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National Provider Call

Updates to the Hospice Item Set Manual V1.02

Presented By: the Centers for Medicare & Medicaid Services (CMS) and RTI International

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Objectives

- Cover updates and changes to the Hospice Item Set (HIS) Manual made from V1.01 to V1.02
  - Download a copy of V1.02 of the HIS manual here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html
- For a comprehensive overview of data collection instructions for each HIS item, providers should view the "Data Collection Training for the Hospice Item Set (HIS)"
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html

Chapter 1: Background and Overview of the Hospice Item Set Manual

Alexis Kirk, RTI International

↘ HIS Manual

Pages 1-1

Background

- Hospice Quality Reporting Program (HQRP) requirement established by Section 3004 of the Affordable Care Act
- Hospice Item Set is a patient-level data collection tool that all Medicare-certified hospice providers are required to use as part of current HQRP requirements
- Providers began using the HIS on all patient admissions on July 1, 2014. Providers must submit 2 HIS records for each patient admission: HIS-Admission & HIS-Discharge
- HIS data can be used to calculate 7 quality measures

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Pages 1-1

1.3 HIS Requirements and Reporting Years

HIS reporting consists of three primary activities:

HIS Data Collection:

Completing the HIS items in conjunction with the patient assessment or by abstracting data from the clinical record

HIS Record Conversion:

Converting HIS data into the proper electronic file format (XML), either using a vendor-designed software or HART (available at www.qtso.com)

HIS Record Submission:

Zipping XML files into the .zip format and submitting to QIES ASAP system

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Pages 1-2

1.3 HIS Requirements and Reporting Years

Figure 2. FY 2017 Reporting Year Activities

First Year: HIS Data Collection and Submission	Second Year: Compliance Determinations	Third Year: Payment Impact
CY 2015: Collect and submit HIS data for all patient admissions occurring during CY 2015 (January 1, 2015 – December 31, 2015).	**CY 2016:** CMS makes compliance determinations based on HIS submissions for patient admissions occurring in 2015.	**FY 2017:** Determinations of noncompliance made in 2016 will go into effect in FY 2017 (10/1/2016), reducing the FY 2017 APU by two percentage points.

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Pages 1-3

1.4 Applicable Facilities and Requirements for New Facilities

- Hospices receiving CMS Certification Number (CCN) notification letter on or after November 1 of the preceding year involved are excluded from any payment penalty for that FY.
- **Example:** Hospice receives CCN notification letter on 11/2/15. This hospice:
  - is not required to submit HIS data on patient admissions occurring in CY 2015
  - is not subject to the payment reduction for FY 2017 APU
  - should begin submitting HIS data 1/1/16 (or before)
  - will be subject to FY 2018 APU payment reduction, if noncompliant
  - https://www.federalregister.gov

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Pages 1-3

1.6 Record Types and Definitions

- Hospices are required to submit a HIS-Admission and a HIS-Discharge record for each patient admission.

- HIS-Admission and HIS-Discharge completion is triggered by the patient's admission or discharge to a Medicare-certified hospice.
  - Definitions for "admission" and "discharge," along with special circumstances, are presented in Section 1.6 of HIS Manual V1.02

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Pages 1-4

1.6: Definition of Admission

- **Admission:** A patient is considered "admitted" to a hospice if:
  1. There is a signed election statement (or other agreement for care for non-Medicare patients) and
  2. The patient did not expire prior to the effective date of the election or agreement for care and
  3. The hospice made a visit in the setting where hospices services are to be initiated.

  – **All three criteria must be met** in order for the patient to be considered "admitted" for the purposes of HIS reporting.

- **Discharge:** A patient is considered discharged when the patient is no longer receiving services from the hospice or there is an interruption in care/services.
  – Patient discharge is the "trigger event" for completing the HIS-Discharge.

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Pages 1-4

1.6: Special Circumstances

- **Patient Transfers from a provider with one CMS Certification Number (CCN) to a provider with different CCN**
  - If a patient's care transfers or changes from one hospice to another, and the two hospices have different CCNs, each hospice should complete a HIS-Admission and a HIS-Discharge *for their respective portion of the care*.

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Pages 1-5

1.6: Special Circumstances, Continued

- **HIS-Discharge is not required in the case of administrative discharges with no interruption in care**, such as:
  - Change in patient's payer source – e.g., patient changes from a private pay patient to Medicare patient
  - Hospice fails to meet the face-to-face requirement, patient remains on service
- In these two situations, the hospice would submit HIS-Discharge once the patient is no longer receiving hospice service or there is an interruption in care related to one of the reasons for discharge listed in Item A2115.

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Pages 1-6

1.6: Special Circumstances, Continued

- **Traveling patients: patient moves out of the service area or transfers to another hospice**
  - If **home hospice** discharged patient and **host hospice** admitted patient and filed a Notice of Election (NOE) in claims processing system:
    - **Home hospice** must submit HIS-Discharge and
    - **Host hospice** must submit HIS-Admission and HIS-Discharge.
  - If no NOE is filed, no action is required.
    - **Home hospice** submits HIS-Discharge once patient is no longer receiving services or there is an interruption in services.

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Pages 1-6

1.7 Timing and Sequence Policies

- If a hospice realizes that it will not meet the timeliness criteria for any given record, it should still complete and submit that record.
- Late completion and submission of HIS records will result in a non-fatal (warning) error.
- Records with non-fatal errors can still be accepted by the QIES ASAP system.

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Pages 1-10

1.9 Compliance with HQRP Requirements and APU Determinations

- "Pay-for-reporting" program → submitting the required HIS records determines compliance.
  - https://www.federalregister.gov
- Beginning in the FY 2017 Reporting Year, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey will be considered part of general HQRP requirements.
  - CAHPS is part of the HQRP, but is separate from the HIS requirement
  - http://www.hospicecahpssurvey.org/Content/HomePage.aspx

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Page 1-11

HIS Manual: Chapter 2 Item-Specific Instructions

Alexis Kirk, RTI International

↘ HIS Manual

Pages 2-1

2.2 General Conventions for Completing the HIS

- Responses to items on the HIS can be selected:
  - By the assessing clinician as part of the patient visit/assessment
  - Based on data information documented in the clinical record that were documented and abstracted on or prior to the Completion Date (Item Z0500B)
- Primary sources of information for completing the HIS include data collected through clinical care processes as they are completed, and/or documentation in the hospice clinical record from which the HIS responses can be abstracted.
- Sources other than the hospice clinical record may be used to complete certain HIS items.
  - Ex: Section A: Administrative Information items may require review of claims or billing records.

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Pages 2-2

Section A: Administrative Information

A0050 Type of Record
A0100 Facility Provider Numbers
A0205 Site of Service at Admission
A0220 Admission Date
A0245 Date of Initial Nursing Assessment
A0250 Reason for Record
A0270 Discharge Date
A0500 Legal Name of Patient

A0600 SS and Medicare Number
A0700 Medicaid Number
A0800 Gender
A0900 Birth Date
A1000 Race/Ethnicity
A1802 Admitted From
A2115 Reason for Discharge

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Pages 2A-1

A0205. Site of Service at Admission

A0205. Site of Service at Admission	
Enter Code ☐☐	01. Hospice in patient's home/residence 02. Hospice in Assisted Living facility 03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF) 04. Hospice provided in a Skilled Nursing Facility (SNF) 05. Hospice provided in Inpatient Hospital 06. Hospice provided in Inpatient Hospice Facility 07. Hospice provided in Long Term Care Hospital (LTCH) 08. Hospice in Inpatient Psychiatric Facility 09. Hospice provided in a place not otherwise specified (NOS) 10. Hospice home care provided in a hospice facility

- Clarification of SNF and NF presented on subsequent slide

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Pages 2A-2 – 2A-3

A1802. Admitted From

A1802. Admitted From. Immediately preceding this admission, where was the patient?	
Enter Code ☐☐	01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care) 02. Long-term care facility 03. Skilled Nursing Facility (SNF) 04. Hospital emergency department 05. Short-stay acute hospital 06. Long-term care hospital (LTCH) 07. Inpatient rehabilitation facility or unit (IRF) 08. Psychiatric hospital or unit 09. ID/DD Facility 10. Hospice 99. None of the above

- 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.

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Page 2A-11

A0205 & A1802: Item-Specific Tips

- Skilled nursing facility (SNF) is not synonymous with nursing facility (NF, also known as a Long Term Care facility).
  - SNF should be used for patients in a SNF or patients in the SNF portion of a dually-certified nursing facility.
  - If patient is in a nursing facility but doesn't meet the criteria above, do not use SNF. Instead, use “NF” or “long-term care facility”

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Pages 2A-3, 2A-11

A0245. Date Initial Nursing Assessment Initiated Item-Specific Instructions

- This is the date on which the initial nursing assessment (as defined in the Medicare Conditions of Participation) was initiated.
- If patient is discharged for any reason before the initial assessment is completed, enter the date on which the initial assessment was initiated.
- If no initial assessment was initiated, enter a dash ("-").

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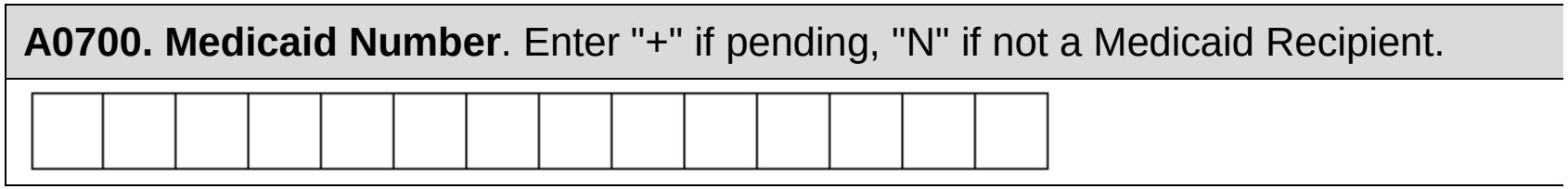
Pages 2A-4

A0700. Medicaid Number



- If the patient refuses to supply his/her Medicaid number or the Medicaid number is unknown, leave A0700 blank.
- Enter “+” if pending, “N” if not a Medicaid recipient

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Pages 2A-9

A1000. Race/Ethnicity

Response Option	OMB Definition
A. American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
B. Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
C. Black or African American	A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
D. Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
E. Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
F. White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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Pages 2A-10

Section Z: Record Administration

Z0400 Signature(s) of Person(s) Completing the Record
Z0500 Signature of Person Verifying Record Completion

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Pages 2Z-1

Z0400: Signature(s) of Person(s) Completing the Record Item-Specific Tips

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 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			

- Z0400 is not submitted as part of the HIS record in the QIES ASAP system.
- It is at the discretion of the hospice to develop internal policies and procedures for completing Z0400.

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Pages 2Z-2

Z0500. Signature of Person Verifying Record Completion, and Date of Completion

Z0500. Signature of Person Verifying Record Completion	
A. Signature: _____	B. Date: Month ☐☐ Day ☐☐ Year ☐☐☐☐

- Z0500A is not submitted as part of the HIS record in the QIES ASAP system.
- In the case of a modification or inactivation request, Z0500B should contain the original date on which the record was completed.

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Pages 2Z-2

Chapter 2: Care Process Items Sections F, J, and N

Franzi Rokoske, RTI International

Section F: Preferences

F2000 CPR Preference
F2100 Other Life-Sustaining Treatment Preferences
F2200 Hospitalization Preference
F3000 Spiritual/Existential Concerns

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Pages 2-F1

F3000. Spiritual/Existential Concerns

F3000. Spiritual/Existential Concerns	
Enter Code ☐	**A. Was the patient and/or caregiver asked about spiritual/existential concerns?** Select the most accurate response. 0. **No** → Skip to I0010, Principal Diagnosis 1. **Yes, and discussion occurred** 2. **Yes, but the patient and/or caregiver refused to discuss** **B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year

- Permissible to consider care processes documented in the clinical record that may have taken place at pre-admission or educational visits.
  - This change makes the HIS guidance for F3000 consistent with Items F2000-2200.

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Pages 2F-12

F3000: Item-Specific Tips

- There is no comprehensive list of spiritual/existential concerns.
- Examples of a discussion regarding spiritual/existential concerns might include:
  - asking the patient/caregiver about need for spiritual or religious support
  - questions about cause or meaning of illness or death
  - discussion of a higher power related to illness
  - offer of a spiritual resource (such as a chaplain)

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Section J: Pain

J0900 Pain Screening
J0910 Comprehensive Pain Assessment

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Pages 2J-1

J0900. Pain Screening

J0900. Pain Screening

Enter Code ☐

A. Was the patient screened for pain?

0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

B. Date of first screening for pain:

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

C. The patient's pain severity was:

0. **None** → Skip to J2030, Screening for Shortness of Breath
1. **Mild**
2. **Moderate**
3. **Severe**
9. **Pain not rated**

Enter Code ☐

D. Type of standardized pain tool used:

1. **Numeric**
2. **Verbal descriptor**
3. **Patient visual**
4. **Staff observation**
9. **No standardized tool used**

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Pages 2J-1

J0900: Item-Specific Instructions

- J0900A – Was the patient screened for pain?
- J0900B – Date of first screening for pain
- J0900C – What was the patient's pain severity?
  - Scale has been modified to reflect the scale used by the National Comprehensive Cancer Network Pain Management Guidelines
  - www.nccn.org
  - 4-6 on a 10-point numeric scale is moderate
  - 7-10 on a 10-point numeric scale is severe
- J0900D – What kind of Standardized Pain Scale was used?

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Pages 2J-2

J0900: Pain Screening Example

Situation E:

- Current pain at time of visit: 0/10
- History of pain, at its worst: 6/10
  - Dull, aching pain in lower abdomen
  - Pain is worse when walking
  - Pain is better when lying down

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Pages 2J-5

J0900: Responses for Pain Screening Example

Situation E - HIS Response Selection:

- **J0900A: Was the patient screened for pain?** 1, Yes
- **J0900B: Date of first screening for pain:** 08-14-2015
- **J0900C: The patient's pain severity was:** 0, None
  - Complete J0900C based on patient's pain severity **at the time of the visit in which pain screening was conducted**
  - Do not consider historical reports of pain or whether pain is an "active problem"
- **Skip J0900D and J0910, Comprehensive Pain Assessment**

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Pages 2J-5

J0910. Comprehensive Pain Assessment

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

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Pages 2J-6

J0910: Item-Specific Tips

- A comprehensive pain assessment should address multiple aspects of pain, beyond a determination of presence of pain and its severity.
- There are seven characteristics included in a comprehensive pain assessment.
- A comprehensive assessment can be conducted on comatose/unresponsive patients as well.
  - Use clinical observation or family report

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Section J: Respiratory Status

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

↘ HIS Manual

Pages 2J-10

J2030. Screening for Shortness of Breath

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

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Pages 2J-10

J2030: Item-Specific Tips

- Evidence of a "positive" screen for shortness of breath
  - Consider whether shortness of breath (SOB) is an **active problem** for the patient at the time of the screening
  - Clinician may determine that SOB is an active problem, **even if SOB does not occur during the assessment visit**
  - If the patient is receiving treatment for SOB, that indicates SOB is an active problem.
  - This is different than determining severity of pain in J0900C (which is determined **at the time of the visit**)

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Pages 2J-11

J2030: Screening for SOB Example

Situation E:

- **Patient's initial assessment contains the following information:**
  - Patient currently not experiencing any SOB
  - Patient reports experiencing SOB when walking from the bed to the bathroom
  - SOB is mild to moderate, depending on activity level

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Pages 2J-13

J2030: Response for Screening for SOB Example

Situation E - HIS Response Selection:

- **J2030A: Was the patient screened for SOB?** 1, Yes
- **J2030B: Date of first screening for SOB:** 08-15-2015
- **J2030C: Did the screening indicate the patient had shortness of breath?** 1, Yes
  - Based on documentation indicating SOB was an "active problem" for the patient, even though the patient was not experiencing SOB at the time of the visit

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Pages 2J-13

J2040. Treatment for Shortness of Breath

J2040. Treatment for Shortness of Breath	
Enter Code ☐	**A. Was treatment for shortness of breath initiated?** Select the most accurate response 0. **No** → Skip to N0500, Scheduled Opioid 1. **No, patient declined treatment** → Skip to N0500, Scheduled Opioid 2. **Yes** **B. Date treatment for shortness of breath initiated:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year **C. Type(s) of treatment for shortness of breath initiated:**
↓ **Check all that apply**	
☐	1. Opioids
☐	2. Other medication
☐	3. Oxygen
☐	4. Non-medication

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Page 2J-14

J2040: Item-Specific Instructions

- For **comfort kits or pre-printed admission orders**, treatment is "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 for the relevant symptom.
  - Proactive education is not considered "initiation."
- For **non-medication interventions,** providers can use the date on which the hospice first discussed the intervention with the patient/caregiver.

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Page 2J-14

J2040C: Item-Specific Instructions and Tips

- Examples of some non-opioid medications that *might be used* for dyspnea include:
  - inhaled bronchodilators
  - steroids
  - diuretics
  - benzodiazepines
- These medication examples have multiple uses, so the order must indicate these are intended to address the patient's Shortness of Breath.

↘ HIS Manual
Pages 2J-15

J2040C: Item-Specific Tip

- For J2040C, only include treatments that were initiated on the date listed in J2040B
  - If additional treatments are initiated on a later date, do not include these in J2040C

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Pages 2J-16

J2040: Treatment for SOB Example

Situation B:

- **Patient's initial assessment contains the following information:**
  - 9/15/15: Dyspnea/shortness of breath at rest. Instructed family to keep patient's head elevated on pillows while patient is in bed
  - 9/16/15: Oxygen ordered and scopolamine to dry respiratory secretions

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Pages 2J-17

J2040: Response Selection for Treatment for SOB Example

Situation B HIS Response Selection:

- **J2040A: Was treatment for SOB initiated?** 2, Yes
- **J2040B: Date treatment for SOB initiated:** 09-15-2015
- **J2040C: Type(s) of treatment for shortness of breath initiated:** 4, Non-medication.
  - Clinical record documentation indicates that the patient was short of breath and that more than one treatment was initiated for shortness of breath. However, only the treatment initiated on the date in J2040B should be listed in J2040C.

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Pages 2J-17

J2040: Treatment for SOB Example

Situation D:

- **Patient's initial assessment contains the following information:**
  - Comfort pack in patient's home and on stand-by.
  - Patient and family are educated about medications in comfort pack, relevant symptoms, and where to store the comfort pack
  - Patient and family told not to use medications in pack unless advised to do so

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Pages 2J-18

J2040: HIS Response Selection for Treatment for SOB Example

Situation D HIS Response Selection:

- **J2040A: Was treatment for SOB initiated?** 0, No
  - Clinical record documentation indicates that the comfort pack included treatments that could be used for SOB and that the nurse provided proactive education about these treatments. However, the clinical record contains no documentation that the nurse instructed the patient/family to begin using any of the treatments for SOB.
- **Skip J2040B and J2040C**

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Pages 2J-18

Section N: Medications

N0500 Scheduled Opioid
N0510 PRN Opioid
N0520 Bowel Regimen

↘ HIS Manual

Pages 2N-1

N0500. Scheduled Opioid, N0510. PRN Opioid Item-Specific Tips

- An “opioid” includes Schedule II – Schedule IV opioids, including hydrocodone and tramadol
- This is based on the side effect profile for these medications, which includes constipation.

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Pages 2N-2, 2N-4

N0500 & N0510: Item-Specific Instructions

- For **comfort kits or pre-printed admission orders**, 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 for the relevant symptom.
  - Proactive education is not considered "initiation"

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Pages 2N-2, 2N-5

N0520. Bowel Regimen

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

Enter Code ☐

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

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

B. Date bowel regimen initiated or continued:

☐☐ Month ☐☐ Day ☐☐☐☐ Year

↘ HIS Manual

Pages 2N-5

N0520: Item-Specific Tip

- The bowel regimen order **need not** explicitly state it is for the management of opioid induced constipation.
- For Example:
  - Order received on 8/12/15 for Milk of Magnesia 30 ccs daily for constipation.
  - Although order does not state specifically this is constipation related to opioid use, can still respond “yes” to N0520A
- Date bowel regimen initiated can precede date opioid(s) initiated

↘ HIS Manual

Pages 2N-6

Section N Example

- **Situation D: Patient's initial assessment contains the following information:**
  - 7/23/2015: comfort pack in patient's home and on stand-by. Patient/family instructed on what medications are in comfort pack.
  - 7/23/2015: Order for Polyethylene glycol 17 g PO with full glass of water once daily.
  - 7/25/2015: Caregiver called and reported patient in moderate pain; instructed caregiver to open comfort pack and begin oxycodone every 4 hours as needed.

↘ HIS Manual
Pages 2N-9

Response Selection for Section N Example

Situation D HIS Response Selection:

- **N0500A: Was a scheduled opioid initiated or continued?** 0, No
- **N0500B:** Skip
- **N0510A: Was a PRN opioid initiated or continued?** 1, Yes
- **N0510B: Date PRN opioid initiated or continued:** 07-25-2015
  - PRN oxycodone part of comfort pack; medication considered initiated on date the nurse instructed the patient/family to begin using the treatment
- **N0520A: Was a bowel regimen initiated or continued:** 2, Yes
- **N0520B: Date bowel regimen initiated or continued:** 07-23-2015
  - Date in N0520B can precede date in N0500B and/or N0510B
  - Order does not need to specifically state bowel regimen to prevent **opioid-induced** constipation

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Pages 2N-9

Resources

Staying Informed

- **CMS HQRP website:** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html
  - See “Hospice Item Set (HIS)” Section

- **Listservs:**
  - *MLN Connects eNews*
    - https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819
  - ODF listserv
    - http://www.cms.gov/Outreach-and-education/Outreach/OpenDoorForums/ODF_HHHDME.html

- **Federal Register:** http://www.federalregister.gov
  - Review proposed and final rules

Help Desks

- **Quality Help Desk**: HospiceQualityQuestions@cms.hhs.gov
  - Providers can email the Quality Help Desk if they have general questions about the Hospice Quality Reporting Program (HQRP) including, but not limited to: which hospices are required to report, general questions about reporting requirements, questions about quality measures, and reporting deadlines.

- **Technical Help Desk:** help@qtso.com
  - Phone: 1-877-201-4721 (Monday-Friday 7:00 a.m. - 7:00 p.m. Central Time)
  - Use for questions related to the HART tool, QIES ASAP, or other technical assistance information, including error messages or record rejections.

- **Reconsideration Help Desk**: HospiceQRPReconsiderations@cms.hhs.gov.
  - Use to submit a reconsideration request or to ask other questions related to reconsideration.

Question & Answer Session

Send unanswered questions to the Quality Help Desk:
hospicequalityquestions @cms.hhs.gov

Evaluate Your Experience

- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.

- To complete the evaluation, visit http://npc.blhtech.com and select the title for today's call.

Thank You

- For more information about the MLN Connects® National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html.

- For more information about the Medicare Learning Network®, please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.