Hospice Item Set: Item Descriptions

Item	Definition/Description
Section A: Administrative Information	
Note: Items marked with an asterisk (*) are items that appear on both the Admission and Discharge Item Sets. Items marked with two asterisks (**) are items that appear *only* on the Discharge Item Set.	
A0050. Type of Record*	Enter the one-digit code to indicate the type of record. Code 1 if this is a new record that has not been previously submitted and accepted in the QIES ASAP system. Code 2 if this is a request to modify the data for a record that has been previously submitted and accepted in the QIES ASAP system. Code 3 if this is a request to inactivate a record that already has been submitted and accepted in the QIES ASAP system.
A0100. Facility Provider Numbers. Enter code in boxes provided.*	Record the NPI (National Provider Identification) number: 10 digits, no spaces, no letters, no other characters. Record the CCN (CMS Certification Number, also known as the Medicare Provider Number): 6 digits, no spaces, no letters, no other characters.
A0205. Site of Service at Admission	Enter the two-digit code to indicate the patient's site of service at the time of admission to hospice.
A0220. Admission Date*	Record the admission date in MM-DD-YYYY format. For Medicare patients, this date is the effective date of hospice benefit election.
A0245. Date Initial Nursing Assessment Initiated	Record the date the hospice registered nurse began the initial assessment, in MM-DD-YYYY format. This may or may not be the same date as the admission date.
A0250. Reason for Record*	Enter the two-digit code that corresponds to reason for completing the item set. Code 01 for Admission. Code 09 for Discharge.
A0270. Discharge Date**	Record the date the patient was discharged, record the date in MM-DD-YYYY format. This is the date the patient leaves the hospice. If the patient has expired, it is the date of death.
A0500. Legal Name of Patient*	Record the patient's legal name, as it appears on the Medicare card. If the patient is not enrolled in the Medicare program, enter the patient's name as it appears on a Medicaid card or other government-issued document.

Item	Definition/Description
A0600. Social Security and Medicare Numbers*	Record the patient's Social Security and Medicare Numbers for identification purposes. If a patient does not have a Social Security Number, the item may be left blank. Enter the Medicare number exactly as it appears on the patient's Medicare card. If the patient does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. If the patient has neither a Medicare number nor an RRB number, the item may be left blank.
A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient*	Record the Medicaid number if the patient is a Medicaid recipient. Enter a "+" in the left-most box if the number is pending. Enter "N" in the left-most box if the patient is not a Medicaid recipient.
A0800. Gender*	Enter the one-digit code for the patient's gender. Code 1 if the patient is male. Code 2 if the patient is female.
A0900. Birth Date*	Record the birth date of the patient using MM-DD-YYYY format.
A1000. Race/Ethnicity (Check all that apply)	Record the race/ethnicity of the patient. Check all that apply.
A1802. Admitted From. Immediately preceding this admission, where was the patient?	Enter the two-digit code that best describes the setting in which the patient was staying immediately preceding this admission.
A2115. Reason for Discharge**	Enter the two-digit code to indicate the reason for discharge.
Section F: Preferences	
F2000. CPR Preference	
F2000A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?	Enter the one-digit code to indicate whether the patient/responsible party was asked about preference regarding the use of CPR. Code 0 if the patient/responsible party was not asked about preference regarding the use of CPR. Code 1 if the patient/family was asked about preference regarding the use of CPR, and a discussion occurred. Code 2 if the patient/responsible party was asked about preference regarding the use of CPR, but the patient/responsible party refused to discuss.
F2000B. Date the patient/responsible party was first asked about preference regarding the use of CPR	Record the date the patient/responsible party was first asked about preference regarding the use of CPR in MM-DD-YYYY format.

Item	Definition/Description
F2100. Other Life-Sustaining Treatment Preferences	
F2100A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR?	Enter the one-digit code to indicate whether the patient/responsible party was asked about preferences regarding life-sustaining treatments other than CPR. Code 0 if the patient/responsible party was not asked about preferences regarding life-sustaining treatments other than CPR. Code 1 if the patient/responsible party was asked about preferences regarding life-sustaining treatments other than CPR, and a discussion occurred. Code 2 if the patient/responsible party was asked about preferences regarding life-sustaining treatments other than CPR, but the patient/responsible party refused to discuss.
F2100B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR.	Record the date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR in MM-DD-YYYY format.
F2200. Hospitalization Preference	
F2200A. Was the patient/responsible party asked about preference regarding hospitalization?	Enter the one-digit code to indicate whether the patient/responsible party was asked about preference regarding hospitalization. Code 0 if the patient/responsible party was not asked about preference regarding hospitalization. Code 1 if the patient/responsible party was asked about preference regarding hospitalization, and a discussion occurred. Code 2 if the patient/responsible party was asked about preference for hospitalization, but the patient/responsible party refused to discuss.
F2200B. Date the patient/responsible party was asked about preference regarding hospitalization	Record the date the patient/responsible party was first asked about preference regarding hospitalization in MM-DD-YYYY format.
F3000. Spiritual/Existential Concerns	
F3000A. Was patient and/or caregiver asked about spiritual/existential concerns?	Enter the one-digit code to indicate whether the patient and/or caregiver was asked about spiritual/existential concerns. Code 0 if the patient and/or caregiver was not asked about spiritual/existential concerns. Code 1 if the patient and/or caregiver was asked about spiritual/existential concerns, and a discussion occurred. Code 2 if the patient and/or caregiver was asked about spiritual/existential concerns, but the patient and/or caregiver refused to discuss.
F3000B. Date patient and/or caregiver was first asked about spiritual/existential concerns	Record the date the patient and/or caregiver was first asked about spiritual/existential concerns in MM-DD-YYYY format.

Item	Definition/Description
Section I: Active Diagnoses	
I0010. Principal Diagnosis	Enter the two-digit code that best describes the patient's principal diagnosis. Code 01 if the patient's principal diagnosis is cancer. Code 02 if the patient's principal diagnosis is dementia/Alzheimer's. Code 99 if the patient's principal diagnosis is a disease/condition other than cancer or dementia/Alzheimer's.
Section J: Health Conditions	
Pain	
J0900. Pain Screening	
J0900A. Was the patient screened for pain?	Enter the one-digit code to indicate whether or not the patient was screened for pain. A pain screening includes activities to discern the presence and severity of pain symptoms. Enter 0 if a pain screening was not conducted. Enter 1 if a pain screening was conducted.
J0900B. Date of first screening for pain	Record the date in MM-DD-YYYY format of the first screening for pain.
J0900C. The patient's pain severity was:	Enter the one-digit code to indicate the patient's pain severity score. Code 0 if the patient's pain was none. Code 1 if the patient's pain was mild. Code 2 if the patient's pain was moderate. Code 3 if the patient's pain was severe. Code 9 if the pain was not rated.
J0900D. Type of standardized pain tool used	Enter the one-digit code to indicate the type of standardized pain tool used. Code 1 if a numeric scale was used. Code 2 if a verbal descriptor scale was used. Code 3 if a patient visual scale was used. Code 4 if a staff observation tool was used. Code 9 if pain was not rated using a standardized tool.
J0910. Comprehensive pain assessment	
J0910A. Was a comprehensive pain assessment done?	Enter the one-digit code to indicate whether or not the patient had a comprehensive pain assessment. A comprehensive pain assessment includes activities to gain an understanding of the location, severity, character, duration, frequency, and impact on function and what relieves or worsens pain. Enter 0 if a comprehensive pain assessment was not conducted. Enter 1 if a comprehensive pain assessment was conducted.
J0910B. Date of comprehensive pain assessment	Record the date of comprehensive assessment of pain in MM-DD-YYYY format.

Item	Definition/Description
J0910C. Comprehensive pain assessment included (Check all that apply)	Record each characteristic included in the comprehensive pain assessment. Check all that apply from: 1. Location 2. Severity 3. Character 4. Duration 5. Frequency 6. What relieves/worsens pain 7. Effect or function on quality of life 9. None of the above
Respiratory Status	
J2030. Screening for Shortness of Breath	
J2030A. Was the patient screened for shortness of breath?	Enter the one-digit code to indicate whether or not the patient was screened for shortness of breath. A screening for shortness of breath would include self-report questions or clinical observations to discern the presence and severity of shortness of breath. Enter 0 if the patient was not screened for shortness of breath. Enter 1 if the patient was screened for shortness of breath.
J2030B. Date of first screening for shortness of breath	Record the date in MM-DD-YYYY format of the first screening for shortness of breath.
J2030C. Did the screening indicate the patient had shortness of breath?	Enter the one-digit code to indicate whether the shortness of breath screening indicated the patient has shortness of breath. Code 0 if the screening indicated the patient did not have shortness of breath. Code 1 if the screening indicated the patient had shortness of breath.
J2040. Treatment for Shortness of Breath	
J2040A. Was treatment for shortness of breath initiated?	Enter the one-digit code to indicate whether treatment for shortness of breath was initiated. Treatment can include medication, equipment, and/or non-medication interventions. Enter 0 if the treatment for shortness of breath was not initiated. Enter 1 if patient declined treatment. Enter 2 if treatment for shortness of breath was initiated.
J2040B. Date treatment for shortness of breath initiated	Enter the date that treatment for shortness of breath was initiated in MM-DD-YYYY format. “Initiated” is defined as the date the order (verbal or written) was received. For non-medication interventions, there may be no orders; in this case, use the date the intervention was delivered.
J2040C. Type(s) of treatment for shortness of breath initiated (Check all that apply)	Indicate the type of treatment initiated for shortness of breath. Check all that apply from: 1. Opioids 2. Other medication 3. Oxygen 4. Non-medication

Item	Definition/Description
Section N: Medications	
N0500. Scheduled Opioid	
N0500A. Was a scheduled opioid initiated or continued?	Enter the one-digit code to indicate whether a scheduled opioid was initiated or continued from the previous care setting. Code 0 if a scheduled opioid was neither initiated nor continued from the previous care setting. Code 1 if a scheduled opioid was initiated or continued from the previous care setting.
N0500B. Date scheduled opioid initiated or continued	Indicate the date the scheduled opioid was initiated or continued in MM-DD-YYYY format. The date should reflect the date the order (verbal or written) for the medication was received.
N0510. PRN Opioid	
N0510A. Was PRN opioid initiated or continued?	Enter the one-digit code to indicate whether a PRN opioid was initiated or continued from the previous care setting. Code 0 if a PRN opioid was neither initiated nor continued from the previous care setting. Code 1 if a PRN opioid was initiated or continued from the previous care setting.
N0510B. Date PRN opioid initiated or continued	Indicate the date the PRN opioid was initiated or continued in MM-DD-YYYY format. The date should reflect the date the order (verbal or written) for the medication was received.
N0520. Bowel Regimen	
N0520A. Was a bowel regimen initiated or continued?	Enter the one-digit code to indicate whether a bowel regimen was initiated or continued from the previous care setting. A bowel regimen is defined as a laxative or stool softener, a high fiber supplement, or a high fiber diet. Code 0 if the medical record indicates that a bowel regimen was neither initiated nor continued from the previous care setting. Code 1 if the medical record indicates why a bowel regimen was not initiated or continued. Documentation for why a bowel regimen was not initiated or continued could include, but is not limited to: clinical contraindication or patient declined treatment offered. Code 2 if the medical record indicates a bowel regimen was either initiated or continued from the previous care setting
N0520B. Date bowel regimen initiated or continued	Indicate the date the bowel regimen was initiated or continued in MM-DD-YYYY format. The date should reflect the date the order (verbal or written) for the bowel regimen was received.

Item	Definition/Description
Section Z: Record Administration	
Z0400. Signature(s) of person(s) completing the record.*	All staff that completed any part of the Hospice Item Set should enter their signature, title, section, or portion(s) of a section(s) they completed, and the date completed. Each person who completed any portion of the Hospice Item Set will need to sign Z0400.
Z0500. Signature of Person Verifying Record Completion*	The staff member verifying that then entire Hospice Item Set is completed should sign and date Z0500 A and B. The signature in Z0500 certifies that all sections are complete. The person completing Z0500 is not certifying the accuracy of portions of the record that were completed by other hospice staff members. For Z0500B, use the actual date that the Hospice Item Set was completed, reviewed, and signed as complete by an individual authorized to do so.