August 23 CMS Quality Vendor Workgroup

August 23, 2018
12:00 – 1:30 p.m. ET

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Agenda

Topic	Speaker
Quality Payment Program Updates	**Adam Richards** *Division of End-Stage Renal Disease, Population and Community Health, CMS*
Updated 2018 CMS QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals	**Shanna Hartman** *CMS Division of Electronic and Clinician Quality CMS/CCSQ/QMVIG* **Matthew Tiller** *ESAC, Inc.* *Healthcare IT and Life Sciences Data Management Solutions Contractor*
FY 2019 Medicare IPPS and LTCH Final Rule Updates	**Jessica Wright** *Division of Health Information Technology, CMS*
Hospital Inpatient Quality Reporting (IQR) Program Update	**Artrina Sturges, EdD** *Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor*
Post- Acute Care Announcements • **IRF PPS FY 2019 Final Rule** • **IPPS/LTCH PPS FY 2019 Final Rule** • **SNF PPS FY 2019 Final Rule** • **FY 2019 Hospice Final Rule**	**Katie Brooks, MS, RN** **Lorraine Wickiser, BSN, RN** **Casey Freeman, MSN, ANP-BC** **Cindy Massuda, JD** *Division of Chronic and Post Acute Care, CMS*
HITAC Updates	**Lauren Richie** *Office of the National Coordinator for Health IT*
CMS Data Element Library	**Beth Connor, MS RN** *Division of Chronic and Post Acute Care, CMS*
Questions	

Quality Payment Program Updates

Adam Richards

Division of End-Stage Renal Disease, Population and Community Health, CMS

Quality Payment Program Year 1 (2017)

MIPS Performance Feedback and Targeted Review Request

- If you participated in MIPS **in 2017**, your MIPS final score and performance feedback are now available on the Quality Payment Program website

- The payment adjustment you will receive in 2019 is based on this final score

- MIPS eligible clinicians or groups, including those who are subject to the APM scoring standard, may request for CMS to review their performance feedback and final score though a targeted review process

MIPS Targeted Review Request Deadline

- You can submit a targeted review until **October 1, 2018 at 8:00 p.m. ET**

- To request a targeted review:
  - Go to the Quality Payment Program website
  - Log in using your Enterprise Identity Management (EIDM) credentials; these are the same EIDM credentials that allowed you to submit your MIPS data. Please refer to the EIDM User Guide for additional details

- For more information, visit the Quality Payment Program Resource library on CMS.gov

Resources

Performance Feedback

- MIPS Performance Feedback Fact Sheet
- MIPS 2017 Performance Feedback User Guide

Targeted Review

- Targeted Review of the 2019 MIPS Payment Adjustment
- Targeted Review of the 2019 MIPS Payment Adjustment User Guide

Payment Adjustment

- 2019 MIPS Payment Adjustment for 2017 Performance Year Infographic
- Fact Sheet: 2019 MIPS Payment Adjustments based on the 2017 MIPS Final Scores

Resources

Performance Feedback Demo Videos

- How to access performance feedback for APM Entities
- How to access performance feedback for individuals
- How to access performance feedback for voluntary submitters
- How to access performance feedback for groups

Targeted Review Demo Video:

- How to request a targeted review

Quality Payment Program Year 2 (2018)

QPP Status Tool Update

- CMS has updated the QPP Status Tool to include Qualifying APM Participant (QP) and MIPS APM status
- The first snapshot includes data from Medicare Part B claims with dates of service between **January 1 and March 31, 2018**
- Later this year, CMS will release and announce the second and third QP and MIPS APM status data based on snapshots of claims between January 1 and August 31, 2018
- To learn more about how CMS determines QP and MIPS APM status for each snapshot, please view the QP Methodology Fact Sheet

QPP Status Tool Update

- To view your QP or MIPS APM status at the individual level:
  - Go to: https://qpp.cms.gov/participation-lookup
  - Enter your 10-digit National Provider Identifier (NPI)

- To check your group's 2018 eligibility at the APM entity level:
  - Log into the CMS QPP website with your EIDM credentials
  - Browse to the Taxpayer Identification Number affiliated with your group
  - Access the details screen to view the eligibility status of every clinician based on their NPI

QPP Exception Applications Now Available

- The 2018 Quality Payment Program (QPP) Exception Applications for the Promoting Interoperability (PI) performance category and Extreme and Uncontrollable Circumstances for MIPS are now available on the QPP website

PI Hardship Exceptions

- 2018 MIPS participants can submit a Hardship Exception Application for the PI performance category, citing one of the following reasons:
  - MIPS-eligible clinicians in small practices (new for 2018)
  - MIPS-eligible clinicians using decertified electronic health record (EHR) technology (new for 2018)
  - Insufficient Internet connectivity
  - Extreme and uncontrollable circumstances
  - Lack of control over the availability of certified electronic health record technology (CEHRT)

PI Hardship Exceptions

- An approved QPP Hardship Exception will:
  - Reweight your PI performance category score to 0 percent of the final score
  - Reallocate the 25 percent weighting of the PI performance category to the Quality performance category

- You must submit a Hardship Exception application by December 31, 2018 for CMS to reweight the PI performance category to 0 percent

Extreme and Uncontrollable Circumstances

- MIPS eligible clinicians who are impacted by extreme and uncontrollable circumstances may submit a request for reweighting of the Quality, Cost, and Improvement Activities performance categories

- "Extreme and uncontrollable circumstances" are defined as rare events (highly unlikely to occur in a given year) entirely outside your control and the facility in which you practice

- These circumstances would cause you to be unable to collect information necessary to submit for a performance category, or to submit information that would be used to score a performance category for an extended period of time (for example, 3 months unable to collect data for the Quality performance category)

For More Information

- Review the 2018 Exceptions FAQ Sheet
- Contact the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292/TTY: 1-877-715-6222
- Visit the Quality Payment Program Website

Quality Payment Program Year 3 (2019)

Proposed Rule for Year 3 of the Quality Payment Program

- On June 29, 2019 CMS released its proposed policies for Year 3 (2019) of the Quality Payment Program via the Medicare physician fee schedule Notice of Proposed Rulemaking (NPRM)

- CMS is seeking comment on a variety of proposals in the NPRM

Proposed Rule for Year 3 of the Quality Payment Program

- Comments are due by **Monday, September 10, 2018**
- Instructions for submitting comments can be found in the proposed rule; fax transmissions will not be accepted
- You must officially submit your comments in one of the following ways:
  - Electronically through Regulations.gov
  - By regular mail
  - By express or overnight mail
  - By hand or courier
- When commenting refer to file code **CMS-1693-P**
- For additional information, please go to: qpp.cms.gov

Virtual Group Election Process

- If you are interested in forming a Virtual Group for the 2019 MIPS performance year, you must follow an election process and submit your election to CMS between **October 1 and December 31, 2018**

- For more information, visit the Quality Payment Program Resource library on CMS.gov

Upcoming Webinars

- **Virtual Groups**
  - Monday, August 27; 2:00-3:00 p.m. ET
  - Register
- **2019 MIPS Self-Nomination**
  - Thursday, August 30; 2:00-3:30 p.m. ET
  - Register

Updated 2018 CMS QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals

Shanna Hartman
CMS Division of Electronic and Clinician Quality
CMS/CCSQ/QMVIG

Matthew Tiller
ESAC, Inc.
Healthcare IT and Life Sciences Data Management Solutions Contractor

Updated 2018 CMS QRDA III IG for Eligible Clinicians and EPs

- Background
  - The Centers for Medicare & Medicaid Services (CMS) has published an update to the 2018 CMS Quality Reporting Document Architecture Category III (QRDA III) Implementation Guide (IG) for Eligible Clinician and Eligible Professional (EP) Programs
  - This replaces the 2018 CMS QRDA III IG for Eligible Clinicians and EPs last updated on 3/12/2018
  - The updated 2018 CMS QRDA III IG for Eligible Clinicians and EPs provides technical instructions for QRDA III reporting for these programs
    - Merit-based Incentive Payment System (MIPS)
    - Comprehensive Primary Care Plus (CPC+)
    - Medicaid Promoting Interoperability (PI)

Changes to the 2018 CMS QRDA III IG for Eligible Clinicians and EPs (1 of 3)

- Renaming of the Merit-based Incentive Payment System (MIPS) performance category **Advancing Care Information (ACI) to Promoting Interoperability (PI)**.

- New CMS program name code **"MIPS_VIRTUALGROUP"** to support MIPS virtual group reporting.

- **Eight new PI measure identifiers** have been developed that indicate active engagement with more than one registry.
  - The new measure identifiers consist of an existing measure identifier appended with "_MULTI".
  - For example, the new measure identifier "PI_PHCDRR_1_MULTI" indicates immunization registry reporting for multiple registry engagement.

Changes to the 2018 CMS QRDA III IG for Eligible Clinicians and EPs (2 of 3)

- Performance period reporting:
  - **MIPS quality measures** and **improvement activities (IA)** performance periods can be reported at either of the following levels:
    - **Individual** – The individual measure or activity level for the quality measure or IA, respectively, as defined by CMS.
    - **Category** – The performance category level for Quality and IA performance categories, as previously specified in the 2018 CMS QRDA III IG.
  - **Reports submitted to the Quality Payment Program (QPP) with performance periods at the individual measure or activity level will be converted by CMS to the performance category level** using the earliest start date and the latest end date. These converted performance periods may not be a full 12 months for the Quality performance category and may not be the 90 day minimum for the IA performance category.
  - **MIPS PI** performance period reporting will remain at the performance **category level only.**
  - **CPC+** performance period reporting for the Quality performance category remains at the **category level only.**

Changes to the 2018 CMS QRDA III IG for Eligible Clinicians and EPs (3 of 3)

- The 2015 Edition (c)(4) **filter certification criterion** (45 CFR 170.315(c)(4)) is **no longer a requirement for CPC+ reporting**. However, practices must continue to report eCQM data at the CPC+ practice site level (practice site location, TIN(s)/NPI(s)).

QRDA Resources

- Link: 2018 CMS Quality Reporting Document Architecture Category III (QRDA III) Implementation Guide (IG) for Eligible Clinicians and Eligible Professionals (EPs)

- You can find additional QRDA-related resources, as well as current and past IGs, on the eCQI Resource Center QRDA page

- For questions related to the QRDA Implementation Guides and/or Schematrons, visit the ONC QRDA JIRA Issue Tracker

- For questions related to Quality Payment Program/Merit-based Incentive Payment System data submissions, visit the Quality Payment Program website or contact by phone 1-866-288-8292, TTY: 1-877-715-6222 or email QPP@cms.hhs.gov

FY 2019 Medicare IPPS and LTCH Final Rule Updates

Jessica Wright

Division of Health Information Technology, CMS

IPPS and LTCH Final Rule

- On August 2, the Centers for Medicare & Medicaid Services (CMS) issued updates to Fiscal Year (FY) 2019 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule.

IPPS and LTCH Final Rule Program Changes

- The final rule changes the following aspects of the Promoting Interoperability (PI) Programs (formerly known as the EHR Incentive Programs):
  - Sets a new performance-based scoring methodology for the Medicare PI Program, that has a smaller set of objectives that will provide a more flexible, less-burdensome structure.
  - Requires the use of 2015 Edition CEHRT for eligible hospitals and critical access hospitals (CAHs) beginning in Calendar Year (CY) 2019.
  - Finalizes an EHR reporting period of any consecutive 90-day period for new and returning CMS or State Medicaid agency participants in CYs 2019 and 2020.

IPPS and LTCH Final Rule Program Changes Cont.

- The final rule changes the following aspects of the Promoting Interoperability (PI) Programs (formerly known as the EHR Incentive Programs):
  - Finalizes changes to measures and removes certain measures that do not emphasize interoperability and the electronic exchange of health information beginning in CY 2020.
  - Requires eligible hospitals and CAHs to select one quarter of CY 2019 data during the EHR reporting period and choose at least four self-selected electronic clinical quality measures (eCQMs) from a set of 16 for eCQM reporting.

IPPS and LTCH Final Rule Resources

- To learn more about these and other finalized changes, review the final rule, press release, and the fact sheet.

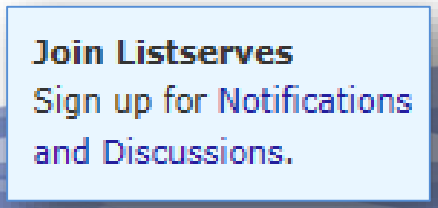
- For more information on the PI Programs, visit the PI Programs landing page.

Hospital Inpatient Quality Reporting (IQR) Program Update

Artrina Sturges, EdD
Hospital Inpatient Value, Incentives, and Quality Reporting
Outreach and Education Support Contractor

Availability of the CY 2018 CMS Data Receiving System and PSVA Tool

- Calendar Year (CY) 2018 CMS Data Receiving System
  - ListServe distributed mid-August 2018
  - System is on track to be available week of September 10, 2018, for test and production Quality Reporting Document Architecture (QRDA) Category I file submissions for electronic clinical quality measure (eCQM) reporting.
- Pre-Submission Validation Application (PSVA) Tool
  - ListServe distributed August 10, 2018
  - PSVA tool released with 2018 updates
  - Hospitals and health information technology (IT) vendors will be able to utilize the PSVA tool to submit validated test and production QRDA Category I files once the CMS data receiving system opens the week of September 10, 2018.
- Notifications
  - Distributed through *QualityNet* ListServes and communicated through hospital quality reporting (HQR) newsletters, CMS Partner Workgroup Call, etc.
  - Sign up for IQR and electronic health record (EHR) notifications on the *QualityNet.org* Home page.



Voluntary Hybrid Hospital-Wide Readmission (HWR) Measure

- CY 2018 CMS Data Receiving System
  - ListServe distributed mid-August 2018
  - System available to receive test and production QRDA Category I files developed for the voluntary Hybrid HWR measure
- Pre-Submission Validation Application (PSVA) Tool
  - ListServe distributed August 10, 2018
  - PSVA tool updated to perform file format validation for test and production QRDA Category I files for voluntary Hybrid HWR measure; can use the PSVA tool to submit files to the CMS data receiving system
  - Hybrid HWR measure-specific QRDA Category I files can be submitted under the HQR_IQR_VOL program name to the CMS data receiving system within the *QualityNet Secure Portal*

Voluntary Hybrid HWR Measure (Cont.)

- For CY 2018 reporting of Medicare Fee-for-Service patients 65 years and older discharged in quarter one and quarter two of 2018 (between January 1, 2018 and June 30, 2018)
  - Hospitals may **voluntarily** report EHR data using QRDA Category I files that contain 13 core clinical data elements and six linking variables to help CMS match EHR data to the CMS claims data.
- Voluntary Hybrid HWR Measure Overview web page on *QualityNet* at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228776337082
- Questions
  - CMShybridmeasures@yale.edu (measure methodology)
  - JIRA CMS Hybrid Measures (electronic specifications, measure authoring to output, value sets, and QRDA Category I files)
- Archived webinars on *QualityReportingCenter.com* at https://www.qualityreportingcenter.com/inpatient/ecqm-archived-events/

eCQM Data Validation

- eCQM data validation started with CY 2017 data for the fiscal year (FY) 2020 annual payment update determination.
  - CMS distributed a ListServe August 15, 2018.
  - CMS released the list of hospitals selected for the validation of eCQM measures for the CY 2017 reporting period. The link to the list of selected hospitals is posted on the *QualityNet* Data Validation (Chart-Abstracted & eCQMs) web page.
  - Hospitals selected for eCQM data validation received direct notification.
- Visit eCQM Data Validation – Overview web page on *QualityNet* at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228776288801.
- The May 15, 2018 webinar, *Hospital IQR Program CY 2017 (FY 2020 Payment Determination) eCQM Validation Overview for Selected Hospitals,* is on *QualityReportingCenter.com* at https://www.qualityreportingcenter.com/inpatient/ecqm-archived-events/.

Webinars

- Archived
  - June 27, 2018: *Navigating EHR Reports for CY 2018 Hospital eCQM Reporting*
  - July 24, 2018: *CY 2018 eCQM Self-Directed Tools and Resources for the Hospital IQR and Promoting Interoperability Programs*
  - August 8, 2018*: Pre-Submission Validation Application (PSVA) Overview for Electronic Clinical Quality Measure (eCQM) Data Submission in Calendar Year (CY) 2018*
- Upcoming
  - September 12, 2018: *FY 2019 IPPS* Final Rule – Acute Care Hospital Quality Reporting Programs Overview*
  - September 26, 2018: *FY 2019 IPPS Final Rule – Overview of eCQM Reporting and Promoting Interoperability Programs*

NOTE: To register for upcoming webinars and to locate archived webinar materials, please visit *QualityReportingCenter.com*.

Support Resources

Topic	Contact	How to Contact
Hospital IQR Program and policy	Hospital Inpatient Support Team	(844) 472-4477 https://cms-ip.custhelp.com
Promoting Interoperability Program (previously known as EHR Incentive Program) (objectives, attestation, and policy)	*QualityNet* Help Desk	(866) 288-8912 qnetsupport@hcqis.org
• eCQM specifications (code sets, measure logic, and measure intent) • QRDA-related questions (CMS implementation guide, sample files, and schematrons)	ONC* JIRA Issue Trackers	eCQM Issue Tracker or QRDA Issue Tracker
QualityNet Secure Portal (reports, PSVA tool, troubleshooting file errors, and uploading data)	*QualityNet* Help Desk	(866) 288-8912 qnetsupport@hcqis.org
eCQM data validation	Validation Support Team	validation@hcqis.org or https://cms-ip.custhelp.com

Post- Acute Care Announcements

Katie Brooks, MS, RN

Lorraine Wickiser, BSN, RN

Casey Freeman, MSN, ANP-BC

Cindy Massuda, JD

Division of Chronic and Post Acute Care, CMS

Inpatient Rehabilitation Facility (IRF) Quality Reporting Program

FY 2019 IRF Prospective Payment System (PPS) Final Rule

CMS-1688-F

Background

- The Affordable Care Act amended the Social Security Act to authorize a quality reporting program for Inpatient Rehabilitation Facilities (IRF). Beginning in FY 2014, the annual payment update for any IRFs that did not submit the required data to CMS was reduced by 2 percentage points.

- In the FY 2019 IRF PPS Final Rule, the IRF QRP is aligning with the Meaningful Measures Initiative to achieve the goal of a parsimonious measure set that focuses on the most critical quality issues with the least burden for clinicians and providers.

FY 2019 IRF Prospective Payment System Final Rule

- Published on August 6, 2018 at https://www.federalregister.gov/documents/2018/08/06/2018-16517/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

- Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019 (CMS-1688-F)
  - Docket Number CMS-2018-0050

- Section X. Updates to the IRF Quality Reporting Program (QRP) Pages 38555-38564

Summary of Updates to IRF QRP

- **Removed** National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)

- **Removed** Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)

Summary of Updates to IRF QRP (cont.)

- **Added** measure removal factor: Factor 8—The costs associated with a measure outweigh the benefit of its continued use in the program

- **Clarified** policies for provider notification of non-compliance with IRF QRP requirements

- **Finalized** the public display of the four IRF QRP Functional Outcome Measures

Clarification of Provider Notification

- Providers will be notified of IRF Quality Reporting non-compliance via a letter sent using at least one of the following methods:
  - The QIES-ASAP System
  - The United States Postal Service
  - The Medicare Administrative Contractor (MAC)

- Providers will be notified regarding the specific method of communication that will be used via the IRF QRP Reconsideration and Exception & Extension website and announcements via the PAC listserv.

Finalized Public Display of Function Outcome Measures in CY 2020

- IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
- IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
- IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
- IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)

IRF Helpdesks

- CMS IRF Quality Questions:
  - IRF.questions@cms.hhs.gov

- CMS IRF QRP Reconsiderations Questions:
  - IRFQRPReconsiderations@cms.hhs.gov

- CMS Public Reporting/IRF Compare Questions:
  - IRFPRquestions@cms.hhs.gov

Long Term Care Hospital Quality Reporting Program

FY 2019 In hospital Prospective Payment System LTCH Prospective Payment System Final Rule

CMS -1694-F

Background

- The Affordable Care Act amended the Social Security Act to authorize a quality reporting program for Long-Term Care Hospitals (LTCH). Beginning in FY 2014, the annual payment update for any LTCH's that did not submit the required data to CMS was reduced by 2 percentage points.

- There are 19 measures currently adopted in the LTCH QRP. Measures adopted are publicly reported on the Long-Term Care Hospital Compare Website

Background (cont.)

- In the FY 2019 IPPS/LTCH Final Rule, the LTCH QRP is aligning with the Meaningful Measures Initiative to achieve the goal of a parsimonious measure set that focuses on the most critical quality issues with the least burden for clinicians and providers.

FY 2019 IIPPS/LTCH PPS Final Rule

- Published, August 2, 2018 at https://www.federalregister.gov/public-inspection/current Inpatient Prospective Payment Systems Long Term Care Hospital Prospective Payment System for Federal Fiscal Year 2019 (CMS-1694-F)

- Section VIII.C Final Revisions and Updates to LTCH Quality Reporting Program (QRP) Pages 1873 –1915 FDF

- LTCH IPPS/PPS FR 2019 on display August 17, 2018

LTCH QRP Summary of Finalized Proposals

- **Removed** National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)

- **Removed** National Healthcare safety Network NHSN) Ventilator-Associated Event (VAE) Outcome Measure

- **Removed** Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)

LTCH QRP Summary cont.

- **Added** measure removal factor: Factor 8—The costs associated with a measure outweigh the benefit of its continued use in the program

- **Clarified** policies for provider notification of non-compliance with LTCH QRP requirements

LTCH QRP Finalized Policies

- Providers will be notified of LTCH Quality Reporting non-compliance via a letter sent using at least one of the following methods:
  - The QIES-ASAP System
  - The United States Postal Service
  - The Medicare Administrative Contractor (MAC)

- We also finalized to clarify that we will notify LTCHs, in writing, of our final decision regarding any reconsideration request using the same notification process.

LTCH Helpdesks:

- CMS LTCH Quality Questions:
  - LTCHQualityQuestions@cms.hhs.gov
- CMS LTCH QRP Reconsiderations Questions:
  - LTCHQRPReconsiderations@cms.hhs.gov
- CMS Public Reporting/LTCH Compare Questions:
  - LTCHPRquestions@cms.hhs.gov

Skilled Nursing Facility (SNF) Quality Reporting Program

FY 2019 SNF Prospective Payment System (PPS) Final Rule

CMS -1696-F

Background

- The Impact Act amended the Social Security Act to authorize a quality reporting program for Skilled Nursing Facilities (SNF). Beginning in FY 2016, the annual payment update for any SNF's that did not submit the required data to CMS was reduced by 2 percentage points.

- The SNF QRP applies to SNFs that are paid under the SNF Prospective Payment System (PPS).

FY 2019 SNF Prospective Payment System Final Rule: References

- Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities(SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program
- Published on August 8, 2018 at https://www.federalregister.gov/documents/2018/08/08/2018-16570/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities
- 42 CFR Parts 411, 413, and 424
- [CMS-1696-F]
- Section VI.B. Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Pages 39265 - 39272

FY 2019 SNF Prospective Payment System Final Rule Summary

- **No** measures were added or removed from the SNF QRP

- The following administrative policies were finalized:
  - **Added** measure removal factor: Factor 8—The costs associated with a measure outweigh the benefit of its continued use in the program
  - **Clarified** policies for provider notification of non-compliance with SNF QRP requirements

- Public Reporting change: the following measures will be reported with 2 years of data beginning in CY 2019
  - Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
  - Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

SNF QRP Quality Measures Beginning FY 2020

Data collection for the FY 2020 SNF QRP begins October 1, 2018 for the following measures:

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer /Injury which replaces the current pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (Short Stay)

- Drug Regimen Review Conducted with Follow-Up for Identified Issues- Past Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program(QRP)

SNF QRP Quality Measures Beginning FY 2020 (cont.)

- Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)

- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)

- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)

- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)

SNF QRP Public Reporting Proposals

- Public reporting for the SNF QRP is planned for Fall 2018.

- Nursing Home Compare will host this data.

- The SNF QRP Public Reporting inaugural release will be comprised of 6 measures, which began collection in October 2016.

SNF Helpdesks:

- CMS SNF Quality Questions:
  - SNFQualityQuestions@cms.hhs.gov
- CMS SNF QRP Reconsiderations Questions:
  - SNFQRPReconsiderations@cms.hhs.gov
- CMS Public Reporting/SNF Compare Questions:
  - SNFQRPPRQuestions@cms.hhs.gov

Hospice Quality Reporting Program

FY 2019 Hospice Final Rule

CMS-1692-F

Background

- The Affordable Care Act amended the Social Security Act to authorize a quality reporting program for hospices. Beginning in FY 2014, hospices that do not submit required quality data on quality measures to CMS will have their annual percentage update reduced by 2 percentage points for the fiscal year involved.

- Hospices currently submit data on 9 quality measures using the Hospice Item Set (HIS), a chart abstracted tool. In addition, beginning January 2015, hospices have been required to participate in the Consumer Assessment Health Provider & Systems Hospice Survey (CAHPS).

Updates related to the HQRP

- The FY 2019 Hospice final rule was posted to the Federal Register on August 6, 2018.

- The final rule can be accessed at: https://www.gpo.gov/fdsys/pkg/FR-2018-08-06/pdf/2018-16539.pdf

Updates related to the HQRP

- HQRP-related proposals and updates in FY 2019 final rule include:
  - Revised Data Review and Correction Timeframes for Data Submitted to Hospice Compare Using the HIS
  - CAHPS® Hospice Survey Participation Requirements for FY 2023 and Subsequent Years
  - Adding Quality Measures to Publically Available Websites – Procedures to Determine Quality Measure Readiness for Public Reporting
  - Quality Measures to be Displayed on Hospice Compare in FY 2019
  - Updates to the Public Display of HIS Measures
  - Display of Public Use File Data and/or other publicly available CMS data on the Hospice Compare Website

Updates in Detail

Revised Data Review and Correction Timeframes for Data Submitted to Hospice Compare Using the HIS

- To ensure that data reported on Hospice Compare is accurate and to align with other QRPs, we finalized that hospices have 4.5 months after the end of each quarter to review and correct data that is to be publicly reported.

- This policy will go into effect January 1, 2019.

- Hospices will have until August 15, 2019 to correct any HIS records with target dates before January 1, 2019 for the purposes of public reporting.

- This policy does not impact the current 36-month timeframe providers have to correct records via modification and inactivation requests

Updates in Detail

Revised Data Review and Correction Timeframes for Data Submitted to Hospice Compare Using the HIS

- Data Correction Deadlines for Public Reporting beginning CY 2019

Data Reporting Period	Data Correction Deadline for Public Reporting
Before January 1, 2019	August 15, 2019
January 1, 2019 – March 31, 2019	August 15, 2019
April 1, 2019 – June 30, 2019	November 15, 2019
July 1, 2019 – September 30, 2019	February 15, 2020
October 1,2019 – December 31, 2019	May 15, 2020

Updates in Detail

Quality Measures to be Displayed on Hospice Compare in FY 2019

- CMS Hospice Compare web site during FY 2019:
  - HIS-based Hospice Comprehensive Assessment Measure (NQF #3235)
  - Hospice Visits when Death is Imminent Measure Pair

Updates in Detail

Display of Public Use File Data and/or other publicly available CMS data on the Hospice Compare Website

- Examples of information trended over multiple years:
  - Percent of days a hospice provided only routine home care (RHC) to patients,
  - Percentages of primary diagnosis of patients served by the hospice (cancer, dementia, circulatory/heart disease, stroke, respiratory disease)
  - Locations where the hospice has served patients

Help Desks for All of Your Questions

- General HQRP or HIS-specific Inquiries
  - Hospice Quality Help Desk: HospiceQualityQuestions@cms.hhs.gov

- CAHPS®-specific Inquiries
  - hospicecahpssurvey@HCQIS.org or 1-844-472-4621
  - CMS staff about implementation issues: hospicesurvey@cms.hhs.gov

- For Technical Assistance (QTSO, QIES, HART, or CASPER)
  - QTSO Help Desk:
  - Email: help@qtso.com
    Phone: 1-877-201-4721 (M-F, 7AM-7PM CT)

The Office of the National Coordinator for Health Information Technology

Health Information Technology Advisory Committee

Lauren Richie
Office of the National Coordinator for Health IT

August 23, 2018

Industry Input into Federal Health IT Policy & Standards

- The Health Information Technology Advisory Committee, or HITAC, makes recommendations to the National Coordinator for Health IT, addressing:
  - Policies
  - Standards
  - Implementation Specifications
  - Certification Criteria
- Recommendations inform the implementation of a health IT infrastructure, nationally and locally, that advances the electronic access, exchange, and use of health information

Priority Target Areas

- The HITAC develops and makes recommendations for the following priority target areas as defined by the 21st Century Cures Act:
  - Achieving a health information technology infrastructure that allows for the electronic access, exchange, and use of health information
  - The promotion and protection of privacy and security of health information in health IT
  - The facilitation of secure access by an individual to such individual's protected health information
  - Any other target area that the HITAC identifies as an appropriate target area to be considered

Ways to Participate

Follow the Conversation

- HITAC, and its Task Forces, hold meetings open to the public
- Schedule of meetings and participation information is available on HealthIT.gov

Make Public Comments

- Each meeting includes dedicated time for the public to make comments

Apply to Participate on Task Forces

- Apply to serve on a Task Force
- Submit your application at HealthIT.gov

HITAC Membership

- Members are non-federal and appointed to represent a particular health IT sector
- Members serve for one-, two-, or three-year terms
  - » Members may be reappointed for subsequent three-year terms
  - » Members are limited to two three-year terms, not to exceed six years
- 15 members appointed by GAO
- Three individuals selected by HHS Secretary
- Eight Congressional appointments
- Four federal representatives (non-voting)

HITAC Activity

- Activities to date since January 2018 include (aligned with priority target areas):
  - Trusted Exchange Framework (TEF) Task Force
  - U.S. Core Data for Interoperability (USCDI) Task Force
  - Interoperability Standards Priorities Task Force
  - Annual Progress Report to Congress (Workgroup)
  - ONC's upcoming rule to implement Cures Act provisions (TBD)
- HITAC meetings, materials, and recommendations to date are available on HealthIT.gov

CMS Data Element Library

Beth Connor, MS RN

DCPAC, CMS

Disclaimer

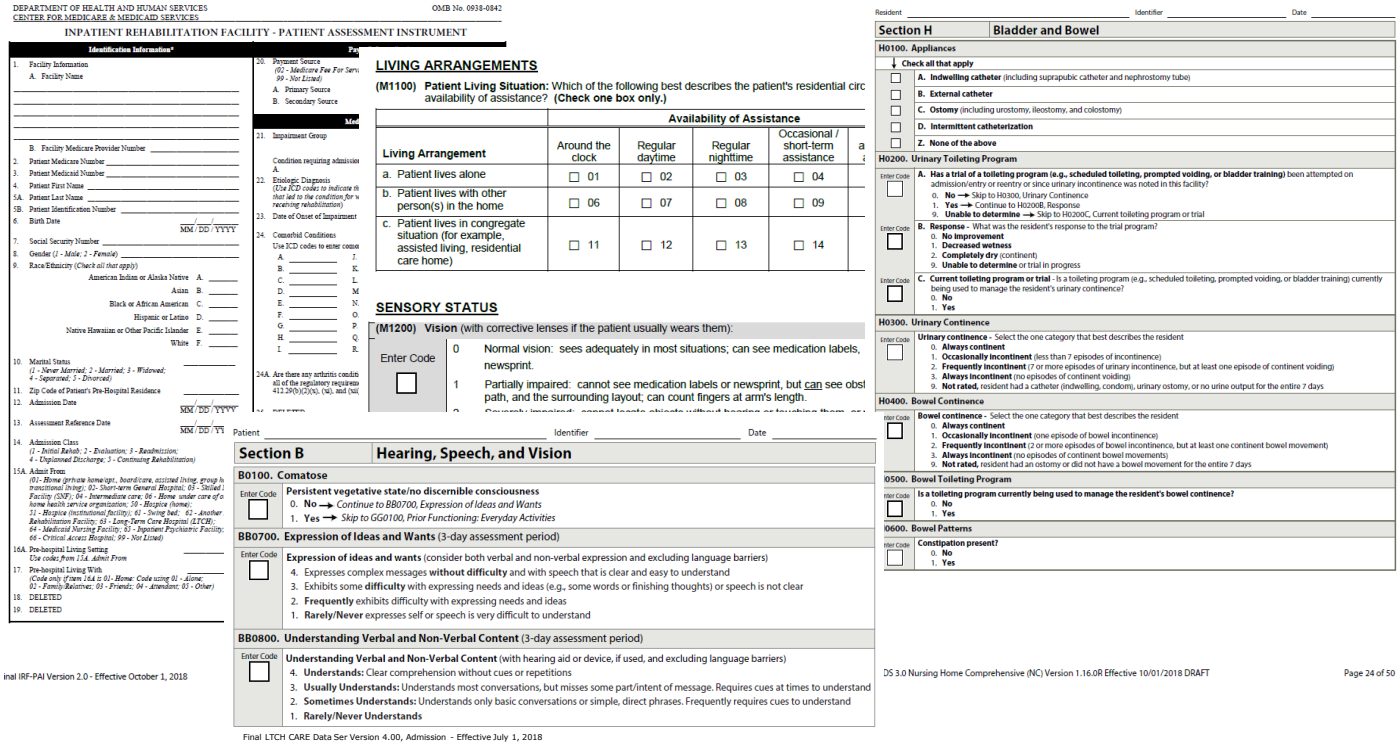
This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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 information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Topics

- **DEL Background**
  - PAC Assessments
  - IMPACT Act
  - Standardization and Interoperability
- **CMS Data Element Library (DEL)**
  - Contents, Uses
  - DEL Demonstration
  - Next Steps

Post-Acute Care Assessments



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

OMB No. 0938-0842

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

Identification Information*

1. Facility Information
   A. Facility Name
   B. Facility Medicare Provider Number
2. Patient Medicare Number
3. Patient Medicaid Number
4. Patient First Name
5A. Patient Last Name
5B. Patient Identification Number
6. Birth Date — MM / DD / YYYY
7. Social Security Number
8. Gender (*1 - Male; 2 - Female*)
9. Race/Ethnicity (*Check all that apply*)
   American Indian or Alaska Native A.
   Asian B.
   Black or African American C.
   Hispanic or Latino D.
   Native Hawaiian or Other Pacific Islander E.
   White F.
10. Marital Status (*1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced*)
11. Zip Code of Patient's Pre-Hospital Residence
12. Admission Date — MM / DD / YYYY
13. Assessment Reference Date — MM / DD / YY
14. Admission Class (*1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation*)
15A. Admit From (*01- Home (private home/apt., board/care, assisted living, group h transitional living); 02- Short-term General Hospital; 03 - Skilled I Facility (SNF); 04 - Intermediate care; 06 - Home under care of a home health service organization; 50 - Hospice (home); 51 - Hospice (institutional facility); 61 - Swing bed; 62 - Another Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital; 99 - Not Listed*)
16A. Pre-hospital Living Setting — Use code from 15A. Admit From
17. Pre-hospital Living With (*Code only if item 16A is 01- Home: Code using 01 - Alone; 02 - Family/Relatives; 03 - Friends; 04 - Attendant; 05 - Other*)
18. DELETED
19. DELETED

20. Payment Source (*02 - Medicare Fee For Servi 99 - Not Listed*)
   A. Primary Source
   B. Secondary Source
21. Impairment Group
   Condition requiring admissio A.
22. Etiologic Diagnosis (*Use ICD codes to indicate th that led to the condition for w receiving rehabilitation*)
23. Date of Onset of Impairment
24. Comorbid Conditions
   Use ICD codes to enter comor
   A. B. C. D. E. F. G. H. I. J. K. L. M N. O. P. Q. R.
24A. Are there any arthritis conditi all of the regulatory requirem 412.29(b)(2)(x), (xi), and (xii

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circ availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance: Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	a
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them):

Enter Code ☐

0 Normal vision: sees adequately in most situations; can see medication labels, newsprint.

1 Partially impaired: cannot see medication labels or newsprint, but can see obst path, and the surrounding layout; can count fingers at arm's length.

Patient _____ Identifier _____ Date _____

Section B — Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness
0. **No** → *Continue to BB0700, Expression of Ideas and Wants*
1. **Yes** → *Skip to GG0100, Prior Functioning: Everyday Activities*

BB0700. Expression of Ideas and Wants (3-day assessment period)

Enter Code ☐

Expression of ideas and wants (consider both verbal and non-verbal expression and excluding language barriers)
4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

BB0800. Understanding Verbal and Non-Verbal Content (3-day assessment period)

Enter Code ☐

Understanding Verbal and Non-Verbal Content (with hearing aid or device, if used, and excluding language barriers)
4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**

Resident _____ Identifier _____ Date _____

Section H — Bladder and Bowel

H0100. Appliances

↓ Check all that apply

- ☐ **A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ **B. External catheter**
- ☐ **C. Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ **D. Intermittent catheterization**
- ☐ **Z. None of the above**

H0200. Urinary Toileting Program

Enter Code ☐ **A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?
0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

Enter Code ☐ **B. Response** - What was the resident's response to the trial program?
0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

Enter Code ☐ **C. Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?
0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code ☐ **Urinary continence** - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐ **Bowel continence** - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

I0500. Bowel Toileting Program

Enter Code ☐ **Is a toileting program currently being used to manage the resident's bowel continence?**
0. **No**
1. **Yes**

I0600. Bowel Patterns

Enter Code ☐ **Constipation present?**
0. **No**
1. **Yes**

inal IRF-PAI Version 2.0 - Effective October 1, 2018

Final LTCH CARE Data Ser Version 4.00, Admission - Effective July 1, 2018

DS 3.0 Nursing Home Comprehensive (NC) Version 1.16.0R Effective 10/01/2018 DRAFT

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IMPACT Act of 2014

- **Bi-partisan bill passed on September 18, 2014, and signed into law October 6, 2014**
- **The Act requires the submission of *standardized* patient assessment data elements by:**
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI
- **The Act specifies that data** "… be **standardized and interoperable** so as to allow for the **exchange of such data among such post-acute care providers and other providers** and the use by such providers of such data that has been so exchanged, including by **using common standards and definitions** in order to provide access to **longitudinal information** for such providers to **facilitate coordinated care** and **improved Medicare beneficiary outcomes**…".

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

Data Elements: Standardization
One Question: Much to Say → One Response: Many Uses

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

Code the patient's usual performance using the 6-point scale below.

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

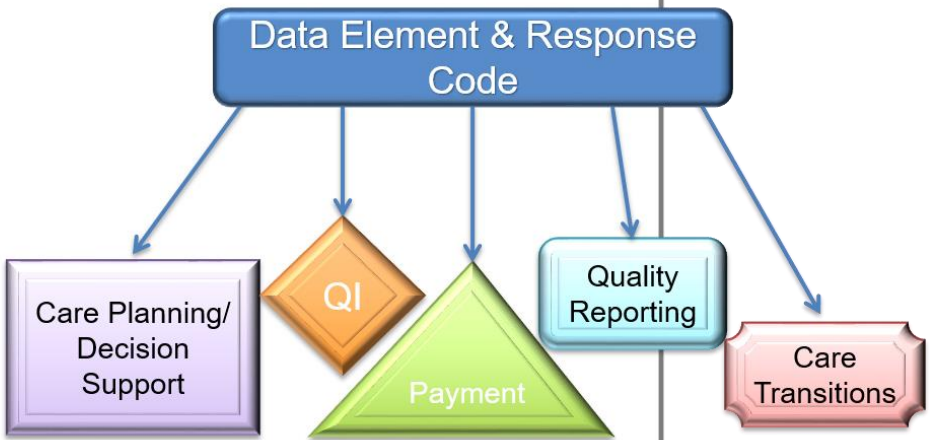
06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

07. **Patient refused**
09. **Not applicable**

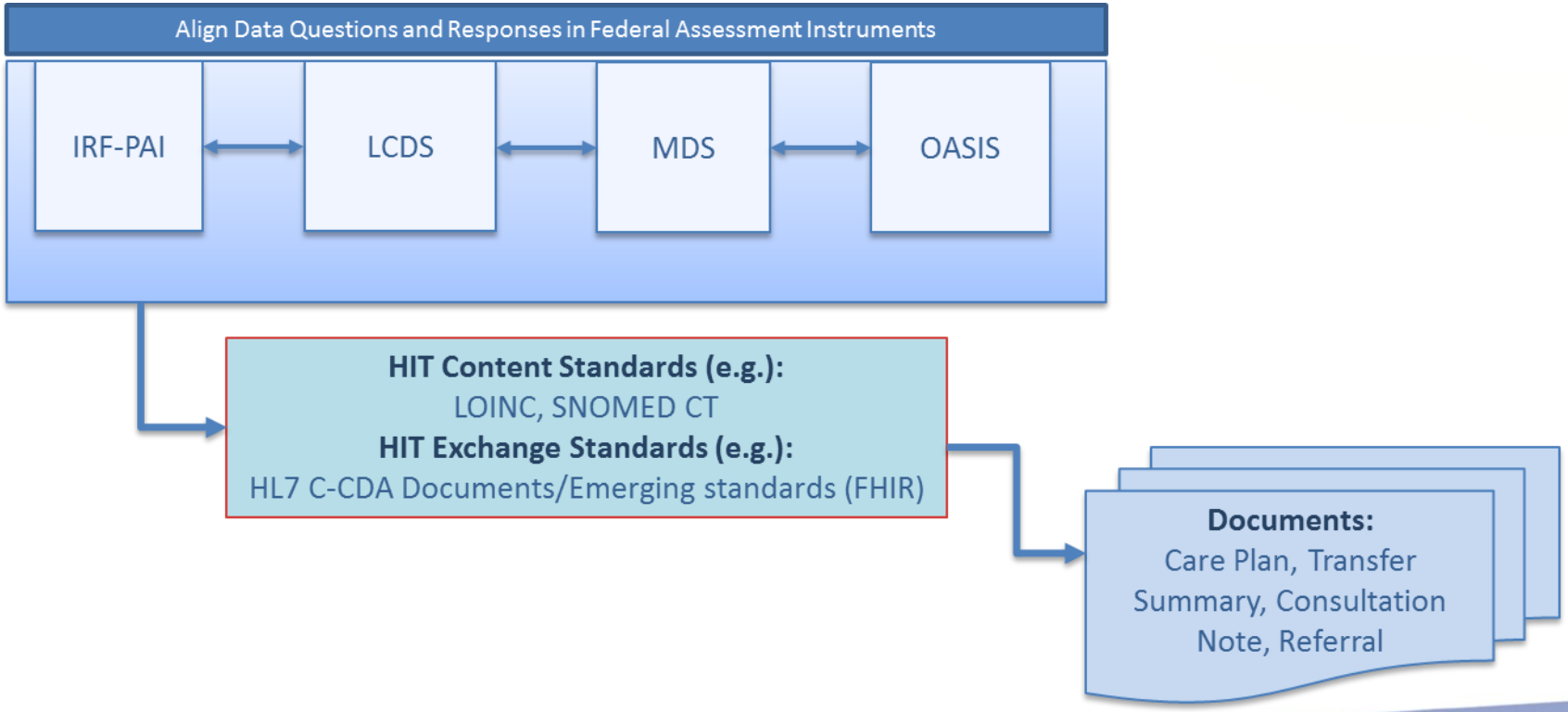
If activity was not attempted, code:
88. Not attempted due to **medical condition or safety concerns**

↓ **Enter Codes in Boxes**

☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.



Making PAC Assessment DEs Standardized/Aligned and Interoperable



Data Element Library

CMS Assessments

- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Long-Term Care Hospital Clinical Data Set (LCDS)
- Minimum Data Set (MDS)
- Outcome and Assessment Information Set (OASIS)
- Hospice Item Set (HIS)
- Functional Assessment Standardized Items (FASI)*

*Under development for Home and Community Based Services

Data Element Attributes

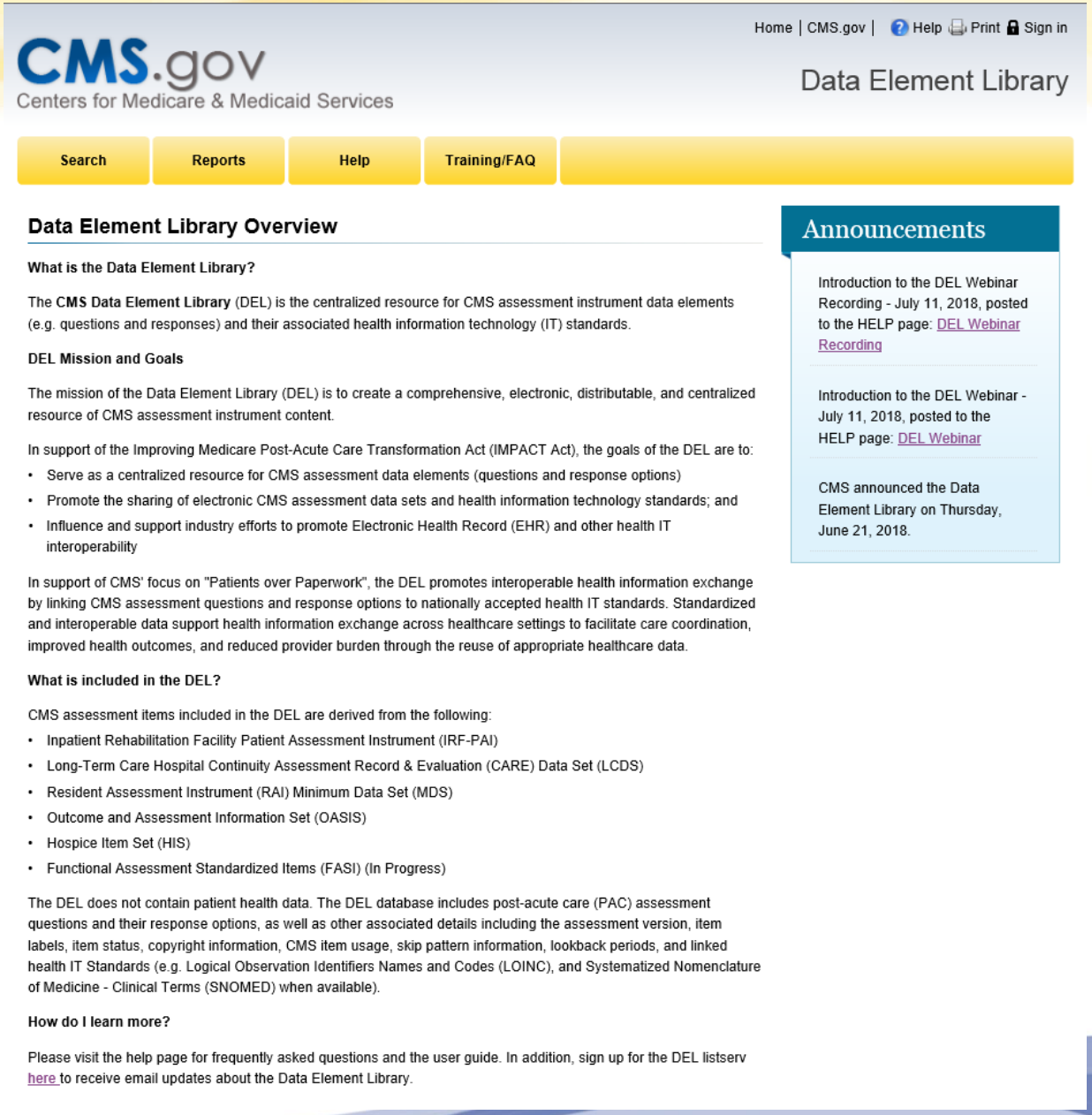
- Assessment and version (e.g., MDS 3.0 v. 1.16)
- Item label (e.g.- GG0170)
- Item status (Published, Active, Inactive)
- Copyright status (if applicable)
- CMS item usage (Payment, Quality Measure, Survey and Certification, etc.)
- Identification of skip pattern triggers and lookback periods
- Mapped HIT codes (LOINC and SNOMED when available)

Data Element Library

DEL Demonstration

https://del.cms.gov

DEL Home Page



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Data Element Library Overview

What is the Data Element Library?

The **CMS Data Element Library** (DEL) is the centralized resource for CMS assessment instrument data elements (e.g. questions and responses) and their associated health information technology (IT) standards.

DEL Mission and Goals

The mission of the Data Element Library (DEL) is to create a comprehensive, electronic, distributable, and centralized resource of CMS assessment instrument content.

In support of the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act), the goals of the DEL are to:

- Serve as a centralized resource for CMS assessment data elements (questions and response options)
- Promote the sharing of electronic CMS assessment data sets and health information technology standards; and
- Influence and support industry efforts to promote Electronic Health Record (EHR) and other health IT interoperability

In support of CMS' focus on "Patients over Paperwork", the DEL promotes interoperable health information exchange by linking CMS assessment questions and response options to nationally accepted health IT standards. Standardized and interoperable data support health information exchange across healthcare settings to facilitate care coordination, improved health outcomes, and reduced provider burden through the reuse of appropriate healthcare data.

What is included in the DEL?

CMS assessment items included in the DEL are derived from the following:

- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Long-Term Care Hospital Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)
- Resident Assessment Instrument (RAI) Minimum Data Set (MDS)
- Outcome and Assessment Information Set (OASIS)
- Hospice Item Set (HIS)
- Functional Assessment Standardized Items (FASI) (In Progress)

The DEL does not contain patient health data. The DEL database includes post-acute care (PAC) assessment questions and their response options, as well as other associated details including the assessment version, item labels, item status, copyright information, CMS item usage, skip pattern information, lookback periods, and linked health IT Standards (e.g. Logical Observation Identifiers Names and Codes (LOINC), and Systematized Nomenclature of Medicine - Clinical Terms (SNOMED) when available).

How do I learn more?

Please visit the help page for frequently asked questions and the user guide. In addition, sign up for the DEL listserv here to receive email updates about the Data Element Library.

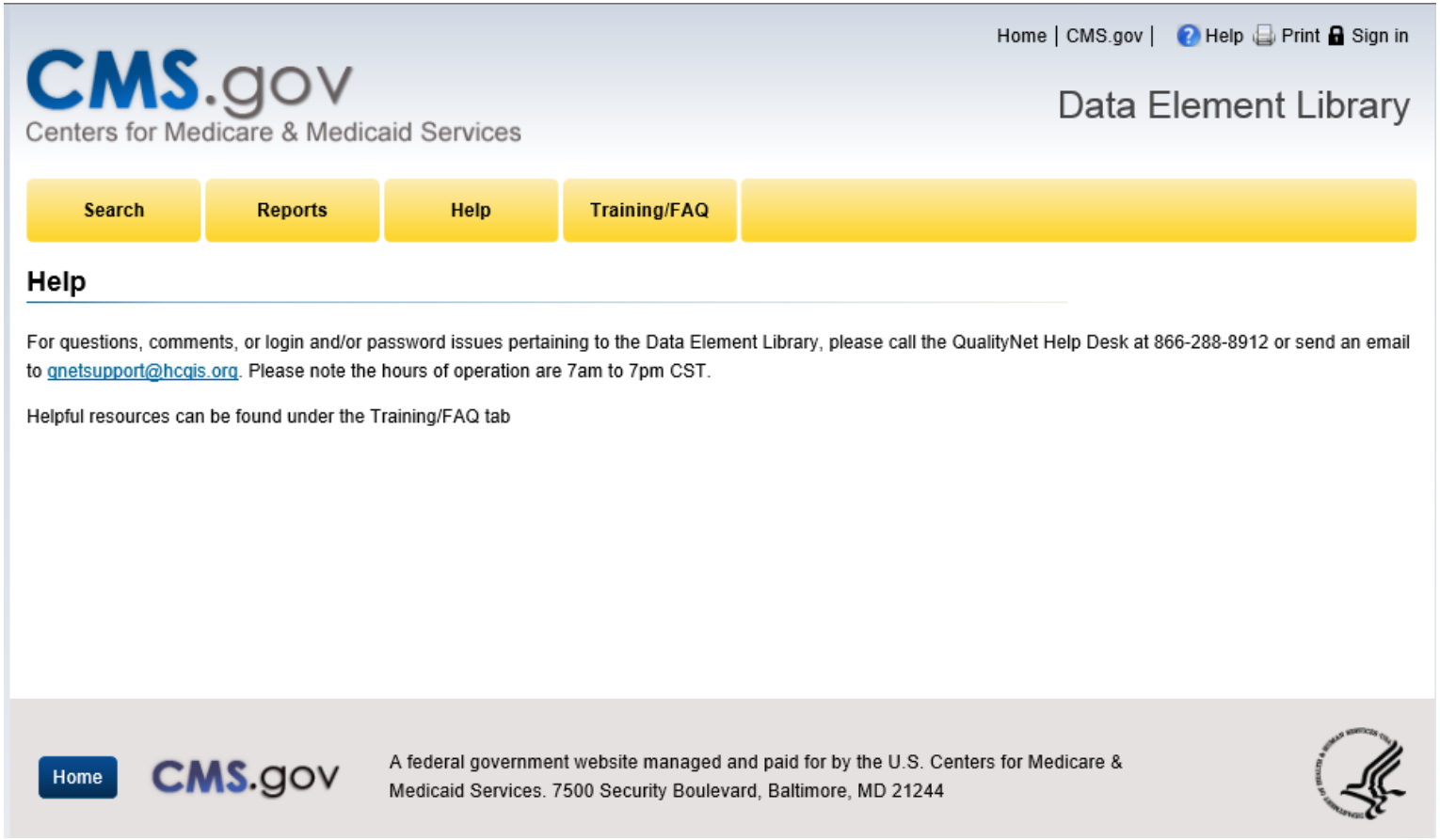
Announcements

Introduction to the DEL Webinar Recording - July 11, 2018, posted to the HELP page: DEL Webinar Recording

Introduction to the DEL Webinar - July 11, 2018, posted to the HELP page: DEL Webinar

CMS announced the Data Element Library on Thursday, June 21, 2018.

DEL Help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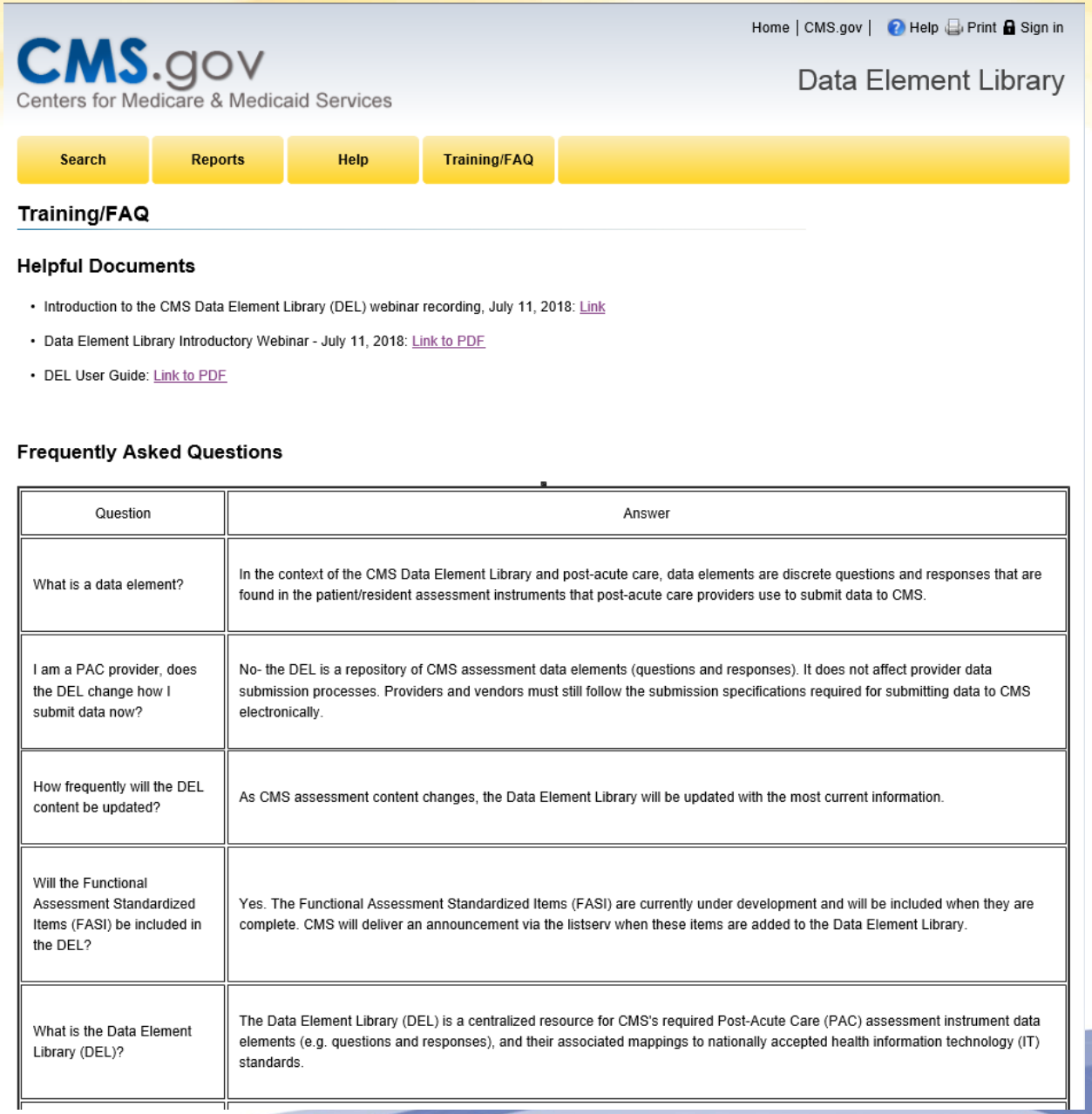
For questions, comments, or login and/or password issues pertaining to the Data Element Library, please call the QualityNet Help Desk at 866-288-8912 or send an email to qnetsupport@hcqis.org. Please note the hours of operation are 7am to 7pm CST.
Helpful resources can be found under the Training/FAQ tab
Home
CMS.gov
A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244

DEL Training/FAQs



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Training/FAQ

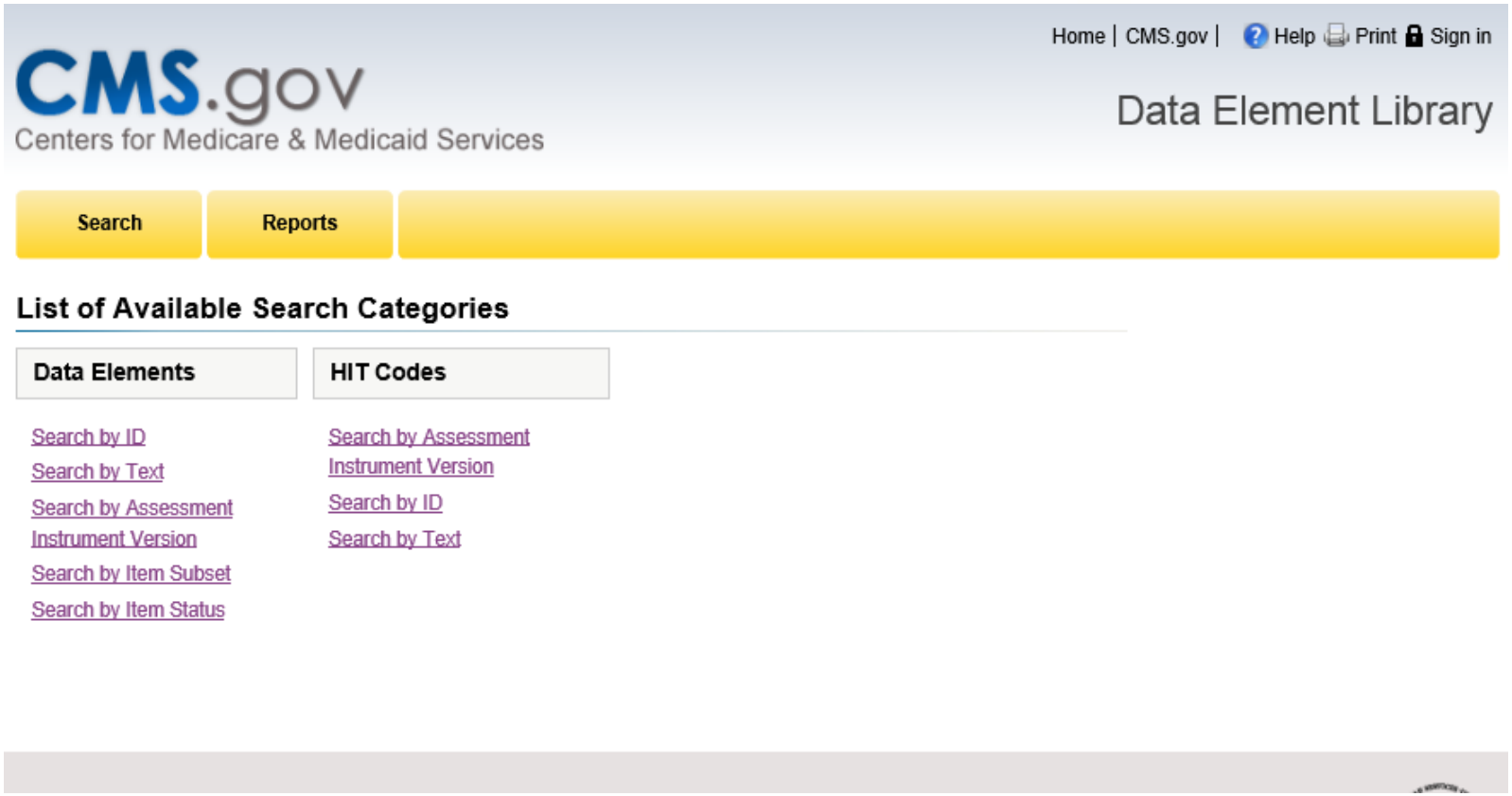
Helpful Documents

- Introduction to the CMS Data Element Library (DEL) webinar recording, July 11, 2018: Link
- Data Element Library Introductory Webinar - July 11, 2018: Link to PDF
- DEL User Guide: Link to PDF

Frequently Asked Questions

Question	Answer
What is a data element?	In the context of the CMS Data Element Library and post-acute care, data elements are discrete questions and responses that are found in the patient/resident assessment instruments that post-acute care providers use to submit data to CMS.
I am a PAC provider, does the DEL change how I submit data now?	No- the DEL is a repository of CMS assessment data elements (questions and responses). It does not affect provider data submission processes. Providers and vendors must still follow the submission specifications required for submitting data to CMS electronically.
How frequently will the DEL content be updated?	As CMS assessment content changes, the Data Element Library will be updated with the most current information.
Will the Functional Assessment Standardized Items (FASI) be included in the DEL?	Yes. The Functional Assessment Standardized Items (FASI) are currently under development and will be included when they are complete. CMS will deliver an announcement via the listserv when these items are added to the Data Element Library.
What is the Data Element Library (DEL)?	The Data Element Library (DEL) is a centralized resource for CMS's required Post-Acute Care (PAC) assessment instrument data elements (e.g. questions and responses), and their associated mappings to nationally accepted health information technology (IT) standards.

Searches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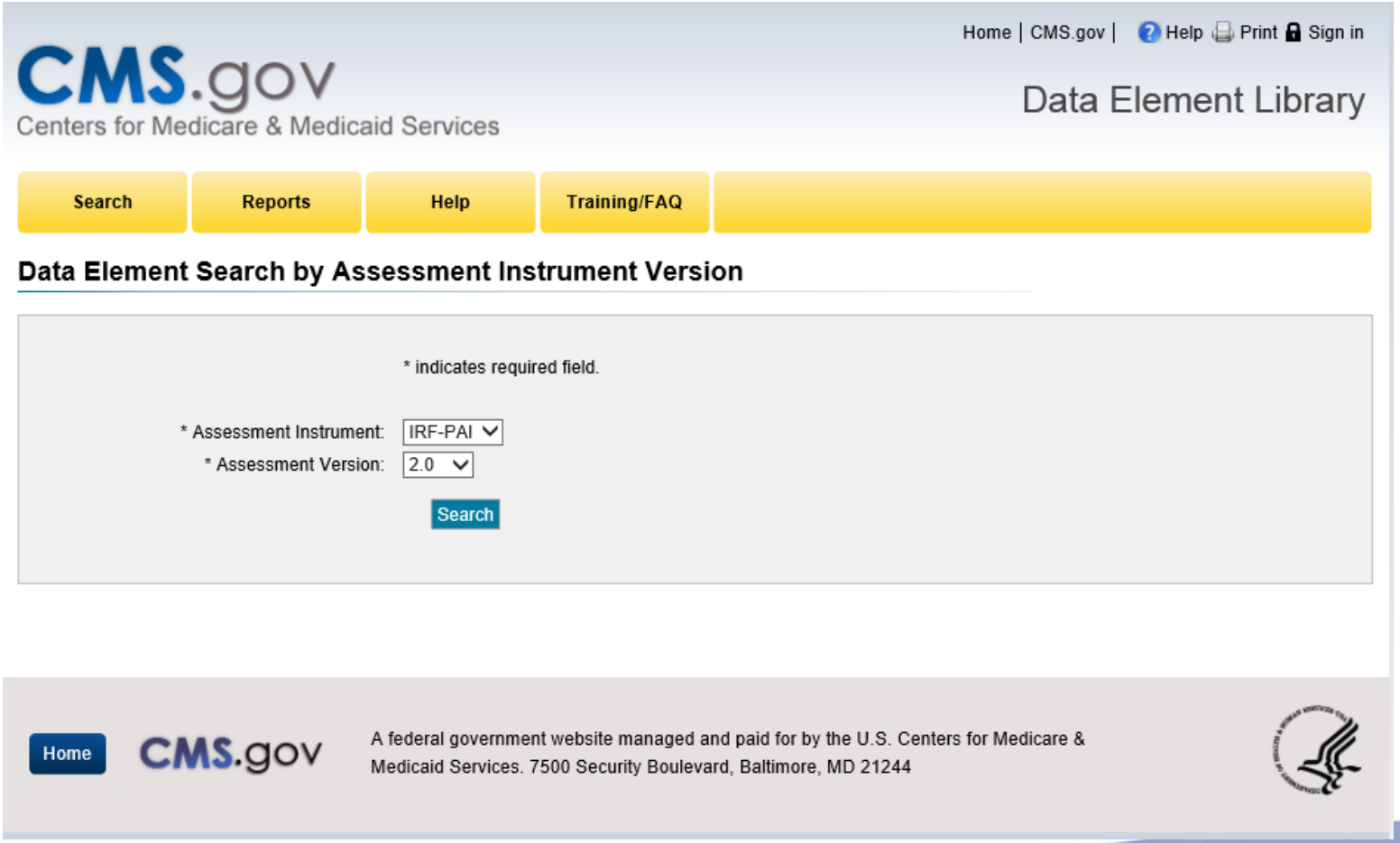
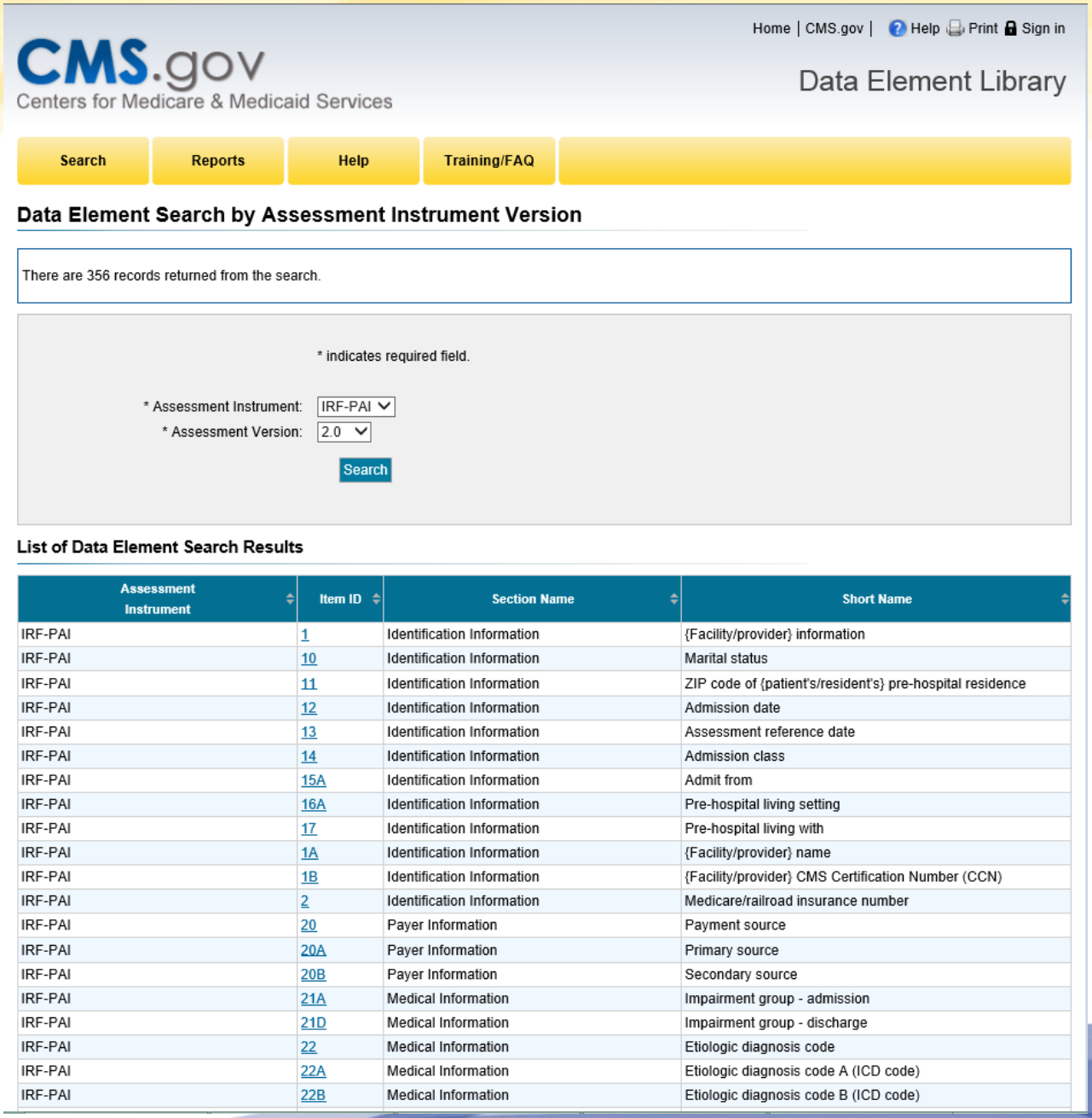
Data Elements
Search by ID
Search by Text
Search by Assessment Instrument Version
Search by Item Subset
Search by Item Status
HIT Codes
Search by Assessment Instrument Version
Search by ID
Search by Text

Search by Assessment



Search by Assessment – Results List



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Data Element Library

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Data Element Search by Assessment Instrument Version

There are 356 records returned from the search.

* indicates required field.

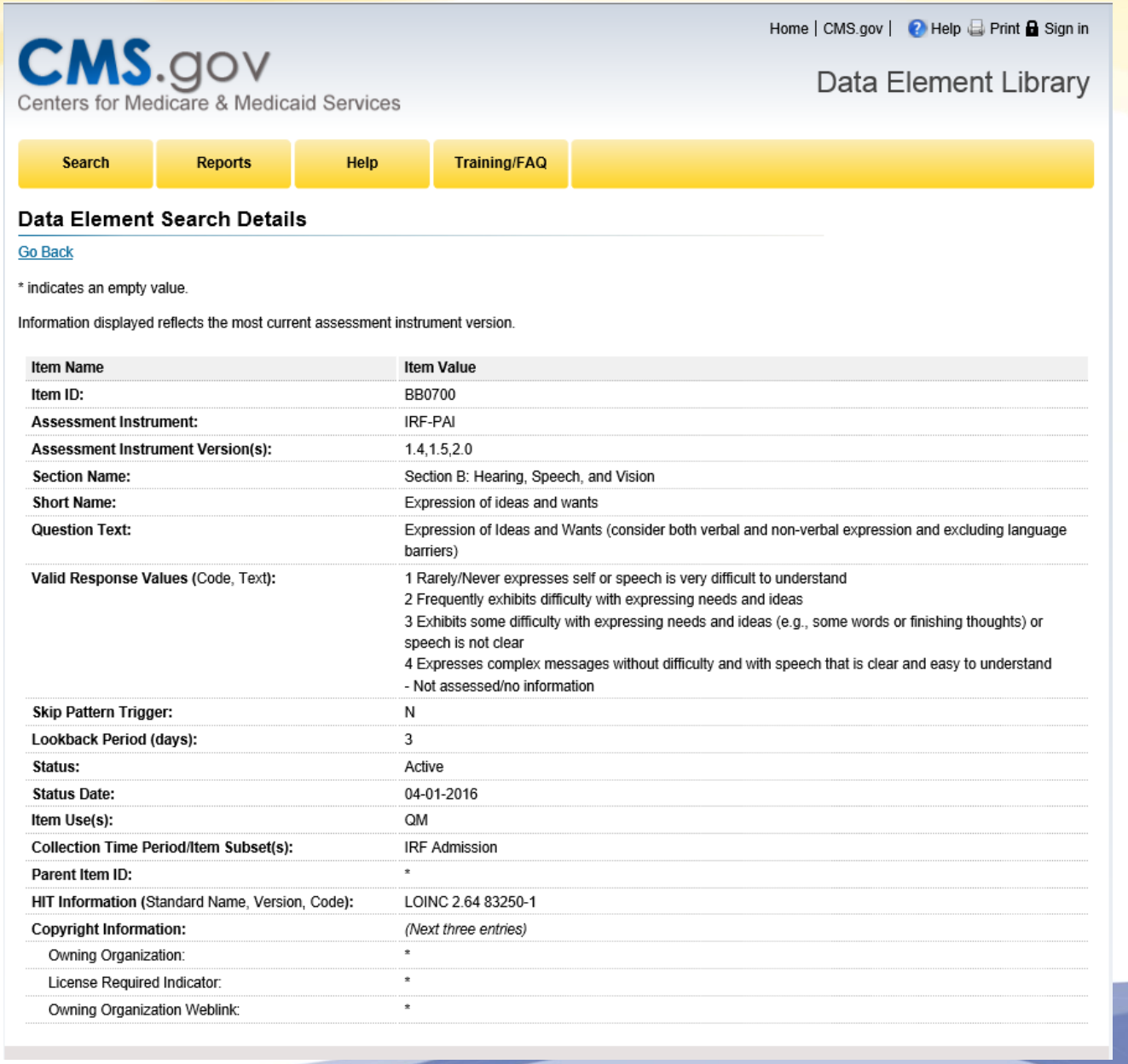
* Assessment Instrument: IRF-PAI
* Assessment Version: 2.0

Search

List of Data Element Search Results

Assessment Instrument	Item ID	Section Name	Short Name
IRF-PAI	1	Identification Information	{Facility/provider} information
IRF-PAI	10	Identification Information	Marital status
IRF-PAI	11	Identification Information	ZIP code of {patient's/resident's} pre-hospital residence
IRF-PAI	12	Identification Information	Admission date
IRF-PAI	13	Identification Information	Assessment reference date
IRF-PAI	14	Identification Information	Admission class
IRF-PAI	15A	Identification Information	Admit from
IRF-PAI	16A	Identification Information	Pre-hospital living setting
IRF-PAI	17	Identification Information	Pre-hospital living with
IRF-PAI	1A	Identification Information	{Facility/provider} name
IRF-PAI	1B	Identification Information	{Facility/provider} CMS Certification Number (CCN)
IRF-PAI	2	Identification Information	Medicare/railroad insurance number
IRF-PAI	20	Payer Information	Payment source
IRF-PAI	20A	Payer Information	Primary source
IRF-PAI	20B	Payer Information	Secondary source
IRF-PAI	21A	Medical Information	Impairment group - admission
IRF-PAI	21D	Medical Information	Impairment group - discharge
IRF-PAI	22	Medical Information	Etiologic diagnosis code
IRF-PAI	22A	Medical Information	Etiologic diagnosis code A (ICD code)
IRF-PAI	22B	Medical Information	Etiologic diagnosis code B (ICD code)

Search by Assessment - Details



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Data Element Search Details

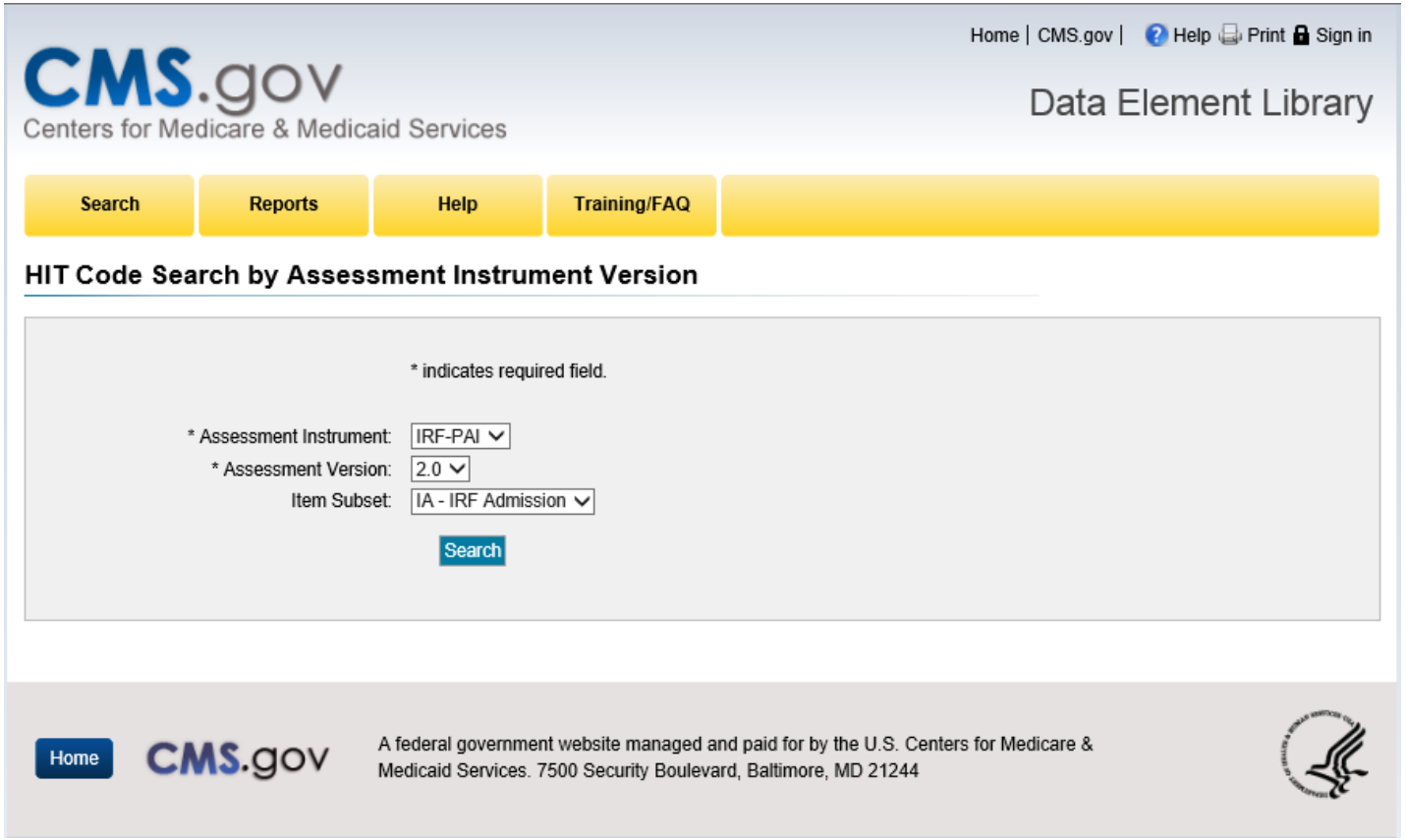
Go Back

* indicates an empty value.

Information displayed reflects the most current assessment instrument version.

Item Name	Item Value
Item ID:	BB0700
Assessment Instrument:	IRF-PAI
Assessment Instrument Version(s):	1.4,1.5,2.0
Section Name:	Section B: Hearing, Speech, and Vision
Short Name:	Expression of ideas and wants
Question Text:	Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)
Valid Response Values (Code, Text)**:**	1 Rarely/Never expresses self or speech is very difficult to understand 2 Frequently exhibits difficulty with expressing needs and ideas 3 Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear 4 Expresses complex messages without difficulty and with speech that is clear and easy to understand - Not assessed/no information
Skip Pattern Trigger:	N
Lookback Period (days):	3
Status:	Active
Status Date:	04-01-2016
Item Use(s):	QM
Collection Time Period/Item Subset(s):	IRF Admission
Parent Item ID:	*
HIT Information (Standard Name, Version, Code)**:**	LOINC 2.64 83250-1
Copyright Information:	*(Next three entries)*
Owning Organization:	*
License Required Indicator:	*
Owning Organization Weblink:	*

Search for Health IT Codes



Health IT Code -Results List

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HIT Code Search by Assessment Instrument Version

There are 1081 records returned from the search. To limit amount of records returned, please refine your search criteria.

* indicates required field.

* Assessment Instrument: IRF-PAI
* Assessment Version: 2.0
Item Subset: IA - IRF Admission

Search

List of HIT Codes Search Results

* indicates an empty value.

Type (Response or Question)	HIT Standard Name	HIT Standard Version	Assessment Instrument	HIT Code	HIT Text
Question	LOINC	2.64	IRF-PAI	85396-0	IRF-PAI - Facility information [CMS Assessment]
Question	LOINC	2.64	IRF-PAI	45404-1	Marital status
Question	LOINC	2.64	IRF-PAI	52539-4	Prior zip code
Question	LOINC	2.64	IRF-PAI	52455-3	Admission date
Question	LOINC	2.64	IRF-PAI	52456-1	Assessment reference date
Question	LOINC	2.64	IRF-PAI	85397-8	Inpatient rehabilitation facility admission [CMS Assessment]
Question	LOINC	2.64	IRF-PAI	85398-6	Admitted from
Question	LOINC	2.64	IRF-PAI	85399-4	Prior residence
Question	LOINC	2.64	IRF-PAI	85400-0	Prior living arrangement [CMS Assessment]
Question	LOINC	2.64	IRF-PAI	76696-4	Name Facility
Question	LOINC	2.64	IRF-PAI	69417-4	CMS certification # Facility
Question	LOINC	2.64	IRF-PAI	45397-7	Medicare or comparable #
Question	LOINC	2.64	IRF-PAI	85813-4	Payment source [CMS Assessment]
Question	LOINC	2.64	IRF-PAI	85402-6	Payment source.primary [CMS Assessment]
Question	LOINC	2.64	IRF-PAI	85403-4	Payment source.secondary [CMS Assessment]
Question	LOINC	2.64	IRF-PAI	85845-6	Impairment group [CMS Assessment]
Question	LOINC	2.64	IRF-PAI	52797-8	Dx ICD code
Question	LOINC	2.64	IRF-PAI	52797-8	Dx ICD code
Question	LOINC	2.64	IRF-PAI	52797-8	Dx ICD code

Health IT Code - Details

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HIT Code Search Details

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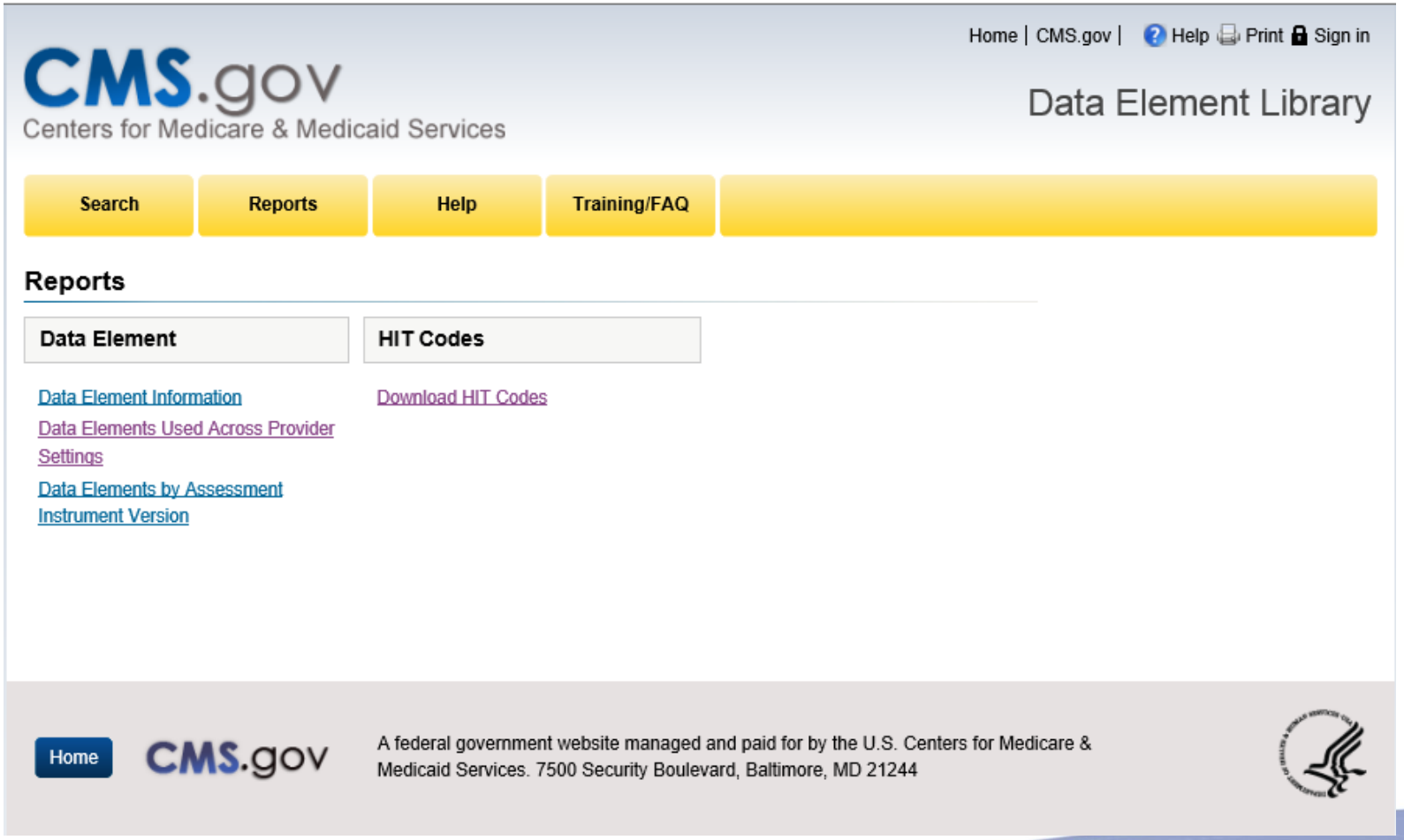
* indicates an empty value.

Item Name	Item Value
Item HIT Standard Name:	LOINC
Item HIT Standard Version:	2.64
Item HIT Code:	83229-5
Item HIT Text:	Oral hygiene - functional goal recorded during 3D assessment period [CMS Assessment]
Assessment Instrument:	IRF-PAI
Assessment Instrument Version:	2.0
Item ID:	GG0130B2
Short Name:	Self-care (discharge goal) - oral hygiene
Item Subsets:	IA

Responses:

Response HIT Standard Name	Response HIT Standard Version	Response Code	Response HIT Code	Response HIT Text
LOINC	2.64	01	LA27665-1	Dependent - Helper does all of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.
LOINC	2.64	02	LA11759-0	Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
LOINC	2.64	03	LA10055-4	Partial/moderate assistance - Helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
LOINC	2.64	04	LA28225-3	Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
LOINC	2.64	05	LA10073-7	Setup or clean-up assistance - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.

Reports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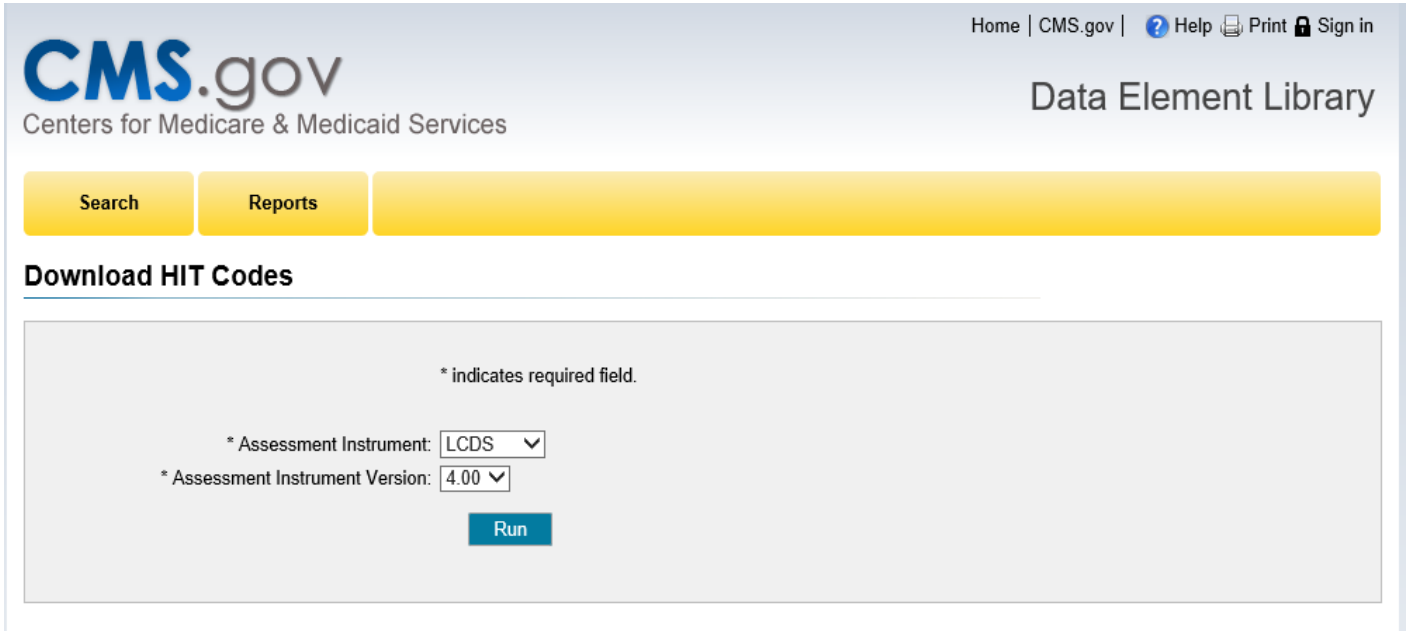
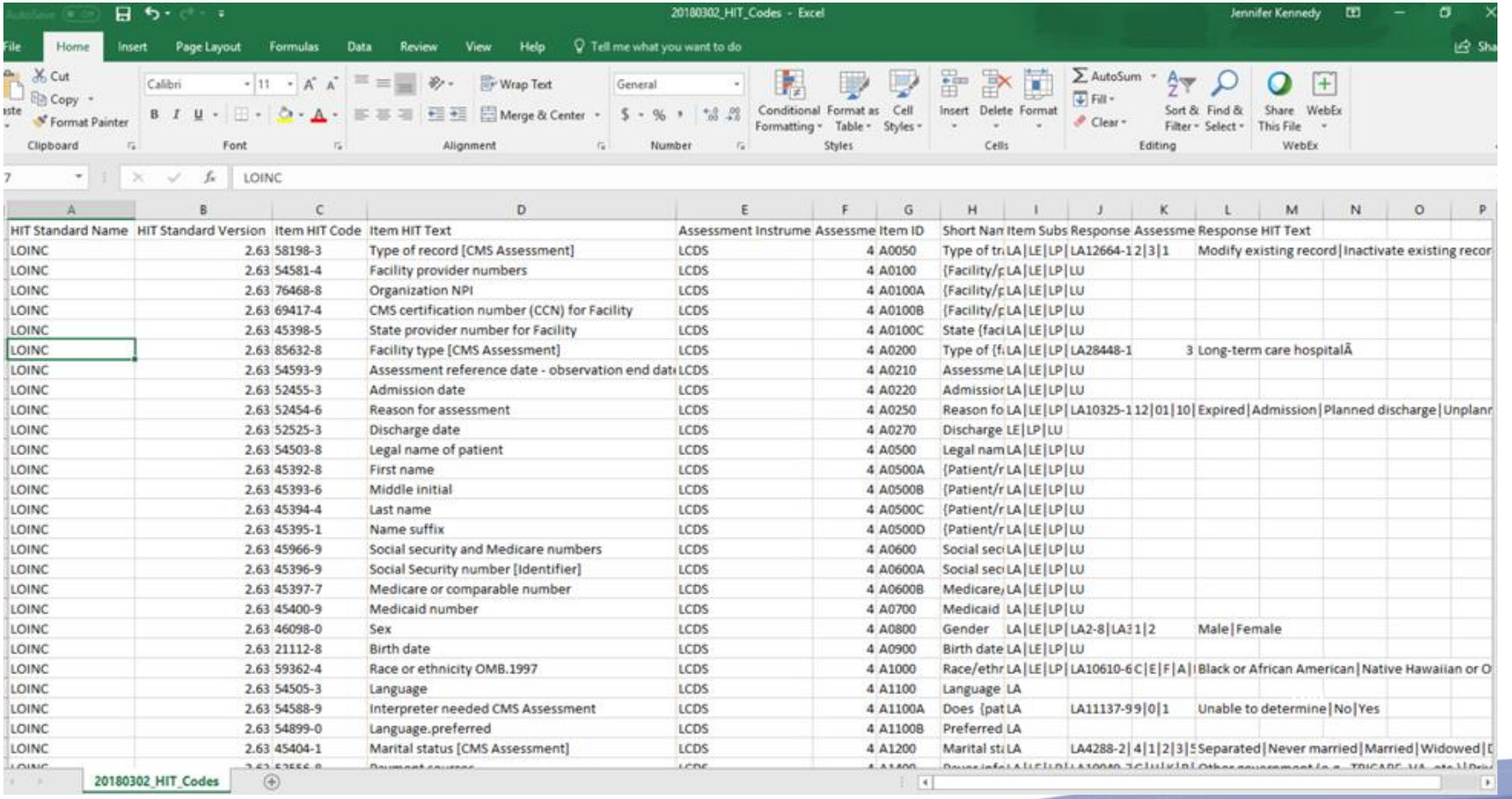


Health IT Code Report



20180302_HIT_Codes - Excel

HIT Standard Name	HIT Standard Version	Item HIT Code	Item HIT Text	Assessment Instrume	Assessme	Item ID	Short Nan	Item Subs	Response	Assessme	Response HIT Text
LOINC	2.63	58198-3	Type of record [CMS Assessment]	LCDS	4	A0050	Type of tr	LA|LE|LP	LA12664-1	2|3|1	Modify existing record|Inactivate existing recor
LOINC	2.63	54581-4	Facility provider numbers	LCDS	4	A0100	(Facility/p	LA|LE|LP|LU			
LOINC	2.63	76468-8	Organization NPI	LCDS	4	A0100A	(Facility/p	LA|LE|LP|LU			
LOINC	2.63	69417-4	CMS certification number (CCN) for Facility	LCDS	4	A0100B	(Facility/p	LA|LE|LP|LU			
LOINC	2.63	45398-5	State provider number for Facility	LCDS	4	A0100C	State (faci	LA|LE|LP|LU			
LOINC	2.63	85632-8	Facility type [CMS Assessment]	LCDS	4	A0200	Type of (fi	LA|LE|LP	LA28448-1	3	Long-term care hospitalÃ
LOINC	2.63	54593-9	Assessment reference date - observation end dat	LCDS	4	A0210	Assessme	LA|LE|LP|LU			
LOINC	2.63	52455-3	Admission date	LCDS	4	A0220	Admissior	LA|LE|LP|LU			
LOINC	2.63	52454-6	Reason for assessment	LCDS	4	A0250	Reason fo	LA|LE|LP	LA10325-1	12|01|10	Expired|Admission|Planned discharge|Unplanr
LOINC	2.63	52525-3	Discharge date	LCDS	4	A0270	Discharge	LE|LP|LU			
LOINC	2.63	54503-8	Legal name of patient	LCDS	4	A0500	Legal nam	LA|LE|LP|LU			
LOINC	2.63	45392-8	First name	LCDS	4	A0500A	(Patient/r	LA|LE|LP|LU			
LOINC	2.63	45393-6	Middle initial	LCDS	4	A0500B	(Patient/r	LA|LE|LP|LU			
LOINC	2.63	45394-4	Last name	LCDS	4	A0500C	(Patient/r	LA|LE|LP|LU			
LOINC	2.63	45395-1	Name suffix	LCDS	4	A0500D	(Patient/r	LA|LE|LP|LU			
LOINC	2.63	45966-9	Social security and Medicare numbers	LCDS	4	A0600	Social sec	LA|LE|LP|LU			
LOINC	2.63	45396-9	Social Security number [Identifier]	LCDS	4	A0600A	Social sec	LA|LE|LP|LU			
LOINC	2.63	45397-7	Medicare or comparable number	LCDS	4	A0600B	Medicare/	LA|LE|LP|LU			
LOINC	2.63	45400-9	Medicaid number	LCDS	4	A0700	Medicaid	LA|LE|LP|LU			
LOINC	2.63	46098-0	Sex	LCDS	4	A0800	Gender	LA|LE|LP	LA2-8|LA3	1|2	Male|Female
LOINC	2.63	21112-8	Birth date	LCDS	4	A0900	Birth date	LA|LE|LP|LU			
LOINC	2.63	59362-4	Race or ethnicity OMB.1997	LCDS	4	A1000	Race/ethr	LA|LE|LP	LA10610-6	C|E|F|A|	Black or African American|Native Hawaiian or O
LOINC	2.63	54505-3	Language	LCDS	4	A1100	Language	LA			
LOINC	2.63	54588-9	Interpreter needed CMS Assessment	LCDS	4	A1100A	Does (pat	LA	LA11137-9	9|0|1	Unable to determine|No|Yes
LOINC	2.63	54899-0	Language.preferred	LCDS	4	A1100B	Preferred	LA			
LOINC	2.63	45404-1	Marital status [CMS Assessment]	LCDS	4	A1200	Marital st	LA	LA4288-2	4|1|2|3|5	Separated|Never married|Married|Widowed|D

Resources

- For more information on the IMPACT Act, visit the IMPACT Act webpage
- To keep up to date on the DEL, sign up for the listserv here
- For more information on Post-Acute Care Quality Reporting Programs, visit:
  - Home Health Agencies
  - Hospice Agencies
  - Inpatient Rehab Facilities
  - Long-term Care Hospitals
  - Skilled Nursing Facilities
- If you have any questions or would like to provide feedback to help with future DEL development, please feel free to contact:
  - DELHelp@cms.hhs.gov

Questions?

cmsqualityteam@ketchum.com

Thank you!

CMS has resumed holding the Vendor calls on a monthly basis. The next CMS Quality Vendor Workgroup will tentatively be held on **Thursday, September 20, 2018 from 12 – 1:30 p.m. ET**. CMS will share more information when it becomes available.