Inpatient Rehabilitation Facility Quality Reporting Program Provider Training

Focused Review of Sections B, C, H, I, J, K, and O

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Acronyms in This Presentation

- Brief Interview for Mental Status (BIMS)
- Centers for Medicare & Medicaid Services (CMS)
- Diabetes Mellitus (DM)
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)
- Long-Term Care Hospital (LTCH)
- LTCH Continuity Assessment Record and Evaluation (LTCH CARE) Data Set
- Peripheral Arterial Disease (PAD)
- Peripheral Vascular Disease (PVD)

Overview

- Identify and explain the intent of each section:
  - Section B: Hearing, Speech, and Vision
  - Section C: Cognitive Patterns
  - Section H: Bladder and Bowel
  - Section I: Active Diagnoses
  - Section J: Health Conditions (Falls)
  - Section K: Swallowing/Nutritional Status
  - Section O: Special Treatments, Procedures, and Programs (Influenza Vaccine)
- Discuss coding instructions and required information
- Review practice coding scenarios

Objectives

- Demonstrate an understanding of the data elements in Sections B, C, H, I, J (Falls), K, and O
- State the intent of Sections B, C, H, I, J (Falls), K, and O
- Apply coding instructions to accurately code practice scenarios

Section B

Hearing, Speech, and Vision

Section B

- Section B items are assessed on admission
  - **BB0700.** Expression of Ideas and Wants
  - **BB0800.** Understanding Verbal and Non-Verbal Content
- Document the patient's ability to understand and communicate with others in his/her primary language, whether in speech, writing, sign language, gestures, or a combination of these

BB0700 Coding Instructions

- Enter the code that best reflects the patient's ability to express ideas and wants

Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas

Section B	**Hearing, Speech, and Vision**
BB0700. Expression of Ideas and Wants (3-day assessment period)	
Enter Code ☐	**Expression of Ideas and Wants** (consider both verbal and non-verbal expression and excluding language barriers) 4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand 3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear 2. **Frequently** exhibits difficulty with expressing needs and ideas 1. **Rarely/Never** expresses self or speech is very difficult to understand

BB0700 Coding Tips

- Complex messages would include:
  - Discussion about medication administration
  - Discharge planning
  - Caregiver issues

BB0800 Coding Instructions

- Enter the code that best reflects the patient's ability to understand content, using his or her preferred method for communication
- **Change:** Clarified that **non-verbal content** can be considered when coding BB0800

Understanding Verbal and Non-Verbal Content
4. Understands
3. Usually Understands
2. Sometimes Understands
1. Rarely/Never Understands

Section B	Hearing, Speech, and Vision
BB0800. Understanding Verbal and Non-Verbal Content (3-day assessment period)	
Enter Code ☐	**Understanding Verbal and Non-Verbal Content** (with hearing aid or device, if used, and excluding language barriers) 4. **Understands:** Clear comprehension without cues or repetitions 3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand 2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand 1. **Rarely/Never Understands**

Section C

Brief Interview for Mental Status (BIMS)

C0200–C0500

Section C: Changes

- Clarified BIMS instructions and response options to align with wording in Minimum Data Set
- The following items were updated:
  - **C0200**
  - **C0300 (C0300A–C)**
  - **C0400 (C0400A–C)**

Section C	Cognitive Patterns
C0200. Repetition of Three Words	
Enter Code ☐	Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue and bed****. Now tell me the three words."* **Number of words repeated after first attempt** 3. **Three** 2. **Two** 1. **One** 0. **None** After the patient's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

Section C: BIMS

- Consists of three components:
  - **C0200.** Repetition of Three Words
  - **C0300.** Temporal Orientation (orientation to year, month, and day)
  - **C0400.** Recall
- Results are totaled into a Summary Score
  - **C0500.** BIMS Summary Score

Section C: BIMS Instructions

1. Interview any patient not screened out by item C0100
   - The interview should not be attempted if the patient is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available; *skip to* **C0900, Memory/Recall Ability**
2. Conduct the interview in a private setting

Section C: BIMS Instructions (cont. 1)

3. Be sure that the patient can hear you
4. Sit so the patient can see your face; minimize glare by directing light sources away from the patient's face
5. Give an introduction before starting the interview

Section C: BIMS Instructions (cont. 2)

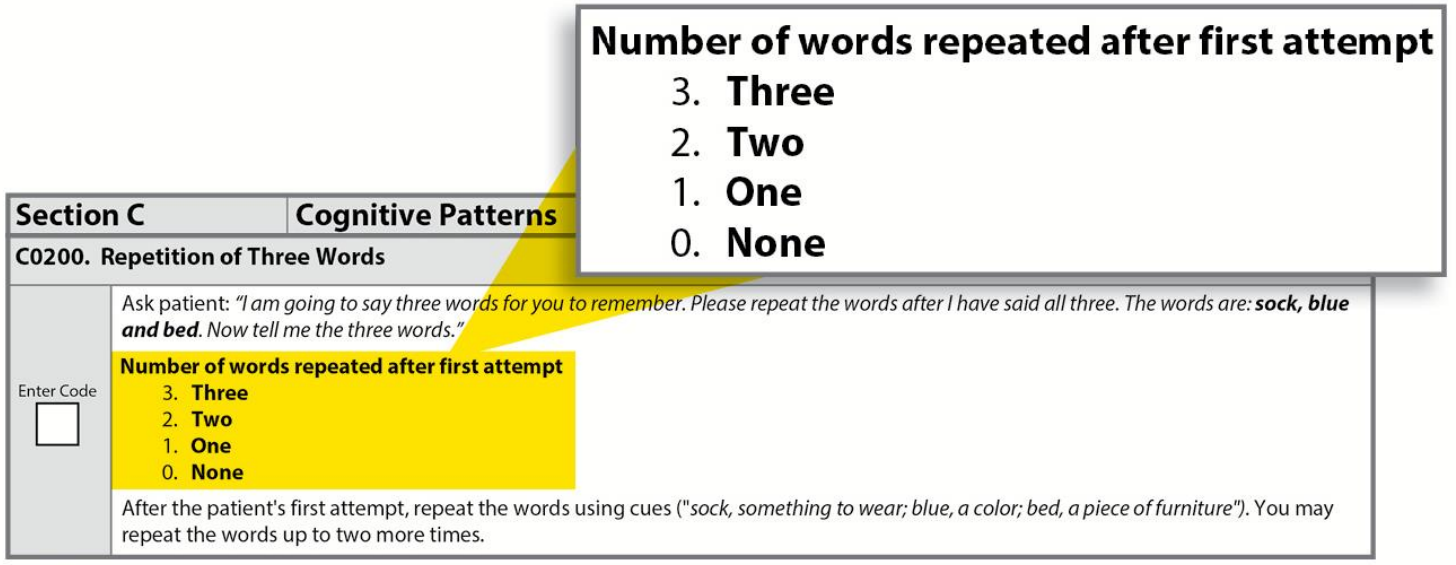
6. If the patient expresses concern, he or she may be more comfortable if you reply:
   - "We ask these questions of everyone so we can make sure that our care will meet your needs"
7. Conduct the interview in one sitting and in the order provided
8. If the patient chooses not to answer a particular item, accept his or her refusal and move on to the next question

Section C: The BIMS in Writing

- If the patient's primary method of communication is in written format, the BIMS can be administered in writing
- The administration of the BIMS in writing should be limited to this circumstance
- Refer to "Guidance for Completing the BIMS Using Alternative Methods" in the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Training Manual, Section C

C0200: Repetition of Three Words

Record the maximum number of words that the patient correctly repeated on the **first attempt only**



Number of words repeated after first attempt
3. **Three**
2. **Two**
1. **One**
0. **None**

Section C	Cognitive Patterns
C0200. Repetition of Three Words	
Enter Code ☐	Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue and bed****. Now tell me the three words."* **Number of words repeated after first attempt** 3. **Three** 2. **Two** 1. **One** 0. **None** After the patient's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0200 Tips

- Words may be recalled in any order and in any context
  - If the words are repeated back in a sentence, they would be counted as repeating the words
- Score the number of words repeated on the first attempt only
  - Do not score the number of repeated words on the second or third attempt
- If the interviewer cannot say words clearly, have another staff member conduct the interview

C0300: Temporal Orientation

- Assess orientation to year, month, and day of the week
- **Code 0** if the patient does not answer

Section C	Cognitive Patterns
C0300. Temporal Orientation (orientation to year, month, and day)	
Enter Code ☐	Ask patient: *"Please tell me what year it is right now."* **A. Able to report correct year** 3. **Correct** 2. **Missed by 1 year** 1. **Missed by 2 - 5 years** 0. **Missed by > 5 years** or no answer
Enter Code ☐	Ask patient: *"What month are we in right now?"* **B. Able to report correct month** 2. **Accurate within 5 days** 1. **Missed by 6 days to 1 month** 0. **Missed by > 1 month** or no answer
Enter Code ☐	Ask patient: *"What day of the week is today?"* **C. Able to report correct day of the week** 1. **Correct** 0. **Incorrect** or no answer

C0400: Recall

Section C	Cognitive Patterns
C0400. Recall	
Enter Code ☐	Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. **A. Able to recall "sock"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("something to wear") 0. **No** - could not recall
Enter Code ☐	**B. Able to recall "blue"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("a color") 0. **No** - could not recall
Enter Code ☐	**C. Able to recall "bed"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("a piece of furniture") 0. **No** - could not recall

C0400 Steps for Assessment

1. Ask the patient the following: “Let’s go back to an earlier question. What were those three words that I asked you to repeat?”
2. Allow up to 5 seconds for spontaneous recall of each word
3. For any word that is not correctly recalled after 5 seconds, provide a category cue
4. Category cues should be used only after the patient is unable to recall one or more of the three words
5. Allow up to 5 seconds after category cueing for each missed word to be recalled

Section C: Stopping the BIMS Interview

- Stop the interview after completing (C0300C) “Day of the Week” if:
  - All responses nonsensical, OR
  - No verbal or written response to any of the questions up to this point, OR
  - No verbal or written response to some questions and nonsensical responses to other questions

Section C: Stopping the BIMS Interview (cont.)

If the interview is stopped prior to completion, do the following:

1. **Code** "–" **(dash)** in C0400A, C0400B, and C0400C
2. **Code 99** in the summary score in C0500
3. **Code 1, Yes**, in C0600. Should the Staff Assessment for Mental Status (C0900) be Conducted?
4. Complete C0900. Staff Assessment for Mental Status

Section C: BIMS Not Attempted

- If the BIMS should have been attempted but was not, code Section C as follows:
  1. Indicate that the BIMS should have been conducted by coding C0100 as **1, Yes**
  2. Enter a **dash** for each of the BIMS items (C0200, C0300A–C, C0400A–C)
  3. Code C0500. BIMS Summary Score as **99**
  4. Code C0600 as **1, Yes**
  5. Complete C0900. Staff Assessment for Mental Status

Section C: BIMS Video

- Visit the Centers for Medicare & Medicaid Services (CMS) YouTube channel to view the BIMS video and other videos about interviewing techniques: https://www.youtube.com/watch?v=DAj3TA5w11Y

Section H

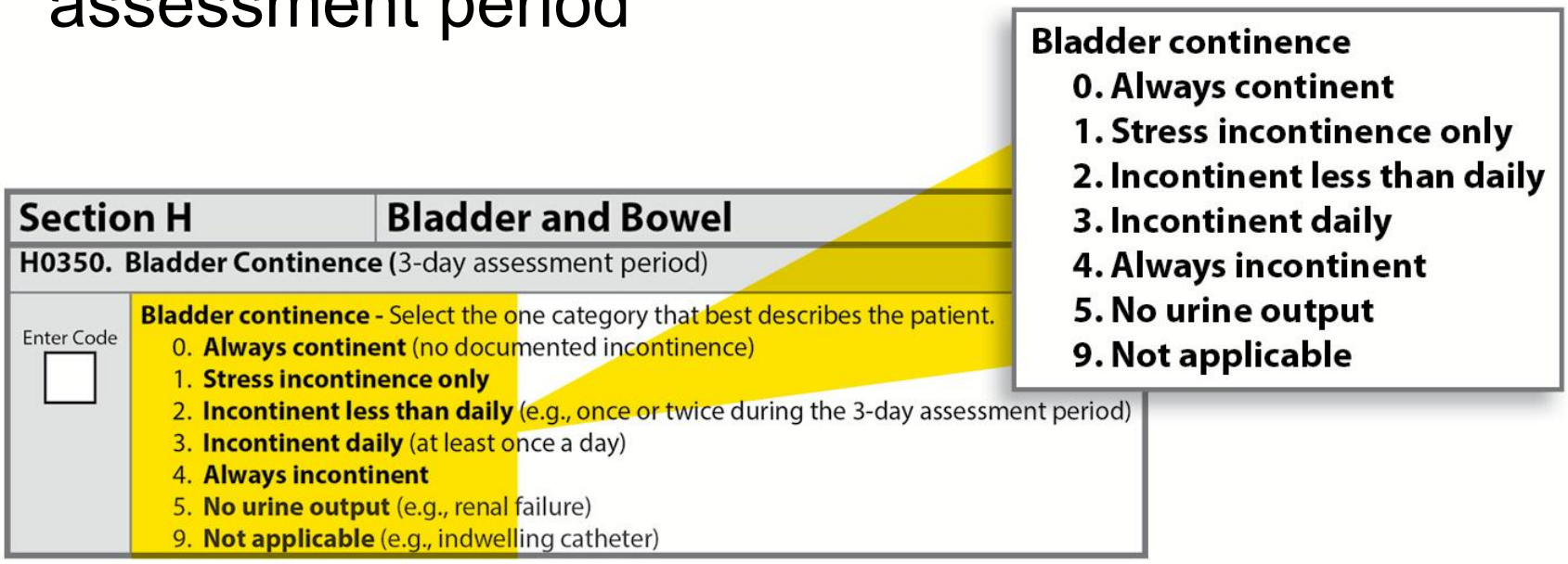
Bladder and Bowel

Bladder Incontinence

- Involuntary loss of urine, when there is a loss of control of the evacuation of urine from the bladder, regardless of whether clothing or linens are wet

H0350 Coding Instructions

- Code according to the amount and number of episodes of incontinence that occur during the assessment period



Section H	Bladder and Bowel
H0350. Bladder Continence (3-day assessment period)	
Enter Code ☐	**Bladder continence** - Select the one category that best describes the patient. 0. **Always continent** (no documented incontinence) 1. **Stress incontinence only** 2. **Incontinent less than daily** (e.g., once or twice during the 3-day assessment period) 3. **Incontinent daily** (at least once a day) 4. **Always incontinent** 5. **No urine output** (e.g., renal failure) 9. **Not applicable** (e.g., indwelling catheter)

Bladder continence
0. Always continent
1. Stress incontinence only
2. Incontinent less than daily
3. Incontinent daily
4. Always incontinent
5. No urine output
9. Not applicable

Stress Incontinence

- Stress incontinence has its own code (Code 1)
- Episodes of a small amount of urine leakage only associated with physical movement or activity, such as:
  - Coughing
  - Sneezing
  - Laughing
  - Lifting heavy objects
  - Exercise

Stress Incontinence (cont.)

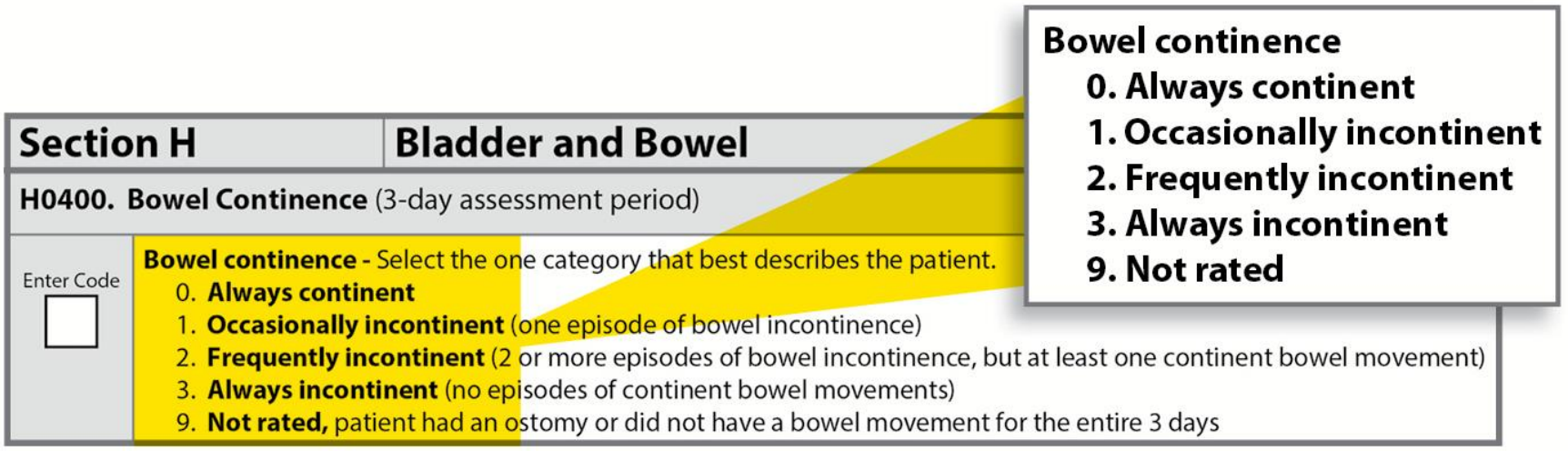
- Stress incontinence may be coded based on the clinician's assessment, patient or family reporting, or physician documentation
- Staff observations would be helpful in distinguishing incontinence (large amount) from stress incontinence (small amount) in nonverbal patients

H0350 Coding Tips

- Three-day assessment period
- Review all documentation and discuss with staff to determine the frequency of incontinence
- If intermittent catheterization is used to drain the bladder, code incontinence level based on continence between catheterizations
- If the patient is continent but, due to behavior, purposely voids on the floor, it is not an incontinent episode

H0400 Coding Instructions

- Code according to the number of episodes of bowel incontinence that occur during the assessment period



H0400 Coding Tips

- Being continent has to do with the ability to voluntarily release stool in a commode, toilet, or bedpan, or as a result of planned bowel movement as part of a bowel program
- Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, or enema) would be considered *continent* of bowel as long as the result of releasing the stool occurred within a reasonable amount of time

H0400 Coding Tips (cont.)

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence

H0350 Practice Coding Scenario 1

- On the day she was admitted to the Inpatient Rehabilitation Facility (IRF), Mrs. H experienced one episode of a large amount of urine leakage. She also reported to her nurse that she has a small amount of urine leakage each day and wears a pad in her underwear. She has otherwise been continent of urine

How Would You Code H0350?

A. Code **0,** Always continent
B. Code **1,** Stress incontinence only
C. Code **2,** Incontinent less than daily
D. Code **3,** Incontinent daily

Section I

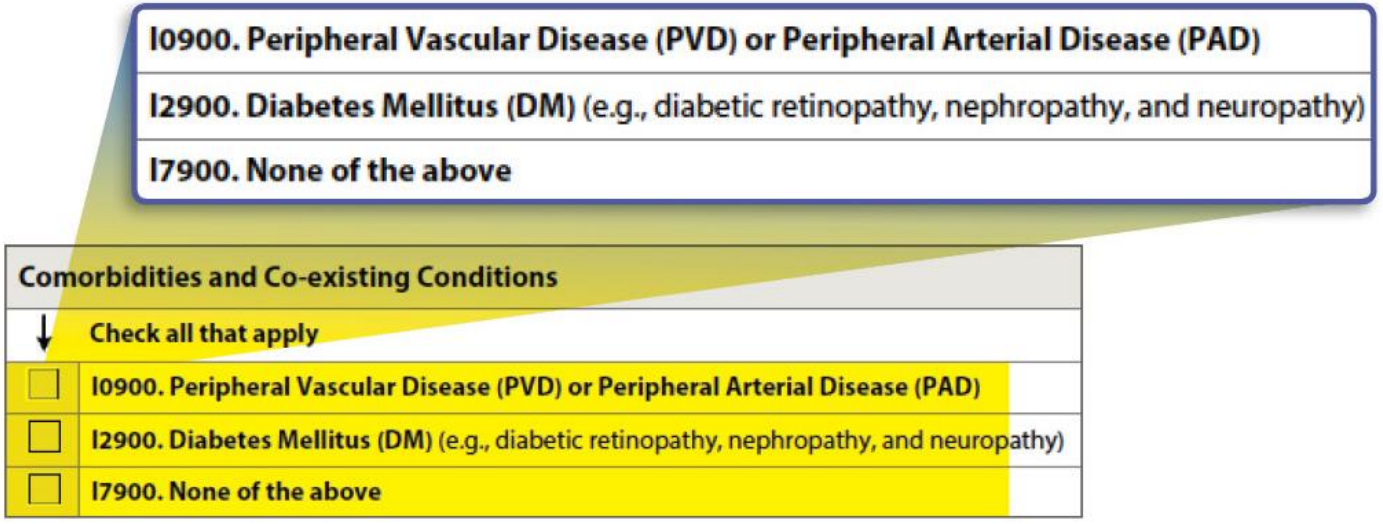
Active Diagnoses

Section I: Changed Items

- Items in Section I are coded on admission
  - **I0900,** Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
  - **I2900,** Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
  - **I7900,** None of the above

Coding Instructions

- Code diseases or conditions that:
  - Have a documented diagnosis at the time of assessment
  - Are active
- Check all that apply



Identify Diagnoses Assessment

- There must be specific documentation in the medical record by authorized licensed staff as permitted by State law:
  - Physician
  - Nurse practitioner
  - Physician assistant
  - Clinical nurse specialist
  - Other authorized licensed staff
- Authorized licensed staff may specifically indicate that a diagnosis is active

Identify Diagnoses Assessment (cont.)

- The patient's active diagnoses must be documented in the medical record
- Specific documents in the medical record may include:
  - Progress notes
  - Admission history and physical
  - Transfer of health information notes
  - Acute care hospital discharge summary
- A diagnosis should not be inferred by association with other conditions

Section J

Health Conditions (Falls)

Fall Definition

- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat)
- May be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground
- Not a result of an overwhelming external force (e.g., a patient pushes another patient)

Fall Definition (cont.)

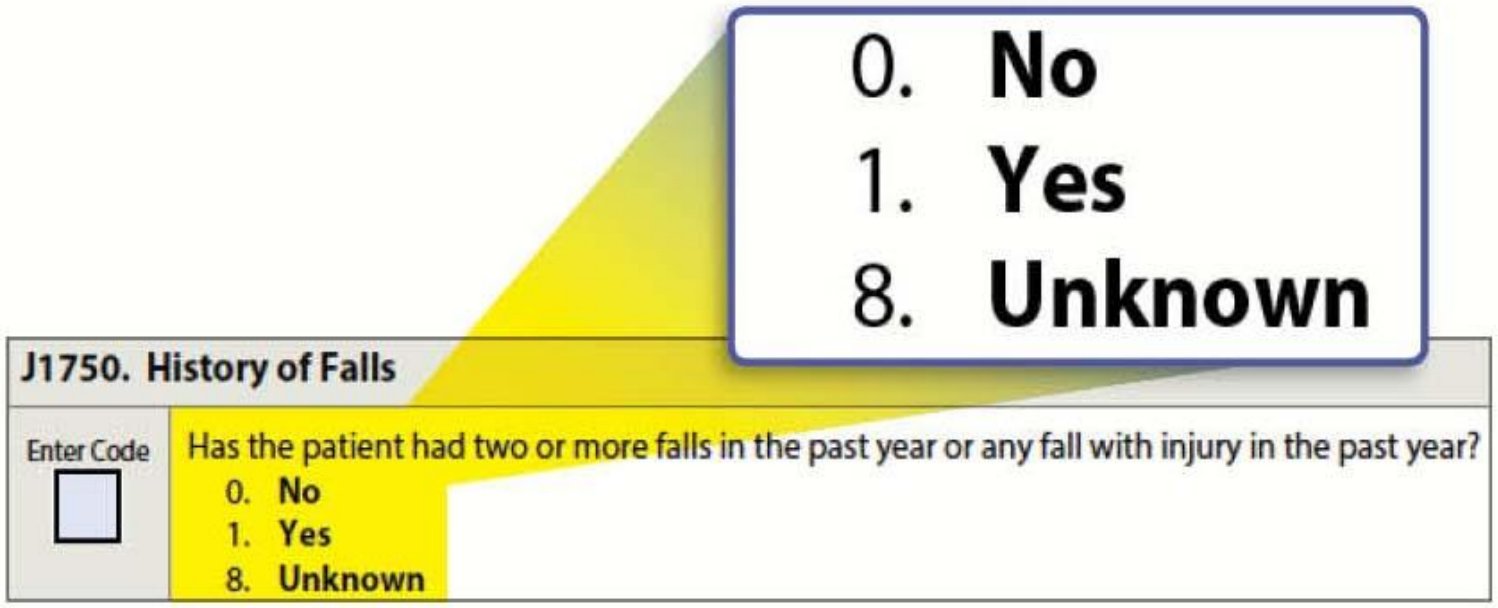
- An **intercepted fall** occurs when the patient:
  - Would have fallen if he or she had not caught him/herself
  - Had not been intercepted by another person
- **An intercepted fall is considered a fall**

Item Intent

- CMS understands that challenging a patient's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and *does not* consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls

J1750 Coding Instructions

- Complete **History of Falls** at the time of admission

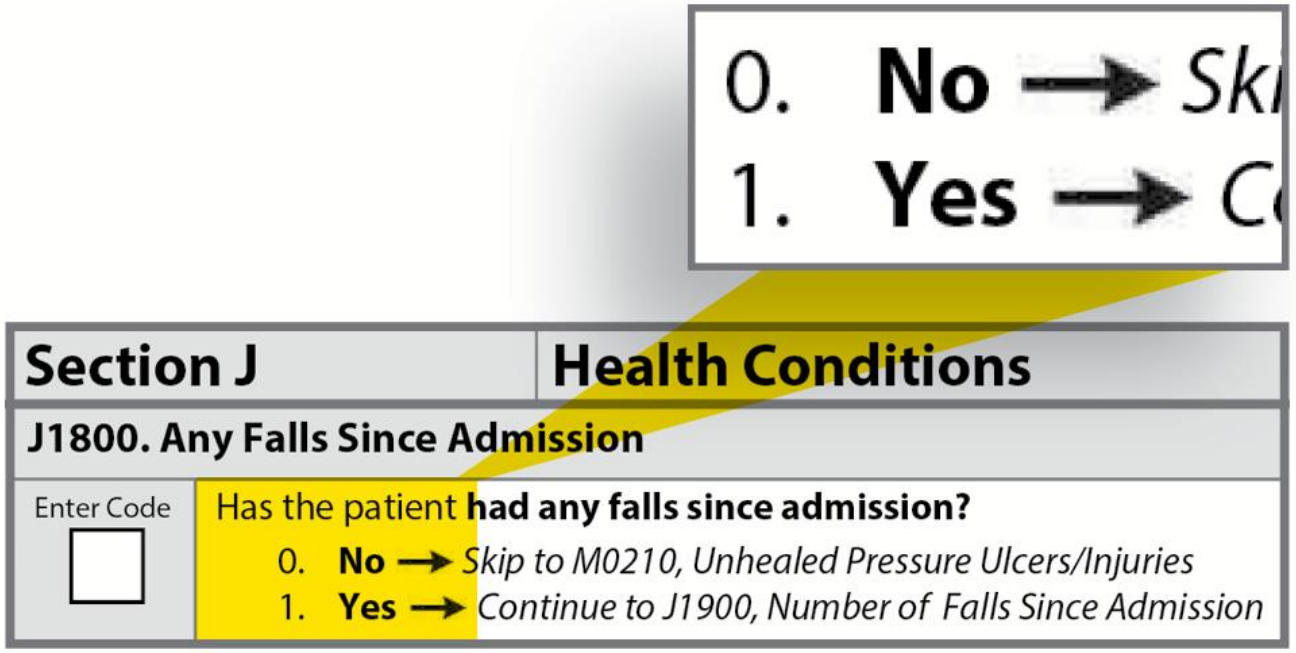


J1750 Steps for Assessment

1. Indicate whether the patient has had:
   - Two or more falls in the past year OR
   - Any fall with injury in the past year
2. Interview the patient if he or she is capable of reliably reporting fall history
   - Speak with family members or significant others to obtain fall history, as appropriate

J1800 Coding Instructions

- Complete only at the time of discharge



J1800 and J1900
Steps for Assessment

- Review IRF medical record:
  - Physician, nursing, therapy, and nursing assistant notes
  - Incident reports
  - Fall logs

J1900 Coding Instructions

- Complete at the time of discharge
- Determine the number of falls that occurred since admission
- Code the level of fall-related injury for each
- Code each fall only once; if the patient has multiple injuries in a single fall, code the fall for the highest level of injury

Coding:
0. None
1. One
2. Two or more

Section J	Health Conditions
J1900. Number of Falls Since Admission	
Coding: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**
☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

Definition: Injury Related to a Fall

Injury Related to a Fall:

- Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after, the fall and attributed to the fall

Injury Related to a Fall

Examples of Injury (Except Major) Include:

- Skin tears
- Abrasions
- Lacerations
- Superficial bruises
- Hematomas
- Sprains
- Any fall-related injury that causes the patient to complain of pain

Examples of Major Injury Include:

- Bone fractures
- Joint dislocations
- Closed head injuries with altered consciousness
- Subdural hematoma

J2000 Prior Surgery

J2000. Prior Surgery

- Asks whether the patient had major surgery during the **100 days prior to admission**
  - **Code 0, No,** if the patient did not have major surgery during the 100 days prior to admission
  - **Code 1, Yes,** if the patient did have major surgery during the 100 days prior to admission

J1800 Practice Coding Scenario 2

- When reviewing Mrs. T's medical records to identify any falls that occurred during the IRF stay, the reviewer finds one note indicating that during the last 5 days of her IRF stay, Mrs. T was asked to stand on one leg to challenge her balance; Mrs. T leaned to the left, requiring the therapist to provide support to Mrs. T to maintain her standing balance

How would you code J1800. Any Falls Since Admission?

A. Code **0**, No
B. Code **1**, Yes

J1800 and J1900 Practice Coding Scenario 3

- Mrs. G was working on stair training with the physical therapist. While Mrs. G was descending the stairs, her left knee gave out, requiring her to be lowered to the bottom step by the therapist. Mrs. G sustained a small superficial bruise on her elbow because she bumped it as she was lowered down

How would you code J1800. Any Falls Since Admission?

A. Code **0,** No

B. Code **1,** Yes

How would you code J1900. Number of Falls Since Admission?

A. Code J1900A. No injury as **1, One**
B. Code J1900B. Injury (except major) as **1, One**
C. Code J1900C. Major injury as **2, Two or more**

Section K

Swallowing/Nutritional Status

K0110 Coding Instructions

- Check **all** that apply

A. Regular food
B. Modified food consistency/supervision
C. Tube/parenteral feeding

Section K	Swallowing/Nutritional Status
K0110. Swallowing/Nutritional Status (3-day assessment period) Indicate the patient's usual ability to swallow.	
↓ Check all that apply	
☐	**A. Regular food** - Solids and liquids swallowed safely without supervision or modified food or liquid consistency.
☐	**B. Modified food consistency/supervision** - Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
☐	**C. Tube/parenteral feeding** - Tube/parenteral feeding used wholly or partially as a means of sustenance.

K0110 Item Rationale

- Diminished nutritional and hydration status can adversely affect patients' health outcomes
- Alterations in the ability to swallow can result in:
  - Choking and aspiration
  - Increased patient risk for malnutrition, dehydration, and aspiration pneumonia

K0110 Steps for Assessment

- Ask the patient whether he or she has had any difficulty swallowing during the 3-day assessment period
- Observe the patient during meals or at other times when he or she is eating, drinking, or swallowing

K0110 Steps for Assessment (cont.)

- Review the medical record:
  - Nursing, physician, dietician, and speech-language pathologist notes
  - Information about swallowing status
  - Dental history or problems

Section O

Special Treatments, Procedures, and Programs

Influenza Vaccine Items

- Influenza season:
  - Begins July 1 of the current year and ends June 30 of the following year

O0250. Influenza Vaccine

O0250. Influenza Vaccine - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.

Enter Code ☐

A. Did the **patient receive the influenza vaccine *in this facility*** for this year's influenza *vaccination* season?

0. **No** → *Skip to O0250C. If influenza vaccine not received, state reason*
1. **Yes** → *Continue to O0250B. Date influenza vaccine received*

B. Date influenza vaccine received → Complete date and skip to Z0400A. Signature of Persons Completing the Assessment

☐☐ ☐☐ ☐☐☐☐
M M D D Y Y Y Y

Enter Code ☐

C. If influenza vaccine not received, state reason:

1. **Patient not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**


Questions?