Eli's Hospice Insider

Data Collection: Use 10 Tips To Master HIS Collection Requirements

Tracking deadlines is essential to compliance.

Your future reimbursement is on the line in more ways now that the Hospice Item Set has taken effect.

The **Centers for Medicare & Medicaid Services** will dock your pay 2 percent in 2016 if you fail to fulfill the HIS requirement. But the HIS data collected also may play a large part in overall hospice payment reform and even a possible move to a case mix system, industry experts point out.

Make sure you comply with HIS regulations and complete the tool as accurately as possible to produce the highest quality data to inform future payment and policy decisions. Heed this expert advice to help you do so:

1. Educate yourself. Use the resources CMS has published to help you understand and implement the new requirement. That includes the 2014 final rule, finalized HIS forms, HIS Manual, fact sheets, question-and-answer set, and more. And view the data collection and technical training sessions (see locations in story, p. 61).

2. Check with your software vendor. If you haven't done so, waste no time in checking with your electronic medical records vendor to see what if any HIS support they will provide. "EMR vendors are not obligated to support a hospice's HIS efforts," reminds consultant **Heather Wilson** with **Weatherbee Resources in Hyannis**, Mass. "HIS compliance responsibility falls on the hospice, not the EMR vendor." After all, "it is the hospice, not the EMR vendor, that will have a 2 percent reduction in reimbursement from CMS if HIS data is not reported on every single patient within the deadlines," Wilson stresses on Weatherbee's blog.

3. Assign HIS duties in your hospice. Even if you have great EMR support, "they still cannot manage the entire HIS process for you," points out Wilson, author of The Hospice Item Set: A Step-by-Step Implementation Guide. "There are parts of the process that can only be done by humans."

Based on the level of support you'll receive from your EMR vendor, you then need to figure out what HIS duties will be on your plate.

Next you need to assign staff to be responsible and accountable for those duties. If EMR is not going to auto-abstract the HIS data, "figure out who is going to do it," Wilson says.

4. **Train staff.** Once you have a list of who's doing what, train those staffers on their areas. "Make sure the staff understand how to answer the questions, realizing that the HIS is a data collection tool and not an assessment tool," advises consultant **Charlene Ross** with **R&C Healthcare Solutions** and **Hospice Fundamentals** in Arizona.

Check out the newly revised version of the HIS Manual for item-by-item guidance. CMS has detailed instructions for each item. And it "has some great examples that help explain the questions and how to answer," Ross offers.

Plus: Don't forget to use CMS fact sheets for training. For example, one of the fact sheets explains that if the patient's status for opioids or bowel regimen changes some time after the hospice enters HIS data, but prior to the completion deadline, the hospice may choose to update the HIS to reflect the clinical documentation of the patient's most current status, points out the **National Association for Home Care & Hospice.** But to minimize burden, "CMS does not require that hospices update items in Section N to reflect that patient's most current status" unless they want to, NAHC says.

5. Beef up documentation. Hospices are supposed to fill out this tool by extracting data from the medical record. "Responses to items on the HIS should be based on data in the clinical record that were documented prior to the

Completion Date (Item Z0500B)," CMS says in the HIS Manual.

That means you need to make sure clinicians are actually getting that information into the record for you to use, Ross says. In your staff training, emphasize the information that must be present in the record.

Bottom line: "If a ... HIS care process is not documented in the hospice clinical record, the care process is considered not to have occurred," the manual instructs. "Complete the HIS items accordingly, following skip patterns outlined in the HIS."

Exception: "In general, sources external to the clinical record should not be used when completing the HIS," CMS says. However, "there are some instances where a provider may consult sources other than the hospice clinical record to complete HIS items. For example, completion of Section A: Administrative Information items may require review of claims or billing records; Section F: Preferences items may require review of POLST (Physician Order for Life-Sustaining Treatment) forms, or other equivalent forms."

To extract the data as quickly as you can, make sure you crosswalk your documentation system to HIS data elements, Wilson advises.

6. Take necessary technical steps. If you haven't done so yet, waste no time in registering for your passwords required for HIS submission. You must register for two separate user IDs, CMS says a CMSNet User ID and a QIES User ID. Also, each provider is allowed two CMSNet User IDs which provide access to CMS's private network where the QIES systems reside.

The CMSNet registration form is at https://www.qtso.com/cmsnet.html scroll down to the second link under "Hospice/IRF/Swing Bed/ LTCH." You'll receive two separate emails with your User ID and password, which you can use to install CMS's Juniper communications software, then log into the CMS Network.

You should also be familiar with HART CMS's new Hospice Abstraction Reporting Tool. HART is a free JAVA-based application provided by CMS to hospice providers "for the entry and validation of HIS Records prior to submission to the QIES ASAP system," the agency notes on its HIS Technical Information website.

"Play with [HART] to get a sense of what is going to be required whether [you] have an EMR vendor or not," Wilson recommends.

7. Know when to use HIS and when not to. Hospices don't have to complete HIS for patients who were already on service as of the July 1 implementation date. The data collection tool will apply only to patients who have both a HIS-Admission and a HIS-Discharge, clarified CMS's **Robin Dowell** in a Jan. 22 Open Door Forum for home health and hospice providers (see Eli's Hospice Insider, Vol. 7, No. 3). So, patients you admitted before July 1 will not need a discharge HIS, even when their episodes end after July 1.

But now that July 1 has passed, hospices must complete a HIS for every newly admitted patient, regardless of payer source, age, site of service, transfer status, or previous revocation/discharge, **Franziska Rokoske**, with CMS HIS contractor **RTI**, said in the January forum.

Clarification: That means when a patient transfers from another hospice to your agency, you need to complete a HIS-Admission just as you would for any patient newly admitted to your program, Dowell explained in the forum.

Hospices may be confused, because CMS will use data only from patients 18 years and older to calculate hospices' quality measure scores. But hospices will need to collect and report data for their under-18 patients, even if CMS won't currently use the data for quality reporting purposes, Dowell noted in the forum.

8. Track deadlines for compliance. HIS records require two deadlines the completion date and submission date.

The 30-day submission deadline is reasonable, Wilson says. But the 14-day completion deadline for a HIS-Admission and seven-day deadline for HIS-Discharge will be a huge burden to hospices, Wilson predicts (see related story, p. 57).

If you haven't already, "establish a process for tracking the timeframes to complete the admission and discharge HIS and timeframes for submitting the data to CMS," Ross recommends.

9. Review HIS records. Especially now when HIS is new, review records to make sure they are filled out accurately. Use examples of inaccuracies to fuel further staff education.

10. Gear up for quality improvement. "Once a hospice is comfortable with the accuracy of the data, begin trending the results to look for opportunities for improvement" in care quality, Ross offers. "While these are process measures, not outcome measures, good processes will lead to better outcomes."