Inpatient Psychiatric Facility Quality Reporting Program Manual

This program manual is a resource for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program for the Centers for Medicare & Medicaid Services (CMS).

February 5, 2015

<u>NOTICES AND DISCLAIMERS</u>

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Section 1: CMS Inpatient Psychiatric Facility Quality Reporting Program

Overview

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program was developed as mandated by section 1886(s)(4) of the Social Security Act, and amended by Sections 3401(f) and 10322(a) of the Affordable Care Act (Pub.L.111-148). It was implemented on October 1, 2012 as a Centers for Medicare & Medicaid Services (CMS) pay-for-reporting program.

The IPFQR pay-for-reporting program is intended to equip consumers with quality of care information to make more informed decisions about healthcare options. It is also intended to encourage psychiatric facilities and clinicians to improve the quality of inpatient care provided to patients by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care. To meet the IPFQR Program requirements, Inpatient Psychiatric Facilities (IPFs) are required to collect and submit all quality measures in the form, manner, and time as specified by the Secretary, to CMS, which began with the Fiscal Year (FY) 2014 annual payment update (APU) and continues in subsequent fiscal years.

This Program Manual is intended for use as a quick reference to assist in the implementation of the program. Links to the websites that display the measure specifications are provided, as this manual does not contain the specifications for the individual measures. Each section of the manual provides detailed instructions for completing the steps necessary for successful implementation of the IPFQR Program:

- *QualityNet* registration;
- Vendor authorization;
- Notice of Participation completion;
- Location of measure specifications;
- Data Accuracy and Completeness Acknowledgement;
- Report review and public reporting; and
- Additional resources.

QualityNet

Established by CMS, *QualityNet* provides healthcare quality improvement news, resources, and data reporting tools and applications used by healthcare providers and others. *QualityNet* is the only CMS-approved website for secure communications and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end-stage renal disease (ESRD) networks and facilities, and data vendors.

Eligibility

All IPFs paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) are subject to the IPFQR program requirements. The IPF PPS applies to inpatient psychiatric services furnished by Medicare participating entities in the United States that are classified as psychiatric hospitals or psychiatric units in acute care or

critical access hospitals (CAHs). This includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Additional Program Information

Additional information about the IPFQR Program can be found on *QualityNet* by selecting the Inpatient Psychiatric Facilities tab (direct link): http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1228772862944.

National Provider Webinars are provided by CMS and by the IPFQR Support Contractor on a routine basis. The slides from each of the education sessions are published to the QualityNet website and are available for review under the Inpatient Psychiatric Facilities tab, by selecting the Webinars/Calls link from the drop-down menu.

Glossary of Terms

Acute Care Hospital (ACH) – A hospital providing inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

Aggregate (data) – Aggregate data elements derived for a specific hospital from the results of each measures algorithm over a given period of time period (e.g. quarterly).

Algorithm – An ordered sequence of data element retrieval and aggregation through which numerators and denominators are identified.

Calendar Year – Time period between January 1 and December 31 of a given year.

Critical Access Hospital (CAH) – A small facility that gives limited outpatient and inpatient services to people in rural areas.

Data Accuracy and Completeness Acknowledgement (DACA) – A requirement for IPFQR Program participating facilities, the DACA is an electronic acknowledgement indicating that the data provided to meet the APU data submission requirements are accurate and complete to the best of the facility's knowledge at the time of data submission.

Data Collection – The act or process of capturing raw or primary data from a single or number of sources, also called "data gathering."

Denominator – The lower part of a fraction used to calculate a rate, proportion, or ratio.

Excluded Populations – Detailed information describing the populations that should not be included in the indicator. For example, specific age groups, ICD-9-CM procedure or diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

Initial Patient Populations – Detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups, diagnoses, ICD-9-CM diagnostic and procedure codes, CPT codes, revenue codes, enrollment periods, insurance and health plan groups, etc.

Format – Specifies the character length of a specific data element; the type of information the data element contains: numeric, decimal, number, date, time, character, or alphanumeric; and the frequency with which the data element occurs.

Hospital Based Inpatient Psychiatric Services (HBIPS) Core Measure Set – A specific set of measures developed and maintained by The Joint Commission for the inpatient psychiatric population, some of which are used by CMS in the IPFQR Program. In 2007, The Joint Commission, the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the NASMHPD Research Institute, Inc. (NRI) collaborated on the development of performance measures specific to hospital-based inpatient psychiatric services.

Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) – A payment system for specialty hospitals and units established according to Section 1886(b) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Facilities are paid on the basis of Medicare reasonable costs per case, limited by a hospital specific target amount per discharge. The base year target amount is adjusted annually by an update factor and published in the IPF PPS Rule. Facilities paid under this system are required to report under the CMS IPFQR Program.

Measure Information Form – This tool provides specific clinical and technical information on a measure. The information contained includes: measure set, performance measure name, description, rationale, type of measure, improvement noted as, numerator/ denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, data collection approach, data accuracy, measure analysis suggestions, sampling, data reported as, and selected references.

Medical Record (Data Source) – Data obtained from the records or documentation maintained on a patient in any healthcare setting (for example, hospital, home care, long-term care, practitioner's office); includes automated and paper medical record systems.

Notice of Participation (NOP) – A requirement for IPFQR Program participating facilities, the NOP indicates a facility's agreement to participate in the program and to allow public reporting of its measure rates. The NOP has three options: agree to participate, do not agree to participate, and request to be withdrawn from participation.

Numerator – The upper portion of a fraction used to calculate a rate, proportion, or ratio.

Patient Level Data – Collection of data elements that depict the healthcare services provided to an individual (patient). Patient-level data are aggregated to generate data at the setting level (e.g., hospital) and/or comparison group data.

Process – An interrelated series of events, activities, actions, mechanisms, or steps that transform inputs into outputs.

Reporting Period – The defined time period for medical record review.

Sampling Method – Describes the process used to select a sample. Sampling approaches for the IPFQR Program are simple random sampling and systematic random sampling. Refer to the "Sampling Approaches" discussion in the Population and Sampling Specifications section of the respective manuals for further information.

Sampling Size – The number of individuals or particular patients included.

Simple Random Sample – A process in which a sample is selected from the total population in such a way that every case has a similar chance of being selected.

Specifications Manual for Joint Commission National Quality Core Measures – A manual that contains the specifications for The Joint Commission measures used in the IPFQR Program. This manual includes detailed information about the HBIPS measures, with a data dictionary and Measurement Information Forms.

Specifications Manual for National Hospital Inpatient Quality Measures – A manual that includes detailed information for the SUB, TOB, and IMM measures, with a data dictionary and Measurement Information Forms.

Strata – See stratified measure.

Stratified Measure – A measure that is classified into a number of categories to assist in analysis and interpretation. The overall or un-stratified measure evaluates all of the strata together. A stratified measure, or each stratum, consists of a subset of the overall measure. For example, the HBIPS measures are stratified by age group.

Systematic Random Sampling – A process in which the starting case is selected randomly and the next cases are selected according to a fixed interval based upon the number of cases in the population. Refer to the "Sampling Approaches" discussion in the Population and Sampling Specifications section of the respective manuals for further information.

Proposed Rule and Final Rule Publication Site

Every year, CMS publishes proposed program and policy changes to the IPFQR Program in April. The proposed changes are published to the *Federal Register* and are open to the public for review and comment for 60 days. CMS also provides notices through the *QualityNet* website to ensure broad awareness. Following the comment period, CMS summarizes the comments and responds to them in the final rule. The final rule is published in August.

The IPFQR Program was implemented with the FY 2013 IPPS Final Rule, published August 31, 2012. Information for the IPFQR Program begins on page 53644 of the FY 2013 IPPS Final Rule (direct download, 15.16 MB): http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/FR-2012-08-31.pdf.

The FY 2014 IPPS Final Rule was published August 19, 2013. The rule contained updated information applicable for FY 2015 and beyond. Information for the IPFQR Program begins on page 50887 (direct download, 15.16 MB): http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf.

The FY 2015 IPFPPS Final Rule was published on August 6, 2014. The rule contained changes to the IPFQR Program applicable for FY 2016 and beyond (direct download, 15.16 MB): http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18329.pdf

IPFQR Program Requirements

FY 2016 Requirements

The FY 2016 IPFQR program requirements are listed below. Click on the hyperlink imbedded within the text to be directed to detailed instructions for each step, as necessary.

1. Register with *QualityNet*.

    a. Enroll in the *QualityNet Secure Portal.*

2. Maintain an active *Security Administrator.*

3. Have a *Notice of Participation*.

4. Submit data July 1, 2015 through August 15, 2015 for seven chart-abstracted IPF quality measures and two structural measures. The claims-based measure is calculated by CMS using Medicare fee-for-service Parts A and B claims data; no action is required by IPFs for this measure.

5. Measure reporting period: January 1, 2014 through December 31, 2014 (1Q 2014 through 4Q 2014).

6. Complete the Data Accuracy and Completeness Acknowledgement (DACA) by the August 15, 2015 submission deadline.

FY 2017 Requirements

The FY 2017 IPFQR requirements are listed below. Click on the hyperlink imbedded within the text to be directed to detailed instructions for each step, as necessary.

1. Register with *QualityNet*.

    a. Enroll in the *QualityNet Secure Portal.*

2. Maintain an active *Security Administrator.*

3. Have a *Notice of Participation*.

4. Submit data July 1, 2016 through August 15, 2016 for 10 chart-abstracted IPF quality measures and two structural measures. The claims-based measure is calculated by CMS using Medicare fee-for-service Parts A and B claims data; no action is required by IPFs for this measure. Submit the Influenza Vaccination Coverage Among Healthcare Personnel measure to NHSN; the reporting deadline for this measure is May 15, 2016.

5. Measure reporting period January 1, 2015 through December 31, 2015 (1Q 2015 through 4Q 2015). For IMM-2 and Influenza Vaccination Coverage Among Healthcare Personnel, the reporting period is October 1, 2015 through March 31, 2016.

6. Complete the Data Accuracy and Completeness Acknowledgement (DACA) by the August 15, 2016 submission deadline.

Section 2: Measure Specifications

Information for this program manual was developed for use by facilities participating in the CMS IPFQR Program. Measures adopted by CMS for the IPFQR program are from a variety of sources, and unless otherwise indicated, the specifications are generally the same as those of the original measure steward. **They are not intended to provide direction for reporting to The Joint Commission, the National Committee for Quality Assurance (NCQA), or the National Healthcare and Safety Network (NHSN)**. For detailed measure specifications please refer to: The *Specifications Manual for Joint Commission National Quality Core Measures*, The *Specifications Manual for National Hospital Inpatient Quality Measures*, the HEDIS® Measures Technical Specifications, and the NHSN specifications.

The measure specifications are periodically updated by the measure stewards. IPFs and vendors must update their documentation and software when applicable, based on the published manuals.

Vendors supporting the IPFQR Program must be aware that the reporting and submission requirements for CMS may differ from The Joint Commission. Generally, measure specifications are released on a bi-annual basis, spanning two calendar quarters, in January and July of each year. When abstracting data for a particular quarter, it is important for the facility to use the specifications applicable to that quarter. For example, for IPFQR reporting applicable to the FY 2015 annual payment update, the quarters being collected were 2Q 2013 – 4Q 2013. This required the facility to reference one *Specifications Manual* for collection of 2Q 2013 and a different version of the *Specifications Manual* for collection for 3Q 2013 and 4Q 2013.

CMS requires the submission of aggregate numerator and denominator data. There are no patient-level data reported to CMS for the IPFQR Program.

Inpatient Psychiatric Facility Quality Measures

FY 2016

Effective for FY 2016 payment determination and subsequent years, CMS added four new measures for the IPFQR program. The first measure is a chart-abstracted measure: Alcohol Use Screening (SUB-1). This measure assesses the number of patients who are screened for alcohol use within the first three days after admission. **NOTE: The data reporting period for this measure begins with 1Q 2014 discharges.**

The second new measure is a claims-based measure: Follow-Up After Hospitalization for Mental Illness (FUH). This measure calculates the percentage of patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders who had a follow-up outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner after discharge. There is no action required by the facility for reporting this measure as it is calculated by CMS using Medicare fee-for-service Parts A and B claims data.

NOTE: The data reporting period for this measure begins with 3Q 2014 discharges.

The third and fourth new measures, Assessment of Patient Experience of Care and Use of an Electronic Health Record (EHR), will be submitted annually through the web-based application. The Assessment of Patient Experience of Care determines whether the facility administers a detailed assessment of patient experience of care using a standardized collection protocol with a structured instrument. If so, the name of the survey is collected. The measure on the use of an EHR determines the extent of EHR integration within the facility and whether transfers of health information at times of transitions in care included the exchange of interoperable health information with a health information service provider (HISP).

The HBIPS and SUB measures will be collected for all four calendar quarters of 2014 (January 1, 2014 through December 31, 2014). The Assessment of Patient Experience of Care and Use of an Electronic Health Record are attestations only and based on the status as of December 31, 2014. The measures are shown in the table below:

TABLE 1: FY 2016 Measures

Measure ID	Measure Description
HBIPS-2	Hours of Physical Restraint Use*
HBIPS-3	Hours of Seclusion Use*
HBIPS-4	Patients Discharged on Multiple Antipsychotic Medications*
HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification*
HBIPS-6	Post-Discharge Continuing Care Plan Created*
HBIPS-7	Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge*
SUB-1	Alcohol Use Screening**
FUH	Follow-Up After Hospitalization for Mental Illness**
N/A	Assessment of Patient Experience of Care**
N/A	Use of an Electronic Health Record**

  * Previously adopted quality measures for the FY 2014 payment determination and subsequent years

  ** New quality measures for the FY 2016 payment determination and subsequent years

FY 2017

Effective for FY 2017 payment determination and subsequent years, CMS added four new measures for the IPFQR Program. Three are chart-abstracted measures: Tobacco Use Screening (TOB-1); Tobacco Use Treatment Provided or Offered (TOB-2) and Tobacco Use Treatment (TOB-2a); and Influenza Immunization (IMM-2).

The fourth new measure is Influenza Vaccination Coverage Among Healthcare Personnel. The facility will report data through the National Healthcare Safety Network (NHSN) website. **NOTE: Data collection for all new measures begins with 1Q 2015 discharges, except IMM-2 and Influenza Coverage Among Healthcare Personnel, which begin with 4Q 2015.** The measures are shown in the table below:

TABLE 2: FY 2017 Measures

Measure ID	Measure Description
HBIPS-2	Hours of Physical Restraint Use
HBIPS-3	Hours of Seclusion Use
HBIPS-4	Patients Discharged on Multiple Antipsychotic Medications
HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
HBIPS-6	Post-Discharge Continuing Care Plan
HBIPS-7	Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge
SUB-1	Alcohol Use Screening
FUH	Follow-Up After Hospitalization for Mental Illness**
TOB-1	Tobacco Use Screening*
TOB-2/-2a	Tobacco Use Treatment Provided or Offered*/Tobacco Use Treatment*
N/A	Assessment of Patient Experience of Care
N/A	Use of an Electronic Health Record
IMM-2	Influenza Immunization*
N/A	Influenza Vaccination Coverage Among Healthcare Personnel*

* New quality measures for the FY 2017 payment determination and subsequent years

Identifying the Initial Patient Population

The initial selection of cases (i.e., patient medical records) intended for data abstraction under the IPFQR Program must meet the following criteria:

- The cases must be from psychiatric hospitals paid under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS); or

- The cases must be psychiatric units within acute care and critical access hospitals paid under IPF PPS; and

- The cases must be patients (Medicare and non-Medicare) receiving care in a psychiatric hospital or psychiatric unit paid under IPF PPS.

For specific details regarding the Initial Patient Population, refer to the corresponding Measure Information Form (MIF) published within the applicable *Specifications Manual*:

- HBIPS - https://manual.jointcommission.org/

- SUB, TOB, IMM - https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099

HBIPS Population

The HBIPS measure set is unique in that there are two distinct Initial Patient Populations within the measure set, one for the event measures (HBIPS-2 and HBIPS-3) and one for the discharge measures (HBIPS-4, HBIPS-5, HBIPS-6, and HBIPS-7).

For the purposes of reporting the HBIPS measures, the initial population is identified by age stratum:

- Stratum 1 - Children (1 - 12 years)
- Stratum 2 - Adolescents (13 - 17 years)
- Stratum 3 - Adult (18 - 64 years)
- Stratum 4 - Older adults (≥ 65 years)

Event Measures (HBIPS 2 and HBIPS 3)

All patients within an IPF or an acute care hospital/critical access hospital's psychiatric unit reimbursed under IPF PPS during the reporting quarter are included in the initial patient population for events.

Facilities must use the entire Initial Patient Population for reporting, including all payor sources (Medicare and non-Medicare). The Event Measures (HBIPS-2 and HBIPS-3) **are not eligible for sampling**.

Discharge Measures (HBIPS 4 through 7)

The discharge measures can include sampling methodologies. If a facility elects to sample, they must meet the minimum requirements for each age strata.

SUB, TOB, and IMM Population

Note: The initial patient population for the SUB, TOB and IMM measure sets differs for CMS IPF reporting as compared to The Joint Commission. These measure sets were initially part of a group of global measure sets, where all inpatients in the acute care setting were included in the initial patient population. Since the SUB-1, TOB-1, TOB-2/-2a, and IMM-2 measures were adopted for the IPFQR Program; **CMS is not collecting data for all inpatients within the acute care setting.**

Identifying the Patient Sample

IPFs are *not* required to sample. IPFs submit data for either a complete population of cases or a random sample for each of the measure sets covered by the quality measures. Your facility must meet the sampling requirements for each discharge quarter. If the initial patient population size does not exceed the minimum number of cases per quarter for the measure set, the facility **must submit 100% of the initial patient population**.

HBIPS Sampling

CMS adopted the sampling methodology and sample sizes as described in the Hospital-Based Inpatient Psychiatric Services (HBIPS) subsection of Section 1 of the *Specifications Manual for Joint Commission National Quality Core Measures* for the HBIPS measures.

Sampling must be done for each of the individual age strata. There are sampling requirements for quarterly and monthly sampling. If electing to sample, the facility must submit at least the minimum required sample size. IPFs may choose to use a larger sample size than is required, or they may choose not to sample and include 100% of the cases in the submission. **The event measures (HBIPS-2 and HBIPS-3) are not eligible for sampling. The facility must include 100% of the population for each age stratum.**

The table below provides an example of the quarterly sampling table for the HBIPS measures 4 through 7.

Quarterly Stratum Initial Patient Population Size "N" (upper case)	Minimum Required Stratum Sample Size "n" (lower case)
>877	176
221-877	20% of the Initial Patient Population
44-220	44
<44	No sampling: 100% of the Initial Patient Population Required

SUB, TOB, and IMM Sampling

CMS adopted the sampling methodology and sample sizes as described in Section 2.9 of *The Specifications Manual for National Hospital Inpatient Quality Measures* for the SUB, TOB, and IMM measure sets. The information is in the Global Initial Patient Population Section of the *Specifications Manual*. There are sampling requirements for quarterly and monthly sampling. If electing to sample, the facility must submit at least the minimum requirement sample size. The IPF may choose to use a larger sample size than is required, or they may choose not to sample and include 100% of the cases in the submission. Note: SUB-1, TOB-1, TOB-2/-2a, and IMM-2 are not reported by age strata.

The table below provides an example of the quarterly sampling table for the SUB-1, TOB-1, TOB-2/-2a, and IMM-2 measures.

Average Quarterly Initial Patient Population "N"	Minimum Required Sample Size "n"
≥ 1,530	306
765 – 1,529	20% of the Initial Patient Population
153 – 764	153
6 – 152	No sample: 100% of the Initial Patient Population
0 – 5	Facilities may submit actual values or zero during the submission period

Chart Abstraction

The facility may elect to use a vendor to electronically enter their data, and obtain the aggregate data to be manually entered in the CMS web-based measure tool via the *QualityNet* Secure Portal. The facility may authorize the vendor to enter the data on its behalf; however, the facility is responsible for the data. For facilities that do not have a vendor tool, a paper-based data collection tool is available for manual collection of the data elements for each case. The tool is arranged to follow the measure process flow, or algorithm, to assist in determining whether the case is included or excluded for the measure population and determining the measure outcome. The facility must also have access to the data definitions from the associated *Specifications Manual* to ensure the collection of valid and reliable data. Refer to the Resources section of the manual for more information about the paper-based data collection tools.

Chart-Based Measures: HBIPS 2 through 7

The HBIPS measure set was developed by The Joint Commission as part of a group of global measure sets. Although CMS is collecting the aggregate numerators and denominators in each age stratum for each HBIPS measure, it is necessary to collect the patient level data for each measure as defined in the applicable *Specifications*

Manual. The data dictionary is a valuable document as it provides detailed information about each of the data elements needed for determining the numerators and denominators.

HBIPS-2: Hours of Physical Restraint Use

The use of physical restraints increases a patient's risk of physical injury as well as psychological harm. This intervention is intended for use only if a patient is in imminent danger to him/herself or others and if less restrictive interventions have failed. It is not intended to address staff shortages or to be used as a form of discipline or coercion. This measure evaluates the total number of hours that all patients admitted to the IPF were maintained in physical restraints.

The numerator is defined as the total number of hours that all psychiatric inpatients were maintained in physical restraint. The denominator is defined as the number of psychiatric inpatient hours overall. Total leave days are excluded from the denominator.

HBIPS-3: Hours of Seclusion Use

The use of seclusion increases a patient's risk of physical injury as well as psychological harm. This intervention is intended for use only if a patient is in imminent danger to him/herself or others and if less restrictive interventions have failed. It is not intended to address staff shortages or to be used as a form of discipline or coercion. This measure is reported as the total number of hours of seclusion use for all patients admitted to an IPF.

The numerator is defined as the total number of hours all psychiatric inpatients were held in seclusion. The denominator is defined as the number of psychiatric inpatient hours overall. Total leave days are excluded from the denominator.

HBIPS-4: Patients Discharged on Multiple Antipsychotic Medications

An estimated 30 percent to 50 percent of patients in IPFs are treated with two or more antipsychotic medications, which can lead to serious side effects. Among patients without a history of treatment failure on a single antipsychotic, there is insufficient evidence to conclude that patients experience better outcomes if they are prescribed multiple antipsychotics compared to a single antipsychotic. The American Psychiatric Association recommends the use of multiple antipsychotics only if a patient has had failed attempts on single antipsychotics. HBIPS-4 is reported as the rate of patients discharged on multiple antipsychotics among patients discharged on at least one antipsychotic medication. We believe that lower rates are indicative of higher quality of care because reducing the use of multiple antipsychotics reduces the potential risks of harmful side effects to patients. However, there is no expectation that zero percent is the desired outcome because it is recognized that in some circumstances, use of multiple antipsychotics may be appropriate.

The numerator is defined as psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications. The denominator is defined as all psychiatric inpatient discharges in which the patient was discharged on one or more antipsychotic medications. The measure excludes patients who died, patients with an unplanned

departure resulting in discharge due to elopement, and patients with an unplanned departure resulting in discharge due to failing to return from leave.

HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification

This measure is collected on those patients discharged on multiple antipsychotics and is reported as the rate of patients discharged on multiple antipsychotics with appropriate justification. This measure was designed in recognition that there is a subsample of patients for whom multiple antipsychotic use may be appropriate. The Joint Commission has identified the following justifications as appropriate reasons for discharging a patient on multiple antipsychotics: (1) The medical record contains documentation of a history of a minimum of three failed trials of monotherapy; (2) the medical record contains documentation of a recommended plan to taper to monotherapy or documentation of a plan to decrease the dosage of one or more antipsychotic medications while increasing the dosage of another antipsychotic medication to a level that manages the patient's symptoms with one antipsychotic medication (that is, cross-taper); and (3) the medical record contains documentation of augmentation of Clozapine. Higher rates on HBIPS-5 indicate higher quality of care because documenting the reasons for assigning two or more antipsychotics suggests that careful consideration of the benefits of this course of treatment were weighed against the potential patient side effects.

The numerator statement is defined as psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification. The denominator is defined as psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications. The measure excludes patients who died, patients with an unplanned departure resulting in discharge due to elopement, patients with an unplanned departure resulting in discharge due to failing to return from leave, and patients with a length of stay less than or equal to three days.

HBIPS-6: Post-Discharge Continuing Care Plan

When patients are discharged from the hospital, they may benefit from communication of information regarding the care they received or recommendations for their continued care. For a seamless transition from one treatment setting to another, providers that receive patients from inpatient settings need to know information regarding the patient's treatment during hospitalization, recommendations for post-discharge care, and any medications on which the patient was discharged. A discharge plan facilitates this transition of information from one setting to another and has been shown to have positive effects on readmissions.

The numerator is defined as psychiatric inpatients for whom the post-discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications, and next level of care recommendations. The denominator is defined as all psychiatric inpatient discharges. Populations excluded from the denominator include patients who died or were readmitted within five days after discharge, patients with an unplanned departure resulting in discharge due to elopement, patients or their guardians who refused

aftercare, patients or guardians who refused to sign authorization to release information, patients who discharge to a residence outside the United States, and patients with an unplanned departure resulting in discharge due to failing to return from leave.

HBIPS-7: Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge

While the creation of a discharge care plan (as measured in HBIPS-6) is an important part of providing coordinated care, simply creating the plan does not ensure that the necessary information is transferred to the patient's next provider. HBIPS-7 measures both aspects of coordinated care - the creation of a discharge plan and the transmittal of that plan to the next provider. Together, these two measures can assist facilities in determining where breakdowns in care processes occur.

The numerator is defined as psychiatric inpatients for whom the post-discharge continuing care plan was transmitted to the next level of care. The denominator statement is defined as all psychiatric inpatient discharges. Populations excluded from the denominator include patients who died or were readmitted within five days after discharge, patients with an unplanned departure resulting in discharge due to elopement, patients who refused (or whose guardians refused) aftercare, patients who refused to sign (or whose guardians refused to sign) authorization to release information, patients who discharge to a residence outside the United States, and patients with an unplanned departure resulting in discharge due to failing to return from leave.

For detailed HBIPS measure information, including specific data element definitions, please refer to the *Specifications Manual for Joint Commission National Quality Measures* - https://manual.jointcommission.org/. The measure information is contained in Section 1 under the Measure Information Forms Section. The HBIPS data elements are located under Section 2- Data Dictionary. The Paper Abstraction Tools are located under the IPFQR Measures Resource section: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228773653066

Chart-Based Measures: SUB-1, TOB-1, TOB-2 and -2a, and IMM-2

There is **no age stratum** for these measure sets. As with the HBIPS measures, it is necessary to collect patient-level data, as defined in the applicable *Specifications Manual*. Facilities are required to submit aggregate data (one numerator and one denominator) for each quarter.

SUB-1: Alcohol Use Screening

The SUB measure set was developed by The Joint Commission as part of a group of global measure sets. The first measure of this set was adopted by CMS for use in the IPFQR Program.

Individuals with mental health conditions experience substance use disorders (SUDs) at a much higher rate than the general population. Individuals with the most serious mental illnesses have the highest rates of such disorders. Co-occurring SUDs often go

undiagnosed and, without treatment, contribute to a longer persistence of disorders, poorer treatment outcomes, lower rates of medication adherence, and greater impairments to functioning. This measure is intended to assess efforts by IPFs to screen for the most common type of such disorder, alcohol abuse.

The numerator is defined as the number of patients who were screened for alcohol use using a validated screening questionnaire within the first three days of admission. The denominator is defined as the number of psychiatric inpatients 18 years of age and older. The measure excludes patients who: are less than 18 years of age; are cognitively impaired; have a duration of stay less than or equal to three days, or greater than 120 days; or have Comfort Measures Only documented.

For SUB-1 measure information, please refer to the *Specifications Manual for National Hospital Inpatient Quality Measures*:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773564870

TOB-1: Tobacco Use Screening

The TOB measure sets were developed by The Joint Commission as part of a group of global measure sets. Tobacco use is currently the single greatest cause of disease in the U.S., accounting for more than 435,000 deaths annually. Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases. This health issue is especially important for persons with mental illness and substance use disorders.

The Tobacco Use Screening (TOB-1) chart-abstracted measure assesses hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe, and cigar) within the previous 30 days. The numerator includes the number of patients who were screened for tobacco use status within the first three days of admission. The denominator includes the number of hospitalized inpatients 18 years of age and older. The measure excludes patients who: are less than 18 years of age; are cognitively impaired; have a duration of stay less than or equal to three days, or greater than 120 days; or have Comfort Measures Only documented.

TOB-2 (Tobacco Use Treatment Provided or Offered) and TOB-2a (Tobacco Use Treatment)

As stated above, tobacco use is currently the single greatest cause of disease in the U.S. The Tobacco Use Treatment Provided or Offered (TOB-2) chart-abstracted measure is reported as an overall rate that includes all patients to whom tobacco use treatment was provided or offered and refused. A second rate (Tobacco Use Treatment TOB-2a), a subset of the first, includes only those patients who received tobacco use treatment.

The overall rate, TOB-2, assesses patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit and receive or refuse

Food and Drug Administration (FDA)-approved cessation medications during the first three days following admission. The numerator includes the number of patients who received or refused practical counseling to quit and received or refused FDA-approved cessation medications or had a reason for not receiving the medication during the first three days after admission.

The second rate, TOB-2a, assesses patients who received counseling and medication, as well as those who received counseling and had a reason for not receiving the medication during the first three days following admission. The numerator includes the number of patients who received practical counseling to quit and received FDA-approved cessation medications or had a reason for not receiving the medication during the first three days after admission.

The denominator for both TOB-2 and TOB-2a includes the number of hospitalized patients 18 years of age and older identified as current tobacco users. The measure excludes patients who: are less than 18 years of age; are cognitively impaired; are not current tobacco users; refused or were not screened for tobacco use during the hospital stay; have a duration of stay less than or equal to three days, or greater than 120 days; or have Comfort Measures Only documented.

For TOB measure information, please refer to the *Specifications Manual for National Hospital Inpatient Quality Measures*:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773564870

IMM-2: Influenza Immunization

Increasing influenza (flu) vaccination can reduce unnecessary hospitalizations and secondary complications, particularly among high risk populations such as the elderly. Each year, approximately 226,000 people in the U.S. are hospitalized with complications from influenza, and between 3,000 and 49,000 die from the disease and its complications. Vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications, and vaccination is associated with reductions in influenza among all age groups.

This prevention measure addresses hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine and patients who received the vaccine during the current year's influenza season but prior to the current hospitalization are captured as numerator events.

For IMM-2 measure information, please refer to the *Specifications Manual for National Hospital Inpatient Quality Measures*:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773564870.

Claims Based Measure: Follow-Up After Hospitalization for Mental Illness (FUH)

Note: This measure is collected by CMS through claims data. There is no action required by facilities to collect and submit data for this measure.

The Follow-Up After Hospitalization for Mental Illness (FUH) measure was developed and is maintained by the National Committee for Quality Assurance (NCQA). Mental illness accounts for a very large disease burden, and it is estimated that half of first-time psychiatric patients are readmitted within two years of hospital discharge. Continuity of treatment and appropriate follow-up care and management of chronic diseases, such as mental illnesses, are known to reduce the risk of repeated hospitalizations. Proper follow-up treatment for psychiatric hospitalization can lead to improved quality of life for patients, families, and society as a whole.

The Follow-Up After Hospitalization for Mental Illness measure assesses the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who subsequently had an outpatient visit or an intensive outpatient encounter with a mental health practitioner, or received partial hospitalization services. Two rates are reported:
- The percentage of discharges for which the patient received follow-up within 30 days of discharge
- The percentage of discharges for which the patient received follow-up within seven days of discharge

As this is a claims-based measure, CMS will calculate the measure outcome using Part A and Part B claims data that are received by Medicare for payment purposes. CMS will calculate this measure by linking Medicare FFS claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges. This approach requires no additional data collection or reporting by IPFs. Completion of this measure does not affect an IPF's payment determination.

Definitions

The definition of **outpatient follow-up care** is a mental health procedure (identified by CPT/HCPCS/UB Revenue codes) provided by a mental health practitioner - a psychiatrist, psychologist, or social worker according to the Healthcare Effectiveness Data and Information Set (HEDIS) definition. Health plan records are used to determine whether a provider is a mental health practitioner. CMS uses provider taxonomy and specialty codes in Medicare claims to make this determination. Specifically, providers' National Provider Identifier (NPI) numbers are used to determine the exact taxonomy code and specialty. Diagnosis codes are not used to identify follow-up mental health visits.

A **mental health practitioner** is a practitioner who provides mental health services and meets any of the following criteria:

- An MD or Doctor of Osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in his/her state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- Additionally, a neurologist with a specialty in neuropsychiatry or a psychiatric nurse will be considered to be a mental health practitioner for purposes of the measure.

The **eligible population** includes IPF discharges for Medicare patients 6 years and older as of the date of discharge with a selected principal mental health diagnosis included in Table A in Appendix B, during the first 11 months of the measurement year.

The **denominator** includes IPF discharges remaining in the eligible population after denominator exclusions. Denominator exclusions include:

- Both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., after December 1)
- Discharges followed by readmission or direct transfer to a non-acute facility for any mental health principal diagnosis within the 30-day follow-up period
- Discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis

The **numerator** includes an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 or 7 days of discharge, for patients receiving care in a psychiatric hospital or psychiatric unit paid under IPF PPS.

Attestation: Assessment of Patient Experience of Care and Use of Electronic Health Record

Assessment of Patient Experience of Care
Note: This is a measure that does not depend on systems for collecting and abstracting individual patient information and only requires simple attestation.

Improvement of experience of care for patients, families, and caregivers is one of the objectives within the CMS Quality Strategy and is not currently addressed in the IPFQR Program. Surveys of individuals about their experience in all healthcare settings provide important information as to whether or not high-quality, person-centered care is actually provided and address elements of service delivery that matter most to recipients of care.

The measure asks IPFs whether they routinely assess patient experience of care using a standardized collection protocol and a structured instrument. The attestation should be based on the hospital's activities on December 31.

Use of Electronic Health Record
Note: This is a measure that does not depend on systems for collecting and abstracting individual patient information and only requires simple attestation.

A measure of the degree of EHR implementation provides important information about an element of healthcare service delivery shown to be associated with the delivery of quality care. It provides useful information to consumers and others in choosing among different facilities. A key issue in EHR adoption and implementation is the use of this technology to support health information exchange. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work to promote the adoption of health information technology. The use of certified EHRs by IPFs can effectively and efficiently help providers improve internal care delivery practices, support the exchange of important information across care partners and during transitions of care, and could enable the reporting of electronically specified clinical quality measures (eCQMs).

The measure will assess the degree to which facilities employ EHR systems in their service program and use such systems to support health information exchange at times of transitions in care. It is a structural measure that only requires the facility to attest to one of **three** statements that best describes the facility's highest level typical use of an EHR system (excluding the billing system) during the reporting period, and whether this use includes the exchange of interoperable health information with a health information service provider**.**

The three statements are as follows:
  a. The facility most commonly used paper documents or other forms of information exchange (for example, email) not involving the transfer of health information using EHR technology at times of transitions in care.
  b. The facility most commonly exchanged health information using non-certified EHR technology (that is, not certified under the ONC HIT Certification Program) at times of transitions in care.

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c. The facility most commonly exchanged health information using certified EHR technology (certified under the ONC HIT Certification Program) at times of transitions in care.

The attestation should be based on the hospital's activities on December 31.

NHSN-Collected Measure: Influenza Vaccination Coverage Among Healthcare Personnel (HCP)

Note: IPFs will use the CDC National Healthcare Safety Network (NHSN) infrastructure and protocol to report the measure for IPFQR Program purposes. If the IPF has not reported to NHSN in the past, it will be necessary to perform setup prior to reporting. Step by step instructions are available at http://www.cdc.gov/nhsn/acute-care-hospital/setup.html.

The measure assesses the percentage of HCP who receive the influenza vaccination. The measure is designed to ensure that reported HCP influenza vaccination percentages are consistent over time within a single healthcare facility, as well as comparable across facilities.

The numerator includes HCP in the denominator population who, during the time from October 1 (or when the vaccine became available) through March 31 of the following year:
a. Received an influenza vaccination administered at the healthcare facility or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere;
b. Were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine or history of Guillain-Barre Syndrome within six weeks after a previous influenza vaccination;
c. Declined influenza vaccination; or
d. Had an unknown vaccination status or did not otherwise fall under any of the abovementioned numerator categories.

The denominator includes the number of HCP working in the healthcare facility for at least one working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact, and is calculated separately for employees, licensed independent practitioners, and adult students/trainees and volunteers. The measure has no exclusions.

For further information, refer to http://www.NHSN@CDC.gov.

Data Submission

The submission period is from July 1 through August 15 each year, unless otherwise specified. The FY 2016 payment determination year includes data reported for all four quarters of calendar year (CY) 2014.

Payment Determination	Reporting Period for Services Provided	Data Submission Timeframe	Public Display (Calendar Year)
FY 2016	<u>HBIPS-2 through -7, SUB-1, Use of EHR, Assessment of Patient Experience of Care</u> 1Q 2014 (January 1, 2014 – March 31, 2014) 2Q 2014 (April 1, 2014 – June 30, 2014) 3Q 2014 (July 1, 2014 – September 20, 2014) 4Q 2014 (October 1, 2014 – December 31, 2014)	July 1 – August 15, 2015	April 2016
	<u>FUH</u> July 1, 2013 – June 30, 2014	Calculated by CMS	April 2016
FY 2017	<u>HBIPS-2 through -7, SUB-1, Use of EHR, Assessment of Patient Experience of Care, TOB-1, -2/-2a</u> 1Q 2015 (January 1, 2015 – March 31, 2015) 2Q 2015 (April 1, 2015 – June 30, 2015) 3Q 2015 (July 1, 2015 – September 20, 2015) 4Q 2015 (October 1, 2015 – December 31, 2015)	July 1 – August 15, 2016	April 2017

Payment Determination	Reporting Period for Services Provided	Data Submission Timeframe	Public Display (Calendar Year)
FY 2017 (continued)	FUH July 1, 2014 – June 30, 2015	Calculated by CMS	April 2017
	IMM-2 October 1, 2015 – March 31, 2016	July 1 – August 15, 2016	April 2017
	Influenza Vaccination Coverage Among Healthcare Personnel October 1, 2015 – March 31, 2016	October 1, 2015 – May 15, 2016	April 2017

Note that the reporting period for IMM-2 and Influenza Vaccination Coverage Among Healthcare Personnel cross over 2 calendar years, from October 1, 2015 – March 31, 2016. While the data submission timeframe for IMM-2 aligns with the other measures (July 1 – August 15, 2016), the Influenza Vaccination Coverage Among Healthcare Personnel will be from October 1, 2015 – May 15, 2016.

Submission Information

Screenshots of the portal submission pages are unavailable at this time, as the secure portal is being updated for the next submission period. Generally, this information is available immediately prior to the submission period, and providers will be notified via ListServe when new tools displaying the updated collection and submission fields have been released. The tools with screenshots will be located on QualityNet.org under the IPFQR Resources tab as well as on the www.QualityReportingCenter.com website.

Submission of Non-Measure Data

Beginning with FY 2017, IPFs are required to submit aggregate population counts for Medicare and non-Medicare discharges by age group, diagnostic group, payer, and quarter. It is vital for IPFs to accurately determine and submit general population data for CMS to assess data reporting completeness for their total population, both Medicare and non-Medicare. This information is expected to improve CMS' ability to interpret measure results and assess the relevance and impact of potential future measures. Understanding that the size of subgroups of patients addressed by a particular measure varies over time could be helpful in assessing the stability of reported measure values and in subsequent decision-making concerning measure retention. Similarly, better understanding of the size of particular subgroups in the overall population will assist CMS in making choices among potential future measures specific to a particular subgroup (e.g., patients with depression).

Diagnostic Categories

- Diagnostic code grouping for the purpose of reporting non-measure data utilizes the categories developed for the Clinical Classifications Software (CCS) under the Healthcare Cost and Utilization Project (H-CUP) by the Agency for Healthcare Research and Quality (AHRQ). The Clinical Classifications Software (CCS) for ICD-9-CM is a diagnosis and procedure categorization scheme that collapses individual codes into a smaller number of clinically meaningful categories. Categorization should be based on the primary diagnosis at discharge.
- Analysis of Medicare claims indicate that six CCS categories account for more than 90% of patients treated by inpatient psychiatric facilities. The following CCS categories should be used for grouping and reporting diagnostic codes:
  - Anxiety disorders (651)
  - Delirium, dementia, and amnestic and other cognitive disorders (653)
  - Mood disorders (657)
  - Schizophrenia and other psychotic disorders (659)
  - Alcohol-related disorders (660)
  - Substance-related disorders (661)
  - Other diagnosis – all other diagnoses not falling into one of the above categories
- A list of individual codes for each clinical category can be found here: http://www.hcup-us.ahrq.gov/toolssoftware/ccs/AppendixASingleDX.txt.

Facility data for non-measure data submission will be required as displayed in the tables below. CMS will use the quarterly population counts and measure denominator values to determine whether sampling guidelines are being followed for measures that allow sampling (HBIPS-4 through 7, SUB-1, TOB-1, TOB-2/-2a, IMM-2).

Non-Measure Data Annual Collection

	1Q	2Q	3Q	4Q	Annual Sum of Discharges
Discharges by Quarter					

Age Strata	Total Discharges Annually
Children (≥ 1yr. and < 13 yrs.)	
Adolescent (≥ 13 and < 18 yrs.)	
Adult (≥ 18 yrs. and < 65 yrs.)	
Older Adult (≥ 65 yrs.)	

Non-Measure Data Annual Collection (continued)

Diagnostic Categories	Total Discharges Annually
Anxiety disorders (651)	
Delirium, dementia, and amnestic and other cognitive disorders (653)	
Mood disorders (657)	
Schizophrenia and other psychotic disorders (659)	
Alcohol-related disorders (660)	
Substance-related disorders (661)	
Other diagnosis – Not included in one of the above categories	

Payer	Total Discharges Annually
Medicare	
Non-Medicare	

Section 3: QualityNet Registration

To participate in the IPFQR Program and submit data for reporting, facilities must obtain a *QualityNet* user account and register with the *QualityNet Secure Portal*. All users requesting access to the *QualityNet Secure Portal* must be individually approved and verified at the facility level and submitted to *QualityNet*. This mandatory registration process is used to maintain the confidentiality and security of healthcare information and data transmitted via the *QualityNet Secure Portal*. These are CMS-approved sites for secure healthcare quality data exchange for facility reporting.

The *QualityNet* website is located at http://www.qualitynet.org. On the Home page, on the left side of the screen, there is a section labeled QualityNet Registration. Select the Inpatient Psychiatric Facilities hyperlink.

This web page contains an overview of the registration process and helpful links for getting started with *QualityNet*. Users should review the system requirements and test their system to ensure compatibility. You can select the Security Administrator link to access the QualityNet Registration packet.

To download the QualityNet Registration Packet, select the QualityNet Security Administrator Registration Packet link under the QualityNet Security Administrator Registration Inpatient Psychiatric Facilities page.
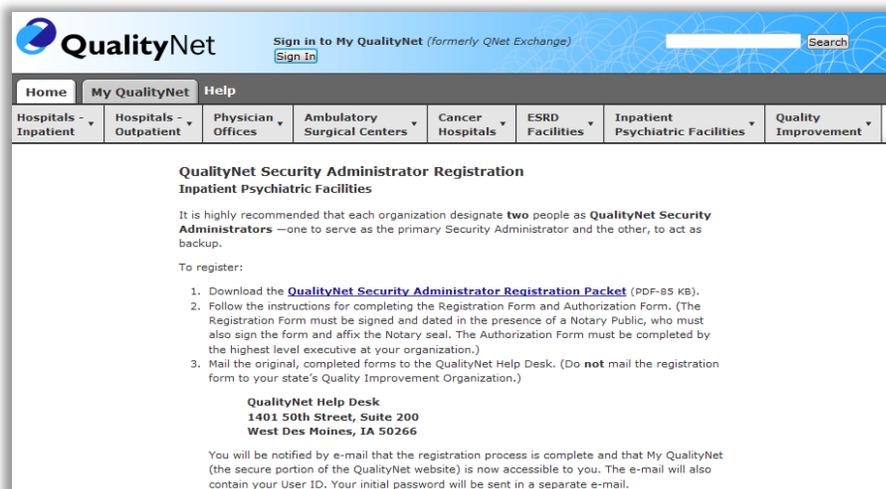
QualityNet Security Administrator

The IPFQR Program requires the facility to have at <u>least</u> one active *QualityNet* Security Administrator. It is recommended that facilities designate a minimum of two *QualityNet* Security Administrators. To keep the facility's account active, your SA should sign in at least once a month.

> **Best Practice:** We recommend facilities designate a minimum of two QualityNet Security Administrators (SA) - one to serve as the primary QualityNet Security Administrator and the other to serve as the alternate SA. To keep the facility's account active, your SA should sign in at least once a month. If it becomes necessary to reactivate your account, call the QualityNet Help Desk at 866.288.8912.

Security Administrator Responsibilities

The security administrator has the following responsibilities:

- Creating, approving, editing, and/or terminating QualityNet user accounts within the IPF;
- Assigning user roles for basic users within the IPF in order to access the secure web-based applications;
- Monitoring QualityNet usage at the IPF to ensure security and confidentiality is maintained; and
- Serving as a point of contact for information regarding *QualityNet*;

Non-Administrative User

Any user not designated as a QualityNet Security Administrator or a QualityNet Security Designate is considered a Non-administrative User (Basic user). Various roles to fit job needs can be assigned to the Non-administrative User.

If assigned the appropriate roles, the user may perform one or more of the following tasks:

- Access reports;
- Authorize vendors to submit data;
- Manage measures;
- Manage security;
- Manage Notice of Participation; and
- View/edit online forms.

Completing the *QualityNet* Registration Form

When completing the *QualityNet* Registration form, print the information legibly and completely in each of the applicable fields. For the "Specify Setting" section, check the Inpatient Psychiatric Facility box.

QualityNet Security Administrator Registration Form			
*NOTE: All fields marked with an asterisk are required and must be completed to obtain approval.			
Access Request			
*Request Date:	*First Name:	Middle Initial:	*Last Name:
*Business E-Mail Address:			
*Job Title:			
*Business Name:			

Specify Setting: *(Check all that apply)*

☐ ASC ☐ ESRD Facility ☐ Home Health Agency ☐ Inpatient Psychiatric Facility ☐ Physician Office

☐ CMS ☐ ESRD Network ☐ Hospital-Inpatient ☐ Long-Term Care Facility ☐ PPS-Exempt Cancer Hospital

☐ EHR ☐ Healthcare System ☐ Hospital-Outpatient ☐ Nursing Home ☐ QIO

Sign and date the **QualityNet Security Administrator Form** in the presence of a Notary Public, obtaining the Notary's stamp and seal on the form. Even though not all states require the stamp or seal of the notary, it is a requirement for *QualityNet*.

Have the highest-level executive at your location complete and sign the **QualityNet Security Administrator Authorization Form.** Depending on the facility, this may be the Chief Executive Officer, Administrator, Medical Director, or other similar position.

Refer to the information below for mailing instructions of the original, completed **QualityNet Security Administrator Registration Form** and the **QualityNet Security Administrator Authorization Form**. Photocopies or faxes of the forms will not be accepted. The facility should retain a copy of all forms for their records.

Mail the original completed form (not a copy) to the QualityNet Help Desk at the following address:

QualityNet Help Desk
1401 50th St., Suite 200
West Des Moines, IA 50266

For questions regarding the QualityNet Registration Form, contact:

QualityNet Help Desk
Monday through Friday
7:00 a.m. to 7:00 p.m. Central Time

E-mail: qnetsupport@hcqis.org
Phone: 866.288.8912
TTY: 877.715.6222

Activating the Security Administrator Account

Once the QualityNet Registration Forms are processed by *QualityNet*, the approved security administrator(s) will receive an email notification with the individual assigned user name and a temporary password. In order to activate the account, the user must sign in to *My QualityNet* and establish a password.

After the password is established, the user must complete the enrollment to obtain access to the *QualityNet Secure Portal*. This establishes access to the web-based Notice of Participation (NOP), Web-Based Measures, Data Accuracy and Completeness Acknowledgement (DACA) applications, and IPFQR Program reports.

QualityNet Secure Portal Access

Before logging in to *QualityNet Secure Portal* for the first time, a user must complete the New User Enrollment Process. The prerequisites for this process are:

- A completed *QualityNet* Registration;
- Receipt of the applicable user roles assigned by your facility security administrator; and
- A Symantec VIP multifactor credential application in order to obtain VeriSign, an authentication service that enables secure access to networks and applications. To download the multifactor authentication application to the your PC or tablet, access the Verisign ID Protection Center website: https://idprotect.vip.symantec.com/mainmenu.v
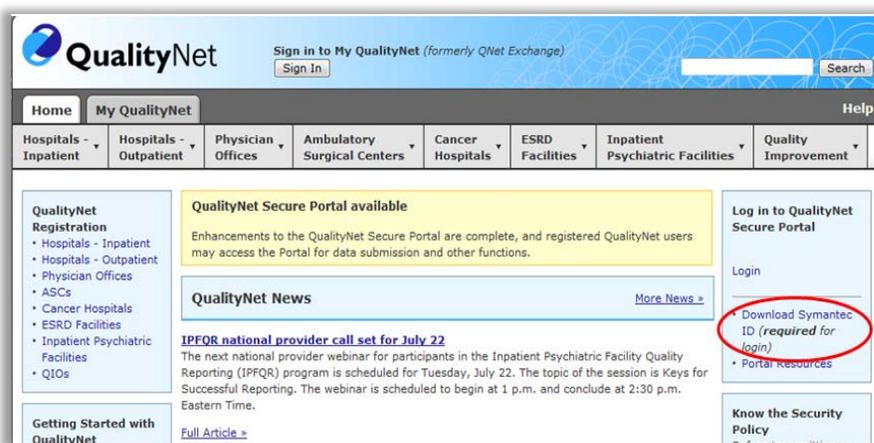
After selecting the "Download Symantec ID" link, the page below will display. Users will make the download selection that is appropriate for their device (Windows or Mac).

It may be necessary to consult with your IT department before downloading the VeriSign ID to the PC due to system firewalls or other restrictions.

Access the *QualityNet Secure Portal* on the *QualityNet* website
https://www.qualitynet.org. Select "Login" to begin.

Each IPFQR user must complete the authenticating (proofing), required by the Federal
Information Security Management Act (FISMA), for accessing government systems.
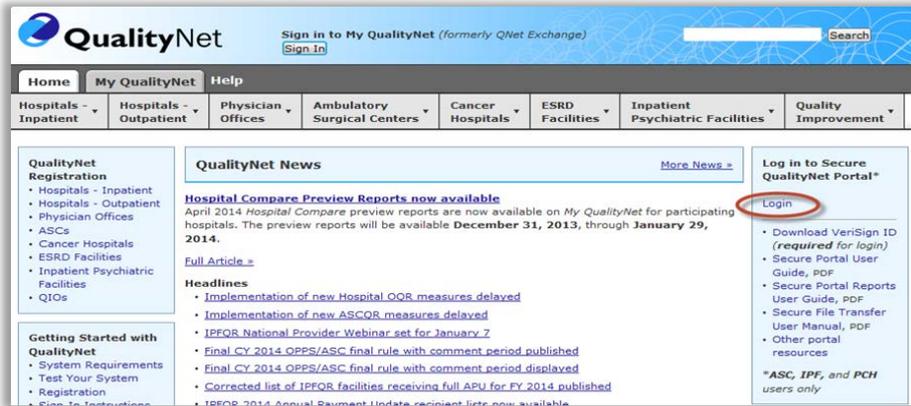
Select the link "Start/Complete New User Enrollment" on the login page to begin the
enrollment process.

Enter the User ID supplied by *QualityNet* followed by the revised password. Next,
select "Submit."

Verifying Identity

To verify a user's identity, enter the required information within each field on the screen. A social security number is required for users residing within the United States. A social security number is considered the most available source of identification that can be verified, as not all users have a driver's license or passport. When a user enters a social security number, the screen displays hash marks instead of numbers to protect privacy.

Please note: you must enter your personal street address, NOT your associated facility's address.

Once the required fields have been entered, check the privacy statement, and click "Submit."

CMS is aware of the privacy concerns regarding disclosure of personal data including social security numbers. CMS is collecting the Personally Identifiable Information (PII) on this screen and on the identity question screen to verify identity only. Verifying a user's identity meets the National Institute of Standards and Technology (NIST) and the Federal Information Security Management Act (FISMA) requirements. FISMA was passed as Title III of the E-Government Act (Public Law 107-347) in December 2002. FISMA requires each federal agency to develop, document, and implement an agency-wide program to provide information security for the information and information systems that support the operations and assets of the agency, including those provided or managed by another agency, contractor, or other source. This Act assigned NIST the responsibility to develop standards to be used by Federal agencies to categorize information and information systems based on the objectives of providing appropriate levels of information security according to a range of risk levels. CMS is complying with the NIST standards by verifying a user's identity using Experian's Precise ID platform (an external authentication service provider). To maintain the privacy of users, social security numbers will be masked and encrypted during this transaction to ensure it is secure. Other than a name, none of the PII data collected in this process is retained by CMS.

The screen will display a message stating that the information has been sent to Experian and will instruct the user to wait as the information is being processed. A set of questions will be generated that will need to be answered. Example questions may be downloaded from the User Guide located on *QualityNet*.

Typical Types of Identity Proofing Questions include:

- Verification of where you have lived (street address, city, and state);
- Verification of the type of car you own or have leased (color, make, license plate number);
- Verification of banking institutes that you may have used for banking or various types of loans;
- Verification of phone numbers (home and cell);
- Verification of education completed;
- Verification of where you have been employed; and
- Verification of dates associated with any of the above activities.

Answer the identity challenge questions, and then select "Submit." Examples of questions that may be included in the identity proofing are provided below:
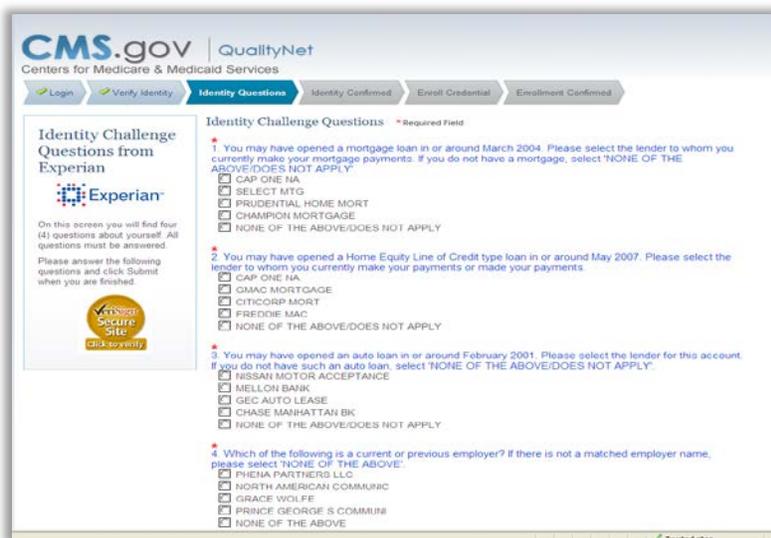
Once a user has completed the identity proofing questions correctly, the verification will display on the computer screen indicating successful completion of the CMS identity proofing.

If the questions are not answered accurately or if there is an alert on the credit report due to identity theft, the user will be prompted to call Experian to complete telephone verification. A phone number will appear on the screen. If unsuccessful during the telephone verification, the user will be referred to the facility's Security Administrator to complete a face-to-face verification.

An individual user must have attempted both the online and telephone verification before a face-to-face verification can be done.

Enrolling the Credentials

Steps for enrolling the credentials are as follows:

1. Access the Symantec VIP Access Application.

2. Enter the credential ID number in the first field.

3. Enter a security code within the 30-second freshness period. A counter will display the seconds from 30 with a countdown until the next code displays. The security code may be typed in the field or copied by performing a right-click with the mouse and pasting the number in the Security Code field.

4. Select "Submit."

For additional information on the New User Enrollment Process, select the Secure Portal User Guide link displayed in the following location: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228773343598. The information is contained in Section 4 of the guide.
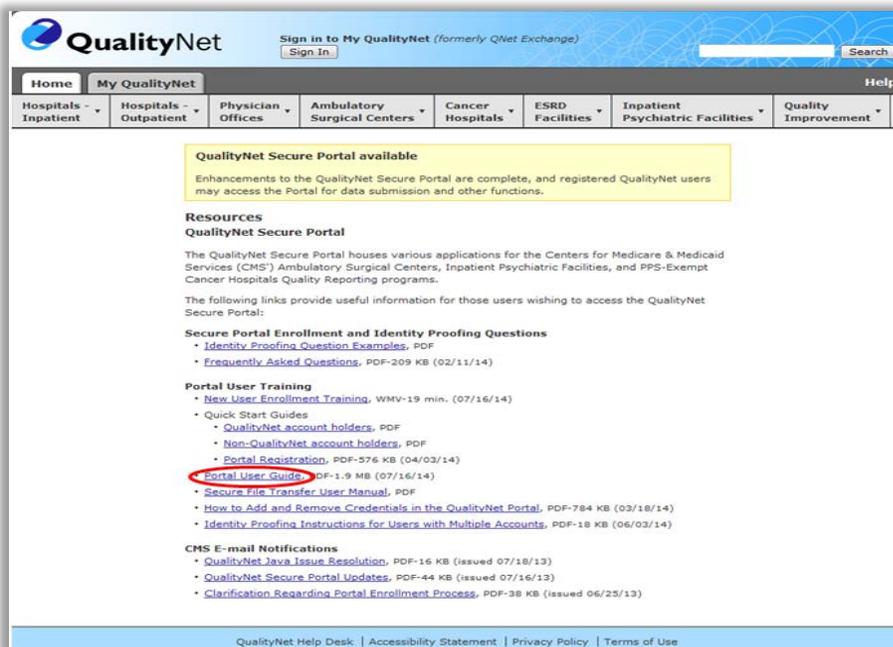
Logging In to the *QualityNet Secure Portal*

After completing the New User Enrollment, enter a User ID, Password, and Security Code for each login to the *QualityNet Secure Portal*.

After entering the User ID, Password, and Security Code and selecting "Submit," the security screen will be displayed, indicating the user has accessed a U.S. Government Information system. The user must accept the terms before proceeding to the *QualityNet Secure Portal*.
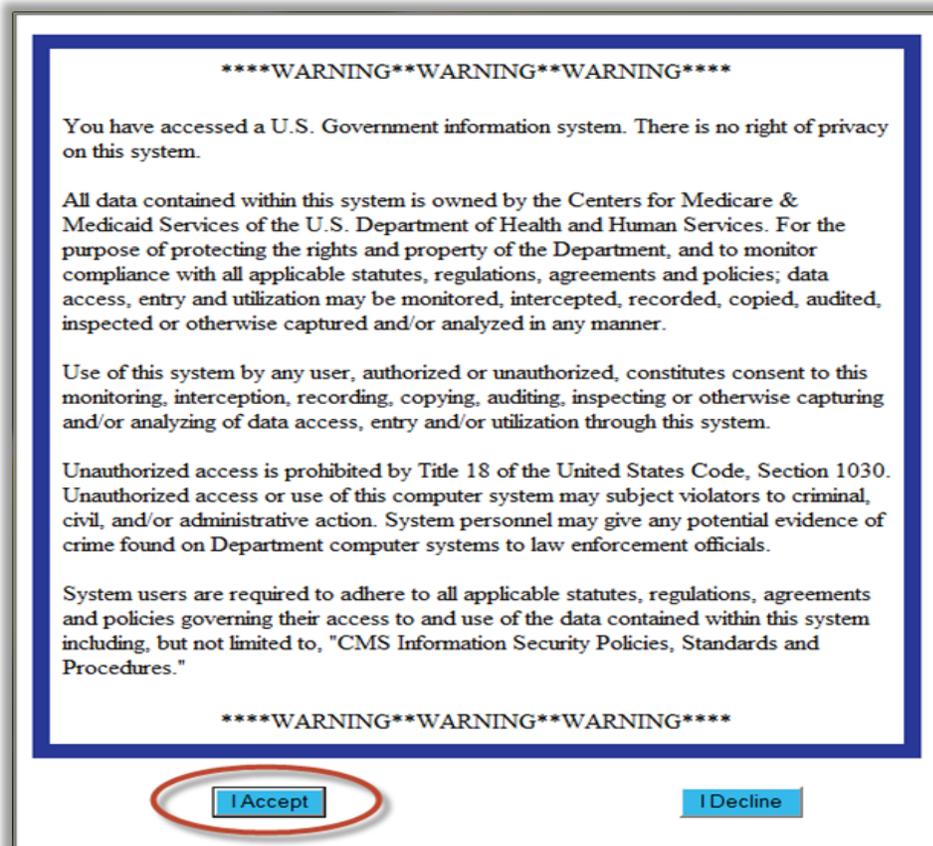
To access the IPFQR Program, select Quality Program (1.) then the Hospital Quality Reporting: IQR, OQR, ASC, IPFQR, PCHQR option from the drop down menu (2.).
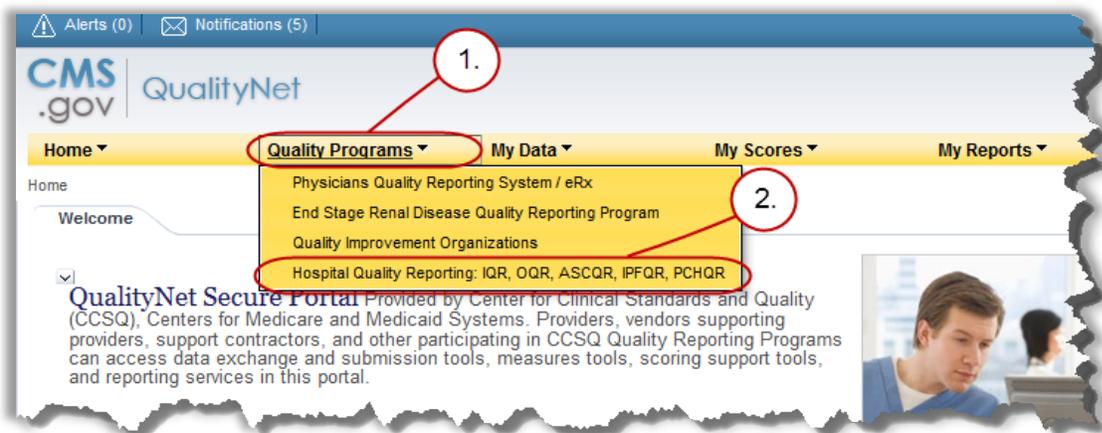
After selecting the Quality Program, the My Tasks page is displayed on the next screen. The content of the My Tasks page is dependent upon the user roles assigned to the individual. If assigned the appropriate roles, the user may perform one or more of the following tasks:

- Access reports;
- Authorize vendors to submit data;
- Manage measures;
- Manage security;
- Manage Notice of Participation; and
- View/edit online forms.

User Roles

For the IPFQR Program, there are two types of user roles that may be assigned. Those roles are the "Read Only" role and the "Update" role. The "Update" role allows the user to edit information within the application, whereas the "read only" role allows the user to read the information only. For more information regarding roles, refer to Section 3 QualityNet Registration in this manual.

Below is a list of roles that must be assigned to a user.

IPFQR Notice of Participation
- IPFQR Notice of Participation Read
- IPFQR Notice of Participation Update

IPFQR Web-Based Measure/DACA Application
- IPFQR Web-Based MSR DACA Read
- IPFQR Web-Based MSR DACA Update

IPFQR Reports
- IPFQR Reports Read
- IPFQR Reports Update

IPFQR Vendor Authorization
- IPF Vendor Authorization
- Hospital Reporting Feedback - IPFQR

Online Forms
- Online Forms View - Inpatient Psych
- Online Forms - Upload - Inpatient Psych

File Exchange
- File Search and Exchange

Below is an example of the Quality Reporting System: My Tasks page.
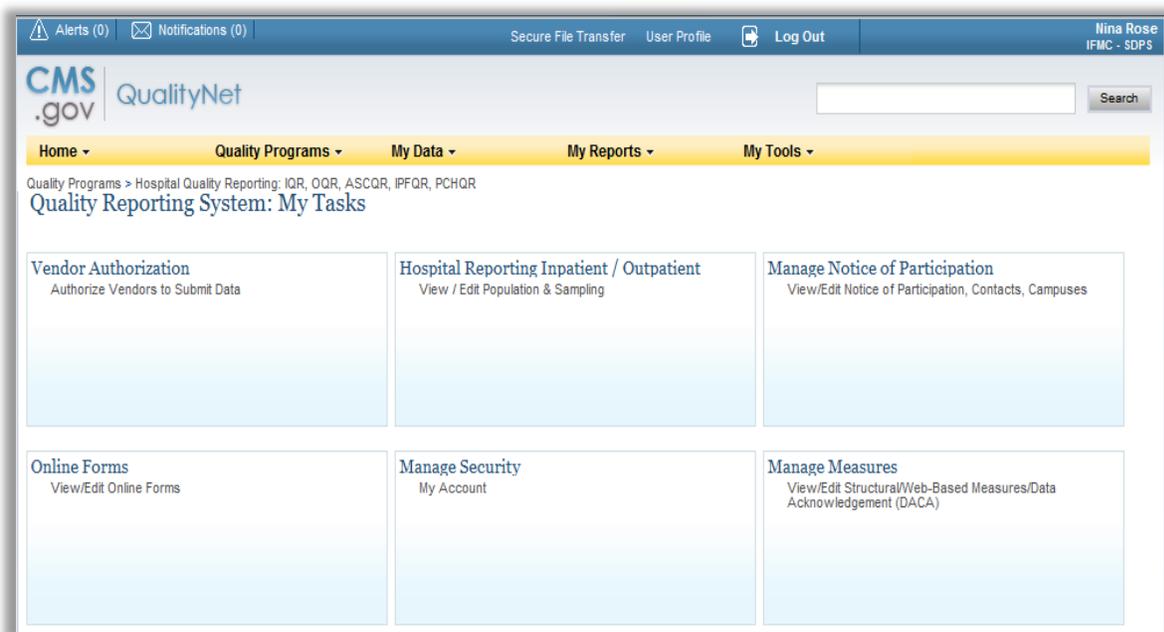
Section 4: Vendor Authorization

Facilities may elect to use a vendor to collect and submit data on their behalf. A vendor must have an assigned vendor ID and be authorized to submit data to the QIO Clinical Warehouse, prior to the IPF authorizing them to submit data or to have access to their facility's data and/or reports.

To receive the vendor registration information, the vendor may submit an email request to one of the following email addresses: vendorreg@hcqis.org **or** qnetsupport@hcqis.org.

IPFs may authorize a vendor to submit data on the behalf of the facility. Please note, however, that CMS holds **an IPF responsible for ALL data submission, even when contracting with a vendor.**

Vendors must be authorized to submit data on behalf of providers. The Authorize Vendors to Submit Data option enables providers to authorize vendors to submit web-based IPF measures information. It also enables providers to update existing authorizations.

IPFs must have the IPF Vendor Authorization role to access the Vendor Authorization link.

1.   From the Quality Programs tab on the QualityNet Secure Portal Landing page, click the Quality Programs: Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR link. The following page appears:
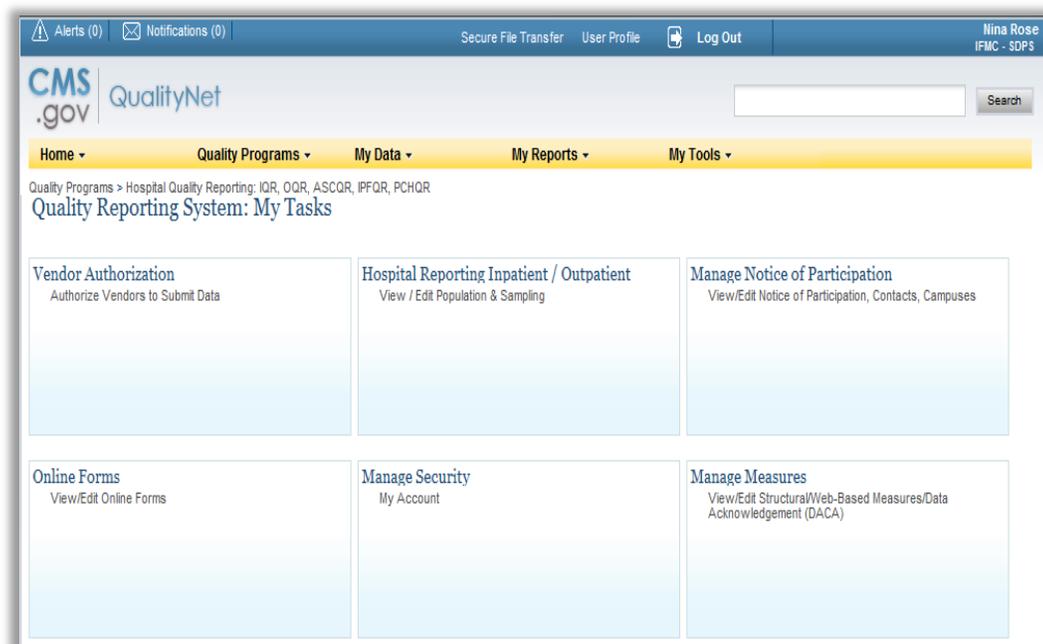
2. Then, from the Quality Reporting System: My Tasks page, choose the Authorize Vendors to Submit Data>Vendor Authorization link. The following page appears:
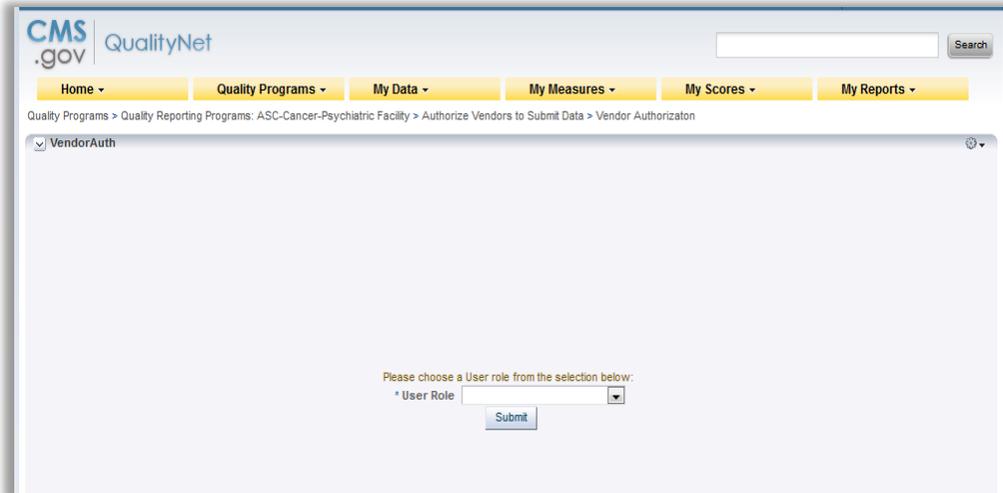
3. Select the IPF Vendor Authorization role from the drop-down box and click "Submit." The following page appears:
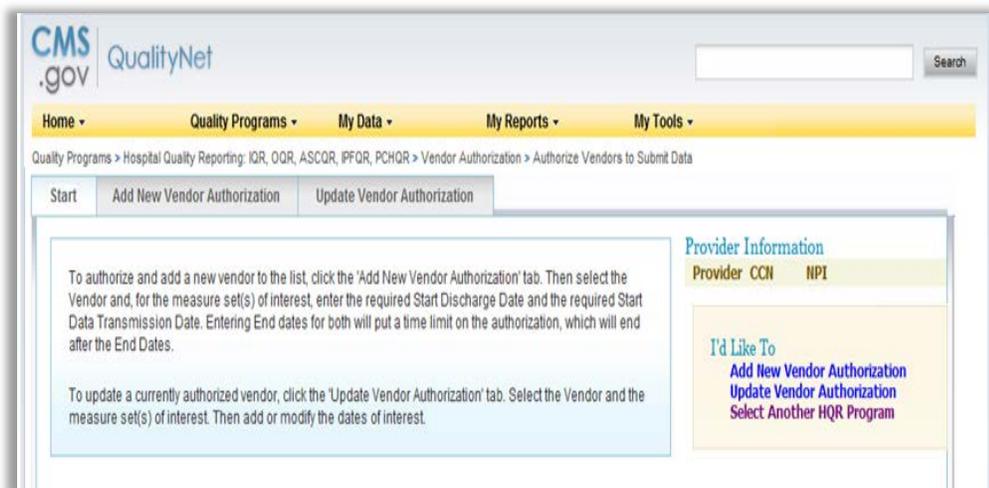
4. Select either the Add New Vendor Authorization or the Update Vendor Authorization link. All vendors that you have allowed to submit clinical data on your behalf are automatically authorized to submit IPF web-based measures for the data submission period beginning July 1, 2014.

5. The Authorized Vendors to Submit Data page appears.

6. Select a vendor from the list.

7. Verify the correct vendor is displayed. Use the Cancel button to return to the previous page to make a vendor change, if necessary.

8. Scroll to the IPF measure.

9. Click the Calendar icon buttons to select a Discharge/Encounter Date>Start and Data Transmission Date>Start for the IPF measures. Both start dates are required but end dates are not. Discharge/Encounter Date>Start Date must be the first day of a quarter. The Data Transmission Date>Start Date must be equal to or greater than the current date.

10. The Discharge/Encounter Date>End and Data Transmission Date>End fields are optional. It is recommended that you do not enter end dates unless you know that you will no longer want this specific vendor to submit data after the specified end dates, or if you are converting from one CCN to a new CCN. The Discharge/Encounter Date>End Date must be the last day of a quarter.

11. If you are terminating a vendor relationship at the end of a submission period, it is recommended that you do not enter the submission deadline date as the Data Transmission Date>End Date, due to the possibility of a submission date extension. It is recommended that you enter the Data Transmission Date>End Date when all data have been transmitted.

12. If more than one vendor is authorized for the same topic and timeframe, a message indicating there is more than one vendor authorized to submit data for the same measure set and time period will display. You will be able to proceed but will need to verify that the dates entered are correct.

13. Click "Cancel" to return you to the vendor's currently authorized page without saving changes.

14. Click "Continue" to proceed. The Approve New or Changed Vendor Authorization page appears.

15. Verify that the vendor information and authorized dates are correct. Click Submit or use the Edit button to return to the previous page to make any date changes. Once an authorization has been submitted, the only dates that can be modified are future dates. If incorrect dates were entered and need to be modified, please send an email to qnetsupport@hcqis.org or call 866.288.8912.

16. The Vendor Authorization Complete page will display and summarize the submitted Vendor Authorization.

17. Click "Print" for a printer-friendly copy of the authorization, if desired.

Additional information is available in the Using the QualityNet Secure Portal Applications User Guide, available at the following link:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228773343598.

Section 5: Notice of Participation

Overview

To participate in the IPFQR Program, each facility must complete a Notice of Participation (NOP). During the first year of the program, facilities had the option of submitting a paper NOP or completing the NOP online. Once completed, the NOP remains in effect until an IPF decides to withdraw from the program or there is a change in their eligibility status.

Facilities that completed a NOP for FY 2016 and plan to continue to participate in the IPFQR Program do not need to complete a NOP for FY 2017. The system will automatically update their NOP and populate the FY 2015 screen and annually thereafter. To verify the NOP was updated, it is recommended that the facility log in to the NOP application. It is also recommended that facilities log in to the NOP application to update their facility contacts, since this information was not available if a facility completed the paper NOP form.
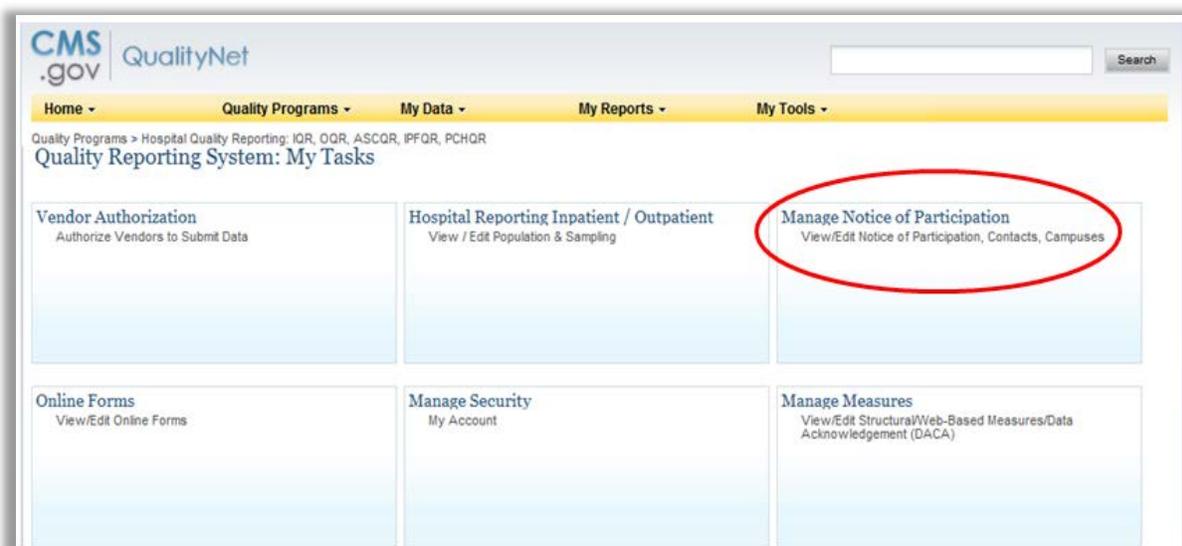
Eligible facilities that did not participate in the IPFQR Program previously may complete an online NOP for FY 2016 by August 15, 2015.

New facilities must complete the NOP no more than 180 days from the Medicare Accept Date.

> **NOTE:** Once an IPF has submitted an NOP, the IPF is considered an active IPFQR Program participant until the IPF submits a withdrawal of participation or until there is a change in the eligibility status of the IPF.

Accessing the Online Notice of Participation Application

To access the NOP application, a user must have the IPFQR NOP Read or IPFQR NOP Update (to add or edit) Role assigned by their Security Administrator.

After selecting the View/Edit Notice of Participation, users that are affiliated with only one facility will see their facility's 6-digit CMS Certification Number (CCN) after selecting the Manage Notice of Participation link under the My Tasks screen.

Users that are affiliated with more than one facility will be prompted to enter the 6-digit CCN as shown in the example below:

Next, select the action to be completed:

View, Add or Update the Notice of Participation, Facility Contacts, or Additional Campus information.

The additional campus information may not apply to all IPFs. It is applicable for facilities that have more than one physical location but are licensed and reimbursed under the same CCN. Quality data is reported and published under the same CCN regardless of the number of physical locations associated with a CCN.
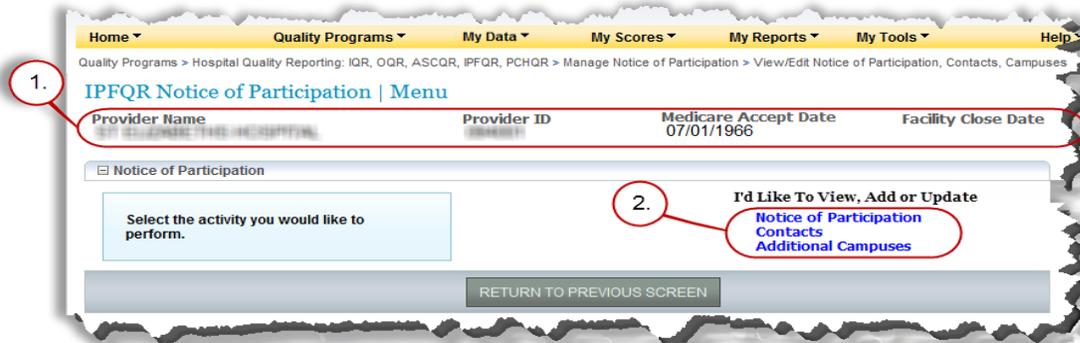
If this is the first time the NOP is being added, then the user must enter the contact information as the first step.
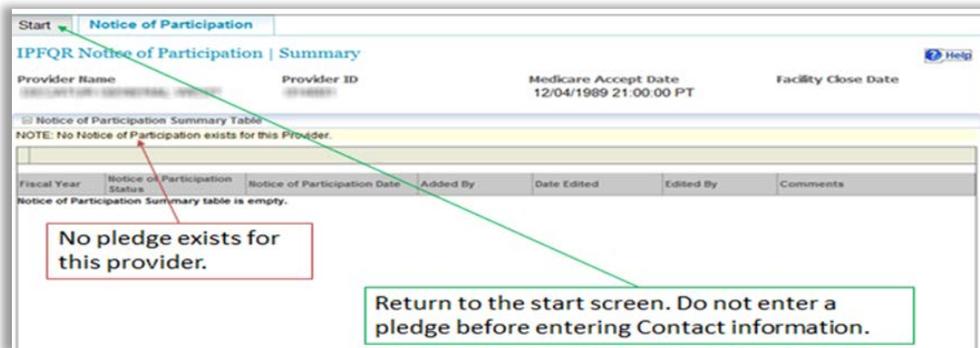
Select Contacts from the list.
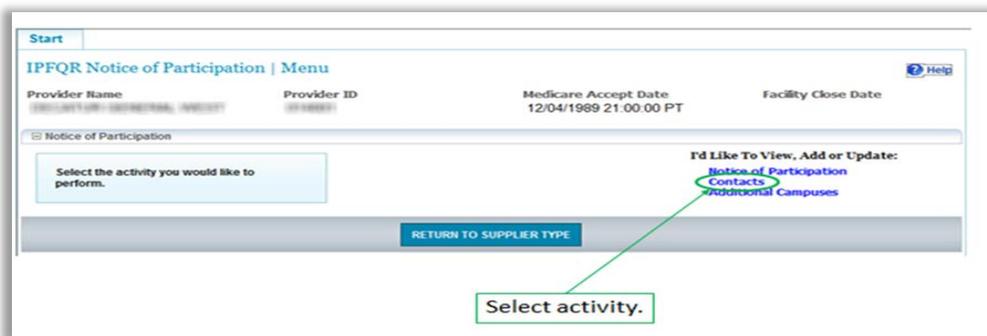
Enter at least **two** facility contacts within the contact screen. The contact information is used for sending email alert notifications if edits are made within the NOP application.

If the facility completed a paper NOP, then there will not be any contact information entered in the application. It is recommended that the facility log in and update the contact information.

Upon initial completion of the NOP, two pledge options are available: "Participate" or "Do not agree to participate."

Select the desired pledge option and the acknowledgement check box.

Following the pledge selection select the "Save" button. A confirmation screen appears asking the user to confirm the selection in order to save the document.

Once a facility has agreed to participate, they remain a program participant until they log in and select the option to withdraw.

Detailed information about the NOP application is accessible on the *QualityNet* Home page by logging in through the *QualityNet Secure Portal*. Here is the direct link: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetHomepage&cid=1120143435363.

Section 6: Data Accuracy and Completeness Acknowledgement

IPFQR program participants enter NOP and measure data using the web-based applications on *QualityNet*. Following the submission of the measure data, each IPF must attest to the accuracy and completeness of the entered data via a Data Accuracy and Completeness Acknowledgement (DACA) statement. The DACA must be completed annually by the August 15th submission deadline, prior to the respective payment determination year.

After submitting data select the Return to the Summary button to return to the summary screen and continue submitting data for each measure.

As you complete submission of data for each measure, the status will change from "Incomplete" to "Completed."

When you have completed submitting data for all measures select the DACA link to complete your "Data Accuracy and Completeness Acknowledgement."

The following page appears:

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

*Data Accuracy and Completeness Acknowledgement for FY 2015 and Subsequent Fiscal Years

(*****) indicates required for providers participating in the Inpatient Psychiatric Quality Reporting Program.

To the best of my knowledge, at the time of submission, all of the information reported for this Inpatient Psychiatric Facility (IPF) for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, as required for the Fiscal Year 2015 and subsequent fiscal years IPFQR Program requirements, is accurate and complete. This information includes the following:

- Aggregated measure sets;
- Current Notice of Participation and QualityNet Security Administrator.

I understand that this acknowledgement covers all IPFQR information reported by this IPF (and any data or survey vendor(s) acting as agents on behalf of this hospital) to CMS and its contractors for the FY 2015 and subsequent fiscal years.

To the best of my knowledge, at the time of submission, this information was collected in accordance with all applicable requirements. I understand that this information is used as the basis for the public reporting of quality of care.

I understand that this acknowledgement is required for purposes of meeting any Fiscal Year 2015 IPFQR Program requirements.

Enter your position and click 'Submit'.   1.

○ **Yes, I Acknowledge***

Name   ▓▓▓▓▓ ▓▓▓▓▓   2.

Position [   ]   3.

[Return to Summary] [**Submit**] [**Print**]

1. Select the radio button in the front of "Yes, I Acknowledge*"

2. Type in your position or title

3. Select the Submit button

Section 7: Accessing and Reviewing Reports

Report(s) described in this section are helpful in monitoring IPF status as it relates to the IPFQR program. The reports should be used as a reference tool and do not guarantee a facility will receive its full APU.

Types of Reports

Facility, State, and National Report

The Facility, State and National Report provide information about the data that is submitted to the clinical warehouse, following entry into the web-based application. The facility rate is specific to the facility accessing the report.

The state and national rates are calculated approximately 30 days following the end of the submission period. This information is used for an individual facility to compare its facility-specific rates with state and national averages for each measure.

To run a Hospital Reporting-Inpatient Psychiatric Facility, State, and National Report:

1. Select "**Run Reports**" from the "**My Reports**" drop down menu in the yellow tool bar near the top of the summary screen.

2. Select the "**Run Report(s)**" tab.

3. Select "IPFQR" for **Report Program** and "Hospital Reporting Feedback – IPFQR" for **Report** Category. Select the **[VIEW REPORTS]** button.

4. Select the "Hospital Reporting – Inpatient Psychiatric Facility, State and National Report".

5. Enter your desired report parameters. Enter "2014" for **Payment Year**.

6. Select the **[Run Report]** button.

7. Select the "**Search Reports**" tab.

8. Select the new report and open it.

The IPFQR Provider Participation Report

The Provider Participation Report will be available in the future. This report provides the facility with a summary of the requirements for participation in the IPFQR program. The report assists IPFs in determining their facility's status towards meeting the program requirements. However, the information provided does not guarantee the hospital will receive the full APU.

Section 8: Public Reporting of IPFQR Data

Background

Section 1886(s)(4)(E) of the Social Security Act requires the Secretary of Health and Human Services to establish procedures for making the data submitted under the IPFQR program available to the public.

The Department of Health & Human Services (HHS) hosts the Hospital Compare website, http://www.hospitalcompare.hhs.gov/ which publicly reports hospital performance on numerous measures. Quality performance information is collected from more than 4,000 participating hospitals. Hospital Compare is designed to make meaningful, relevant and easily understood information about hospital performance accessible to the public and to inform and encourage efforts to improve care quality. Accessibility and use of performance information spurs positive changes in healthcare delivery.

Effective April 17, 2014, the IPFQR program data are located at the following link: http://medicare.gov/hospitalcompare/search.html.

Public Display Timeline

The IPFQR program will have quality of care data publicly displayed on an annual basis. The data will be published during April of each year beginning in April 2014 and subsequent years.

Payment Determination Year (Fiscal Year)	Reporting Period (Calendar Year)	Public Display (Calendar Year)
2015	Q2 2013 (April 1 – June, 2013) Q3 2013 (July 1 – September 30, 2013) Q4 2013 (October 1, December 31, 2013)	April 2015
2016	Q1 2014 (January 1 – March 31, 2014) Q2 2014 (April 1 – June, 2014) Q3 2014 (July 1 – September 30, 2014) Q4 2014 (October 1 – December 31, 2014)	April 2016
2017	Q1 2015 (January 1 – March 31, 2015) Q2 2015 (April 1 – June, 2015) Q3 2015 (July 1 – September 30, 2015) Q4 2015 (October 1 – December 31, 2015)	April 2017

Preview

Prior to the public release of data on CMS website, facilities are given the opportunity to preview data for 30 days. Preview reports will be accessible for download by the facility, via the *QualityNet Secure Portal*, beginning with the April 2015 preview. Providers will be notified via list serve when the reports are available.

Preview Report Content

The report contains Facility, State, and National level data listed by age category (stratum) and overall rate in an aggregate annualized format. The reporting quarters and measures included on the report are the same as that which was submitted for the specific program year. For example, for FY 2015, the HBIPS measures 2 through 7 were reported for the period of 2nd through 4th Quarter 2013.

Footnotes

There are times in which footnotes are necessary to further explain the data displayed in the report. There are five footnotes that may be applicable for the IPFQR program preview report.

An example of the IPFQR Program Review Report is described below:

- Starting at the top of the report, the Report Header contains the program as Inpatient Psychiatric Facility Quality Reporting and the reporting period for Fourth Quarter 2012 through First Quarter 2013 Discharges. Note there is also a Report Run date and Page numbering in the top section.

- The Facility CMS Certification Number is followed by the Facility Name. Note that there are a few instances where your facility name may have changed; however, if the information has not been updated by the state survey and certification department, then it may still display as the previous name.

- Just below the facility name, there is a section containing facility demographic information such as the City, State, Zip, Phone Number, County where the facility is located, the type of facility (such as an acute, critical access or psychiatric hospital), the type of ownership, and whether your facility provides emergency services.

- The report is separated into three columns. The first column on the left is the facility specific data. The column in the middle contains the data for all facilities within your individual state, and the far right column contains the national data.

- The data are displayed in measure order, starting with HBIPS-2. The data is displayed by stratum or age group. There is a column for the numerator and one for the denominator. Note for the HBIPS-2 and HBIPS-3 event measures, the rates are calculated per 1000 patient hours. For this report, it is rounded to two decimals.

Example of page 1 of the Preview Report is displayed below:

Report Run Date: 10/22/2014

Hospital Compare Preview Report: Improving Care Through Information
Inpatient Psychiatric Facility Quality Reporting Preview Report
Reporting Period for IPFQR Measures:Second Quarter 2013 through Fourth Quarter 2013 Discharges

Address: .
City, State, ZIP:
Phone Number:
County Name:

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

Web-Based Measures Set IPFQR-HBIPS		Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours
HBIPS-2: Hours Of Physical-Restraint Use										
	1 - 12 years	0	0	N/A(7)	11.03	29772	0.02	4726.502558	694887	0.28
	13 - 17 years	0	0	N/A(7)	50.46	90323	0.02	11532.192989	1815080	0.26
	18 - 64 years	806	265	126.73	3963.21	308993	0.53	107798.598533	17501590	0.26
	65 and over	2411	2649	37.92	7172.35	38884	7.69	106935.015347	4415221	1.01
	Overall	3217	2914	46.00	11197.06	467972	1.00	230992.309427	24426778	0.39

Web-Based Measures Set IPFQR-HBIPS		Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours
HBIPS-3: Hours Of Seclusion										
	1 - 12 years	0	0	N/A(7)	45.38	29772	0.06	5897.823783	697497	0.35
	13 - 17 years	0	0	N/A(7)	60.45	90323	0.03	5679.880822	2001233	0.12
	18 - 64 years	0	265	0.00	584.75	308919	0.08	89235.732819	17831840	0.21

Footnote Legend
1 . The number of cases/patients is too few to report.
3 . Results are based on a shorter time period than required.
4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.

The discharge measures are displayed the same way as the event measures with the exception that the rate is displayed as a percentage of the total.

In the example below, footnote four applies because CMS suppressed the data for HBIPS-4 and -5 for public reporting. If the facility successfully submitted the data, it was displayed on the preview report, with the footnote four. For the April public reporting, this data will not be displayed.

Example of page 2 of Preview Report is displayed below:

Report Run Date: 10/22/2014

Hospital Compare Preview Report: Improving Care Through Information
Inpatient Psychiatric Facility Quality Reporting Preview Report
Reporting Period for IPFQR Measures:Second Quarter 2013 through Fourth Quarter 2013 Discharges

Web-Based Measures Set IPFQR-HBIPS		Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours
HBIPS-3: Hours Of Seclusion										
	65 and over	0	2649	0.00	152.58	38879	0.16	12786.854037	3569691	0.15
	Overall	0	2914	0.00	843.17	467893	0.08	113600.291461	24100261	0.20

Web-Based Measures Set IPFQR-HBIPS		Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total
HBIPS-4: Patients Discharged On Multiple Antipsychotic Medications										
	1 - 12 years	N/A	N/A	N/A(5)	0	0	0.00%(4)	126	4858	2.59%(4)
	13 - 17 years	N/A	N/A	N/A(5)	0	1	0.00%(4)	194	8657	2.24%(4)
	18 - 64 years	N/A	N/A	N/A(5)	85	684	12.43%(4)	6892	73988	9.32%(4)
	65 and over	N/A	N/A	N/A(5)	14	238	5.88%(4)	2045	30139	6.79%(4)
	Overall	N/A	N/A	N/A(5)	99	923	10.73%(4)	9257	117642	7.87%(4)

Web-Based Measures Set IPFQR-HBIPS		Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total
HBIPS-5: Patients Discharged On Multiple Antipsychotic Medications With Appropriate Justification										
	1 - 12 years	N/A	N/A	N/A(5)	0	0	0.00%(4)	55	126	43.65%(4)

Footnote Legend
1 . The number of cases/patients is too few to report.
3 . Results are based on a shorter time period than required.
4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.

Page 3 of the sample report shows the HBIPS-5, -6, and -7 measures. The rate is displayed as a percentage of the total, as shown below:

Report Run Date: 10/22/2014

Hospital Compare Preview Report: Improving Care Through Information
Inpatient Psychiatric Facility Quality Reporting Preview Report
Reporting Period for IPFQR Measures:Second Quarter 2013 through Fourth Quarter 2013 Discharges

Web-Based Measures Set IPFQR-HBIPS		Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total
HBIPS-5: Patients Discharged On Multiple Antipsychotic Medications With Appropriate Justification										
	13 - 17 years	N/A	N/A	N/A(5)	0	0	0.00%(4)	94	194	48.45%(4)
	18 - 64 years	N/A	N/A	N/A(5)	42	85	49.41%(4)	3289	6881	47.80%(4)
	65 and over	N/A	N/A	N/A(5)	3	14	21.43%(4)	868	2042	42.51%(4)
	Overall	N/A	N/A	N/A(5)	45	99	45.45%(4)	4306	9243	46.59%(4)

Web-Based Measures Set IPFQR-HBIPS		Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total
HBIPS-6: Post-Discharge Continuing Care Plan Created										
	1 - 12 years	N/A(1)	N/A(1)	N/A(7)	152	200	76.00%	20220	23011	87.87%
	13 - 17 years	N/A(1)	N/A(1)	N/A(7)	593	839	70.68%	41981	48990	85.69%
	18 - 64 years	N/A(1)	N/A(1)	88.46	3647	4986	73.14%	204220	278872	73.23%
	65 and over	N/A(1)	N/A(1)	79.27	594	1155	51.43%	58562	91176	64.23%
	Overall	N/A(1)	N/A(1)	82.84	4986	7180	69.44%	324983	442049	73.52%

Footnote Legend
1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.

Report Run Date: 10/22/2014

Hospital Compare Preview Report: Improving Care Through Information
Inpatient Psychiatric Facility Quality Reporting Preview Report
Reporting Period for IPFQR Measures:Second Quarter 2013 through Fourth Quarter 2013 Discharges

Web-Based Measures Set IPFQR-HBIPS		Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total
HBIPS-7: Post-Discharge Continuing Care Plan Transmitted To The Next Level Of Care Provider Upon Discharge										
	1 - 12 years	N/A(1)	N/A(1)	N/A(7)	142	201	70.65%	17560	23011	76.31%
	13 - 17 years	N/A(1)	N/A(1)	N/A(7)	465	839	55.42%	36269	48988	74.04%
	18 - 64 years	N/A(1)	N/A(1)	76.92	3087	4986	61.91%	172210	278725	61.78%
	65 and over	N/A(1)	N/A(1)	71.95	494	1155	42.77%	51205	91144	56.18%
	Overall	N/A(1)	N/A(1)	73.88	4188	7181	58.32%	277244	441868	62.74%

Footnote Legend
1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.

Note at the bottom of every page of the report, there is a footnote legend that lists the footnotes that may appear on the report. The footnotes applied are individual to the facility based on their data, so not every footnote may be used.

Medicare.gov Website

Direct Link: http://medicare.gov/hospitalcompare/search.html

Medicare.gov Home Page

The IPFQR announcement is located under the Spotlight section on the lower left portion of the page. The "Find a hospital" function does not provide access to the quality measures submitted by IPFs.

Select the announcement link to navigate to the IPFQR program's information page.

The IPFQR program page includes a brief description of the program and the measures. It includes public access to performance measure data provided by IPFs; however, it does not generate a report equivalent to the Facility, State, and National report available to a facility through the secure portal. The data is in an aggregate annualized format of the quarters for the reporting period. This data may be calculated from the Facility, State, and National report.

Scroll down the page to see the next section - Data by Facility. The upper left corner of the data table is labeled as Data.Medicare.gov. This is where the data resides. A drop down "Menu" with options to sort and filter data is located in the top right corner.

After selecting the menu list, you may access the download option. Once the download is complete, filtering and other types of data manipulation are available depending on the file format selected.

Continue to scroll down the IPFQR Program page to locate the next section, Data by State. The menu list provides access to the download function.

Continue to scroll down the IPFQR Program page to locate the final section, Data by Nation. The menu list provides access to the download function. Hospital Compare Archives are available for historical data.

An alternate method to access the data is to access the Data.Medicare.gov website at the direct link: http://data.medicare.gov

Section 9: Resources

The following information contains additional resources available for IPFs participating in the CMS IPFQR Program.

For resources and tools from the IPFQR Support Contractor, users can access the website http://www.QualityReportingCenter.com. Data collection tools, timelines, and calendars, as well as other valuable resources, can be located on this website. In the dropdown menu for the Inpatient tab, select the IPFQR Program.

National Provider Webinars are provided by CMS and by the IPFQR Support Contractor on a routine basis. The slides from each of the education sessions are published to the QualityNet website and are available for review under the Inpatient Psychiatric Facilities tab by selecting the Webinars/Calls link from the drop down menu.

IPFQR ListServe

To receive important IPFQR program updates and notifications, please subscribe to the ListServe on the *QualityNet* website. On the left side of the page, navigate to the "Join ListServes" box and select the "Notifications and Discussions" link. Check the box next to Inpatient Psychiatric Facility Quality Reporting Program, enter your User Information, and click Submit.

Questions & Answers

The CMS Q&A tool is also a good resource for program information. The tool is intended to help users quickly find program answers when they are needed. The Q&A tool can be accessed from QualityNet by selecting the "Inpatient Psychiatric Facilities" link from the Questions & Answers section on the right side of the page and then choosing the "Inpatient Psychiatric Facility Quality Reporting" link (direct link): https://cms-ip.custhelp.com/app/home4.

If needed information is not in the Q&A Tool, select the "Ask a Question" link to submit a question to the IPFQR Support Contractor.

IPFQR Support Contractor

Toll-Free Telephone: 844.472.4477 or 866.800.8765

Email: IPFQualityReporting@hcqis.org

Hours of Operation: 8:00 a.m. – 8:00 p.m. Eastern Time

Help Desk - *QualityNet*

For technical issues contact the *QualityNet* Help Desk at:

Toll-Free Telephone: 866.288.8912

Email: qnetsupport@hcqis.org

Hours of Operation: 7:00 a.m. – 7:00 p.m. Central Time

QualityNet Website

The IPFQR program uses *QualityNet* to publish information including requirements, announcements about educational offerings, and news stories. The IPFQR Program home page is located at the following link: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772250192.

The *QualityNet* home page (www.qualitynet.org) offers a User Guide for the Secure Portal and User Guide for the Secure Portal Reports. Links are located on the right side of the webpage just below the "Log in to QualityNet Secure Portal" at the following link: http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/Page/QnetHomepage.

Paper Abstraction Tools

Paper Abstraction Tools have been developed for IPFs to use as an **optional** mechanism to aid in the collection of the HBIPS measure data for the CMS IPFQR Program. The Paper Abstraction Tools are located under the IPFQR Measures Resource section: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228773653066.

Specification Manuals

Specifications Manual for Joint Commission National Quality Core Measures Manual

To access this manual for specific detailed information for the HBIPS measures, use the following link: http://manual.jointcommission.org/bin/view/Manual/WebHome.

Specifications Manual for National Hospital Inpatient Quality Measures

To access this manual for specific detailed information for the SUB, TOB, and IMM measures, use the following link: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099.

National Committee for Quality Assurance (NCQA)

The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality (http://www.ncqa.org/).

Other Resources

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of the 27 institutes and centers that comprise the National Institutes of Health (NIH). NIAAA supports and conducts research on the impact of alcohol use on human health and well-being. It is the largest funder of alcohol research in the world. The NIAAA has published a list of validated screening tools that may be used by facilities in conducting their Alcohol Screening for the SUB-1 Measure (http://www.niaaa.nih.gov/).

Appendix A: Components of the Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures

Table of Contents - The Table of Contents provides a list of all of the documents contained within the respective manual with corresponding page numbers. The electronic online version of the manual is bookmarked and contains hyperlinks to easily navigate through documents.

Introduction - The Introduction contains a history of the CMS/Joint Commission Measure alignment and activities.

Using the Manual - This document provides a brief description of the content in each section of the manual and the appendices.

Data Dictionary Section - The Data Dictionary is provided to define data elements and provide guidance for abstraction of data. To ensure standardized and comparable data across all hospitals, it is of primary importance that all hospitals using the National Quality Core Measures (HBIPS) and the National Quality Inpatient Measures (SUB-1) gather and use the data elements as defined in the Data Dictionary.

> Introduction to the Data Dictionary - The Introduction to the Data Dictionary describes the data elements required to calculate the measures. It contains general abstraction guidelines; however, the instructions under each data element take precedence over general guidelines.

> Data Element List - The Data Element List contains an alphabetical list of all the data elements that are collected for the measures/measure sets included in the Specification Manual.

> Alphabetical Data Dictionary - The Alphabetical Data Dictionary is the largest of all of the documents contained within the manual. It is extremely important for the abstractor to have the correct version of the document based on the discharge period as abstraction instructions can change from period to period.

> A comprehensive list of each of the data elements is provided along with the page number and a list of specific measures in which the data element is used. Many data elements are used for more than one measure or measure set.

> Data Element Sections - Each data element is described in detail following the comprehensive list. There are multiple sections within the data element information.

> - **Data Element Name -** A short phrase identifying the data to be collected. For ease of identification, the data element name is italicized.

> - **Collected For -** Identifies the measures and the organization for which the element is collected: CMS, The Joint Commission, both, or neither organization.

> - **Definition –** A detailed explanation of the data element.

> - **Suggested Data Collection Question -** Provided as an example of wording for a data element question that may be found in a data abstraction tool.

> Data Element Sections (continued)

- **Format -** Identifies the criteria (length, type, occurs) of data that is being collected for transmission purposes.

   o Length - Number of characters or digits allowed for the element.

   o Type - Identifies the allowed data value: numeric, alphanumeric, date or time.

   o Occurs - Number of times the data element occurs in a single episode of care record.

- **Allowable Value -** A list of acceptable responses for the element. In some data elements, the response may be limited to one while others may allow for multiple values.

- **Notes for Abstraction -** Provided to assist the abstractor in the selection of the correct Appropriate Value for the data element. The Notes section may include examples of documentation encountered in the medical record.

- **Suggested Data Sources -** Provides a list of source documents from which data can be identified, such as an administrative or medical record. The sources are usually listed alphabetically for guidance locating the information within records. The information listed is for suggested sources only; however, other sources may be used, unless otherwise noted.

- **Guideline for Abstraction -** Designed to assist abstractors in determining how a data element should be answered. The instructions can reference inclusions abstracted as a positive finding. Unless specified within the data element, the inclusions listed are **not** considered all inclusive. The data element can contain specific exclusions or unacceptable terms abstracted as negative findings. Also, the instructions can reference an appendix in the *Specifications Manual*, such as a medication table. Element specific notes and guidelines take precedence over the "General Abstraction Guidelines" found in the "Introduction to the Data Dictionary."

Measure Information Form (MIF) - The measure information section in the *Specifications Manual for National Hospital Inpatient Quality Measures* and the *Specifications Manual for Joint Commission National Quality Core Measures* is divided by measure sets. There is a list of measures comprising each set, including the set measure identification number (alphanumeric number to identify a measure within a set) and the measure short name. For example, in the Hospital Based Inpatient Psychiatric Services (HBIPS) measure set, the measure that addresses Hours of Physical Restraint Use is listed as: HBIPS-2a and measure short name: Physical Restraint-Overall Rate. This is followed by a data element list for the measure set, including the general data elements, algorithm output data elements, and the specific measure set data elements. Next is a document that describes the Initial Patient Population and the sample size requirements for each measure set. Also included are subsections for each specific measure. These contain a Measure Information Form (MIF) and the Measure Algorithm.

The MIF has an identification section which includes name and identification code information. As with other documents within the manual, the notation in the top right corner indicates when the document was last revised. Each measure has a notation indicating whether it is endorsed by the National Quality Forum (NQF).

Measure numerator and denominator information is provided with included and excluded populations specified.

Numerator Statement - Represents the portion of the denominator satisfying the conditions of the performance measure. When the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed.

- **Included Populations -** Describes the population(s) comprising the numerator, not contained in the numerator statement, or not applicable.

- **Excluded Populations -** Describes the population(s) not included in the numerator or none.

- **Data Elements -** Data elements necessary or required to determine (or establish) the numerator.

Denominator Statement - Represents the population evaluated by the performance measure. When the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed.

- **Included Populations -** Describes the population(s) comprising the denominator, not contained in the denominator statement, or not applicable.

- **Excluded Populations -** Describes the population(s) not included in the denominator or none.

- **Data Elements -** Data elements required to determine (or establish) the denominator.

Measure Information Algorithms - Algorithms illustrate the calculation steps needed for a measure. Each algorithm provides the logical steps, data element evaluation, arithmetic calculations and data manipulation information required to calculate a measure. The algorithms are used by vendors to design software applications and are helpful as a visual aid. For example, "Appendix E" of the manual provides more details and the definition of each field contained within the MIF. Data elements used in the calculation of the measure are italicized within the algorithm.

A narrative description of the algorithm immediately follows the algorithm diagram. The information is supplemental and explains the flow in less technical terms. It is not intended to be used for programming purposes; however, the narrative steps may be of assistance for abstractors in understanding how the algorithm functions.

Appendix B: Follow-Up After Hospitalization for Mental Illness (FUH) Data Tables

Eligible Population	
Data Sources	**Eligible Population** is comprised of fee-for-service Medicare claims for IPF discharges with a principal mental health diagnosis (Table B). **Denominator** is the eligible population minus exclusions. The denominator is based on discharges, not individuals. **Denominator exclusions** are defined using fee-for-service Medicare claims. **Numerator** is populated using Medicare fee-for-service claims.
Ages	6 years and older
Continuous Enrollment	Includes discharges for Medicare beneficiaries having continuous coverage (no gaps) for Part A and Part B as of the date of discharge through the 30 days following discharge date. Excludes claims for dual eligible beneficiaries.
Event/Diagnosis	IPF discharges occurring within the reporting period (July 1 through June 30). If individuals have more than one discharge in the reporting period, then include all discharges in the eligible population.

Denominator Exclusions	
IPF Readmission or Direct Transfer	A 30-day follow-up period is used for all exclusions related to the 7-day and 30-day measures.
	If the initial IPF discharge is followed by readmission or direct transfer to an IPF for a principal mental health diagnosis on Table B within the 30-day follow-up period, count only the readmission discharge or the discharge from the IPF to which the individual was transferred.
	Exclude both the initial IPF discharge and the IPF readmission/direct transfer discharge if the IPF readmission/direct transfer discharge occurs after June 30 of the reporting period.
	If the initial IPF discharge is followed by readmission/direct transfer to an IPF for a principal mental health diagnosis not on Table B within the 30 day follow-up period, then exclude the initial IPF discharge.
Non-IPF Readmission or Direct Transfer	Exclude IPF discharges that are followed by admission or direct transfer to an acute care (non-IPF) facility within the 30-day follow-up period. These discharges are excluded from the measure because the admission or transfer to the hospital may prevent an outpatient follow-up visit from taking place. Refer to Table C for rules to identify acute care facilities.
	Exclude IPF discharges followed by admission or direct transfer to a non-acute (non-IPF) facility within the 30-day follow-up period. These discharges are excluded from the measure because the admission or transfer to the non-acute facility may prevent an outpatient follow-up visit from taking place. Refer to Table D for rules to identify admission to non-acute care facilities.
Exclusions Related to Discharge Status or Death	Exclude IPF discharges followed by discharge/transfer to other institutions, including direct transfer to a prison, within the 30-day follow-up period. Refer to Table E for rules to identify these transfers.
	Exclude individuals who died during the stay and discharges followed by patient death within the 30-day follow-up period. Refer to Table E for relevant codes related to patient death.

Table A. Codes to identify IPF discharges

Facility codes (Medicare inpatient file)
• Last 4 digits of 4000–4499 (Psychiatric Hospital excluded from PPS)
• 3rd digit of 'S' (distinct part Psychiatric Unit in an acute care hospital)
• 3rd digit of 'M' (Psychiatric Unit in a CAH)
Note: A stay in any facility that meets one of the three criteria above constitutes an IPF stay.

Table B. Codes to identify principal mental health diagnosis ICD-9

Diagnosis codes
295–299, 300.3, 300.4, 301, 308, 309, 311–314

Table C. Codes to identify acute care facilities

Description (Medicare inpatient file)	Provider Number
Provider number corresponding to acute care facilities	5th through 8th digit (0001-0899)
Notes: Medicare files are used to identify all exclusions. Any acute care stay during the 30-day period following IPF discharge constitutes an exclusion.	

Table D. Codes to identify admission to non-acute care

Description	HCPCS (Medicare carrier file)	UB Revenue (Medicare SNF, hospice, outpatient, and HHA files)	UB type of bill (Medicare SNF, hospice, outpatient, and HHA files)	POS (Medicare carrier files)
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Comprehensive inpatient rehabilitation facility		0118, 0128, 0138, 0148, 0158		61
Respite		0655		
Intermediate care facility (ICF)				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Notes: Medicare files are used to identify all exclusions. Any code corresponding to the 30-day period following IPF discharge constitutes an exclusion.				

Table E. Codes to identify patient deaths and transfer/discharge to another institution (exclusion)

Description	Discharge Code (Medicare inpatient file)
Discharged/transferred to other short term general hospital for inpatient care	02
Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care - for hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non- certified SNF, the hospital must use Code 04 - ICF.	03
Discharged/transferred to intermediate care facility (ICF)	04
Discharged/transferred to another type of institution for inpatient care	05
Expired	20
Discharged/transferred to a federal hospital	43
Hospice – Home	50
Hospice - medical facility	51
Discharged/transferred within this institution to a hospital-based Medicare approved swing bed 61 swing bed	61
Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital 62 units of a hospital	62
Discharged/transferred to a long term care hospital	63
Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	64
Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital 65 hospital	65
Discharged/transferred to a Critical Access Hospital	66
Discharged/transferred to another type of health care institution not defined 70 elsewhere in code list	70
Died during the 30-day follow-up period	Medicare enrollment file
Note: Medicare files are used to identify all exclusions. Any code corresponding to the 30-day period following IPF discharge constitutes an exclusion.	

Table F. Codes to identify outpatient visits, intensive outpatient encounters, and partial hospitalizations

CPT	HCPCS
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

CPT with POS		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	with	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	with	52, 53

CPT with TYPSVC/FACTYP		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876 99221-99223, 99231-99233, 99238, 99239, 99251-99255	with	TYPSVC of 2 or 3 if FACTYP = 1-6 or 9 FACTYP = 7 FACTYP = 8

UB Revenue

0513, 0900-0905, 0907, 0911-0917, 0919 – does not have to be with mental health practitioner

0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983 - must be with either a principal mental health diagnosis or practitioner

ER visits cannot count toward numerator (Medicare carrier/outpatient)

No line-level claim information related to ER services can count as a numerator hit. These are defined as [revenue center code values of 0450-0459 (Emergency room) or 0981 (Professional fees-Emergency room) or HCPCS codes associated with ER use (99281, 99282, 99283, 99284, 99285) in the OP file] OR [Place of Service code (23=Emergency room-hospital) or BETOS code (M3 = Emergency Room visit) in the carrier file]

Note: A claim meeting any of the requirements above constitutes an outpatient visit.

Table G: Codes to identify mental health practitioners in Medicare

HEDIS definition of mental health practitioner	Specialty code	Taxonomy (linked to NPI)
An MD or Doctor of Osteopathy (DO) who is certified as a psychiatrist or child psychiatrist	26	2084P0800X 2084P0804X
Neurologist (not in original HEDIS specification)	13	2084V0102X; 2084N0400X 2084N0402X
An MD or Doctor of Osteopathy (DO) who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry	86	2084A0401X; 2084P0802X 2084B0002X; 2084N0600X 2084D0003X ; 2084F0202X 2084P0805X ; 2084H0002X 2084P0005X ; 2084N0008X 2084P2900X ; 2084P0015X 2084S0012X; 2084S0010X
Licensed Psychologist	62	103T00000X; 103TA0400X 103TA0700X; 103TC0700X 103TC2200X; 103TB0200X 103TC1900X; 103TE1000X 103TE1100X; 103TF0000X 103TF0200X; 103TP2701X 103TH0004X; 103TH0100X 103TM1700X; 103TM1800X 103TP0016X; 103TP0814X 103TP2700X; 103TR0400X 103TS0200X; 103TW0100X
Certified in Clinical Social Work	80	1041C0700X
Psych Nurse, PA, or Occupational Therapist	89; 50; 67	364SP0808X 364SP0809X 364SP0807X 364SP0810X 364SP0811X 364SP0812X 364SN0800X 364SP0813X 363LP0808X 225XM0800X

Notes: All codes are found in Medicare outpatient/carrier files. Either a Medicare specialty code OR taxonomy code qualifies as a numerator hit.

Specialty codes and Taxonomy codes are the best match with mental health practitioners defined in HEDIS specifications. National Provider Identifier (NPI) codes and specialty codes in Medicare claims can be used to determine provider taxonomy and type, respectively.