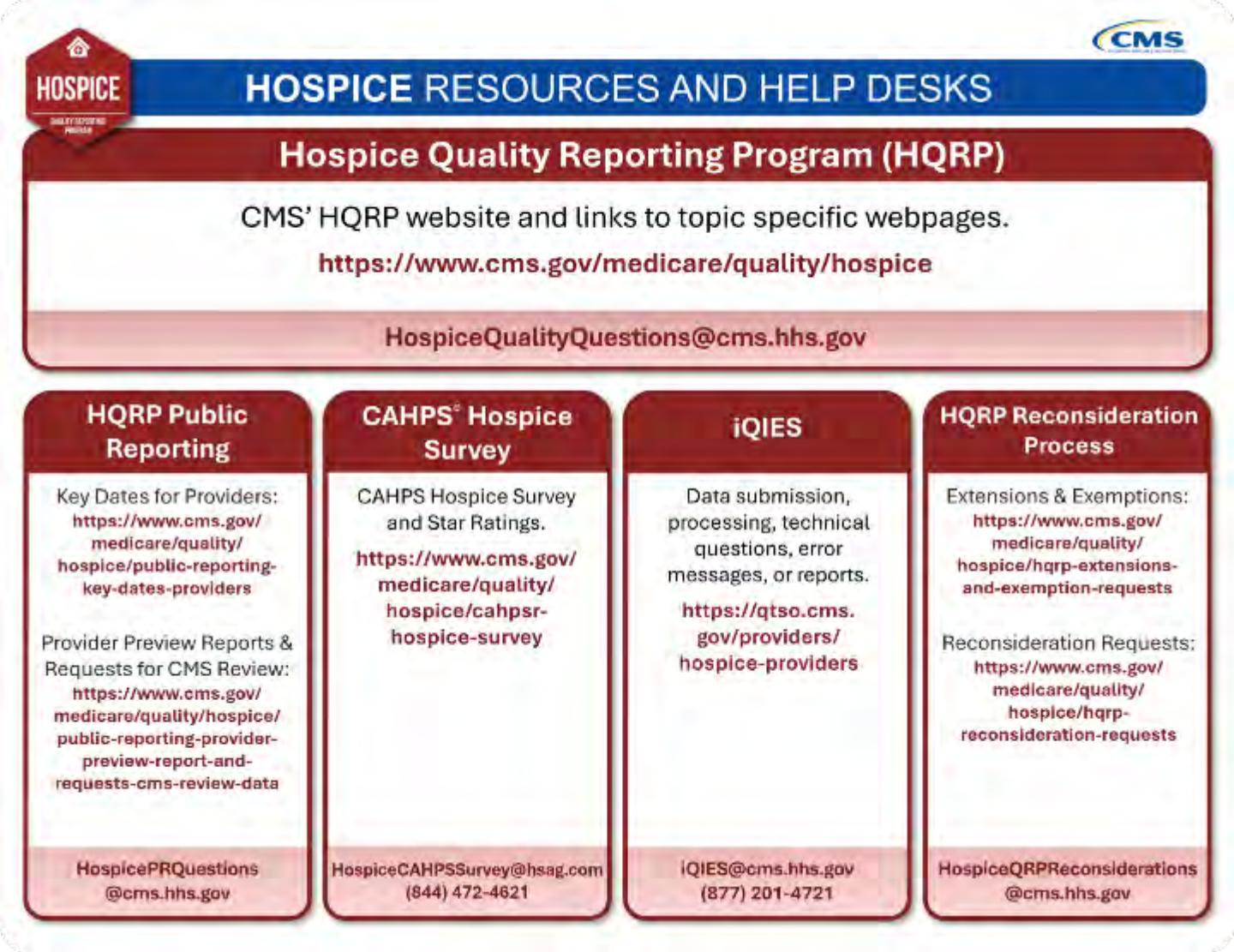
APPENDIX B: RESOURCES

Websites

The following links provide more information about the Hospice Quality Reporting Program (HQRP), and Hospice Outcomes and Patient Evaluation (HOPE). The Centers for Medicare & Medicaid Services (CMS) HQRP website is the official source of information about HQRP requirements. Providers should bookmark this website and visit it on a regular basis to make sure they have the most current information pertinent to the HQRP.

1. CMS HQRP Main Page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/
    - This website contains additional information about data collection and submission, HOPE Quality Measures, and HOPE technical requirements.
2. Updates and resources related to HOPE data submission specifications and other technical information can be found on the HOPE Technical Information webpage at: https://www.cms.gov/medicare/quality/hospice-quality-reporting-program/hospice-outcomes-and-patient-evaluation-hope-technical-information.
3. QIES Technical Support Office (QTSO): Vendors and software developers should familiarize themselves with this website and review it regularly for important technical information and updates: https://qtso.cms.gov
    - Vendors should register at https://qtso.cms.gov/vendors/hospice-vendors/training to receive important announcements.
4. The HQRP includes the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. This manual only includes guidance specific to HOPE. For details about participation requirements and CAHPS Hospice Survey implementation, visit the CAHPS Hospice Survey webpage: https://www.hospicecahpssurvey.org/.
5. Hospice Conditions of Participation: These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. Hospice Conditions of Participation can be found at https://www.ecfr.gov/current/title-42/part-418.

Help Desks



Listservs

Open Door Forum (ODF) listserv

CMS regularly holds Open Door Forums in which it makes announcements pertinent to various programs/care settings. Open Door Forums are also an opportunity for live dialogue between CMS and the provider Medical Equipment Open Door Forum. Use the link to sign up: https://public.govdelivery.com/accounts/USCMS/subscriber/new.

MLN Connects® Provider eNews Listserv

CMS sends out a weekly e-Newsletter, which contains information pertinent to various Medicare programs and care settings. Use the link to sign up: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html.

APPENDIX C: INSTRUMENTS

Admission (ADM)

OMB Control Number 0938-1153
Expiration 03/31/2028

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. HOPE is a patient assessment instrument that intends to collect data during a hospice patient's stay. Data collected using this instrument will be used to measure the quality of care provided by a hospice provider. The valid OMB control number for this information collection is 0938-1153. Submission of this data is required by Section 1814(i)(5) of the Social Security Act. The time required to complete this data collection per item set is estimated to average 41 minutes for the Admission, 22 minutes for the Hope Update Visit, and 9 minutes for the Discharge, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the data collected. Submitted patient-level data will remain confidential and is protected from public dissemination in accordance with the Privacy Act of 1974, as amended. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Jermama Keys, National Coordinator, Hospice Quality Reporting Program Centers for Medicare & Medicaid Services, at Jermama.Keys@cms.hhs.gov.

HOPE 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

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

☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐■■■■■■

A0215. Site of Service at Admission

Enter Code ☐☐

01. Patient's Home/Residence
02. Assisted Living Facility
03. Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)
04. Skilled Nursing Facility (SNF)
05. Inpatient Hospital
06. Inpatient Hospice Facility (General Inpatient (GIP))
07. Long Term Care Hospital (LTCH)
08. Inpatient Psychiatric Facility
09. Hospice Home Care (Routine Home Care (RHC)) Provided in a Hospice Facility
99. Not listed

A0220. Admission Date

☐☐ ☐☐ ☐☐☐☐

Month Day Year

A0250. Reason for Record

Enter Code ☐

1. Admission (ADM)
2. HOPE Update Visit 1 (HUV1)
3. HOPE Update Visit 2 (HUV2)
9. Discharge (DC)

A0500. Legal Name of Patient

A. **First name:**

B. **Middle initial:**

C. **Last name:**

D. **Suffix:**

A0550. Patient Zip Code

–

A0600. Social Security and Medicare Numbers

A. **Social Security Number:**

– –

B. **Medicare Number:**

A0700. Medicaid Number

Enter " +" if pending, "N" if not a Medicaid Recipient

A0810. Sex

Enter Code

1. Male
2. Female

A0900. Birth Date

Month Day Year

A1005. Ethnicity	
Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, Another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

A1010. Race	
What is your race?	
↓ Check all that apply	
☐	A. White
☐	B. Black or African American
☐	C. American Indian or Alaska Native
☐	D. Asian Indian
☐	E. Chinese
☐	F. Filipino
☐	G. Japanese
☐	H. Korean
☐	I. Vietnamese
☐	J. Other Asian
☐	K. Native Hawaiian
☐	L. Guamanian or Chamorro
☐	M. Samoan
☐	N. Other Pacific Islander
☐	X. Patient unable to respond
☐	Y. Patient declines to respond
☐	Z. None of the above

A1110. Language	
Enter Code ☐	A. **What is your preferred language?** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ B. **Do you need or want an interpreter to communicate with a doctor or health care staff?** 0. No 1. Yes 9. Unable to determine

A1400. Payer Information	
↓ Check all existing payer sources that apply at the time of this assessment	
☐	A. Medicare (traditional fee-for-service)
☐	B. Medicare (managed care/Part C/Medicare Advantage)
☐	C. Medicaid (traditional fee-for-service)
☐	D. Medicaid (managed care)
☐	G. Other government (e.g., TRICARE, VA, etc.)
☐	H. Private Insurance/Medigap
☐	I. Private managed care
☐	J. Self-pay
☐	K. No payer source
☐	X. Unknown
☐	Y. Other

A1805. Admitted From	
Enter Code	**Immediately preceding this admission, where was the patient?**
☐☐	01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 99. Not Listed

A1905. Living Arrangements	
Enter Code	**Identify the patient's living arrangement at the time of this admission.**
☐	1. Alone (no other residents in the home) 2. With others in the home (e.g., family, friends, or paid caregiver) 3. Congregate home (e.g., assisted living or residential care home) 4. Inpatient facility (e.g., skilled nursing facility, nursing home, inpatient hospice, hospital) 5. Does not have a permanent home (e.g., has unstable housing or is experiencing homelessness)

A1910. Availability of Assistance	
Enter Code	**Code the level of in-person assistance from available and willing caregiver(s), excluding hospice and facility staff, at the time of this admission.**
☐	1. Around-the-clock (24 hours a day with few exceptions) 2. Regular daytime (all day every day with few exceptions) 3. Regular nighttime (all night every night with few exceptions) 4. Occasional (intermittent) 5. No assistance available

Section F Preferences

F2000. CPR Preference

Enter Code ☐

A. **Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?** - Select the most accurate response

0. **No** — Skip to F2100, Other Life-Sustaining Treatment Preferences
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preference regarding the use of CPR:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

F2100. Other Life-Sustaining Treatment Preferences

Enter Code ☐

A. **Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR?** - Select the most accurate response

0. **No** — Skip to F2200, Hospitalization Preference
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

F2200. Hospitalization Preference

Enter Code ☐

A. **Was the patient/responsible party asked about preference regarding hospitalization?** - Select the most accurate response

0. **No** — Skip to F3000, Spiritual/Existential Concerns
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preference regarding hospitalization:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

F3000. Spiritual/Existential Concerns

Enter Code ☐

A. **Was the patient and/or caregiver asked about spiritual/existential concerns?** - Select the most accurate response.

0. **No** — Skip to I0100, Principal Diagnosis
1. **Yes, and discussion occurred**
2. **Yes, but the patient/caregiver refused to discuss**

B. **Date the patient and/or caregiver was first asked about spiritual/existential concerns:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

Section I	Active Diagnoses

I0010. Principal Diagnosis	
Enter Code ☐☐	01. Cancer 02. Dementia (including Alzheimer's disease) 03. Neurological Condition (e.g., Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS)) 04. Stroke 05. Chronic Obstructive Pulmonary Disease (COPD) 06. Cardiovascular (excluding heart failure) 07. Heart Failure 08. Liver Disease 09. Renal Disease 99. None of the above

Comorbidities and Co-existing Conditions	
↓ Check all that apply	
	Cancer
☐	I0100. Cancer
	Heart/Circulation
☐	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	I0950. Cardiovascular (excluding heart failure)
	Gastrointestinal
☐	I1101. Liver disease (e.g., cirrhosis)
	Genitourinary
☐	I1510. Renal disease
	Infections
☐	I2102. Sepsis
	Metabolic
☐	I2900. Diabetes Mellitus (DM)
☐	I2910. Neuropathy
	Neurological
☐	I4501. Stroke
☐	I4801. Dementia (including Alzheimer's disease)
☐	I5150. Neurological Conditions (e.g., Parkinson's disease, multiple sclerosis, ALS)
	I5401. Seizure Disorder
	Pulmonary
☐	I6202. Chronic Obstructive Pulmonary Disease (COPD)
	Other
☐	I8005. Other Medical Condition

Section J Health Conditions

J0050. Death is Imminent

Enter Code	
☐	**At the time of this assessment and based on your clinical assessment, does the patient appear to have a life expectancy of 3 days or less?** 0. **No** 1. **Yes**

J0900. Pain Screening

Enter Code	
☐	A. **Was the patient screened for pain?** 0. **No** — Skip to J0905, Pain Active Problem 1. **Yes** B. **Date of first screening for pain** ☐☐ ☐☐ ☐☐☐☐ Month Day Year
☐	C. **The patient's pain severity was:** 0. None 1. Mild 2. Moderate 3. Severe 9. Pain not rated
☐	D. **Type of standardized pain tool used:** 1. Numeric 2. Verbal descriptor 3. Patient visual 4. Staff observation 9. No standardized tool used

J0905. Pain Active Problem

Enter Code	
☐	**Is pain an active problem for the patient?** 0. **No** — Skip to J2030, Screening for Shortness of Breath 1. **Yes**

J0910. Comprehensive Pain Assessment

Enter Code	
☐	A. **Was a comprehensive pain assessment done?** 0. **No** — Skip to J2030, Screening for Shortness of Breath 1. **Yes** B. **Date of Comprehensive pain assessment:** ☐☐ ☐☐ ☐☐☐☐ Month Day Year C. **Comprehensive pain assessment included:**

↓ Check all that apply	
☐	1. Location
☐	2. Severity
☐	3. Character
☐	4. Duration
☐	5. Frequency
☐	6. What relieves/worsens pain
☐	7. Effect on function or quality of life
☐	9. None of the above

J0915. Neuropathic Pain

Enter Code	
☐	**Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)?** 0. **No** 1. **Yes**

J2030. Screening for Shortness of Breath

Enter Code	
☐	A. **Was the patient screened for shortness of breath?** 0. **No** — Skip to J2050, Symptom Impact Screening 1. **Yes** B. **Date of first screening for shortness of breath:** ☐☐ ☐☐ ☐☐☐☐ Month Day Year
Enter Code	C. **Did the screening indicate the patient had shortness of breath?**
☐	0. **No** — Skip to J2050, Symptom Impact Screening 1. **Yes**

J2040. Treatment for Shortness of Breath

Enter Code	
☐	A. **Was treatment for shortness of breath initiated?** 0. **No** — Skip to J2050, Symptom Impact Screening 1. **No, patient declined treatment** — Skip to J2050, Symptom Impact Screening 2. **Yes** B. **Date treatment for shortness of breath initiated:** ☐☐ ☐☐ ☐☐☐☐ Month Day Year

J2050. Symptom Impact Screening

Enter Code	
☐	A. **Was a symptom impact screening completed?** 0. **No** — Skip to M1190, Skin Conditions 1. **Yes** B. **Date of symptom impact screening:** ☐☐ ☐☐ ☐☐☐☐ Month Day Year

J2051. Symptom Impact	
Over the past 2 days, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others. Coding: 0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment 1. Slight 2. Moderate 3. Severe 9. Not applicable (the patient is not experiencing the symptom)	
	Enter Code ↓
A. **Pain**	☐
B. **Shortness of breath**	☐
C. **Anxiety**	☐
D. **Nausea**	☐
E. **Vomiting**	☐
F. **Diarrhea**	☐
G. **Constipation**	☐
H. **Agitation**	☐

J2052. Symptom Follow-up Visit (SFV) (complete only if any response to J2051 Symptom Impact = 2. Moderate or 3. Severe)

An in-person **Symptom Follow-up Visit (SFV)** should occur within 2 calendar days as a follow-up for any moderate or severe pain or non-pain symptom identified during Symptom Impact assessment at Admission or HOPE Update Visit (HUV).

Enter Code

A. **Was an in-person SFV completed?**
0. **No** — Skip to J2052C. Reason SFV Not Completed.
1. **Yes**

B. **Date of in-person SFV** — Complete and skip to J2053, SFV Symptom Impact.

Month Day Year

Enter Code

C. **Reason SFV not completed** — Skip to M1190, Skin Conditions.
1. Patient and/or caregiver declined an in-person visit.
2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired).
3. Attempts to contact patient and/or caregiver were unsuccessful.
9. None of the above

J2053. SFV Symptom Impact

Since the last Symptom Impact assessment was completed, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:
0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. **Pain**	
B. **Shortness of breath**	
C. **Anxiety**	
D. **Nausea**	
E. **Vomiting**	
F. **Diarrhea**	
G. **Constipation**	
H. **Agitation**	

Section M Skin Conditions

M1190. Skin Conditions	
Enter Code	**Does the patient have one or more skin conditions?** 0. **No** - Skip to N0500, Scheduled Opioid 1. **Yes**

M1195. Types of Skin Conditions	
Indicate which following skin conditions were identified at the time of this assessment.	
↓ Check all that apply	
☐	A. Diabetic foot ulcer(s)
☐	B. Open lesion(s) other than ulcers, rash, or skin tear (cancer lesions)
☐	C. Pressure Ulcer(s)/Injuries
☐	D. Rash(es)
☐	E. Skin tear(s)
☐	F. Surgical wound(s)
☐	G. Ulcers other than diabetic or pressure ulcers (e.g., venous stasis ulcer, Kennedy ulcer)
☐	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
☐	Z. None of the above were present

M1200. Skin and Ulcer/Injury Treatments	
Indicate the interventions or treatments in place at the time of this assessment.	
↓ Check all that apply	
☐	A. Pressure reducing device for chair
☐	B. Pressure reducing device for bed
☐	C. Turning/repositioning program
☐	D. Nutrition or hydration intervention to manage skin problems
☐	E. Pressure ulcer/injury care
☐	F. Surgical wound care
☐	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
☐	H. Application of ointments/medications other than to feet
☐	I. Application of dressings to feet (with or without topical medications)
☐	J. Incontinence Management
☐	Z. None of the above were provided

Section N | Medications

N0500. Scheduled Opioid

Enter Code ☐

A. **Was a scheduled opioid initiated or continued?**

0. **No** — Skip to N0510, PRN Opioid
1. **Yes**

B. **Date scheduled opioid initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

N0510. PRN Opioid

Enter Code ☐

A. **Was PRN opioid initiated or continued?**

0. **No** — Skip to N0520, Bowel Regimen
1. **Yes**

B. **Date PRN opioid initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)

Enter Code ☐

A. **Was a bowel regimen initiated or continued?** - Select the most accurate response

0. **No** — Skip to Z0400. Signature(s) of Person(s) Completing the Record
1. **No, but there is documentation of why a bowel regimen was not initiated or continued** — Skip to Z0400. Signature(s) of Person(s) Completing the Record
2. **Yes**

B. **Date bowel regimen initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

Section Z Record Administration

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

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

Signatures	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion

A. **Signature**

_____

B. **Date**

☐☐ ☐☐ ☐☐☐☐

Month Day Year

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. HOPE is a patient assessment instrument that intends to collect data during a hospice patient's stay. Data collected using this instrument will be used to measure the quality of care provided by a hospice provider. The valid OMB control number for this information collection is 0938-1153. Submission of this data is required by Section 1814(i)(5) of the Social Security Act. The time required to complete this data collection per item set is estimated to average 41 minutes for the Admission, 22 minutes for the Hope Update Visit, and 9 minutes for the Discharge, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the data collected. Submitted patient-level data will remain confidential and is protected from public dissemination in accordance with the Privacy Act of 1974, as amended. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Jermama Keys, National Coordinator, Hospice Quality Reporting Program Centers for Medicare & Medicaid Services, at Jermama.Keys@cms.hhs.gov.

HOPE Update Visit

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

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

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

A0220. Admission Date

☐☐ ☐☐ ☐☐☐☐

Month Day Year

A0250. Reason for Record

Enter Code ☐

1. Admission (ADM)
2. HOPE Update Visit 1 (HUV1)
3. HOPE Update Visit 2 (HUV2)
9. Discharge (DC)

A0500. Legal Name of Patient

A. **First name:**

B. **Middle initial:**

C. **Last name:**

D. **Suffix:**

A0600. Social Security and Medicare Numbers

A. **Social Security Number:** ___ – ___ – ____

B. **Medicare Number:**

A0700. Medicaid Number

Enter " +" if pending, "N" if not a Medicaid Recipient

A0810. Sex

Enter Code

1. Male
2. Female

A0900. Birth Date

Month Day Year

A1400. Payer Information

↓ **Check all existing payer sources that apply at the time of this assessment**

- A. Medicare (traditional fee-for-service)
- B. Medicare (managed care/Part C/Medicare Advantage)
- C. Medicaid (traditional fee-for-service)
- D. Medicaid (managed care)
- G. Other government (e.g., TRICARE, VA, etc.)
- H. Private Insurance/Medigap
- I. Private managed care
- J. Self-pay
- K. No payer source
- X. Unknown
- Y. Other

Section J Health Conditions

J0050. Death is Imminent

Enter Code ☐

At the time of this assessment and based on your clinical assessment, does the patient appear to have a life expectancy of 3 days or less?

0. **No**
1. **Yes**

J2050. Symptom Impact Screening

Enter Code ☐

A. **Was a symptom impact screening completed?**

0. **No** — Skip to M1190, Skin Conditions
1. **Yes**

B. **Date of symptom impact screening:**

☐☐ ☐☐ ☐☐☐☐

Month Day Year

J2051. Symptom Impact

Over the past 2 days, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:

0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. **Pain**	☐
B. **Shortness of breath**	☐
C. **Anxiety**	☐
D. **Nausea**	☐
E. **Vomiting**	☐
F. **Diarrhea**	☐
G. **Constipation**	☐
H. **Agitation**	☐

J2052. Symptom Follow-up Visit (SFV) (complete only if any response to J2051 Symptom Impact = 2. Moderate or 3. Severe)

An in-person **Symptom Follow-up Visit (SFV)** should occur within 2 calendar days as a follow-up for any moderate or severe pain or non-pain symptom identified during Symptom Impact assessment at Admission or HOPE Update Visit (HUV).

Enter Code

A. **Was an in-person SFV completed?**
0. **No** — Skip to J2052C, Reason SFV Not Completed.
1. **Yes**

B. **Date of in-person SFV** — Complete and skip to J2053, SFV Symptom Impact.

Month Day Year

Enter Code

C. **Reason SFV not completed** — Skip to M1190, Skin Conditions.

1. Patient and/or caregiver declined an in-person visit.
2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired).
3. Attempts to contact patient and/or caregiver were unsuccessful.
9. None of the above

J2053. SFV Symptom Impact

Since the last Symptom Impact assessment was completed, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:
0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. **Pain**	
B. **Shortness of breath**	
C. **Anxiety**	
D. **Nausea**	
E. **Vomiting**	
F. **Diarrhea**	
G. **Constipation**	
H. **Agitation**	

Section M Skin Conditions

M1190. Skin Conditions	
Enter Code	**Does the patient have one or more skin conditions?** 0. **No** - Skip to N0500, Scheduled Opioid 1. **Yes**

M1195. Types of Skin Conditions	
Indicate which following skin conditions were identified at the time of this assessment.	
↓ Check all that apply	
☐	A. Diabetic foot ulcer(s)
☐	B. Open lesion(s) other than ulcers, rash, or skin tear (cancer lesions)
☐	C. Pressure Ulcer(s)/Injuries
☐	D. Rash(es)
☐	E. Skin tear(s)
☐	F. Surgical wound(s)
☐	G. Ulcers other than diabetic or pressure ulcers (e.g., venous stasis ulcer, Kennedy ulcer)
☐	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
☐	Z. None of the above were present

M1200. Skin and Ulcer/Injury Treatments	
Indicate the interventions or treatments in place at the time of this assessment.	
↓ Check all that apply	
☐	A. Pressure reducing device for chair
☐	B. Pressure reducing device for bed
☐	C. Turning/repositioning program
☐	D. Nutrition or hydration intervention to manage skin problems
☐	E. Pressure ulcer/injury care
☐	F. Surgical wound care
☐	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
☐	H. Application of ointments/medications other than to feet
☐	I. Application of dressings to feet (with or without topical medications)
☐	J. Incontinence Management
☐	Z. None of the above were provided

Section N Medications

N0500. Scheduled Opioid

Enter Code ☐

A. **Was a scheduled opioid initiated or continued?**

0. **No** — Skip to N0510, PRN Opioid
1. **Yes**

B. **Date scheduled opioid initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

N0510. PRN Opioid

Enter Code ☐

A. **Was PRN opioid initiated or continued?**

0. **No** — Skip to N0520, Bowel Regimen
1. **Yes**

B. **Date PRN opioid initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)

Enter Code ☐

A. **Was a bowel regimen initiated or continued?** - Select the most accurate response

0. **No** — Skip to Z0350. Date Assessment was Completed
1. **No, but there is documentation of why a bowel regimen was not initiated or continued —** Skip to Z0350. Date Assessment was Completed
2. **Yes**

B. **Date bowel regimen initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

Section Z Record Administration

Z0350. Date Assessment was Completed

Month Day Year

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

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

Signatures	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion

A. **Signature**

_____

B. **Date**

Month Day Year

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. HOPE is a patient assessment instrument that intends to collect data during a hospice patient's stay. Data collected using this instrument will be used to measure the quality of care provided by a hospice provider. The valid OMB control number for this information collection is 0938-1153. Submission of this data is required by Section 1814(i)(5) of the Social Security Act. The time required to complete this data collection per item set is estimated to average 41 minutes for the Admission, 22 minutes for the Hope Update Visit, and 9 minutes for the Discharge, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the data collected. Submitted patient-level data will remain confidential and is protected from public dissemination in accordance with the Privacy Act of 1974, as amended. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Jermama Keys, National Coordinator, Hospice Quality Reporting Program Centers for Medicare & Medicaid Services, at Jermama.Keys@cms.hhs.gov.

HOPE Discharge

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

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

☐☐☐☐☐☐☐☐☐☐

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

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A0220. Admission Date

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Month Day Year

A0250. Reason for Record

Enter Code ☐

1. Admission (ADM)
2. HOPE Update Visit 1 (HUV1)
3. HOPE Update Visit 2 (HUV2)
9. Discharge (DC)

A0270. Discharge Date

☐☐ ☐☐ ☐☐☐☐

Month Day Year

A0500. Legal Name of Patient

A. **First name:**

B. **Middle initial:**

C. **Last name:**

D. **Suffix:**

A0600. Social Security and Medicare Numbers

A. **Social Security Number:**

– –

B. **Medicare Number:**

A0700. Medicaid Number

Enter " +" if pending, "N" if not a Medicaid Recipient

A0810. Sex

Enter Code

1. Male
2. Female

A0900. Birth Date

Month Day Year

A2115. Reason for Discharge	
Enter Code ☐	1. Expired 2. Revoked 3. No longer terminally ill 4. Moved out of hospice service area 5. Transferred to another hospice 6. Discharged for cause

Section Z Record Administration

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

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

Signatures	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion

A. **Signature**

_____

B. **Date**

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Month Day Year