Inpatient Rehabilitation Facility Quality Reporting Program

PRACTICE CODING SCENARIOS DAY 1

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

May 9 and 10, 2019
Sheraton Kansas City Hotel
at Crown Center
Kansas City, MO 64108

Section N: Medications (Drug Regimen Review)

N2001 Practice Coding Scenario 1

- The admitting IRF nurse reviewed and compared the acute care hospital discharge medication orders and the IRF physician's admission medication orders for Ms. W.
- The nurse interviewed Ms. W, who confirmed the medications she was taking for her current medical conditions. Upon the nurse's request, the pharmacist reviewed and confirmed the medication orders as appropriate for the patient.
- As a result of this collected and communicated information, the registered nurse (RN) determined that there were no identified potential or actual clinically significant medication issues.

N2001 Practice Coding Scenario 2

- Mr. C was admitted to an IRF after undergoing mitral valve replacement cardiac surgery. The acute care hospital discharge information indicated that Mr. C had a mechanical mitral heart valve and was to continue receiving anticoagulant medication.
- While completing a review and comparison of the patient's discharge healthcare records from the acute care hospital with the IRF physician's admission medication orders, an RN noted that the admitting physician ordered the patient's anticoagulation medication to be held if the international normalized ratio (INR) was below 1.0.
- However, the physician's admission note indicated that the desired therapeutic INR parameters for Mr. C were 2.5 to 3.5. The RN questioned the INR level listed on the admitting physician's order, based on the therapeutic parameters of 2.5 to 3.5 documented in the physician's admission note. This prompted the RN to call the physician immediately to address the issue.

N2003 Practice Coding Scenario 3

- Mr. B was admitted to the IRF following a hip fracture and with an active diagnosis of pneumonia and atrial fibrillation. The acute care facility medication record indicated that Mr. B was on a 7-day course of antibiotics and he had 3 remaining days of this treatment plan.
- The IRF pharmacist reviewed the discharge records from the acute care facility and the IRF admission medication orders. The pharmacist noted that Mr. B had an order for an anticoagulant medication that required INR monitoring as well as the antibiotic.
- On the date of admission, the IRF pharmacist contacted the IRF physician caring for Mr. B and communicated a concern about a potential increase in the patient's INR with this combination of medications, which placed the patient at greater risk for bleeding.
- The IRF physician provided orders for laboratory testing so that the patient's INR levels would be monitored over the next 3 days, starting that day. However, the first INR laboratory test did not occur until after midnight of the next calendar day.

N2003 Practice Coding Scenario 4

- Ms. S was admitted to an IRF from an acute care hospital. During the admitting nurse's review of the patient's acute care facility discharge records, it was noted that Ms. S had been prescribed metformin. However, admission labs indicated she had a serum creatinine of 2.4, consistent with renal insufficiency.
- The IRF admitting nurse contacted the IRF physician-designee to ask whether this drug would be contraindicated with the patient's current serum creatinine level. Three hours after the patient's admission to the IRF, the IRF physician-designee provided orders to discontinue the metformin and start the patient on a short-acting sulfonylurea for ongoing diabetes management. These medication changes were implemented within the hour.

N2005 Practice Coding Scenario 5

- At discharge from the IRF, the discharging licensed clinician reviewed Ms. T's medical records, which included admission through her entire stay at the IRF. The clinician noted that a clinically significant medication issue was documented during the admission assessment.
- At admission, Ms. T was taking two antibiotics—an antibiotic prescribed during a recent acute care hospital stay that the IRF physician had included in her IRF medication orders, and a second antibiotic prescribed by the IRF physician upon admission that is known for drug-induced nephrotoxicity. Ms. T has renal disease.

N2005 Practice Coding Scenario 5 continued

- Ms. T's medical records further indicated that an IRF nurse had attempted to contact the assigned IRF physician several times about this clinically significant medication issue. After midnight of the second calendar day, the IRF physician communicated to the nurse via a telephone order to administer a newly prescribed antibiotic in addition to the previously prescribed antibiotic. The nurse implemented the physician's order.
- Upon further review of Ms. T's medical records, the discharging nurse determined that no additional clinically significant medication issues had been recorded throughout the remainder of Ms. T's stay.

N2005 Practice Coding Scenario 6

- At discharge, the licensed clinician completing a review of Ms. K's medical records identified and noted two clinically significant medication issues during the patient's stay.
- The patient's record included an order to hold the medication Ms. K was receiving for deep vein thrombosis prophylaxis for a scheduled procedure. The RN noted that this medication had not been restarted 48 hours post-procedure and determined that the physician needed urgent notification. The day after the notification occurred, the IRF physician provided an order to resume the medication, which was carried out by the nursing staff within the hour.
- In addition, a licensed clinician identified a clinically significant medication issue had occurred during the admission assessment period, and the physician had been contacted on the same day.
- Both medication issues identified during the patient's stay were communicated and addressed by midnight of the next calendar day. There were no additional clinically significant medication issues identified during the remainder of the IRF stay.

Section M: Skin Conditions (Pressure Ulcer/Injury)

Practice Coding Scenario 1

- A patient is admitted to the IRF with a Stage 2 pressure ulcer on the left hip. The patient is transported to an acute care hospital and returns to the IRF within 2 days.
- Upon return to the IRF setting, the left hip pressure ulcer is a full thickness ulcer assessed to be a Stage 3. The patient is discharged to home with this Stage 3 pressure ulcer.

Item	Admission Assessment	Discharge Assessment
M0300A1. Number of Stage 1 pressure injuries.		
M0300B1. Number of Stage 2 pressure ulcers.		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission.		
M0300C1. Number of Stage 3 pressure ulcers.		
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission.		
M0300D1. Number of Stage 4 pressure ulcers.		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission.		
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device.		
M0300E2. Number of these unstageable pressure ulcers/ injuries due to non-removable dressing/device that were present upon admission.		
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.		
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission.		
M0300G1. Number of unstageable pressure injuries with deep tissue injury.		
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission.		

Section M: Skin Conditions (Pressure Ulcer/Injury)

Practice Coding Scenario 2

- A patient is admitted to the IRF with a Stage 4 pressure ulcer on her left hip.
- When the pressure ulcer is reassessed at discharge, it is entirely covered with eschar and the wound bed cannot be assessed. The patient is discharged with an unstageable pressure ulcer due to slough/eschar.

Item	Admission Assessment	Discharge Assessment
M0300A1. Number of Stage 1 pressure injuries.		
M0300B1. Number of Stage 2 pressure ulcers.		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission.		
M0300C1. Number of Stage 3 pressure ulcers.		
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission.		
M0300D1. Number of Stage 4 pressure ulcers.		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission.		
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device.		
M0300E2. Number of these unstageable pressure ulcers/ injuries due to non-removable dressing/device that were present upon admission.		
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.		
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission.		
M0300G1. Number of unstageable pressure injuries with deep tissue injury.		
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission.		

Section M: Skin Conditions (Pressure Ulcer/Injury)

Practice Coding Scenario 3

- A patient is admitted to the IRF with documentation in the medical record of a sacral pressure ulcer/injury. This ulcer/injury is covered with a non-removable dressing; therefore, this pressure ulcer/injury is unstageable.
- On Day 4 of the IRF stay, the dressing is removed by the physician and assessment reveals a Stage 3 pressure ulcer.
- On Day 9 of the IRF stay, the pressure ulcer is covered with eschar and is assessed as unstageable. The eschar-covered ulcer is unchanged at the time of discharge.

Item	Admission Assessment	Discharge Assessment
M0300A1. Number of Stage 1 pressure injuries.		
M0300B1. Number of Stage 2 pressure ulcers.		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission.		
M0300C1. Number of Stage 3 pressure ulcers.		
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission.		
M0300D1. Number of Stage 4 pressure ulcers.		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission.		
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device.		
M0300E2. Number of these unstageable pressure ulcers/injuries due to non-removable dressing/device that were present upon admission.		
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.		
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission.		
M0300G1. Number of unstageable pressure injuries with deep tissue injury.		
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission.		

Section M: Skin Conditions (Pressure Ulcer/Injury)

Practice Coding Scenario 4

- A patient is admitted to the IRF with a Stage 3 pressure ulcer on her coccyx.
- On Day 5 of her IRF stay, the ulcer is assessed as a Stage 4 pressure ulcer. She is seen at the wound clinic and returns to the IRF with a dressing and orders that the dressing is to remain intact until the next clinic visit.
- The patient is discharged to a skilled nursing facility prior to the follow-up wound clinic visit. At the time of discharge, this ulcer is covered with a non-removable dressing.

Item	Admission Assessment	Discharge Assessment
M0300A1. Number of Stage 1 pressure injuries.		
M0300B1. Number of Stage 2 pressure ulcers.		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission.		
M0300C1. Number of Stage 3 pressure ulcers.		
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission.		
M0300D1. Number of Stage 4 pressure ulcers.		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission.		
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device.		
M0300E2. Number of these unstageable pressure ulcers/injuries due to non-removable dressing/device that were present upon admission.		
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.		
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission.		
M0300G1. Number of unstageable pressure injuries with deep tissue injury.		
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission.		

Section M: Skin Conditions (Pressure Ulcer/Injury)

Practice Coding Scenario 5

- The patient's skin assessment on admission to the IRF reveals no pressure ulcers or injuries.
- On Day 5, while conducting a skin assessment, a Stage 2 pressure ulcer is identified on the right elbow.
- On discharge, the patient's skin assessment reveals a healed Stage 2 pressure ulcer on the right elbow.

Item	Admission Assessment	Discharge Assessment
M0300A1. Number of Stage 1 pressure injuries.		
M0300B1. Number of Stage 2 pressure ulcers.		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission.		
M0300C1. Number of Stage 3 pressure ulcers.		
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission.		
M0300D1. Number of Stage 4 pressure ulcers.		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission.		
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device.		
M0300E2. Number of these unstageable pressure ulcers/ injuries due to non-removable dressing/device that were present upon admission.		
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.		
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission.		
M0300G1. Number of unstageable pressure injuries with deep tissue injury.		
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission.		

Section M: Skin Conditions (Pressure Ulcer/Injury)

Practice Coding Scenario 6

- A patient is admitted to the IRF with a Stage 1 pressure injury on the coccyx.
- The skin assessment of the tissues surrounding this injury on Day 6 is consistent with a DTI.
- This DTI remains intact at the time of discharge to home 3 days later.

Item	Admission Assessment	Discharge Assessment
M0300A1. Number of Stage 1 pressure injuries.		
M0300B1. Number of Stage 2 pressure ulcers.		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission.		
M0300C1. Number of Stage 3 pressure ulcers.		
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission.		
M0300D1. Number of Stage 4 pressure ulcers.		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission.		
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device.		
M0300E2. Number of these unstageable pressure ulcers/ injuries due to non-removable dressing/device that were present upon admission.		
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.		
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission.		
M0300G1. Number of unstageable pressure injuries with deep tissue injury.		
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission.		

Section M: Skin Conditions (Pressure Ulcer/Injury)

Practice Coding Scenario 7

- A patient is admitted to the IRF with a right ankle foot orthosis (AFO) to compensate for weakness and foot drop.
- On the initial skin assessment, the clinician notes a Stage 2 pressure ulcer at the right calf, that conforms to the shape of the AFO. The orthotist is consulted and the AFO is adjusted.
- The ulcer heals before discharge and no other pressure ulcers/injuries are present.

Item	Admission Assessment	Discharge Assessment
M0300A1. Number of Stage 1 pressure injuries.		
M0300B1. Number of Stage 2 pressure ulcers.		
M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission.		
M0300C1. Number of Stage 3 pressure ulcers.		
M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission.		
M0300D1. Number of Stage 4 pressure ulcers.		
M0300D2. Number of these Stage 4 pressure ulcers that were present upon admission.		
M0300E1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device.		
M0300E2. Number of these unstageable pressure ulcers/ injuries due to non-removable dressing/device that were present upon admission.		
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar.		
M0300F2. Number of these unstageable pressure ulcers due to slough/eschar that were present upon admission.		
M0300G1. Number of unstageable pressure injuries with deep tissue injury.		
M0300G2. Number of these unstageable pressure injuries with deep tissue injury that were present upon admission.		