



Hospice Outcomes and Patient Evaluation (HOPE) National Implementation

Course 2: Coding Workshop



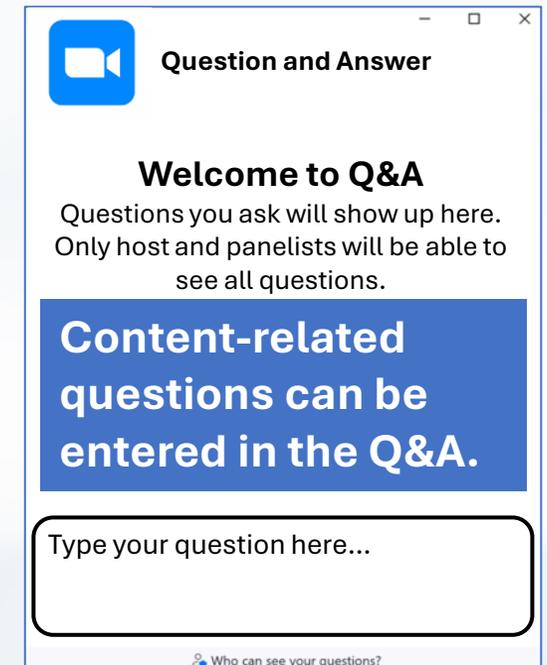
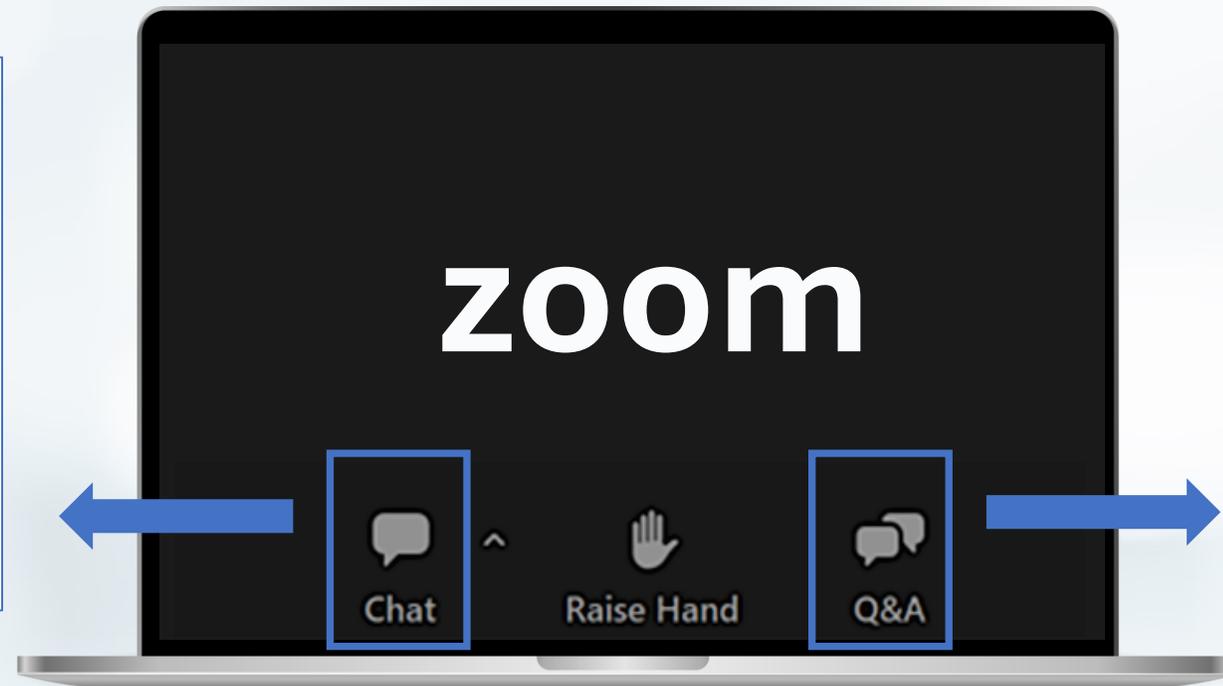
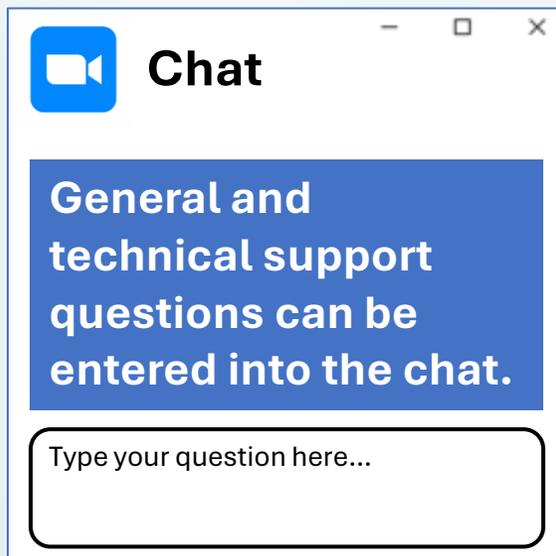
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This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The intent of the information provided is to be a general summary and not to take the place of either the written law or regulations. We encourage readers to review specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Navigation Panel

During the event, a navigation panel can be accessed from the bottom of the screen.



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Today's Agenda

- Section A. Administrative Information
- Section F. Preferences
- Section I. Active Diagnoses

Break

- Section J. Health Conditions
- Section M. Skin Conditions
- Section N. Medications
- Section Z. Record Administration
- Q&A and Resources



Objectives

Attendees will be able to:

- Briefly describe the Hospice Outcomes and Patient Evaluation (HOPE) tool and the plan for its implementation.
- Discuss at least five items that have been added to sections of HOPE for hospice data collection.
- Identify key concepts for collecting HOPE data.
- Explain the Symptom Impact and the HOPE Symptom Follow-up Visits (SFVs).
- List three resources to learn more about HOPE.



Acronyms

For a list of HQRP acronyms, visit the [HQRP Acronym List](#).

LPN
RNCMS SFV
HUV HOPE
HQRP LVN

How often do you access the HQRP webpages?

- A. Once a week or more often.
- B. Once a month.
- C. A few times per year.
- D. I have not accessed or am not familiar with the HQRP webpage.

The screenshot shows the CMS.gov website for the Hospice Quality Reporting Program. The page has a navigation bar with links for Medicare, Medicaid/CHIP, Marketplace & Private Insurance, Initiatives, and Training & Education. The breadcrumb trail indicates the path: Medicare > Quality > Hospice Quality Reporting Program. The main content area is titled "Hospice Quality Reporting Program" and includes an "Overview" section with text explaining the program's purpose and requirements. A sidebar on the left contains a table of contents with links to various sections like "Hospice QRP Announcements & Spotlight", "Hospice QRP Health Equity", "Current Measures", "HQRP Requirements and Best Practices", "Provider and Stakeholder Engagement", "Quality Measure Development", "HQRP-Training and Education Library", "CAHPS® Hospice Survey", "HIS Technical Information", "HOPE", "HOPE Technical Information", and "Hospice Item Set (HIS)".

Hospice Quality Reporting Program

Overview

This website provides information regarding the Hospice Quality Reporting Program (HQRP) as required by Section 1814(j)(5) of the Social Security Act. This is the official website for providers to receive updates and announcements related to the HQRP. The Secretary is authorized to establish quality reporting requirements for hospice programs and is also required to publicly report quality measures that relate to the care provided by hospice programs across the country on the Centers for Medicare & Medicaid Services (CMS) website.

Important subdirectory pages are shown on the left side of the webpage. Providers are encouraged to bookmark the web address and visit the website regularly to stay up-to-date with all information related to the HQRP. In addition to the CMS HQRP website, providers can sign up for listservs pertinent to the HQRP by visiting the [Provider and Stakeholder Engagement](#) webpage.

What is the HQRP?

The HQRP was established under section 1814(j)(5) of the Social Security Act. The HQRP includes data submitted by hospices through the Hospice Item Set (HIS) data collection tool, data from Medicare hospice claims, and an experience of care survey, the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. All Medicare-certified hospice providers must comply with these reporting requirements. The HQRP is currently "pay-for-reporting," meaning it is the timely submission and acceptance of complete data that determines compliance with HQRP requirements. The Performance level is not a consideration when determining market basket updates referred to as Annual Payment Updates (APU). Reporting compliance is determined by successfully fulfilling both the individual requirements of HIS and CAHPS® and the submission of administrative data (Medicare claims).

*The data source for the claims-based measures is Medicare claims data that are already collected and submitted to CMS.

Penalties for Failure to Report

Since fiscal year (FY) 2014, the failure of hospices to comply with quality data reporting requirements results in a percentage-point reduction to the APU for the corresponding FY. Effective with the FY 2022 Final Rule, beginning with the FY 2024 APU and for each subsequent year, the APU penalty is increased from 2% to 4% for hospices that do not comply with the HQRP for that FY.

How long have you been in your current role in a Hospice setting?

- A. More than 10 years.
- B. 5 – 9 years.
- C. 1 – 4 years.
- D. I am new to my current role.

HOPE Overview

Hospice Outcomes and Patient Evaluation (HOPE)

- The new data collection tool for hospices is starting on 10/01/2025.
- HOPE will replace the Hospice Item Set (HIS) as finalized in the FY 2025 Hospice Wage Index Final Rule (CMS-1810-F).
- HOPE will provide assessment-based quality data to enhance the HQRP.

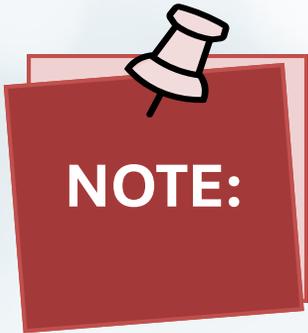
To access the final rule, visit [FY2025 Hospice Final Rule](#).

HOPE Tool Sections

- Section A. Administrative Information (**new items**)
- Section F. Preferences (unchanged)
- Section I. Active Diagnoses (**expanded list + co-morbidities**)
- Section J. Health Conditions (**new items**)
- Section M. Skin Conditions (**all new**)
- Section N. Medications (unchanged)
- Section Z. Record Administration (**new item**)

HOPE Training Course 2: Coding Workshop

- Today you are attending Course 2 to learn how to code HOPE items.
- [Course 1: Didactic Recorded Training Series](#) was released by CMS on 7/14/ 2025.
- Once finalized, the recordings from today's session will be available on the [HQRP Training and Education Library](#).

A red sticky note with a white pushpin icon at the top left corner, containing the word "NOTE:" in white capital letters.

NOTE:

The presentations in Course 1 should be reviewed prior to completing Course 2.

Section A. Administrative Information

A0050. Type of Record

A0050. Type of Record	
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> 1. Add new record 2. Modify existing record 3. Inactivate existing record

UNCHANGED

On Admission,
HUV1, HUV2, and
Discharge

Coding Instructions

A0050. Type of Record

- 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.
- **Code 3, Inactivate existing record**, if this is a request to inactivate a record that has already been submitted and accepted.



Definitions

A0050. Type of Record

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**.

Definitions (cont.)

A0050. Type of Record

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 examples below).

Record Event Identifiers: the Admission Date, Reason for Record, Discharge Date, and Date Assessment was Completed.

Patient Identifiers: the First or Last Name, Social Security Number (SSN), Sex, or Birth Date.

Coding Tips

A0050. Type of Record

- Corrections should be made to any record(s) that has errors to ensure that the information accurately reflects the patient's identification, location, and reason for the record.
- The system will reject duplicate record(s) when submitted.
- A fatal error will be reported to the provider on the Final Validation Report (FVR).
- A Modification Request can be used to correct most errors.

For more details, see Chapter 3 of the HOPE Guidance Manual.

A0100. Facility Provider Numbers

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A0100. Facility Provider Numbers											
A. National Provider Identifier (NPI)											
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. CMS Certification Number (CCN)											
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

A: National Provider Identifier (NPI)
 The NPI is a unique federal number that identifies providers of health care services.

B: CMS Certification Number (CCN)
 The CCN, also known as the Medicare provider number, is a 6-digit number, usually in the format XX-XXXX.

On Admission, HUV1, HUV2, and Discharge

A0215. Site of Service at Admission



A0215. Site of Service at Admission	
Enter Code <input type="text"/> <input type="text"/>	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

Response choices shortened.
 #99 “Not listed” has replaced
 “Not otherwise listed.”

Coding Tips

A0215. Site of Service at Admission

- Codes for Item A0215 are structured to match sites of service found on Medicare claims.
- 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, use the code for nursing long-term care (LTC) (also known as NF or non-skilled nursing facility).

A0220. Admission and A0270. Discharge Dates

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A0220. Admission Date													
	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="4">Year</td></tr></table>	<input type="text"/>	Month	Day	Year								
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month	Day	Year											

On Admission, HUV1, HUV2, and Discharge

A0270. Discharge Date													
	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="4">Year</td></tr></table>	<input type="text"/>	Month	Day	Year								
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month	Day	Year											

On Discharge

Coding Tips

A0220. Admission and A0270. Discharge Dates

- Enter the date the patient was admitted or 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 discharge date is:
 - the date the patient revoked the hospice benefit, or
 - the date the hospice discharged the patient.

A0900. Birth Date

A0900. Birth Date											
		<input type="text"/>									
		Month	Day	Year							

UNCHANGED

On Admission,
HUV1, HUV2, and
Discharge

Coding Tips

A0900. Birth Date

- If part of the patient's birth date is unknown, handle each situation as follows:
 - If only the birth year is known:
 - enter the year and leave the “month” and “day” boxes blank.
 - If the birth year and birth month are known, but not the birthday:
 - enter the year and the month, then leave the “day” boxes blank.

A0250. Reason for Record

A0250. Reason for Record	
<p>Enter Code</p> <input type="checkbox"/>	<ol style="list-style-type: none"> 1. Admission (ADM) 2. HOPE Update Visit 1 (HUV1) 3. HOPE Update Visit 2 (HUV2) 9. Discharge (DC)

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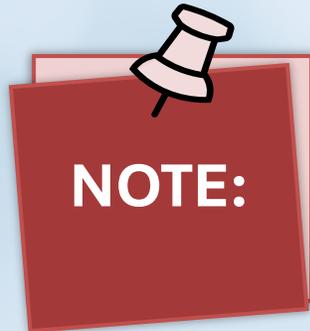
HUV1 & HUV2
timepoints
added

On Admission,
HUV1, HUV2, and
Discharge

Coding Tips

A0250. Reason for Record

- An Admission and Discharge record must be completed for each patient admission.
- Depending on the patient's length of stay (LOS), up to two HUV records are required for each hospice admission.
- Since the LOS for hospice patients varies, CMS understands that the number of HUV records will vary.



More details regarding the HUV timepoints can be found in **Chapter 1. Section 1.3 HOPE Timepoints and Definitions.**

A0500. Legal Name of Patient

A0500. Legal Name of Patient	
	A. First name: <input type="text"/>
	B. Middle initial: <input type="text"/>
	C. Last name: <input type="text"/>
	D. Suffix: <input type="text"/>

UNCHANGED

On Admission,
HUV1, HUV2, and
Discharge

Coding Instructions

A0500. Legal Name of Patient

- This is **the patient's name as it appears on their 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.
- Middle initial:
 - If the patient has no middle name(s), leave it blank.
 - If the patient has two or more middle names, use the initial of the first middle name.
- Suffix: If no suffix, leave it blank.



Coding Tips

A0500. Legal Name of Patient

- 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

UNCHANGED

On Admission

A0550. Patient ZIP Code													

Coding Instructions

A0550. Patient ZIP Code

- Enter the ZIP Code, for the address **where 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.
- Care Compare uses the patient’s ZIP Code to determine the location where your hospice provided services.



Coding Tips

A0550. Patient ZIP Code

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

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

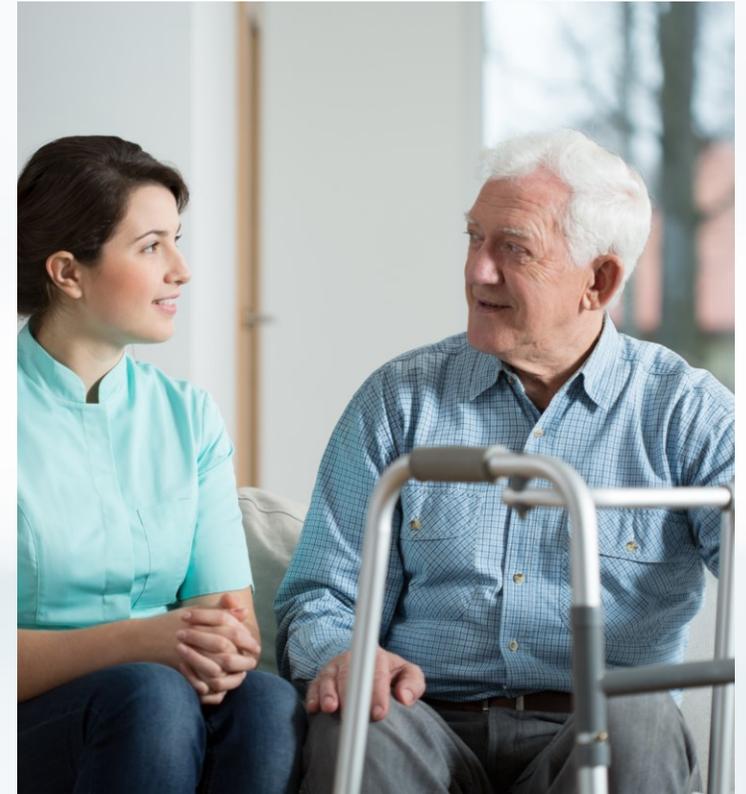
Coding: A0550 would be coded for City B.

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

Practice Scenario:

A0215. Site of Service at Admission and A0550. Patient ZIP Code

- Mr. M was discharged from the hospital after a lengthy acute care hospital stay. His cancer treatments have been stopped, and he was informed of a prognosis of less than 6 months.
- He decided to move into his daughter's home and elected to use hospice services.
- The hospice nurse arrives at the home to conduct the admission to hospice services.



What is the correct response for A0215. Site of Service at Admission?

A0215. Site of Service at Admission	
Enter Code <input type="text"/> <input type="text"/>	<ul style="list-style-type: none">01. Patient's Home/Residence02. Assisted Living Facility03. Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)04. Skilled Nursing Facility (SNF)05. Inpatient Hospital06. Inpatient Hospice Facility (General Inpatient (GIP))07. Long Term Care Hospital (LTCH)08. Inpatient Psychiatric Facility09. Hospice Home Care (Routine Home Care (RHC)) Provided in a Hospice Facility99. Not listed

Q¹

What is the correct response for A0215. Site of Service at Admission? **(Answer)**

A0215. Site of Service at Admission	
Enter Code <input type="text"/> <input type="text"/>	<ul style="list-style-type: none">01. Patient's Home/Residence02. Assisted Living Facility03. Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)04. Skilled Nursing Facility (SNF)05. Inpatient Hospital06. Inpatient Hospice Facility (General Inpatient (GIP))07. Long Term Care Hospital (LTCH)08. Inpatient Psychiatric Facility09. Hospice Home Care (Routine Home Care (RHC)) Provided in a Hospice Facility99. Not listed



When completing the HOPE tool, which ZIP Code should the nurse put in the hospice record for A0550. ZIP Code?

- A. Mr. M's home address and ZIP Code.
- B. The ZIP Code for his daughter's home.
- C. Both ZIP Codes since the patient may return to his home at some point.
- D. None of the above.

Q²

When completing the HOPE tool, which ZIP Code should the nurse put in the hospice record for A0550. ZIP Code? **(Answer)**

- A. Mr. M's home address and ZIP Code.
- B. The ZIP Code for his daughter's home.
- C. Both ZIP Codes since the patient may return to his home at some point.
- D. None of the above.

A0600. Social Security and Medicare Numbers



A0600. Social Security and Medicare Numbers																
	<p>A. Social Security Number:</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 33.33%; height: 30px;"> </td> <td style="width: 33.33%;">-</td> <td style="width: 16.67%; height: 30px;"> </td> <td style="width: 16.67%;">-</td> <td style="width: 33.33%; height: 30px;"> </td> </tr> </table> <p>B. Medicare Number:</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 10%;"> </td> </tr> </table>		-		-											
	-		-													

Reference to railroad insurance # removed

On Admission, HUV1, HUV2, and Discharge

Coding Instructions

A0600. Social Security Number

- Enter the SSN, one number per space, starting with the left-most space.
- **If there is no SSN, or the patient refuses to provide it, the field may be left blank.**
- A valid SSN should be submitted whenever available so that record matching can be performed as accurately as possible.



Coding Instructions

A0600. Medicare Number (or MBI)

- 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).
 - To fight identity theft CMS replaced the SSN-based Health Insurance Claim Number (HICN) with the MBI.
- Confirm that the name on the record matches the patient's name on the Medicare card.
 - If the patient has no Medicare number, the field may be left blank.



Coding Tips

A0600. Social Security and Medicare Numbers

- Item A0600 should only be left blank if the patient does not have an SSN or in rare instances where the SSN is unavailable. This is to avoid inaccuracies in patient record matching.
- The Medicare number is:
 - Not intended to reflect the patient's payer source.
 - Only used for patient identification purposes.

Coding Tips (cont.)

A0600. Social Security and Medicare Numbers

- 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 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
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

UNCHANGED

On Admission,
HUV1, HUV2, and
Discharge

Coding Instructions

A0700. Medicaid Number

- Enter the Medicaid number, if the patient is a Medicaid recipient.
- Enter one number per box, beginning in the left-most box.
 - Enter a “+” if pending.
 - Enter an “N” if not a Medicaid recipient.
- Confirm that the patient’s legal name on the record matches the Medicaid card.
- Leave blank if the patient refuses to supply his or her number or it is unknown.



Coding Tips

A0700. Medicaid Number

- Check the patient's Medicaid card, admission or transfer records, or hospice clinical record for their Medicaid number.
- The Medicaid Number is:
 - Not intended to reflect the patient's payer source.
 - Is for patient identification purposes only.
- Enter the Medicaid Number, even if Medicaid is not a payer (primary or secondary).
- 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 record at a later date does not require a Modification Request.

A0810. Sex

A0810. Sex	
Enter Code <input type="checkbox"/>	1. Male 2. Female

REVISED

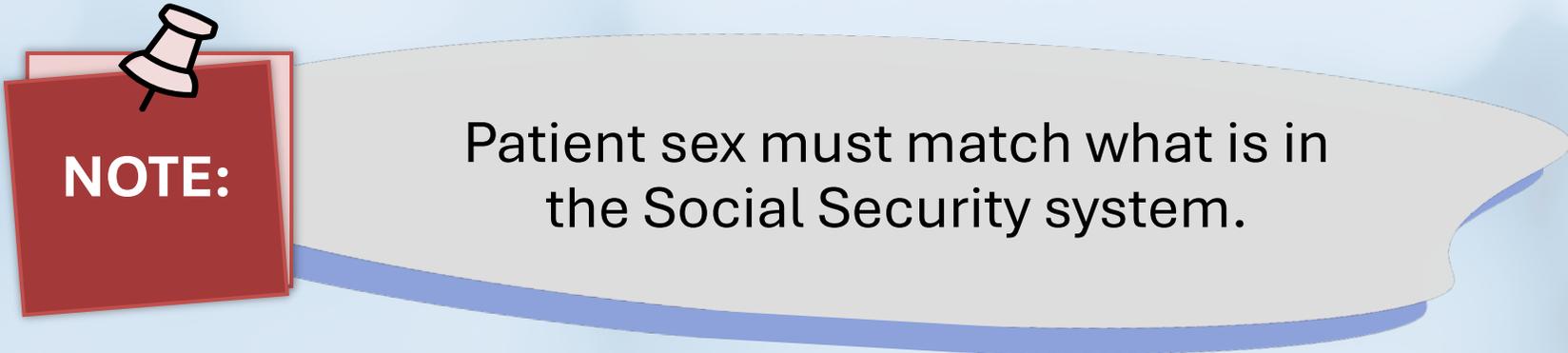
Replaced #
A0800

On Admission,
HUV1, HUV2, and
Discharge

Coding Tips

A0810. Sex

- Assists in correct identification.
- Provides demographic sex-specific health trend information.



NOTE:

Patient sex must match what is in the Social Security system.

A1005. Ethnicity

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



A1010. Race

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



On Admission

Coding Instructions

A1005. Ethnicity and A1010. Race

- Ask the patient to select the category or categories that most closely correspond to the patient's ethnicity (from the list in A1005) and race (from the list in A1010).
- Respondents should be offered the option of selecting one or more categories.



Coding Instructions (cont. 1)

A1005. Ethnicity and A1010. Race

- Check all that apply.
- **If a patient is unable to respond, a response from a caregiver and/or responsible party, or the medical record may be used.**
- **Code X, Patient unable to respond**, if the patient was unable to respond.
 - If the response(s) are determined via caregiver, responsible party, and/or the medical record, check all boxes that apply, including Code “X, Patient unable to respond.”
 - If the patient is unable to respond and no other resources provided the necessary information, code “X, Patient unable to respond,” **only**.



Coding Instructions (cont. 2)

A1005. Ethnicity and A1010. Race

- **Code Y, Patient declines to respond:**
 - **When the patient declines to respond, code only “Y, Patient declines to respond.”**
 - Do not code ethnicity or race based on other resources (caregiver, responsible party, or medical records).
 - Complete as close to the time of admission as possible.



Coding Tips

A1005. Ethnicity and A1010. Race

- Standardizing self-reported data collection for ethnicity and 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.

Coding Instructions

A1110. Language

- 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.



Coding Instructions (cont.)

A1110. Language

- 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.



Coding Tips

A1110. Language

- 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.

Coding for A1005. Ethnicity, A1010. Race, and A1110. Language

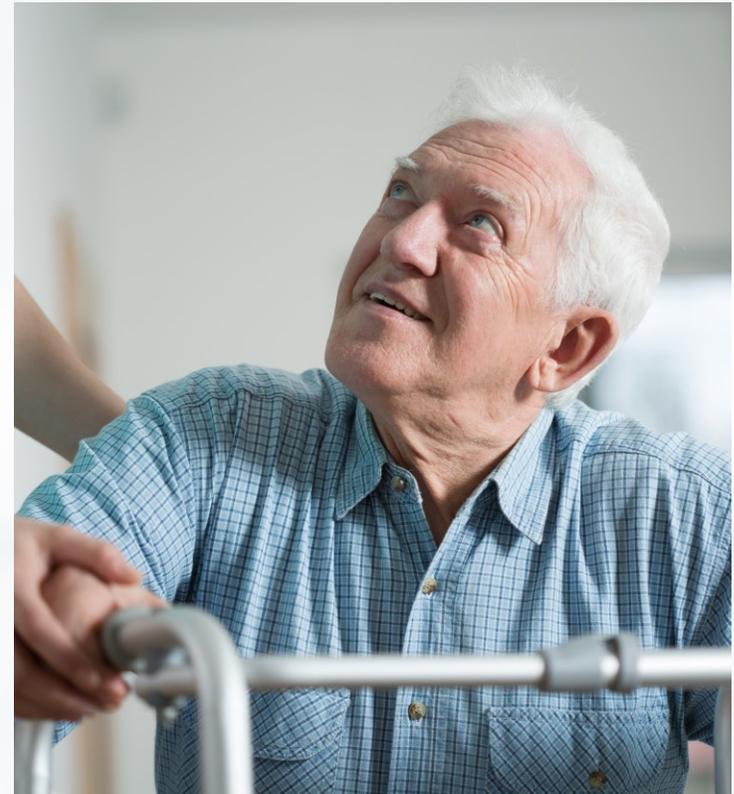
A1005. Ethnicity		A1010. Race	
Are you of Hispanic, Latino/a, or Spanish origin?		What is your race?	
↓ Check all that apply		↓ Check all that apply	
<input type="checkbox"/>	A. No, not of Hispanic, Latino/a, or Spanish origin	<input type="checkbox"/>	A. White
<input type="checkbox"/>	B. Yes, Mexican, Mexican American, Chicano/a	<input type="checkbox"/>	B. Black or African American
<input type="checkbox"/>	C. Yes, Puerto Rican	<input type="checkbox"/>	C. American Indian or Alaska Native
<input type="checkbox"/>	D. Yes, Cuban	<input type="checkbox"/>	D. Asian Indian
<input type="checkbox"/>	E. Yes, Another Hispanic, Latino, or Spanish origin	<input type="checkbox"/>	E. Chinese
<input type="checkbox"/>	X. Patient unable to respond	<input type="checkbox"/>	F. Filipino
<input type="checkbox"/>	Y. Patient declines to respond	<input type="checkbox"/>	G. Japanese
		<input type="checkbox"/>	H. Korean
		<input type="checkbox"/>	I. Vietnamese
		<input type="checkbox"/>	J. Other Asian
		<input type="checkbox"/>	K. Native Hawaiian
		<input type="checkbox"/>	L. Guamanian or Chamorro
		<input type="checkbox"/>	Samoan
		<input type="checkbox"/>	Other Pacific Islander
		<input type="checkbox"/>	Patient unable to respond
		<input type="checkbox"/>	Patient declines to respond
		<input type="checkbox"/>	None of the above

A1110. Language	
Enter Code <input type="checkbox"/>	A. What is your preferred language? <input type="text"/>
	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

Practice Scenario:

A1005. Ethnicity, A1010. Race, and A1110. Language

- When asked about ethnicity Mr. M explains that he was born in Puerto Rico and identifies as Puerto Rican, even though he has been in the USA since he was six years old.
- When asked about race, he declines to respond, does not identify a race, and changes the subject.
- Mr. M. speaks both Spanish and English but prefers speaking English and does not feel he needs an interpreter.



How would you code A1005. Ethnicity for this patient?

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



How would you code A1005. Ethnicity for this patient? (Answer)

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

How would you code A1010. Race for this patient?

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

How would you code A1010. Race for this patient? (Answer)

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

How would you code A1110. Language for this patient?

A1110. Language																
Enter Code <input type="text"/>	<p>A. What is your preferred language?</p> <table border="1"><tr><td> </td><td> </td></tr></table> <p>B. Do you need or want an interpreter to communicate with a doctor or health care staff?</p> <p>0. No 1. Yes 9. Unable to determine</p>															



How would you code A1110. Language for this patient? (Answer)

A1110. Language																
Enter Code <input type="text"/>	<p>A. What is your preferred language?</p> <table border="1"><tr><td> </td><td> </td></tr></table> <p>B. Do you need or want an interpreter to communicate with a doctor or health care staff?</p> <ul style="list-style-type: none">0. No1. Yes9. Unable to determine															

A1400. Payer Information

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



On Admission,
HUV1, and HUV2

Coding Instructions

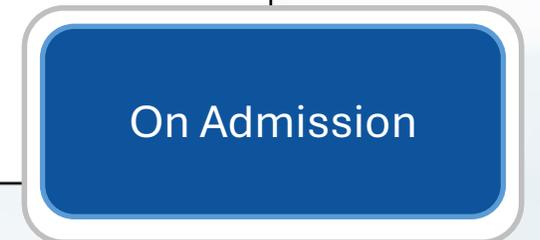
A1400. Payer Information

- Check the box(es) that best correspond(s) to the patient's current existing payment sources.
- Check all that apply.
 - Identifies **all current, existing payer sources that the patient has, regardless of whether 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).



A1805. Admitted From

A1805. Admitted From	
<p>Enter Code</p> <div style="border: 1px solid black; width: 40px; height: 25px; margin: 5px auto; display: flex; justify-content: space-between;"> <div style="width: 15px; height: 15px;"></div> <div style="width: 15px; height: 15px;"></div> </div>	<p>Immediately preceding this admission, where was the patient?</p> <ul style="list-style-type: none"> 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



Coding Tips

A1805. Admitted From

- 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.
 - The location 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.**
 - Use SNF for patients in a skilled nursing facility, SNF swing bed, or the SNF portion of a dually certified nursing facility.
 - If the individual is in a nursing facility but does not meet the criteria (for SNF), do not use the response option for SNF; Code “02, Nursing Home (long-term care facility).”

A1905. Living Arrangements

A1905. Living Arrangements	
<p>Enter Code</p> <input type="checkbox"/>	<p>Identify the patient’s living arrangement at the time of this admission.</p> <ol style="list-style-type: none"> 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)



On Admission

Coding Tips

A1905. Living Arrangements

- If more than one code applies, select the code with the greater numeric value. (e.g., if the patient lives with their spouse in an ALF, select **Code 3, Congregate home (e.g., assisted living or residential care home.)**)

A1910. Availability of Assistance

A1910. Availability of Assistance	
<p>Enter Code</p> <input type="checkbox"/>	<p>Code the level of in-person assistance from available and willing caregiver(s), excluding hospice and facility staff, at the time of this admission.</p> <ol style="list-style-type: none"> 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



On Admission

Coding Instructions

A1910. Availability of Assistance

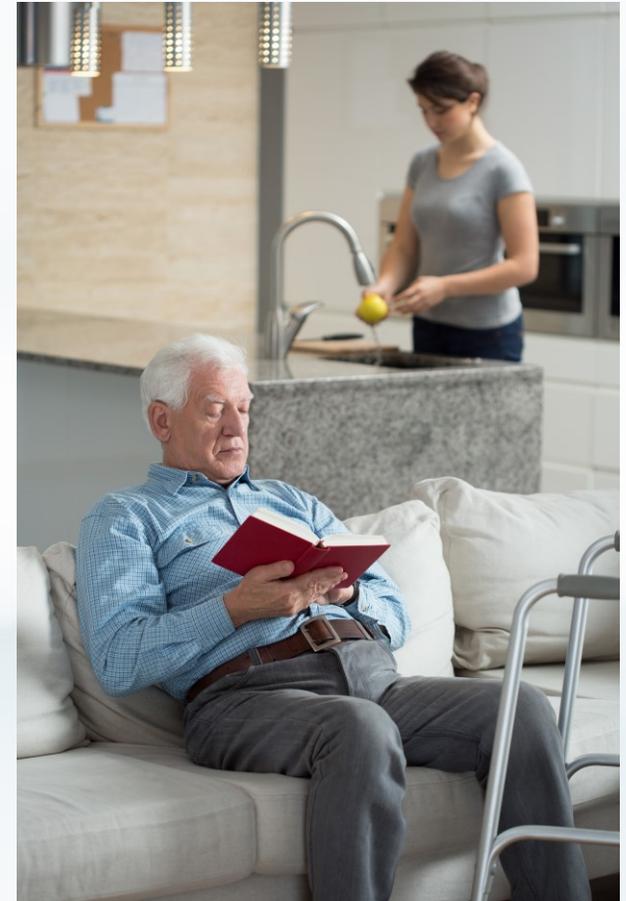
- Patient and/or caregiver interview can be used to code this item.
- In the event the patient cannot respond, and no caregiver is present, facility staff, clinical record, and referral information can be used to code the item.



Practice Scenario:

A1905. Living Arrangements and A1910. Availability of Assistance

- Mr. M is settling into his daughter's home in a room on the first floor. He is still very independent, and his room is close to a bathroom. He can prepare small meals for himself during the day.
- He explains that his daughter leaves very early for her job at the nearby hospital, but his son-in-law works from home and is there with few exceptions.





How would you code A1905. Living Arrangements for this patient?

A1905. Living Arrangements	
Enter Code <input type="checkbox"/>	Identify the patient's living arrangement at the time of this admission. <ol style="list-style-type: none">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)



How would you code A1905. Living Arrangements for this patient? (Answer)

A1905. Living Arrangements	
Enter Code <input type="checkbox"/>	Identify the patient's living arrangement at the time of this admission. <ol style="list-style-type: none">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)



How would you code A1910. Availability of Assistance for this patient?

A1910. Availability of Assistance	
Enter Code <input type="text"/>	Code the level of in-person assistance from available and willing caregiver(s), excluding hospice and facility staff, at the time of this admission. <ol style="list-style-type: none">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



How would you code A1910. Availability of Assistance for this patient? **(Answer)**

A1910. Availability of Assistance	
Enter Code <input type="text"/>	Code the level of in-person assistance from available and willing caregiver(s), excluding hospice and facility staff, at the time of this admission. <ol style="list-style-type: none">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

A2115. Reason for Discharge

A2115. Reason for Discharge	
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none">1. Expired2. Revoked3. No longer terminally ill4. Moved out of hospice service area5. Transferred to another hospice6. Discharged for cause

UNCHANGED

On Discharge

Definitions

A2115. Reason for Discharge

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.

Coding Instructions

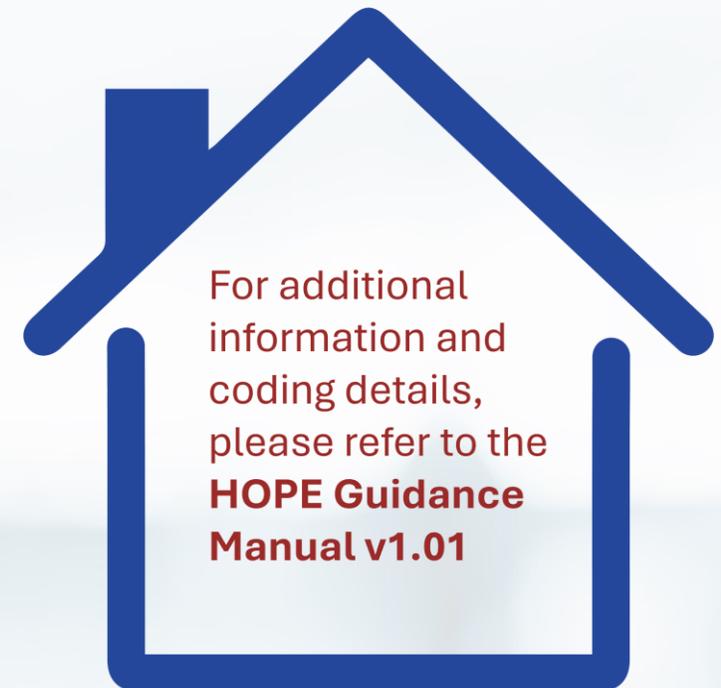
A2115. Reason for Discharge

- 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.



Key Takeaways

- The HOPE tool will be implemented on 10/01/2025.
- Most of the items in **Section A. Administrative Information** are familiar to hospices, although some have been slightly altered.
- **Section A. Administrative Information** does contain several new items.
- Two new items ask about the patient's living conditions and the availability of assistance at the time of admission to hospice.



Section F. Preferences and Section I. Active Diagnoses

Objectives

Attendees will be able to:

- Explain how to code the **Section F. Preferences** items.
- Describe some of the new response options for **I0010. Principal Diagnosis**.
- Discuss coding for the new data elements included in **Section I. Active Diagnoses** for documenting any comorbidities and co-existing conditions.



Section F. Preferences

Items

Section F. Preferences



F2000. CPR Preference

F2100. Other Life-Sustaining
Treatment Preferences

F2200. Hospitalization Preference

F3000. Spiritual/Existential Concerns



F2000. CPR Preference

F2000. CPR Preference	
<p>Enter Code</p> <input type="checkbox"/>	<p>A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? – Select the most accurate response</p> <p>0. No — Skip to F2100, Other Life-Sustaining Treatment Preferences</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preference regarding the use of CPR:</p> <p> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p>Month Day Year</p>

UNCHANGED

On Admission

F2100. Other Life-Sustaining Treatment Preferences

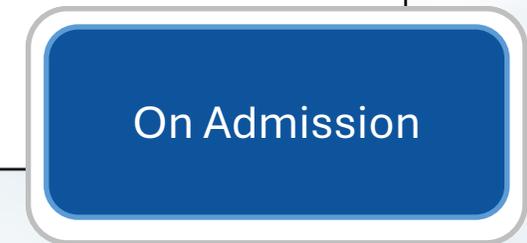
F2100. Other Life-Sustaining Treatment Preferences	
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 10px auto;"></div>	<p>A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? – Select the most accurate response</p> <p>0. No — Skip to F2200, Hospitalization Preference</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 40px; height: 30px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>

UNCHANGED

On Admission

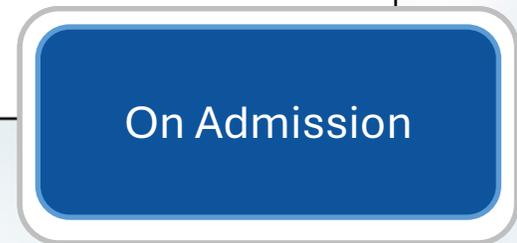
F2200. Hospitalization Preference

F2200. Hospitalization Preference													
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 10px auto;"></div>	<p>A. Was the patient/responsible party asked about preference regarding hospitalization? – Select the most accurate response</p> <p>0. No — Skip to F3000, Spiritual/Existential Concerns</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preference regarding hospitalization:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>							Month	Day	Year			
Month	Day	Year											



F3000. Spiritual/Existential Concerns

F3000. Spiritual/Existential Concerns	
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<p>A. Was the patient and/or caregiver asked about spiritual/existential concerns? – Select the most accurate response</p> <p>0. No — Skip to I0100, Principal Diagnosis</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/caregiver refused to discuss</p> <p>B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 60px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>



Coding Instructions

Section F. Preferences

- 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),
 - Other life-sustaining treatments,
 - Hospitalization, and
 - Spiritual/existential concerns.



Coding Instructions (cont.)

Section F. Preferences

- 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.



Coding Tips

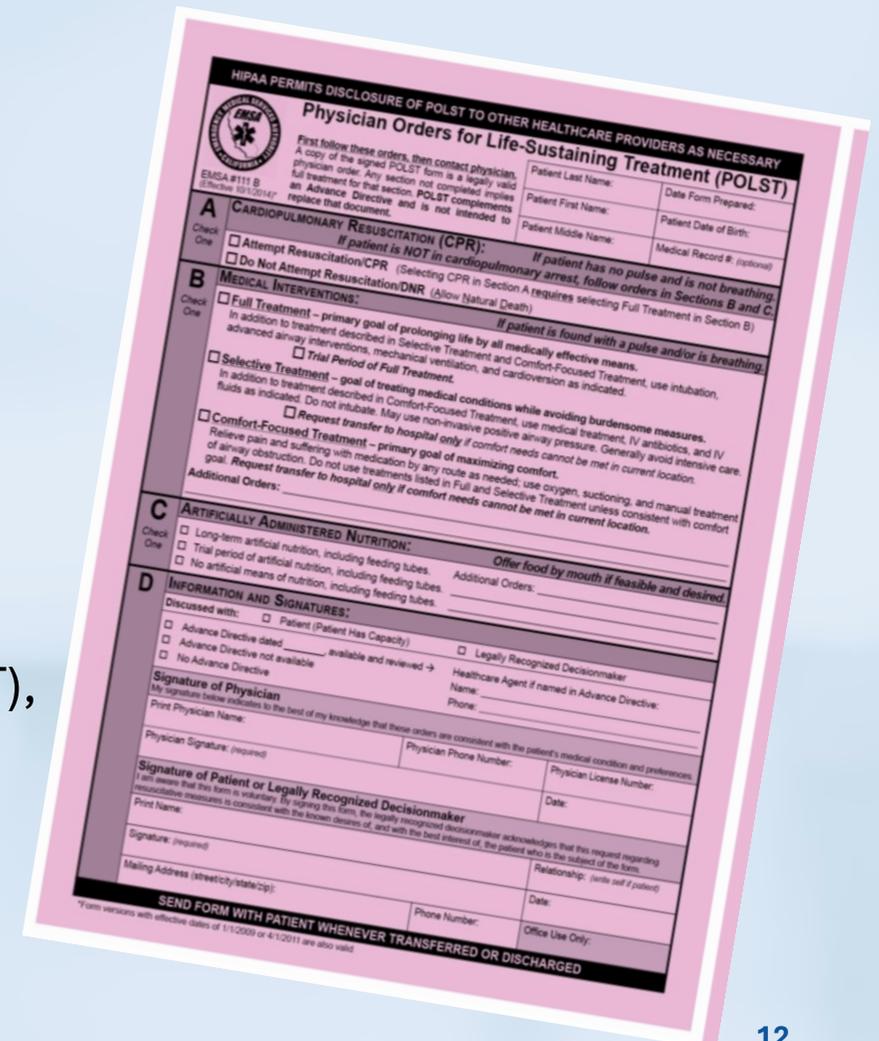
F2000. CPR Preference, F2100. Other Life-Sustaining Treatment Preferences, F2200. Hospitalization Preference

- 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 do not resuscitate (DNR), and/or do not hospitalize (DNH) preferences was confirmed with patient/responsible party).
- **Orders alone** or short statements in the clinical record, such as “DNR/Do Not Intubate (DNI)” or “full code,” without evidence of discussion or involvement from the patient/responsible party, **are not sufficient to code “Yes” for F2000A.**

Coding Tips (cont.)

F2000. CPR Preference, F2100. Other Life-Sustaining Treatment Preferences, F2200. Hospitalization Preference

- 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.
- Documented evidence of a discussion or attempted discussion may be located in the clinical record:
 - DNR, DNI, or DNH orders
 - Physician Orders for Life-Sustaining Treatment (POLST), or the equivalent



The image shows a "Physician Orders for Life-Sustaining Treatment (POLST)" form. The form is titled "Physician Orders for Life-Sustaining Treatment (POLST)" and includes a HIPAA disclosure statement. It is divided into several sections: A. CARDIOPULMONARY RESUSCITATION (CPR), B. MEDICAL INTERVENTIONS, C. ARTIFICIALLY ADMINISTERED NUTRITION, and D. INFORMATION AND SIGNATURES. Section A includes options for "Attempt Resuscitation/CPR" and "Do Not Attempt Resuscitation/CPR". Section B includes options for "Full Treatment", "Selective Treatment", and "Comfort-Focused Treatment". Section C includes options for "Long-term artificial nutrition" and "No artificial means of nutrition". Section D includes fields for "Signature of Physician", "Signature of Patient or Legally Recognized Decisionmaker", and "Mailing Address". The form also includes a "SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED" instruction.

Coding Tips

F2100. Other Life-Sustaining Treatment Preferences

- **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 is sufficient to code either of the following for F2100A:
 - **Code 1, Yes**, and discussion occurred.
 - **Code 2, Yes**, but the patient/responsible party refused to discuss.

Examples of life-sustaining treatments: ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, and intravenous [IV] fluids.

Coding Tips

F3000. Spiritual/Existential Concerns

- **There is no comprehensive list of spiritual/existential concerns.**
- Documentation in the clinical record indicating that a member of the hospice staff or interdisciplinary group (IDG) attempted to discuss spiritual/existential concerns is sufficient to select either of the following for F3000A:
 - **Code 1, Yes**, and discussion occurred.
 - **Code 2, Yes**, but the patient/responsible party refused to discuss.
- Brief statements or data in the clinical record denoting a patient's religious affiliation or denoting that a spiritual visit was offered without documentation of a discussion is not sufficient to code "Yes" for F3000A.

Coding Tips (cont.)

F3000. Spiritual/Existential Concerns

- 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.**

Practice Scenario: Preferences

- During the first visit to the home on 10/23/2025, the hospice admission nurse asks Mrs. T about her preferences for care and treatments.
- Her prolonged illness and complications from cancer have resulted in numerous hospitalizations. She is firm about her preference to remain at home, if possible, during her final months.
- She presents the nurse with the POLST form that was signed by her physician just one week ago.



Practice Scenario: Preferences (cont.)

- When the nurse asks more about the POLST, Mrs. T. explains that she does not want any aggressive treatment such as CPR or ventilation support if she was to stop breathing.
- However, she would like to take antibiotics if she gets an infection and would like IV fluids if she needs them to help her with any severe bouts of dehydration and nausea. Her physician is aware of her preferences.



How would you code F2000. CPR Preference for this patient?

F2000. CPR Preference													
Enter Code <input type="text"/>	<p>A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? – Select the most accurate response</p> <p>0. No — Skip to F2100, Other Life-Sustaining Treatment Preferences</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preference regarding the use of CPR:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="4">Year</td></tr></table>	<input type="text"/>	Month	Day	Year								
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month	Day	Year											



How would you code F2000. CPR Preference for this patient? (Answer)

F2000. CPR Preference	
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 10px auto;"></div>	<p>A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? – Select the most accurate response</p> <p>0. No — Skip to F2100, Other Life-Sustaining Treatment Preferences</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preference regarding the use of CPR:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>



How would you code F2100. Other Life-Sustaining Treatment Preferences for this patient?

F2100. Other Life-Sustaining Treatment Preferences	
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 10px auto;"></div>	<p>A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? – Select the most accurate response</p> <p>0. No — Skip to F2200, Hospitalization Preference</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>



How would you code F2100. Other Life-Sustaining Treatment Preferences for this patient? (Answer)

F2100. Other Life-Sustaining Treatment Preferences	
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 10px auto;"></div>	<p>A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? – Select the most accurate response</p> <p>0. No — Skip to F2200, Hospitalization Preference</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>



How would you code F2200. Hospitalization Preference for this patient?

F2200. Hospitalization Preference													
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 10px auto;"></div>	<p>A. Was the patient/responsible party asked about preference regarding hospitalization? – Select the most accurate response</p> <p>0. No — Skip to F3000, Spiritual/Existential Concerns</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preference regarding hospitalization:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>							Month	Day	Year			
Month	Day	Year											

How would you code F2200. Hospitalization Preference for this patient? (Answer)

F2200. Hospitalization Preference													
<p>Enter Code</p> <input type="text"/>	<p>A. Was the patient/responsible party asked about preference regarding hospitalization? – Select the most accurate response</p> <p>0. No — Skip to F3000, Spiritual/Existential Concerns</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/responsible party refused to discuss</p> <p>B. Date the patient/responsible party was first asked about preference regarding hospitalization:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="4">Year</td></tr></table>	<input type="text"/>	Month	Day	Year								
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month	Day	Year											

Practice Scenario:

F3000. Spiritual/Existential Concerns

- The nurse asks about spiritual concerns, but the patient declines to discuss the subject. She explains that that is something she discusses during regular visits with her Rabbi.



How would you code F3000. Spiritual/Existential Concerns for this patient?

F3000. Spiritual/Existential Concerns													
<p>Enter Code</p> <input type="checkbox"/>	<p>A. Was the patient and/or caregiver asked about spiritual/existential concerns? – Select the most accurate response</p> <p>0. No — Skip to I0100, Principal Diagnosis</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/caregiver refused to discuss</p> <p>B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td colspan="2">Day</td><td colspan="2">Year</td></tr></table>	<input type="text"/>	Month		Day		Year						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month		Day		Year									



How would you code F3000. Spiritual/Existential Concerns for this patient? **(Answer)**

F3000. Spiritual/Existential Concerns	
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 10px auto;"></div>	<p>A. Was the patient and/or caregiver asked about spiritual/existential concerns? – Select the most accurate response</p> <p>0. No — Skip to I0100, Principal Diagnosis</p> <p>1. Yes, and discussion occurred</p> <p>2. Yes, but the patient/caregiver refused to discuss</p> <p>B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>

Section I. Active Diagnoses

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

REVISED

On Admission

I0010. Principal Diagnosis (cont. 1)



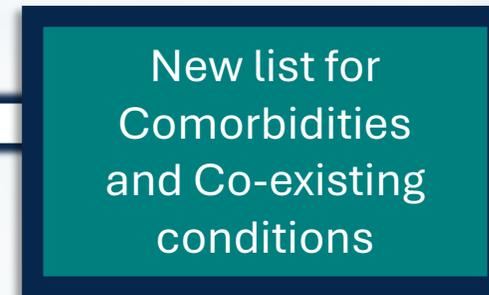
I0010. Principal Diagnosis	
Enter Code <input type="text"/> <input type="text"/>	<ul style="list-style-type: none"> 01. Cancer 02. Dementia (including Alzheimer’s disease) 03. Neurological Condition (e.g., Parkinson’s disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS)) 04. Stroke 05. Chronic Obstructive Pulmonary Disease (COPD) 06. Cardiovascular (excluding heart failure) 07. Heart Failure 08. Liver Disease 09. Renal Disease 99. None of the above

More selections for Principal Diagnosis

On Admission

I0010. Principal Diagnosis (cont. 2)

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



Coding Instructions

10010. Principal Diagnosis

- 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.



Coding Instructions (cont.)

10010. Principal Diagnosis

- 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

I0010. Principal Diagnosis

- **Code 01, Cancer** for all types of cancer, e.g., skin and blood cancers.
- **Code 02, Dementia (including Alzheimer's disease)** 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).

Coding Instructions

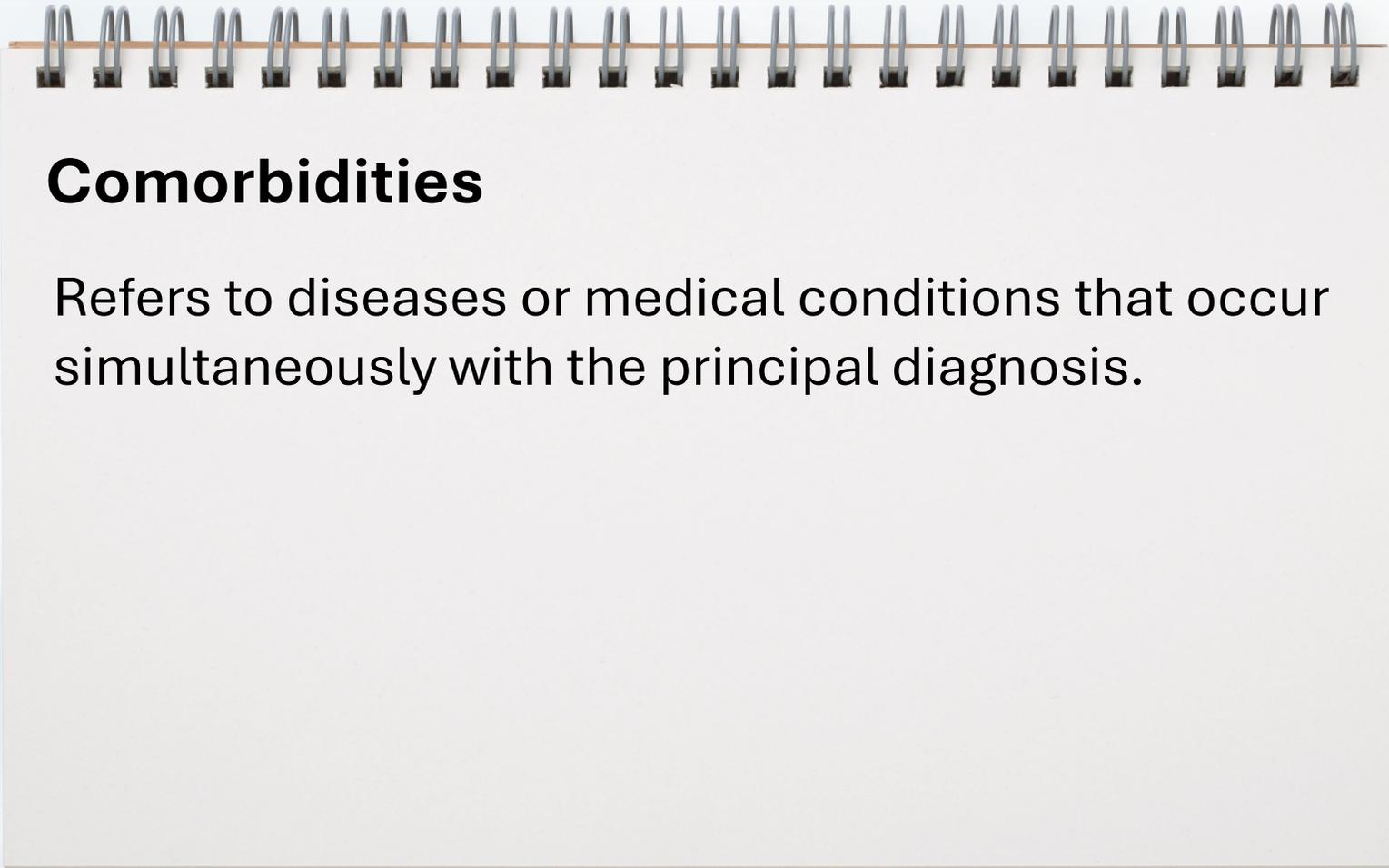
10010. Comorbidities and Co-existing Conditions

- Review the medical record for comorbidities and/or co-existing conditions at the time of admission to hospice.
- Check all comorbid and/or co-existing 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.**



Definitions

10010. Comorbidities and Co-existing Conditions

A spiral-bound notebook with a white cover and a silver metal spiral binding on the left side. The notebook is open to a blank white page.

Comorbidities

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

Practice Scenario:

I0010. Principal Diagnosis

- When completing the hospice admission, the nurse confirms the principal diagnosis by reviewing the documents included in the patient's medical record.
- Based on documentation from her oncologist and confirmed with the hospice medical director, the terminal prognosis is related to her diagnosis of stage four ovarian cancer.



How would you code I0010. Principal Diagnosis for this patient?

I0010. Principal Diagnosis	
Enter Code <input type="text"/> <input type="text"/>	<ol style="list-style-type: none">01. Cancer02. Dementia (including Alzheimer's disease)03. Neurological Condition (e.g., Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS))04. Stroke05. Chronic Obstructive Pulmonary Disease (COPD)06. Cardiovascular (excluding heart failure)07. Heart Failure08. Liver Disease09. Renal Disease99. None of the above

How would you code I0010. Principal Diagnosis for this patient? (Answer)

I0010. Principal Diagnosis	
Enter Code <input type="text"/> <input type="text"/>	<ol style="list-style-type: none">01. Cancer02. Dementia (including Alzheimer's disease)03. Neurological Condition (e.g., Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS))04. Stroke05. Chronic Obstructive Pulmonary Disease (COPD)06. Cardiovascular (excluding heart failure)07. Heart Failure08. Liver Disease09. Renal Disease99. None of the above

Practice Scenario:

10010. Principal Diagnosis for Comorbidities and Co-existing Conditions

- The nurse reviews the list of co-existing conditions and comorbidities found within the clinical record.
- She notes that this patient also has a history of the following:
 - Squamous cell skin cancer
 - Chemotherapy-induced peripheral neuropathy, and
 - Hypoglycemia



What codes should you enter?

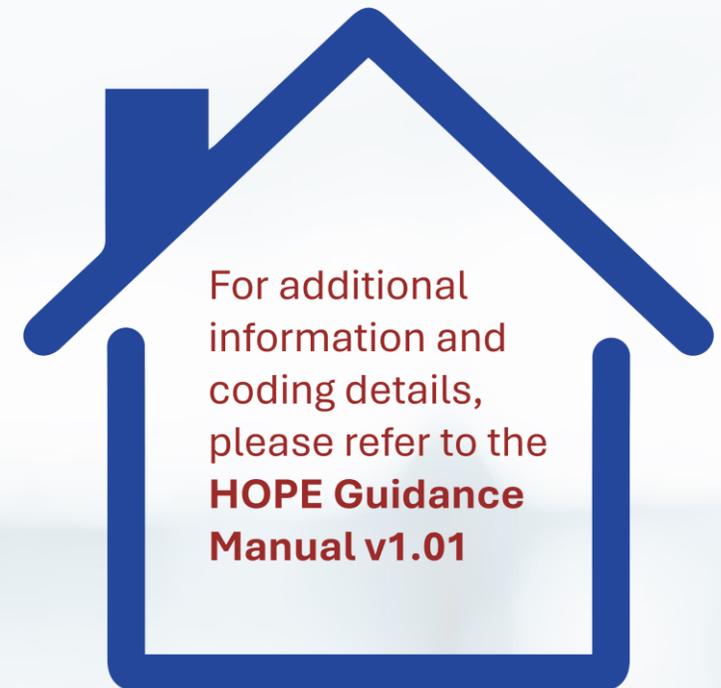
Comorbidities and Co-existing Conditions	
↓ Check all that apply	
	Cancer
<input type="checkbox"/>	I0100. Cancer
	Heart/Circulation
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PDV)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

What codes should you enter? (Answer)

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

Key Takeaways

- **Section F. Preferences** items are collected based on the **first discussion** that occurred, **including those that took place during pre-admission or educational visits.**
- **I0010. Principal Diagnosis** has been expanded to include more options and comorbidities and co-existing conditions.
 - For comorbidities and co-existing conditions, you do not include the principal diagnosis, except if the patient has a secondary cancer.



Break

Section J. Health Conditions

Objectives

Attendees will be able to:

- Identify the new data elements in **Section J. Health Conditions.**
- Discuss the coding of **J0915. Neuropathic Pain.**
- Explain the coding of the symptom impact and symptom follow-up items in **Section J. Health Conditions.**
- Identify who can complete **J0252. Symptom Follow-up.**



Section J: Items



- J0050. Death is Imminent
- J0915. Neuropathic Pain
- J2050. Symptom Impact Screening
- J2051. Symptom Impact
- J2052. Symptom Follow-up Visit (SFV)
- J2053. SFV Symptom Impact



- J0900. Pain Screening
- J0905. Pain Active Problem
- J0910. Comprehensive Pain Assessment
- J2030. Screening of Shortness of Breath



- J2040. Treatment for Shortness of Breath

J0050. Death is Imminent

J0050. Death is Imminent	
Enter Code <input type="checkbox"/>	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

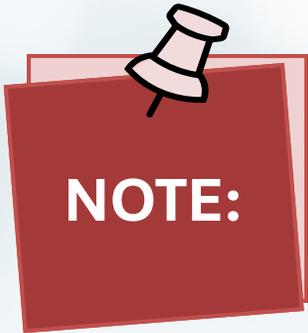


On Admission,
HUV1 and HUV2

Coding Instructions

J0050. Death is Imminent

- **Code 1, Yes**, if clinical assessment and judgement determine the patient is expected to live (3) days or less.
- 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.



NOTE:

In counting the number of days, the day of the **assessment visit is day zero (0)**.

Practice Scenario:

J0050. Death is Imminent

- During the HOPE Admission visit, the nurse assessing Mrs. P observes:
 - No response to verbal stimuli.
 - Accumulating secretions with an inability to clear or swallow them.
 - Upper and lower extremities are mottled, cyanotic, and cool to touch.
- The family reports she is not waking or trying to open her eyes when they talk to her.
- The family also reports Mrs. P has not urinated in more than 24 hours and does not respond when they ask if she needs to urinate.



How would you code J0050. Death is Imminent?

J0050. Death is Imminent	
Enter Code <input type="checkbox"/>	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

How would you code J0050. Death is Imminent? (Answer)

J0050. Death is Imminent	
Enter Code <input type="checkbox"/>	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

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

UNCHANGED

On Admission

Coding Instructions

J0900. Pain Screening

- Assess the patient for the presence of pain.
- 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.
- **Code 0, No, or Code 1, Yes**, 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.



Coding Instructions (cont.)

J0900. Pain Screening

- Enter the date based on the **first** pain screening documented in the clinical record.
 - It is possible that at the time of completion, multiple pain screenings will be documented in the clinical record. Identify and use the **first** one.



Coding Tips

J0900. Pain Screening

- **For C. The patient's pain severity was:**
 - Select the best response for pain severity 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.
- **For D. Type of standardized pain tool used:**
 - 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?
<input type="checkbox"/>	0. No — Skip to J2030, Screening for Shortness of Breath 1. Yes

UNCHANGED

On Admission

Coding Tips

J0905. Pain Active Problem

- **Code 1, Yes**, if the clinician determines pain is an active problem for the patient, even if pain is not present during the clinical encounter.
- The assessing clinician may determine pain is an active problem based on patient-specific findings and/or conversations with family/caregivers.
- 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.

Coding Tips (cont.)

J0905. Pain Active Problem

- 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 **Code 1, Yes**.
- If documentation in the patient's clinical record indicates that pain is not an active problem for the patient, then select **Code 0, No**.

J0910. Comprehensive Pain Assessment

J0910. Comprehensive Pain Assessment																	
Enter Code <input type="checkbox"/>	<p>A. Was a comprehensive pain assessment done?</p> <p>0. No — Skip to J2030, Screening for Shortness of Breath</p> <p>1. Yes</p> <p>B. Date of Comprehensive pain assessment:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="6" style="text-align: center;">Year</td> </tr> </table> <p>C. Comprehensive pain assessment included:</p>									Month	Day	Year					
Month	Day	Year															
↓ Check all that apply																	
<input type="checkbox"/>	1. Location																
<input type="checkbox"/>	2. Severity																
<input type="checkbox"/>	3. Character																
<input type="checkbox"/>	4. Duration																
<input type="checkbox"/>	5. Frequency																
<input type="checkbox"/>	6. What relieves/worsens pain																
<input type="checkbox"/>	7. Effect on function or quality of life																
<input type="checkbox"/>	9. None of the above																

UNCHANGED

On Admission

Coding Tips

J0910. Comprehensive Pain Assessment

- A comprehensive pain assessment should address multiple aspects of pain, beyond a determination of the presence of pain and its severity.
 - 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 is also acceptable.
- For any of the seven characteristics included in the pain assessment, select response options based on whether the clinician attempted to gather the information from the patient/caregiver.

J0915. Neuropathic Pain

J0915. Neuropathic Pain	
Enter Code <input type="checkbox"/>	Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)? 0. No 1. Yes



Definitions

J0915. Neuropathic Pain

Neuropathic Pain

Neuropathic pain is pain caused by a lesion or disease of the somatosensory nervous system.

Source: [International Association for the Study of Pain](#)

Coding Tips

J0915. Neuropathic Pain

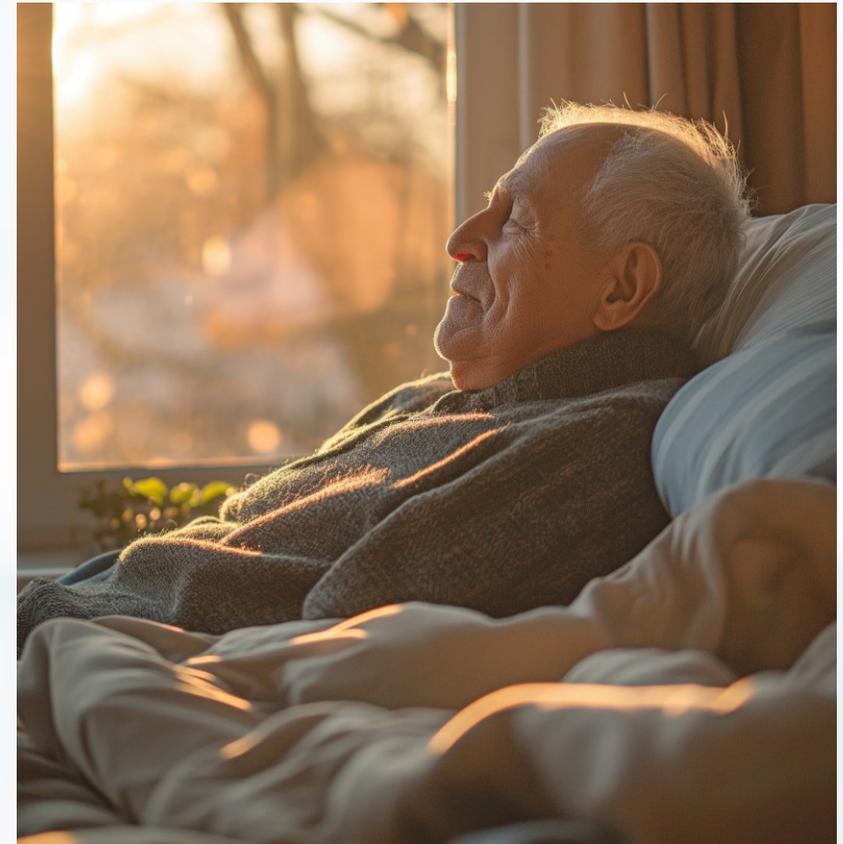
- **Code 0, No, or Code 1, Yes**, based on what is determined during the clinical assessment visit.
 - Patient and/or caregiver interview (including family and facility staff), observation, **clinical assessment, and clinical judgment** are acceptable.



Practice Scenario:

J0900. Pain Screening and J0905. Pain Active Problem

- The hospice nurse conducts the Admission assessment of Mr. K on 11/05/2025. The nurse observes Mr. K while conversing with him and his family.
- Outwardly, he appears comfortable with no nonverbal signs of pain. However, when he stands so the nurse can examine him more closely, the patient grimaces and moans.
- He relaxes once in a resting position again.
- The nurse asks Mr. K about his pain. He responds by saying, “It's not too bad. I take a Tylenol every once in a while.”
- Based on observation and discussion with Mr. K, the nurse determines Mr. K has mild pain.



How would you code J0900. Pain Screening?

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

How would you code J0900. Pain Screening? (Answer)

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

How would you code J0905. Pain Active Problem?

J0905. Pain Active Problem	
Enter Code <input type="checkbox"/>	Is pain an active problem for the patient? 0. No — Skip to J2030, Screening for Shortness of Breath 1. Yes

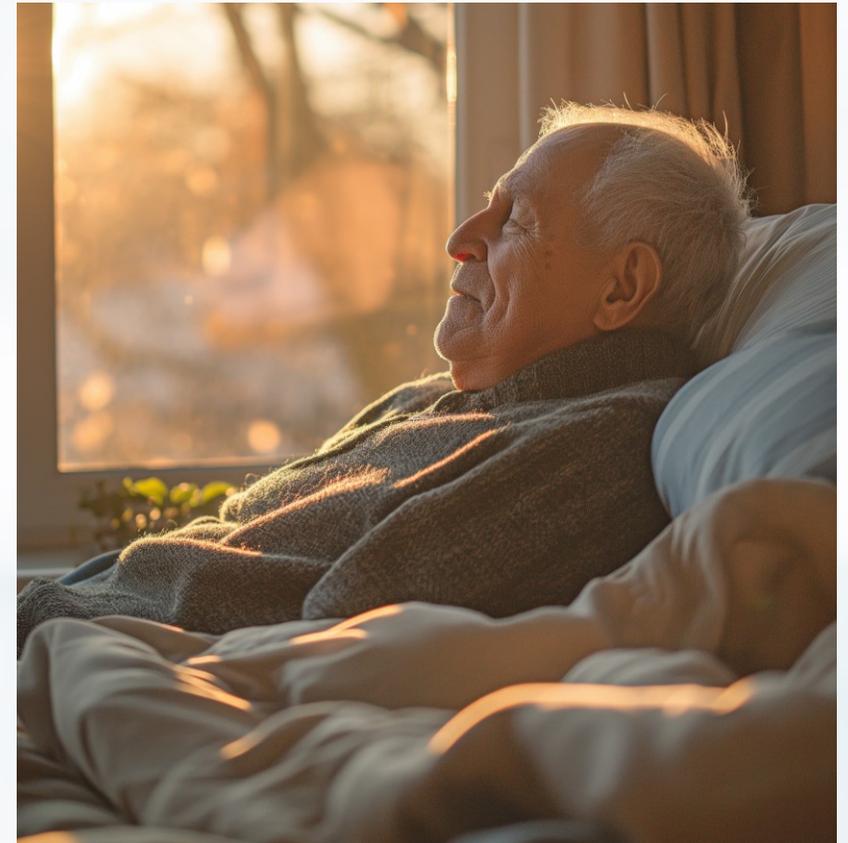
How would you code J0905. Pain Active Problem? (Answer)

J0905. Pain Active Problem	
Enter Code	Is pain an active problem for the patient?
<input type="checkbox"/>	0. No — Skip to J2030, Screening for Shortness of Breath 1. Yes

Practice Scenario:

J0910. Comprehensive Pain Assessment and J0915. Neuropathic Pain

- Mr. K tells the nurse he developed burning, tingling pain in his feet during his cancer treatments. Mr. K says the pain makes standing and walking more difficult. The family tells the nurse they hesitate to take him on outings since they fear hurting him.



How would you code J0910. Comprehensive Pain Assessment?

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

How would you code J0910. Comprehensive Pain Assessment? (Answer)

J0910. Comprehensive Pain Assessment	
<p>Enter Code</p> <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<p>A. Was a comprehensive pain assessment done?</p> <p>0. No — Skip to J2030, Screening for Shortness of Breath</p> <p>1. Yes</p> <p>B. Date of Comprehensive pain assessment:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 60px; height: 30px;"></div> </div> <p style="text-align: center; margin-left: 20px;"> Month Day Year </p> <p>C. Comprehensive pain assessment included:</p>
<p>↓ Check all that apply</p>	
<input type="checkbox"/>	1. Location
<input type="checkbox"/>	2. Severity
<input type="checkbox"/>	3. Character
<input type="checkbox"/>	4. Duration
<input type="checkbox"/>	5. Frequency
<input type="checkbox"/>	6. What relieves/worsens pain
<input type="checkbox"/>	7. Effect on function or quality of life
<input type="checkbox"/>	9. None of the above

How would you code J0915. Neuropathic Pain?

J0915. Neuropathic Pain	
Enter Code <input type="checkbox"/>	Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)? 0. No 1. Yes

How would you code J0915. Neuropathic Pain? (Answer)

J0915. Neuropathic Pain	
Enter Code <input type="checkbox"/>	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

J2030. Screening for Shortness of Breath	
<p>Enter Code</p> <input type="checkbox"/>	<p>A. Was the patient screened for shortness of breath?</p> <p>0. No — Skip to J2050, Symptom Impact Screening</p> <p>1. Yes</p> <p>B. Date of first screening for shortness of breath:</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p>Month Day Year</p>
<p>Enter Code</p> <input type="checkbox"/>	<p>C. Did the screening indicate the patient had shortness of breath?</p> <p>0. No — Skip to J2050, Symptom Impact Screening</p> <p>1. Yes</p>

UNCHANGED

On Admission

Coding Instructions

J2030. Screening for Shortness of Breath

- Assess the patient for the presence of shortness of breath.
- **Code 0, No, or Code 1, Yes**, based on what is determined during the assessment visit and/or included in the clinical record.
 - **For J2030A.**
 - Do not use sources external to the clinical record.
 - Enter the date based on the **first** screening for shortness of breath documented in the clinical record.
 - **For J2030C.**
 - **Code 0, No**, if the documentation indicates the presence of shortness of breath but there is no documentation of severity.



Coding Tips

J2030. Screening for Shortness of Breath

- 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.

Coding Tips (cont.)

J2030. Screening for Shortness of Breath

- 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.

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			



Coding Instructions

J2040 B. Non-medication Interventions

- Since there will be no orders for non-medication interventions **use the date on which the hospice first discussed the intervention** with the patient/caregiver.
 - Examples include:
 - fans
 - positioning
 - patient education efforts
- 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.



Coding Instructions

J2040 B. 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.
- Once this order is received, the date the hospice received the order is entered in J2040B.
- Enter the date of the order, irrespective of if/when the first dose was given.



Coding Tips

J2040. Treatment for Shortness of Breath

- When reviewing the clinical record for treatments initiated for shortness of breath:
 - Include (consider) both non-pharmacologic and pharmacologic treatment suggestions or measures.
 - Include (consider) both scheduled and PRN treatments for shortness of breath.

Coding Tips (cont.)

J2040. Treatment 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 (consider) such treatments 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.

Practice Scenario:

J2030. Screening for Shortness of Breath and J2040. Treatment for Shortness of Breath

- The hospice nurse arrives to conduct the Admission on 12/05/2025.
- The nurse finds Mr. W anxious with a short, shallow breathing pattern with a rate of 30.
- The clinical record shows an order for 10mg of morphine by mouth every 4 hours as needed for shortness of breath.
- The nurse administered a dose of morphine and instructed Mr. W and his family in the dosage schedule.
- The nurse also advised Mr. W to use a fan to keep air moving.



How would you code J2030. Screening for Shortness of Breath?

J2030. Screening for Shortness of Breath													
Enter Code <input type="checkbox"/>	<p>A. Was the patient screened for shortness of breath?</p> <p>0. No — Skip to J2050, Symptom Impact Screening</p> <p>1. Yes</p> <p>B. Date of first screening for shortness of breath:</p> <table style="margin-left: 40px;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td colspan="4" style="text-align: center;">Year</td></tr></table>							Month	Day	Year			
Month	Day	Year											
Enter Code <input type="checkbox"/>	<p>C. Did the screening indicate the patient had shortness of breath?</p> <p>0. No — Skip to J2050, Symptom Impact Screening</p> <p>1. Yes</p>												

How would you code J2030. Screening for Shortness of Breath? (Answer)

J2030. Screening for Shortness of Breath							
<p>Enter Code</p> <input type="checkbox"/>	<p>A. Was the patient screened for shortness of breath?</p> <p>0. No — Skip to J2050, Symptom Impact Screening</p> <p>1. Yes</p> <p>B. Date of first screening for shortness of breath:</p> <table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table> <p>Month Day Year</p>	<input type="text"/>					
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<p>Enter Code</p> <input type="checkbox"/>	<p>C. Did the screening indicate the patient had shortness of breath?</p> <p>0. No — Skip to J2050, Symptom Impact Screening</p> <p>1. Yes</p>						

How would you code J2040. Treatment for Shortness of Breath?

J2040. Treatment for Shortness of Breath													
Enter Code <input type="checkbox"/>	<p>A. Was treatment for shortness of breath initiated?</p> <p>0. No — Skip to J2050, Symptom Impact Screening 1. No, patient declined treatment — Skip to J2050, Symptom Impact Screening 2. Yes</p> <p>B. Date treatment for shortness of breath initiated:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td colspan="2">Day</td><td colspan="2">Year</td></tr></table>	<input type="text"/>	Month		Day		Year						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month		Day		Year									



How would you code J2040. Treatment for Shortness of Breath? (Answer)

J2040. Treatment for Shortness of Breath													
Enter Code <input type="checkbox"/>	<p>A. Was treatment for shortness of breath initiated?</p> <p>0. No — Skip to J2050, Symptom Impact Screening 1. No, patient declined treatment — Skip to J2050, Symptom Impact Screening 2. Yes</p> <p>B. Date treatment for shortness of breath initiated:</p> <table style="margin-left: 40px;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td colspan="4" style="text-align: center;">Year</td></tr></table>							Month	Day	Year			
Month	Day	Year											

J2050. Symptom Impact Screening

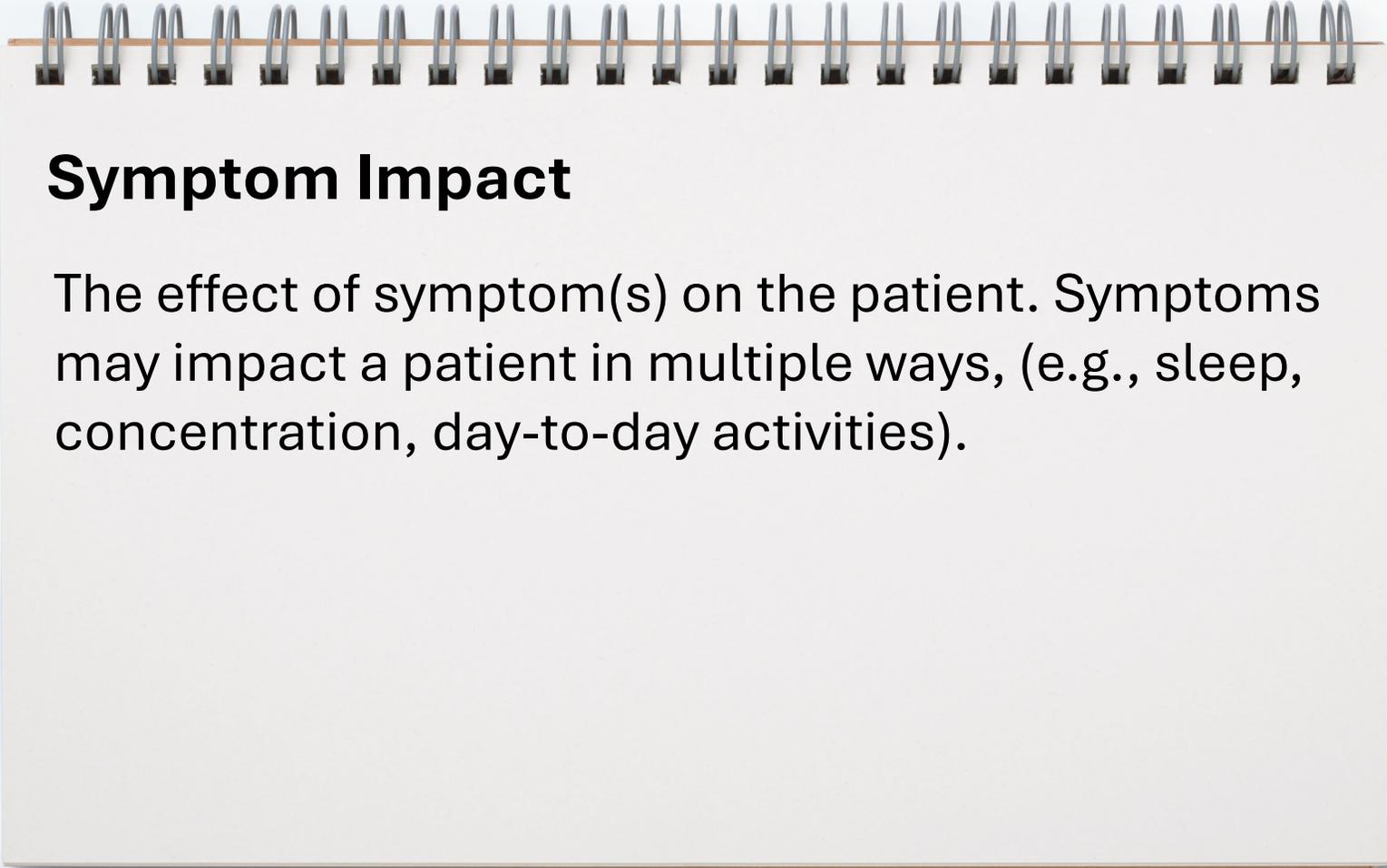
J2050. Symptom Impact Screening																	
<p>Enter Code</p> <input type="checkbox"/>	<p>A. Was a symptom impact screening completed?</p> <p>0. No — Skip to M1190, Skin Conditions 1. Yes</p> <p>B. Date of symptom impact screening:</p> <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>									Month		Day		Year			
Month		Day		Year													



On Admission,
HUV1 and HUV2

Definitions

J2050. Symptom Impact Screening

A spiral-bound notebook with a white cover and a silver metal spiral binding on the left side. The notebook is open to a blank white page. The text is written on this page.

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	
<p>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.</p> <p>Coding:</p> <ul style="list-style-type: none"> 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) 	
	<p>Enter Code</p> <p>↓</p>
A. Pain	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
C. Anxiety	<input type="checkbox"/>
D. Nausea	<input type="checkbox"/>
E. Vomiting	<input type="checkbox"/>
F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>



On Admission,
HUV1 and HUV2

Coding Instructions

J2051. Symptom Impact

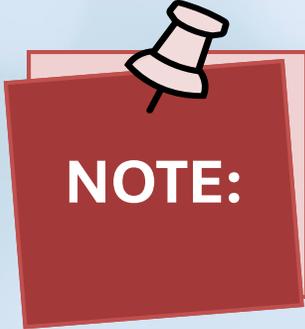
- Based on the patient/caregiver interview, observation, clinical assessment, and clinical judgment, **the assessing clinician decides the effect of each symptom on the patient.**
- For each symptom, enter one code that best describes how the patient has been affected by the symptom.



Coding Tips

J2051. Symptom Impact

- 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.



NOTE:

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.

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)													
<p>Enter Code</p> <input type="checkbox"/>	<p>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).</p> <p>A. Was an in-person SFV completed?</p> <p>0. No — Skip to J2052C, Reason SFV Not Completed</p> <p>1. Yes</p> <p>B. Date of in-person SFV - Complete and skip to J2053, SFV Symptom Impact.</p> <table style="margin-left: 40px;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table> <p>C. Reason SFV not completed — Skip to M1190, Skin Conditions.</p> <ol style="list-style-type: none"> 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. 							Month	Day	Year			
Month	Day	Year											
<p>Enter Code</p> <input type="checkbox"/>													



On Admission,
HUV1 and HUV2

Coding Instructions

J2052. Symptom Follow-up Visit

- **A. Was an in-person SFV completed?**
 - **Code 0, No**, if an in-person SFV was 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.



Coding Instructions (cont.)

J2052. Symptom Follow-up Visit

- **C. Reason SFV not completed:**
 - **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

J2052. Symptom Follow-up Visit

- 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	
<p>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.</p> <p>Coding:</p> <ul style="list-style-type: none"> 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) 	
	<p>Enter Code</p> <p>↓</p>
A. Pain	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
C. Anxiety	<input type="checkbox"/>
D. Nausea	<input type="checkbox"/>
E. Vomiting	<input type="checkbox"/>
F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>



On Admission, HUV1 and HUV2

Coding Instructions

J2053. SFV Symptom Impact

- **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

J2053. SFV Symptom Impact

- 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.



Practice Scenario:

J2050. Symptom Impact Screening and J2051. Symptom Impact

Reminder: During the Admission for Mr. W on 12/05/2025, the nurse found Mr. W anxious and short of breath; she initiated morphine and the use of a fan.

- Mr. W also takes the following medications:
 - Ativan at night to manage agitation.
 - Zofran to control intermittent nausea.
- He reports his agitation and nausea are well managed with no recent episodes.
- No additional symptoms were identified.
- Based on the assessment and conversations with Mr. W and his family, the nurse determined that anxiety and shortness of breath had a moderate impact.
- The nurse told the family she or another nurse would return the next day.



How would you code J2050. Symptom Impact Screening?

J2050. Symptom Impact Screening													
Enter Code <input type="checkbox"/>	<p>A. Was a symptom impact screening completed?</p> <p>0. No — Skip to M1190, Skin Conditions 1. Yes</p> <p>B. Date of symptom impact screening:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td colspan="2">Day</td><td colspan="2">Year</td></tr></table>	<input type="text"/>	Month		Day		Year						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>								
Month		Day		Year									

How would you code J2050. Symptom Impact Screening? (Answer)

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

How would you code J2051. Symptom Impact?

J2051. Symptom Impact	
<p>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.</p> <p>Coding:</p> <ul style="list-style-type: none"> 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	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
C. Anxiety	<input type="checkbox"/>
D. Nausea	<input type="checkbox"/>
E. Vomiting	<input type="checkbox"/>
F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>

How would you code J2051. Symptom Impact? (Answer)

J2051. Symptom Impact	
<p>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.</p> <p>Coding:</p> <ul style="list-style-type: none"> 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
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A. Pain	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
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F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>

Practice Scenario:

J2052. Symptom Follow-up Visit (SFV) and J2053. SFV Symptom Impact

- The LPN returned on 12/06/2025 to conduct the SFV.
- Mr. W was playing cards with his grandson and reported that the fan and the morphine were a big help.
- He told the nurse he can complete his ADLs with minimal SOB and anxiety.
- The nausea and agitation continue to be well controlled.
- No other new symptoms were identified.
- The nurse determines SOB and anxiety have a slight impact and instructs Mr. W to continue the same interventions.



How would you code 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.

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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.

How would you code J2052. Symptom Follow-up Visit (SFV)? (Answer)

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.

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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.

How would you code J2053. SFV Symptom Impact?

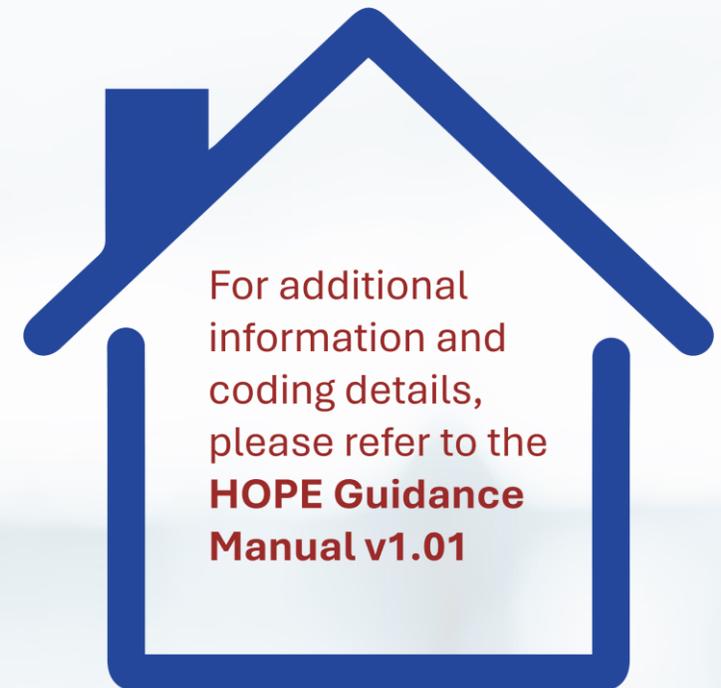
J2053. SFV Symptom Impact	
<p>Since the last Symptom Impact assessment was completed, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.</p> <p>Coding:</p> <ul style="list-style-type: none"> 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) 	
	<p>Enter Code</p> <p>↓</p>
A. Pain	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
C. Anxiety	<input type="checkbox"/>
D. Nausea	<input type="checkbox"/>
E. Vomiting	<input type="checkbox"/>
F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>

How would you code J2053. SFV Symptom Impact? (Answer)

J2053. SFV Symptom Impact	
<p>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.</p> <p>Coding:</p> <ul style="list-style-type: none"> 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) 	
	<p>Enter Code</p> <p>↓</p>
A. Pain	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
C. Anxiety	<input type="checkbox"/>
D. Nausea	<input type="checkbox"/>
E. Vomiting	<input type="checkbox"/>
F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>

Key Takeaways

- The response to **J0500. Death is Imminent** is based on clinical judgement and is not intended as a statement of prognosis.
- **J0915. Neuropathic Pain** is intended to capture a specific type of pain.
- The SFV is a new requirement for an in-person visit **expected to occur within two calendar days if triggered by a moderate or severe symptom impact** (HOPE admission or HUVs).



Section M. Skin Conditions, Section N. Medications, and Section Z. Record Administration

Objectives

Attendees will be able to:

- Identify the new data elements in **Section M. Skin Conditions** and **Section Z. Record Administration**.
- Describe the new timepoints for **Section N. Medications** data collection.
- Summarize the intent and coding instructions for the new items.



Section M. Skin Conditions

Section M: Items

M1190. Skin Conditions

M1195. Types of Skin Conditions

M1200. Skin and Ulcer/Injury Treatments



M1190. Skin Conditions



M1190. Skin Conditions	
Enter Code <input type="checkbox"/>	Does the patient have one or more skin conditions? 0. No – Skip to N0500, Scheduled Opioid 1. Yes

On Admission,
HUV1, and HUV2

Coding Instructions

M1190. Skin Conditions

- **Does the patient have one or more skin conditions?**
 - **Code 0. No**, if the patient does not have any skin conditions.
 - **Code 1. Yes**, if the patient does have any of the listed skin conditions.



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	
<input type="checkbox"/>	A. Diabetic foot ulcer(s)
<input type="checkbox"/>	B. Open lesion(s) other than ulcers, rash, or skin tear (cancer lesions)
<input type="checkbox"/>	C. Pressure Ulcer(s)/Injuries
<input type="checkbox"/>	D. Rash(es)
<input type="checkbox"/>	E. Skin tear(s)
<input type="checkbox"/>	F. Surgical wound(s)
<input type="checkbox"/>	G. Ulcers other than diabetic or pressure ulcers (e.g., venous stasis ulcer, Kennedy ulcer)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
<input type="checkbox"/>	Z. None of the above were present

On Admission,
HUV1, and HUV2

Coding Tips

M1195. Types of Skin Conditions

- **Diabetic Foot Ulcers:** These 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.



Coding Tips (cont. 1)

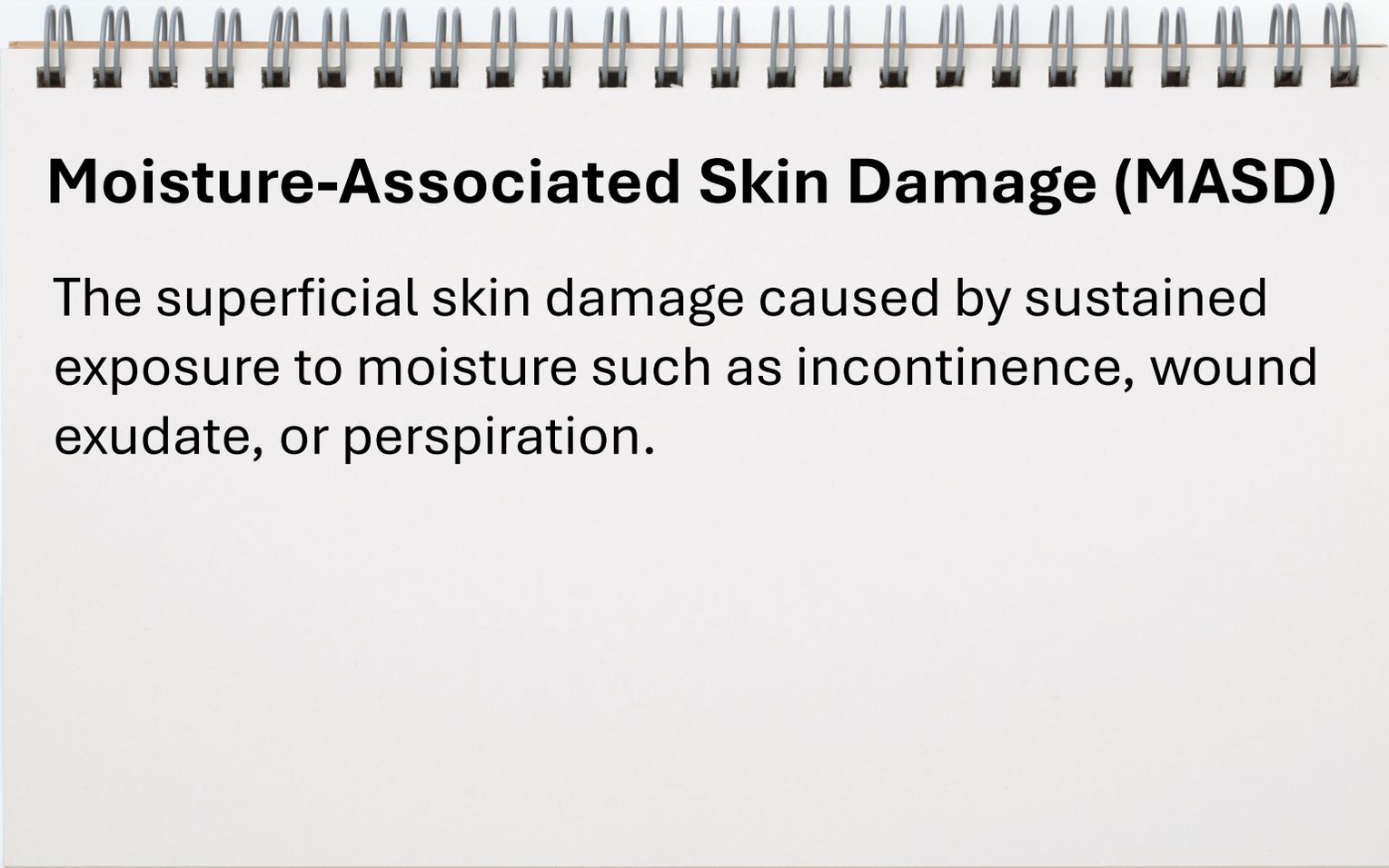
M1195. Types of Skin Conditions

- **Open Lesions:** These include lesions that develop as part of a disease (e.g., boils, cysts, and vesicles)
- **Skin Tears:** The 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.
- **Surgical Wounds:** Do not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. Do include peripherally inserted central catheter (PICC), central line sites, and peripheral IV sites.



Definitions

M1195. Types of Skin Conditions

A spiral-bound notebook with a white cover and a silver metal spiral binding on the left side. The notebook is open to a page with text.

Moisture-Associated Skin Damage (MASD)

The superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration.

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	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer/injury care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Application of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	J. Incontinence Management
<input type="checkbox"/>	Z. None of the above were present



On Admission,
HUV1, and HUV2

Coding Instructions

M1200. Skin and Ulcer/Injury Treatments

- 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

M1200. Skin and Ulcer/Injury Treatments

- **Pressure reducing devices** redistribute pressure so that there is some relief on or near the area of ulcer or 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.
- **Pressure ulcer care** includes any intervention for treating pressure ulcers (e.g., topical dressings, enzymatic, debridement, wound irrigations, negative pressure wound therapy).

Coding Tips (cont. 1)

M1200. Skin and Ulcer/Injury Treatments

- **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).

Coding Tips (cont. 2)

M1200. Skin and Ulcer/Injury Treatments

- **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).

Practice Scenario:

M1190. Skin Conditions

- Ms. L was admitted to hospice with a diagnosis of end-stage lung cancer.
- During the initial nursing assessment, the nurse asked Ms. L and her caregiver about any skin conditions she may have.
- Ms. L explained that she had a skin tear on her left elbow, and a small ulcer on the outside of her right ankle.



Does Ms. L have one or more Skin Conditions?

M1190. Skin Conditions	
Enter Code <input type="checkbox"/>	Does the patient have one or more skin conditions? 0. No – Skip to N0500, Scheduled Opioid 1. Yes

Does Ms. L have one or more Skin Conditions? (Answer)

M1190. Skin Conditions	
Enter Code <input type="checkbox"/>	Does the patient have one or more skin conditions? 0. No – Skip to N0500, Scheduled Opioid 1. Yes

Practice Scenario:

M1195. Types of Skin Conditions

- Upon initial examination, the nurse noted the skin tear on Ms. L's left medial elbow, a Stage 2 pressure ulcer on her right lateral malleolus, and Stage 1 pressure injury as evidenced by non-blanchable skin redness on her coccyx.
- Ms. L did not have any other wounds, lesions, or skin conditions present.



Based on the assessment conducted, which skin condition types should be checked in M1195?

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

Based on the assessment conducted, which skin condition types should be checked in M1195? **(Answer)**

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

Practice Scenario:

M1200. Skin and Ulcer/Injury Treatments

- The nurse consulted the patient's medical records and noted dressing orders.
- She removed the current dressings and cleansed both affected areas.
- She applied a transparent film dressing to Ms. L's left medial elbow skin tear and applied a bordered gauze dressing with hydrogel to the Stage 2 ulcer on her right lateral malleolus.



Practice Scenario (cont.):

M1200. Skin and Ulcer/Injury Treatments

- Related to the Stage 1 pressure injury, the nurse noted that Ms. L has pressure-reducing devices on her bed and chair. She asked how often Ms. L repositions herself, and Ms. L responded, **“Not very often. Maybe every couple of hours when I need to go to the bathroom.”**
- The nurse recommended a more frequent turning and repositioning schedule (every 1 to 1½ hours) as Ms. L and/or her caregiver can perform/tolerate.

Which interventions and/or treatments are in place for Ms. L's skin conditions?

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

Which interventions and/or treatments are in place for Ms. L's skin conditions? (Answer)

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

Practice Scenario (on Admission):

M1190. Skin Conditions

- Mr. A 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 conditions.



Does Mr. A have one or more Skin Conditions on Admission?

M1190. Skin Conditions	
Enter Code <input type="checkbox"/>	Does the patient have one or more skin conditions? 0. No – Skip to N0500, Scheduled Opioid 1. Yes

Does Mr. A have one or more Skin Conditions on Admission? (Answer)

M1190. Skin Conditions	
Enter Code <input type="checkbox"/>	Does the patient have one or more skin conditions? 0. No – Skip to N0500, Scheduled Opioid 1. Yes

Practice Scenario (on HUV 1):

M1190. Skin Conditions and M1195. Types of Skin Conditions

- The nurse returned to Mr. A's home on day eight to conduct the HOPE HUV1. The nurse asked Mr. A about any skin conditions.
- Mr. A stated that he had noticed a wound on his left leg.
- Upon assessment, the nurse identified that Mr. A had a venous stasis ulcer on his left leg.



Does Mr. A have one or more Skin Conditions on HUV1?

M1190. Skin Conditions	
Enter Code <input type="checkbox"/>	Does the patient have one or more skin conditions? 0. No – Skip to N0500, Scheduled Opioid 1. Yes

Does Mr. A have one or more Skin Conditions on HUV1? (Answer)

M1190. Skin Conditions	
Enter Code <input type="checkbox"/>	Does the patient have one or more skin conditions? 0. No – Skip to N0500, Scheduled Opioid 1. Yes

Based on the assessment conducted, which Types of Skin Conditions should be checked in M1195 on HUV 1?

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

Based on the assessment conducted, which Types of Skin Conditions should be checked in M1195 on HUV 1? **(Answer)**

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

Practice Scenario (on HUV 1):

M1200. Skin and Ulcer/Injury Treatments

- 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.



Which interventions and/or treatments are in place for Mr. A's skin conditions on HUV 1?

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

Which interventions and/or treatments are in place for Mr. A's skin conditions on HUV 1? (Answer)

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

Section N. Medications

Section N: Items



N0500. Scheduled Opioid

N0510. PRN Opioid

N0520. Bowel Regimen



Section N. Medications Overview

- 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

N0500. Scheduled Opioid	
Enter Code <input type="checkbox"/>	<p>A. Was a scheduled opioid initiated or continued?</p> <p>0. No — Skip to N0510, PRN Opioid 1. Yes</p> <p>B. Date scheduled opioid initiated or continued:</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p style="text-align: center;"> Month Day Year </p>

UNCHANGED

On Admission,
HUV1, and HUV2

N0510. PRN Opioid

N0510. PRN Opioid													
<p>Enter Code</p> <input style="width: 30px; height: 30px; margin-left: 20px;" type="checkbox"/>	<p>A. Was PRN opioid initiated or continued?</p> <p>0. No — Skip to N0520, Bowel Regimen</p> <p>1. Yes</p> <p>B. Date PRN opioid initiated or continued:</p> <table style="margin-left: 20px;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>							Month	Day	Year			
Month	Day	Year											

UNCHANGED

On Admission,
HUV1, and HUV2

Coding Tips

N0500. Scheduled Opioid and N0510. PRN Opioid

- **Code 1, Yes**, if the clinical record indicates that a regularly scheduled or PRN opioid was initiated for any reason, regardless of symptom.
- For the purposes of completing Item N0500 and 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

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)																					
<p style="text-align: center;">Enter Code</p> <div style="text-align: center; border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<p>A. Was a bowel regimen initiated or continued? – Select the most accurate response</p> <ul style="list-style-type: none"> 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 <p>B. Date bowel regimen initiated or continued:</p> <table style="margin-left: 20px; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="width: 10px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="width: 10px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td></td> <td colspan="2" style="text-align: center;">Day</td> <td></td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>											Month			Day			Year			
Month			Day			Year															

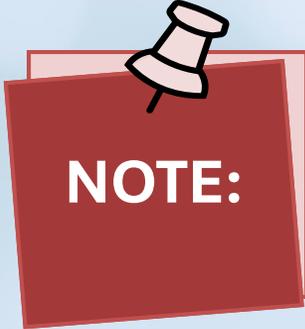
UNCHANGED

On Admission,
HUV1, and HUV2

Coding Tips

N0520. Bowel Regimen

- 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.



NOTE:

Proactive education on medication in a comfort kit in anticipation of symptoms is not considered initiation.

Coding Tips (cont. 1)

N0520. Bowel Regimen

- 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

Coding Tips (cont. 2)

N0520. Bowel Regimen

- 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

Coding Tips (cont. 3)

N0520. Bowel Regimen

- 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 to find evidence about bowel regimen or clinical contraindications to bowel regimen.

Examples include: gastrointestinal assessment, elimination status, and bowel function.

Practice Scenario (on Admission):

N0500. Scheduled Opioid, N0510. PRN Opioid, and N0520. Bowel Regimen

- Ms. J was admitted to hospice on 10/23/2025 with a terminal diagnosis of breast cancer with metastasis to the lungs.
- Upon initial assessment, it was noted that Ms. J had orders for acetaminophen, which for the moment, Ms. J says helps her when she experiences pain in her chest, which she currently rates as a 4.
- Ms. J states that she has no issues with bowel movements.
- Due to this information, in addition to the lack of opioid medication orders, the nurse determines a bowel regimen is not needed.



How would you code N0500 and N0510 on Admission?

N0500. Scheduled Opioid	
Enter Code <input type="checkbox"/>	<p>A. Was a scheduled opioid initiated or continued?</p> <p>0. No — Skip to N0510, PRN Opioid 1. Yes</p> <p>B. Date scheduled opioid initiated or continued:</p> <p><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Month Day Year</p>

N0510. PRN Opioid	
Enter Code <input type="checkbox"/>	<p>A. Was PRN opioid initiated or continued?</p> <p>0. No — Skip to N0520, Bowel Regimen 1. Yes</p> <p>B. Date PRN opioid initiated or continued:</p> <p><input type="text"/><input type="text"/> <input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Month Day Year</p>

How would you code N0500 and N0510 on Admission? (Answer)

N0500. Scheduled Opioid											
Enter Code <input type="checkbox"/>	<p>A. Was a scheduled opioid initiated or continued?</p> <p>0. No — Skip to N0510, PRN Opioid 1. Yes</p> <p>B. Date scheduled opioid initiated or continued:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="3">Year</td></tr></table>	<input type="text"/>	Month	Day	Year						
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Month	Day	Year									

N0510. PRN Opioid											
Enter Code <input type="checkbox"/>	<p>A. Was PRN opioid initiated or continued?</p> <p>0. No — Skip to N0520, Bowel Regimen 1. Yes</p> <p>B. Date PRN opioid initiated or continued:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="3">Year</td></tr></table>	<input type="text"/>	Month	Day	Year						
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Month	Day	Year									

How would you code N0520 on Admission?

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)													
Enter Code <input type="checkbox"/>	<p>A. Was a bowel regimen initiated or continued? – Select the most accurate response</p> <ul style="list-style-type: none">0. No — Skip to Z0400. Signature(s) of Person(s) Completing the Record1. 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 Record2. Yes <p>B. Date bowel regimen initiated or continued:</p> <table style="margin-left: 40px;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td colspan="4" style="text-align: center;">Year</td></tr></table>							Month	Day	Year			
Month	Day	Year											

How would you code N0520 on Admission? (Answer)

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)													
Enter Code <input type="checkbox"/>	<p>A. Was a bowel regimen initiated or continued? – Select the most accurate response</p> <ol style="list-style-type: none">0. No — Skip to Z0400. Signature(s) of Person(s) Completing the Record1. 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 Record2. Yes <p>B. Date bowel regimen initiated or continued:</p> <table style="margin-left: 40px;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td colspan="4" style="text-align: center;">Year</td></tr></table>							Month	Day	Year			
Month	Day	Year											

Practice Scenario (on HUV 1):

N0500. Scheduled Opioid, N0510. PRN Opioid, and N0520. Bowel Regimen

- During the HUV1, Ms. J stated that she has been taking her acetaminophen but has recently been coughing a lot more, and the acetaminophen does not seem to alleviate the chest pressure and increased pain she experiences after coughing.
- Ms. J states that at its worst, her pain is a 7 or 8.



Nurse: “Are you experiencing any pain?”

Ms. J: “Just a little bit in my chest right now, but nothing like it was about 2 hours ago.”

Practice Scenario (on HUV 1) (cont.):

N0500. Scheduled Opioid, N0510. PRN Opioid, and N0520. Bowel Regimen

- The nurse contacted the hospice medical director to obtain orders for pain medication and to initiate a bowel regimen.
- An order dated 11/01/2025 was received for the following:
 - Oxycodone extended-release 10 mg tablets, one tablet by mouth, twice per day.
 - Oxycodone 5mg tablets, one tablet by mouth every four hours, as needed for breakthrough pain.
 - Sennosides 17.2 mg tablets, one tablet by mouth, twice per day.

How would you code N0500 and N0510 on HUV1?

N0500. Scheduled Opioid											
Enter Code <input type="checkbox"/>	<p>A. Was a scheduled opioid initiated or continued?</p> <p>0. No — Skip to N0510, PRN Opioid 1. Yes</p> <p>B. Date scheduled opioid initiated or continued:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="3">Year</td></tr></table>	<input type="text"/>	Month	Day	Year						
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Month	Day	Year									

N0510. PRN Opioid											
Enter Code <input type="checkbox"/>	<p>A. Was PRN opioid initiated or continued?</p> <p>0. No — Skip to N0520, Bowel Regimen 1. Yes</p> <p>B. Date PRN opioid initiated or continued:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="3">Year</td></tr></table>	<input type="text"/>	Month	Day	Year						
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Month	Day	Year									

How would you code N0500 and N0510 on HUV1? (Answer)

N0500. Scheduled Opioid											
Enter Code <input type="checkbox"/>	<p>A. Was a scheduled opioid initiated or continued?</p> <p>0. No — Skip to N0510, PRN Opioid 1. Yes</p> <p>B. Date scheduled opioid initiated or continued:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="3">Year</td></tr></table>	<input type="text"/>	Month	Day	Year						
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Month	Day	Year									

N0510. PRN Opioid											
Enter Code <input type="checkbox"/>	<p>A. Was PRN opioid initiated or continued?</p> <p>0. No — Skip to N0520, Bowel Regimen 1. Yes</p> <p>B. Date PRN opioid initiated or continued:</p> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>Month</td><td>Day</td><td colspan="3">Year</td></tr></table>	<input type="text"/>	Month	Day	Year						
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Month	Day	Year									

How would you code N0520 on HUV1?

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)													
Enter Code <input type="checkbox"/>	<p>A. Was a bowel regimen initiated or continued? – Select the most accurate response</p> <ul style="list-style-type: none">0. No — Skip to Z0400. Signature(s) of Person(s) Completing the Record1. 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 Record2. Yes <p>B. Date bowel regimen initiated or continued:</p> <table style="margin-left: 40px;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td colspan="4" style="text-align: center;">Year</td></tr></table>							Month	Day	Year			
Month	Day	Year											

How would you code N0520 on HUV1? (Answer)

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)													
<p>Enter Code</p> <input type="text"/>	<p>A. Was a bowel regimen initiated or continued? – Select the most accurate response</p> <ul style="list-style-type: none">0. No — Skip to Z0400. Signature(s) of Person(s) Completing the Record1. 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 Record2. Yes <p>B. Date bowel regimen initiated or continued:</p> <table style="margin-left: 40px;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td colspan="4" style="text-align: center;">Year</td></tr></table>							Month	Day	Year			
Month	Day	Year											

Section Z. Record Administration

Section Z: Items



Z0350. Date Assessment was Completed



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

Z0500. Signature of Person Verifying Record Completion

Z0350. Date Assessment was Completed

Z0350: Date Assessment was Completed											
		<input type="text"/>									
		Month	Day	Year							



On HUV1, and
HUV2

Coding Instructions

Z0350. Date Assessment was Completed

- For HUV1 and HUV2 - enter the date that information/responses were gathered and documented by the assessing clinician including any follow-up visit data that was added for a SFV as applicable.
- **This is the date that the entire HUV item set is complete *including SFVs if any.***
- In situations where there is an SFV, this date may extend beyond the HUV assessment timeframes.



Practice Scenario:

Z0530. Date Assessment was Completed

- The nurse visited Mrs. K on 11/05/2025 to complete an HUV1 assessment (day 10).
- Mrs. K mentioned that over the past few nights when she falls asleep, she wakes up within three hours and cannot fall back asleep due to her neck pain.
- After further discussion with the patient, when completing the Symptom Impact item, the nurse determines that the pain is moderately impacting Mrs. K.
- The nurse returned 2 calendar days later on 11/07/2025 to complete an SFV.



Q³⁶

What date should be entered in Z0350 on the HUV1?

- A. The date the HUV1 was completed, 11/05/2025.
- B. The date the SFV was completed, 11/07/2025.
- C. None of the above

What date should be entered in Z0350 on the HUV? **(Answer)**

- A. The date the HUV1 was completed, 11/05/2025.
- B. The date the SFV was completed, 11/07/2025.
- C. None of the above.

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.			

UNCHANGED

On Admission,
HUV1, HUV2, and
Discharge

Z0500. Signature of Person Verifying Record Completion

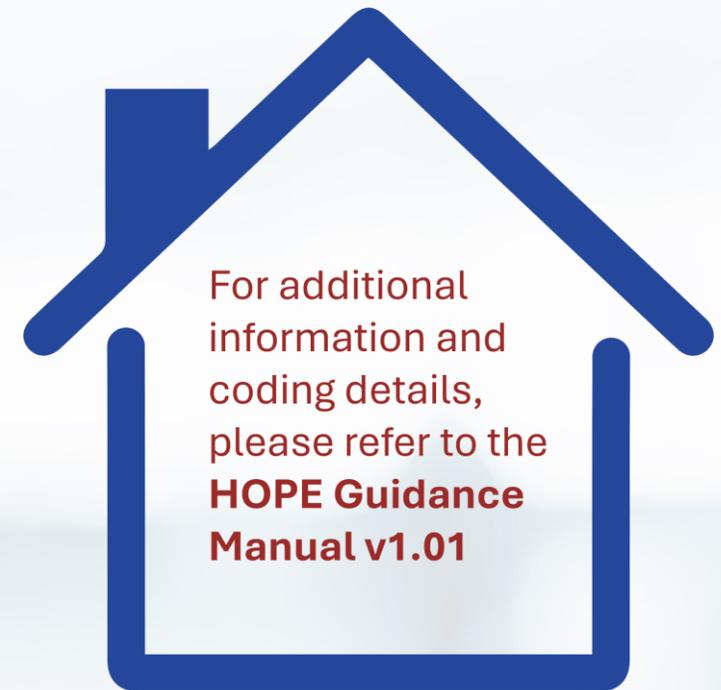
Z0500. Signature of Person Verifying Record Completion						
	A. Signature <hr/>					
	B. Date <table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table> <p>Month Day Year</p>	<input type="text"/>				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

UNCHANGED

On Admission, HUV1, HUV2, and Discharge

Key Takeaways

- HOPE contains a new section, **Section M. Skin Conditions**, to collect data about conditions, such as rashes, lesions, or surgical wounds.
- The items in **Section N. Medications** have not changed but will now be collected at the two new HUV timepoints, in addition to Admission.
- A new item in **Section Z. Record Administration, Z0350. Date Assessment was Completed** will provide the date the entire HUV item set was completed, including any applicable SFVs.

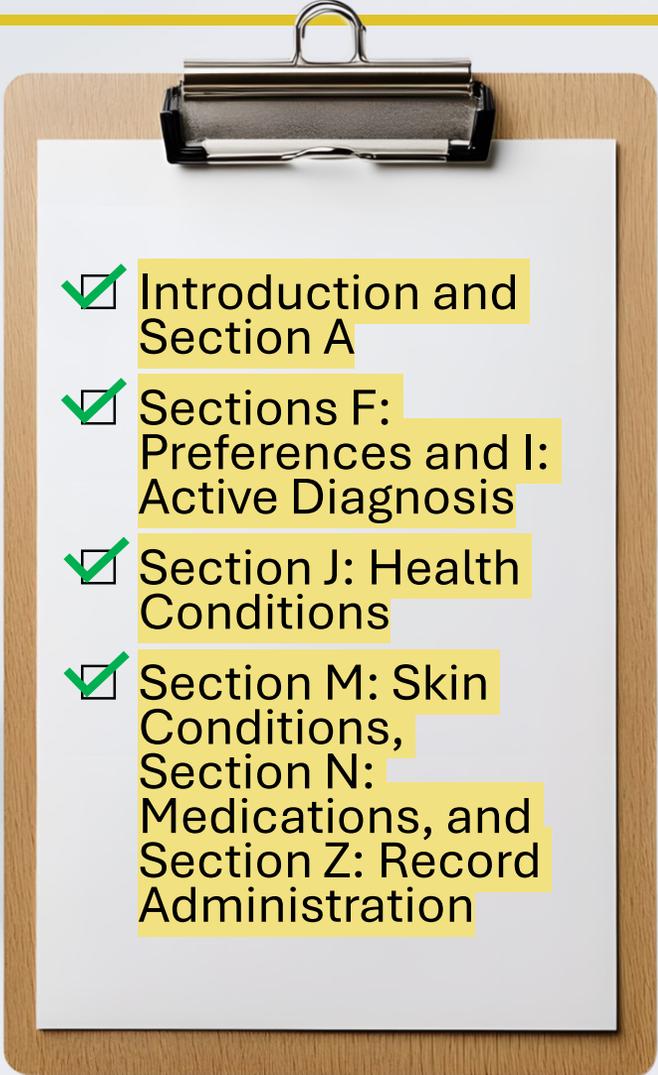


Resources

- [CMS' HQRP Webpage](#)
- [HQRP Announcements and Spotlight](#)
- [HQRP Requirements and Best Practices](#)
- [HOPE Webpage](#)
- [HOPE Technical Information](#)
- [HQRP Help Desk](#)
- [HQRP Training and Education Library](#)
- [iQIES Website](#)
- [iQIES Service Center email](#)
- [iQIES Training Videos](#)
- [CMS Fiscal Year 2025 Hospice Final Rule \(CMS-1810-F\)](#)
- [Sign up for updates via the MLN and PAC Listservs](#)

Thank You!

- You have completed Coding Workshop for HOPE.
- Please join us for the Q&A, Resources, and Closing Remarks.

- 
- ✓ Introduction and Section A
 - ✓ Sections F: Preferences and I: Active Diagnosis
 - ✓ Section J: Health Conditions
 - ✓ Section M: Skin Conditions, Section N: Medications, and Section Z: Record Administration

Questions and Answers

