Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

IPFQR Program: Keys to Successful FY 2018 Reporting

Questions & Answers

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FY 2018 Reporting Requirements

Question 1: **Does CMS require that SUB-1, -2/-2a measures be submitted for payment year (PY) 2018?**

Yes. Please see slide 11 of the presentation for guidance regarding the FY 2018 IPFQR Program participation requirements.

Question 2: **We received confirmation on April 10 that our facility had been successfully withdrawn from the IPFQR Program. My question is this: Since we no longer are in the IPFQR Program are we still required to submit the 2016 data that is due in July?**

On termination of an IPF CCN, the IPFQR Program requirements no longer apply. Please email the IPFQR Program at IPFqualityreporting@hcqis.org for further direction.

Question 3: **How can you determine whether or not your inpatient psychiatric facility is required (or eligible) to participate in the program?**

All IPFs paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) are subject to the IPFQR Program requirements. Consult your billing department to determine whether your IPF is paid under the IPF PPS. You may also contact your regional CMS office to determine if your facility has been certified to bill Medicare for services under the IPF PPS.

Question 4: **For IMM-2, is the period for submission October 1, 2016 to March 31, 2017?**

The data collection time frame is October 1, 2016 to March 31, 2017 for data to be reported July 1-August 15, 2017. Please refer to page 32 of the IPFQR Program Manual for data submission information for all measures.

Key #2: Have Two Active Security Administrators

Question 5:   **Are two security administrators required?**

As noted on slide 20, CMS recommends that IPFs have a second *QualityNet* security administrator (SA), in case the primary SA's account expires.

Key #3: Manage the Notice of Participation

Question 6:   **Is the notice of participation completed just once and carried forward each year or completed annually?**

Yes. Once a notice of participation (NOP) has been submitted, it will carry forward on an annual basis. However, IPFs should access the IPFQR Program NOP on the *QualityNet Secure Portal* to check the status of their NOP by following the instructions on slides 21-23 of the June 20, 2017 webinar before the data submission deadline to ensure accuracy.

Question 7:   **For IPFQR NOP, we already had Medicare accept date 1966 in *QualityNet* (QNET). As we understand, we don't need to do "notice of participation" again. Is it right?**

The Medicare acceptance date signifies when the facility became eligible to submit claims to Medicare. The IPFQR Program NOP is a separate online form that must have a status of "Participating" in order to meet the NOP requirement for the IPFQR Program. IPFs should access the IPFQR Program NOP on the *QualityNet Secure Portal* to check the status of their NOP by following the instructions on slides 21-23 of the June 20, 2017 webinar before the data submission deadline to ensure accuracy.

Key #4: Prepare and Verify Accuracy of Data Prior to Submitting

Question 8:   **When I looked in QNET yesterday at the fiscal year (FY) 2018 web submission area, transition of care and metabolic profile were listed along with the other measures. Will these be removed since abstraction of these measures did not start until January 2017? In other words, should we still be collecting the transition record and metabolic screening data for submission later, i.e., PY 2019?**

Please review the information on slide 40. CMS **does not** require the Screening for Metabolic Disorders measure or the transition record measures to be submitted for PY 2018. The web-based data collection tool (WBDCT) was created prior to CMS' decision to postpone the reporting period for these measures and the WBDCT was not able to be updated prior to this release. Those measures are not required to be submitted for PY 2018. Data for these measures will not be submitted to CMS until the summer of 2018 and will impact PY 2019 APU determination. It is permissible to leave those measures displayed as "Incomplete" on the "Measure Summary" screen in the WBDCT. If you prefer to have all data entry fields display "Complete", then you may enter zeros for the transition record measures and the Screening for Metabolic Disorders measure.

Question 9:   **Is this the first year that the hospital-based inpatient psychiatric services (HBIPS)-2 and -3 measures are being reported by patient days? Is there prior education on how to calculate patient days?**

No, this is not the first year for IPFs to report the denominator of the HBIPS-2 and HBIPS-3 measures as psychiatric inpatient days. Education on how to calculate patient days is available in the following optional paper tool, which includes step-by-step instructions on how to calculate the HBIPS-2 and HBIPS-3 measures: http://www.qualityreportingcenter.com/wp-content/uploads/2017/06/IPF_FY2018_EvntTrckgLog_HBIPS2_3_20170612_vFINAL508.pdf.

Question 10: **Do we need to report chemical restraints, and are these restraints classified the same as manual holds/physical restraints? For example, do we collect restraints that are considered a manual hold to administer a chemical restraint?**

No. The HBIPS-2 measure collects information on physical restraints only. The classifications for chemical restraints and manual holds/physical restraint definitions are not the same. Per the data element in the Joint Commission Manual, "A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement." A chemical restraint is the use of medication to restrict movement or freedom and should not be confused with the use of physical restraint when administering medication. If a physical restraint is used to administer any medication (not just a chemical restraint), this would be reported.

Question 11: **Slide 32, bullet 2, indicates that values of zero numerators with non-zero denominators are considered questionable. We have found that for TOB-2 and 2a we did not have any patients pass the measure (be included in the numerator). We have verified that the values are correct. Will our information be accepted even though flagged as questionable?**

Yes, the data will be accepted. These parameters are provided as guidelines to encourage data accuracy. CMS encourages all IPFs to verify the data for accuracy prior to submission.

Question 12: **What do we do if we have identified an extreme outlier? Should it be excluded?**

If an extreme outlier is identified, then the data should be rechecked. IPFs are expected to submit data that is accurate and correct to meet all measure and non-measure requirements. Extreme outliers are most common with the HBIPS-2 and HBIPS-3 measures, and often occur because values are reported in the wrong units. Verifying your data is correct procedure, as per CMS, when data accuracy is questionable. IPFs should not exclude data that produces extreme outlier values after verifying for accuracy.

Question 13: **If the transmission of the transition of care is completed by faxing within 24 hours to the next level of care provider, how should we answer the Use of an Electronic Health Record (EHR) measure question #2 in regards to a Health Information Service Provider (HISP)?**

The aim is for the IPF to respond to the second question for the Use of an EHR measure to indicate whether any of the transfers of health information at times of transitions in care included the exchange of interoperable health information with an HISP. A facility contracts with an HISP to safely transmit health information between providers. If the exchange of interoperable health information with a HISP occurred for any of the transfers of health information at the IPF then select "Yes".

Question 14: **What do you mean by Non-Measure Data/Population Counts? Is this just for the sample population or the total population?**

Non-measure data is data that is not measure related. This includes overall aggregate, yearly discharge volume, volume broken down by category (payer source, age strata and diagnostic categories), as well as sampling. This information is collected on the total population. Refer to page 36 of the IPFQR Program Manual, Version 3.0 for more information.

Question 15: **Why do slides 34 and 61 each show payer data? Is this required to report Medicare and non-Medicare payers? I thought we were told we didn't have to break the patients down by Medicare or Non-Medicare-just by age groups. Do we have to go back and separate out by Medicare and Non-Medicare now?**

Yes, payer source data must be reported in order to meet to the non-measure data requirement. IPFs started to submit non-measure data for the first time last year for PY 2017 and that included providing non-measure data that includes overall aggregate annual discharge data, as well as the data by the following categories (payer group, age strata, and diagnosis). Refer to page 36 of the IPFQR Program Manual, Version 3.0 for more information.

Question 16: **If you sample the HBIPS-5 measure, but not other IPFQR Program measures, how do you answer the global sampling question on the non-measure screen? "No" to sampling?**

Correct. If you only sampled for HBIPS-5 then you should select "No" to the sampling question. If the global sampling methodology described on page 14 in Section 2: Measure Details of the IPFQR Program Manual (finalized June 13, 2017) was used to sample any of the measure data collected for PY 2018 then answer "Yes" to the sampling question.

Question 17: **In preparation, where can I get the questions for the non-measure data, Assessment of Patient Experience of Care, Use of EHR and DACA?**

Please use the resources on qualityreportingcenter.com at http//www.qualityreportingcenter.com/inpatient/ipf/tools. There is an optional paper tool available for collection of non-measure data posted there. The measure information can be found in the IPFQR Program Manual posted on the *QualityNet* and *Quality Reporting Center* websites. You can also use the slides provided for this webinar.

Question 18: **Can you please elaborate on what satisfies the definition of "standardized collection protocol and a structured instrument"?**

The "standardized collection protocol" describes the process used to administer a structured instrument. A survey is considered a "structured instrument."

Key #5: Enter and Verify Accuracy of Data

Question 19: **I apologize if you clarified this before. We just logged into *QNET* and the IPFQR Web-Based Measures/DACA for PY 2018 is not available for data entry. When will it open?**

The FY 2018 data submission period is scheduled to open on Saturday, July 1, 2017 and close on Tuesday, August 15, 2017 at 11:59:59 p.m., P.T.

Key #6: Review Submission Before Signing the DACA Form

Question 20: **When were vendors allowed to send data? Last year we had to put our own in.**

Vendors are allowed to submit data on behalf of an IPF once the IPF submits the appropriate vendor authorization. Refer to Section 4: Vendor Authorization on pages 62-65 of the IPFQR Program Manual (finalized June 13, 2017) for guidance.

Question 21: **Can the DACA be submitted even if a measure is incomplete? Last year, the DACA could be "signed" even if a measure was incomplete.**

Technically the DACA can be submitted even if a measure is incomplete; however, the DACA is the only opportunity for IPFs to attest to the accuracy and completeness of the data submitted to CMS before the data are publicly displayed on the *Hospital Compare* website. CMS advises IPFs to submit the DACA after all data have been submitted and verified for accuracy and completeness. Please review slides 64-66 or refer to Section 6: Data Accuracy and Completeness Acknowledgement on pages 71-71 of the IPFQR Program Manual (finalized June 13, 2017) for guidance on completing the DACA.