Hospice Quality Reporting Program (HQRP)

Hospice Item Set (HIS)
Questions and Answers (Q+A)
and Quarterly Updates

October 2015

*This document is intended to provide guidance on HIS-related questions that were received by the Hospice Quality Help Desk during the 3rd quarter (July – September) of 2015 (**Section 1**). This document also contains quarterly updates and events from the 3rd quarter (**Section 2**), as well as upcoming updates for the next quarter (**Section 3**). Guidance contained in this document may be time-limited, and may be superseded by guidance published by CMS at a later date.*

Section 1:
HIS Quarterly Questions and Answers

Section A: Administrative Information (Items A0700 and A2115)

Question 1: If a patient's Medicaid number changes after admission, do I change the admission Medicaid # (by modifying) or just update the Medicaid number at Discharge?

Answer 1: According to the HIS Manual v1.02, page 2A-9 in the Item Specific Instructions, if the hospice is notified after the record has been submitted that the patient does have a Medicaid or Medicare number, include it on the next record. For instance, if the Medicaid number is received after submission of the HIS-Admission record, include the patient's Medicaid number on the HIS-Discharge record. Including the Medicaid number on the HIS-Discharge record at a later date does not require a Modification Request to the original HIS-Admission Record. The HIS Manual v1.02 can be accessed here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html

Question 2: We have a patient who was discharged from Hospice because her son called and told us verbally he wanted his mother discharged. The six (6) reasons for discharge listed in the HIS manual does not provide a choice for this discharge reason. We only received a verbal revocation from the son, not a written revocation that is required. The patient was terminally ill as she passed away 2 days after discharge. What do you recommend we enter as the reason for discharge in the HIS assessment?

Answer 2: HIS data is separate from claims data, so guidance for completing HIS items may differ from guidance for completing claims. For HIS reporting purposes, when

completing item A2115, response option '02, Revoked' can be used in these circumstances where the patient/family revokes the philosophy of hospice care, which could include choosing to pursue aggressive therapy or therapy with a curative intent.

Section F: Preferences (Item F2100)

Question 3: Is it permissible to document in a patient's chart the date question F2100B was asked even if it was in the pre-admission time period? For example: a patient's daughter was asked about the patient's preferences regarding life-sustaining treatments other than CPR on 09/18/2015. The admission and initial assessment was done on 09/25/2015. Am I interpreting this correctly?

Answer 3: Your interpretation is accurate; for items in Section F, providers can consider care processes documented in the clinical record at pre-admission or education visits. For a more complete explanation, we suggest you review the HIS Manual v1.02, Chapter 2, Section F, pages 2F-1 through 2F-11. The HIS Manual can be accessed here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html.

Section J: Pain & Shortness of Breath (Item J2030)

Question 4: If the answer to J2030C (Did the screening indicate the patient had shortness of breath?) is 'No' but there is PRN oxygen ordered should the 'No' be changed and the oxygen be added?

Answer 4: According to the HIS Manual v1.02 Item Specific Instructions, it is possible that at the time of HIS completion, multiple screenings for shortness of breath will be documented in the clinical record. Complete HIS shortness of breath screening items based on the **first** shortness of breath screening that appears in the clinical record. Evidence of a "positive" screen for shortness of breath should consider whether shortness of breath was an active problem for the patient at the time of the screening clinical encounter. In determining whether shortness of breath was an active problem for the patient, providers may need to consider historical report of patient's shortness of breath, documentation of patient's self-report of distress, and observed clinical signs of shortness of breath at the time of the visit in which the screening was conducted. On the basis of reports of recent symptoms, current treatment, and so on, 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. The clinical record could include patient's self-report of distress or "trouble breathing" from shortness of breath or dyspnea; documentation of shortness of breath or dyspnea at rest, upon exertion, or at other times; patient/caregiver report of shortness of breath; observed clinical signs of distress from shortness of breath; and/or documentation that the symptom is distressing or limits patient function or quality of life. If the clinician determined that SOB was not an active problem, you should follow the skip patterns (which would skip over J2040). HIS items should be completed based on documentation in the clinical record, so if after review of the clinical record, and in accordance with HIS guidance, you determine "no" is the appropriate response for J2030C, you would select "no" and skip J2040 (even if you see oxygen in the clinical record). You should not change the response to J2030C solely to circumvent skip patterns to list the oxygen as a treatment for J2040.

HIS Completion and Submission

Question 5: As a new hospice provider, new quality manager, new owner, newly cognizant of requirements… can you advise me how I can collect and submit the required data for the HQRP?

Answer 5: We recommend you review the "Getting started with the HIS" Fact Sheet for more information on completing and submitting HIS records electronically. This fact sheet is available here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Fact-Sheet-Getting-Started-with-the-HIS-%E2%80%93-Checklist-and-Quick-Tips.pdf. This fact sheet contains links to training modules and instructions/links for registering for the necessary User IDs to submit HIS data. Please note that the Fact Sheet has links to YouTube videos that explain and clarify the process.

You will also need to download the current copy of the HIS Manual v1.02. The HIS Manual v1.02 can be accessed here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/HIS-Manual-V102-along-with-a-change-table.zip.

And finally, please note the Hospice Quality Reporting Program website which can be accessed here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/. This website will have all the current information on the HQRP program as well as Quarterly Q&As that have been submitted to the Help Desk.

Question 6: If you have a small hospice with less than 50 admissions per year, do you still need to submit an HIS record for each new admission and discharge?

Answer 6: According to the HIS Manual v1.02 pg. 1-3 through 1-4, **any** Medicare certified hospice provider is required to submit HIS admission and discharge records on all patients admitted on or after July 1, 2014. A HIS-Admission and a HIS-Discharge record are submitted for all patient admissions to a Medicare-certified hospice program on or after July 1, 2014, regardless of the following: Payer source (Medicare, Medicaid, or private payer), patient age, where the patient receives hospice services (home, nursing home, assisted living facility, freestanding hospice). There is no participation exemption for size in the HQRP for the submission of HIS records. There is a participation exemption for size for the Hospice CAHPS survey; however, the Hospice CAHPS and the HIS are two separate reporting requirements with different criteria. Information about the Hospice CAHPS survey can be accessed here: http://www.hospicecahpssurvey.org/content/homepage.aspx.

Question 7: Starting on Oct. 1st, will CMS expect ICD 10 codes for all HIS submissions? If so, what would be the suggestion for a pay source that is not accepting ICD 10 therefore still utilizing ICD 9?

Answer 7: Currently, the HIS does not require the use of ICD-9 or ICD-10, so HIS reporting should be unaffected by the change from ICD-9 to ICD-10. Additional information regarding ICD-10 implementation can be found at: https://www.cms.gov/Medicare/Coding/ICD10/index.html.

Questions related to ICD-10 can be directed to ICD10@cms.hhs.gov.

Question 8: When submitting corrections or modifications, we have been getting late warnings, even though the original record was completed on time. We would like assurance that our corrected records are not out of compliance and that we will not be penalized for them, particularly since the original record was submitted on time.

Answer 8: Item Z0500B reflects the date that the hospice designated employee has confirmed that all the information is complete. Therefore, when completing an inactivation or modification record, Z0500B should always have the original date of completion. The only time that date is changed is if the original date in Z0500B is inaccurate.

Question 9: Is Oct 1, 2015 the effective date for the 30-day submission deadline for HIS-Admission and HIS-Discharge records?

Answer 9: According to the HIS Manual v1.02 Chapter 1 pages 1-8 through 1-9, for HIS-Admission records, the submission deadline is defined as the Admission Date + 30 calendar days. This means the Submission Date should be no later than the Admission Date + 30 calendar days. The Submission Date can be equal to the Admission Date, but no greater than 30 days later. The QIES ASAP system will issue a warning on the Final Validation Report if the Submission Date is more than 30 days after the Admission Date. For HIS-Discharge records, the submission deadline is defined as the Discharge Date + 30 calendar days. This means the Submission Date should be no later than the Discharge Date + 30 calendar days. The Submission Date can be equal to the Discharge Date, but no greater than 30 days later. The QIES ASAP system will issue a warning on the Final Validation Report if the Submission Date is more than 30 days after the Discharge Date. In practical terms, there has been no change in the guidance from CMS related to the actual submission deadline itself, which remains 30 days from the event date. If you are referring to the implementation of the Hospice Final Rule related to timeliness compliance thresholds, CMS did finalize timeliness compliance thresholds whereby a provider's compliance with HIS reporting requirements will be determined based on timeliness of submitted records. In the FY 2016 Hospice Final Rule, CMS finalized a timeliness criteria threshold which will take effect for patient admission and discharges beginning January 1, 2016, impacting the FY 2018 APU. For more information on the timeliness compliance threshold, see Sections 2 and 3 of this document. Providers can also review the final rule at: https://www.federalregister.gov/.

Question 10: What methodology will be used by CMS to determine compliance with the 30 day submission requirement?

Answer 10: According to the Federal Register, which can be accessed here: https://www.federalregister.gov/, generally, the methodology that CMS would use for calculating the proposed 70 percent/80 percent/90 percent compliance thresholds would include HIS records (HIS-Admission and HIS-Discharge) submitted for patient admissions and discharges occurring during the reporting period in the denominator of the compliance threshold calculation. The numerator of the compliance threshold calculation would include any records from the denominator that were submitted within the 30 day submission deadline. CMS would like to clarify that the aforementioned methodology would be appropriately adjusted for cases where hospices were granted extensions/exemptions, and instances of modification/inactivation requests so that these instances did not "count against" providers in the proposed compliance threshold calculation. CMS would like to reiterate that rulemaking is the official process through which new requirements are proposed, finalized, and communicated to the provider community. In addition, as further details of the data submission and compliance

threshold are determined by CMS, we anticipate communicating these details through the regular HQRP communication channels, including Open Door Forums, webinars, listening sessions, memos, email notification, and web postings.

CASPER Reports

Question 11: Where can we find state and national NQF measures for HIS? I was looking for a way to compare our agency's results with other state and national providers. I was particularly looking for numbers for the last year, month by month. The NQF measures I was looking for are 1617, 1634, 1637, 1638, 1639, 1641, and 1647.

Answer 11: Quality Measure scores for quality measures calculated using HIS data will be available in the future as "quality reports" in the CASPER Reporting System. Quality Reports in CASPER are under consideration by CMS. Please note that for the FY 2016 Reporting Cycle, there will be no quality reports. As required by the ACA, please note that in addition to Quality Reports in CASPER, there will public reporting of Hospice's Quality data. We have provided more information on the public reporting process below for your information.

Section 2:
What you may have missed from the 3rd Quarter of 2015

Hospice Final Rule published

- The FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule, which includes HQRP requirements and updates, was published in August 2015 in the Federal Register at: https://www.federalregister.gov/articles/2015/08/06/2015-19033/medicare-program-fy-2016-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting
- Rulemaking is the process through which CMS proposes and finalizes any new requirements for the HQRP. Important HIS and HQRP-related provisions that were finalized in the rule include:
  - Quality measures and concepts under consideration for future years (See Section E.5 of the Final Rule)
  - Policy for new facilities to begin submitting quality data (See Section E.6.b of the Final Rule)
  - Data submission and compliance thresholds for the FY 2018 payment determination and subsequent years (See Section E.6.d and E.6.e of the Final Rule)
  - Submission exemption and extension requirements and reconsideration and appeals procedures (See Sections E.7 and E.8 of the Final Rule)
  - Public display of quality measures and other hospice data (See Section E.10 of the Final Rule)

Updated HIS Fact sheet posted; Providers should review the Fact Sheet for new information about Final Validation Reports

- An updated version of the "Getting Started with the HIS" Fact Sheet is now available on the HIS portion of the CMS HQRP website: At http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html. Providers should review this updated fact sheet for more information about Hospice Item Set (HIS) reporting requirements.
- This fact sheet outlines the three primary phases of HIS reporting and provides resources to help providers successfully execute each of these phases. Note that this fact sheet was updated to include instructions for using Final Validation reports to verify that HIS records were successfully received and processed following submission to the QIES ASAP system. **After uploading files to the QIES ASAP system, providers should view Final Validation Reports to confirm successful receipt and processing of HIS files; Final Validation Reports are the only mechanism by which providers can verify successful submission and processing of HIS records. If 1) a Final Validation report is not received following the submission of HIS records or 2) a Final Validation report is received with fatal errors listed, the submission and processing was not successful.** In these instances, the provider must correct any errors and resubmit relevant HIS records to the QIES ASAP system. In addition to viewing Final Validation Reports, **providers should also retain copies of all Final Validation Reports since Final Validation reports are automatically purged after 60 days.** Retaining copies of Final Validation Reports is critical to demonstrate compliance with HIS reporting requirements.

Section 3:
What's coming up

CMS to release more information about the 70/80/90 timeliness compliance threshold that was finalized in the FY 2016 Final Rule

- In Sections E.6.d and E.6.e of the FY 2016 Final Rule, CMS finalized a timeliness compliance threshold for HIS submissions. These policies go into effect for the FY 2018 reporting year, which begins January 1, 2016.
- Section E.6.e of the Final Rule states that beginning with the FY 2018 reporting year, in order to avoid the 2 percentage point reduction in their Annual Payment Update (APU), hospices will be required to submit minimum percentage of their HIS records by the 30 day submission deadline. CMS will implement this compliance threshold over a 3 year period. For the FY 2018 APU determination, at least 70% of all required HIS records must be submitted within the 30 day submission deadline to avoid the 2 percentage point reduction in the FY 2018 APU. For the FY 2019 APU determination, providers must submit 80% of all required HIS records by the 30 day deadline. Finally, for the FY 2020 APU determination and all subsequent years, providers must submit 90% of all required HIS records according to the 30 day deadline. See **Table 1**, below.

Table 1. Compliance Threshold Requirements by Reporting Year

Reporting Year (& Affected APU)	Dates	Requirement
FY 2018	1/1/16 – 12/31/16	70% of all required HIS records submitted w/in 30 days
FY 2019	1/1/17 – 12/31/17	80% of all required HIS records submitted w/in 30 days
FY 2020 & Beyond	1/1/18 – 12/31/18	90% of all required HIS records submitted w/in 30 days

- In the Final Rule, CMS released a preliminary algorithm for how the 70/80/90 compliance thresholds would be calculated. In general, HIS records submitted for patient admissions and discharges occurring during the reporting period (1/1 – 12/31) will be included in the denominator of the compliance threshold calculation. The numerator of the compliance threshold calculation would include any records from the denominator that were submitted within the 30 day submission deadline. CMS will make allowances in the calculation methodology for granted extensions/exemptions and instances of modification/inactivation requests.
- More details about the calculation algorithm for the 70/80/90 compliance threshold will be released by CMS in coming months. In addition to providing additional information on the calculation algorithm, CMS will also provide details about how providers can use the CASPER reporting system to run preliminary reports on their compliance with the 70/80/90 thresholds. Availability of these materials will be announced on the HIS portion of the CMS HQRP website. Providers should check this website regularly for updates.