SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

BACKGROUND

Section 3004(b) of the Affordable Care Act added section 1886(j)(7) to the Act, which requires the Secretary to implement a Quality Reporting Program (QRP) for IRFs. This program applies to freestanding IRF hospitals as well as IRF units that are affiliated with acute care facilities, which includes critical access hospitals (CAHs).

In the FY 2012 IRF PPS Final Rule (76 FR 47836), a QRP for IRFs was established requiring IRFs to submit quality data. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Social Security Act requires that CMS reduce the applicable IRF PPS annual increase factor by 2 percentage points for any IRFs that fail to submit data on the mandatory quality items. In the FY 2015 IRF PPS Final Rule (79 FR 45873), CMS made revisions to the IRF QRP by adding new quality measures and updating others.

For general information about the IRF QRP: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Details.html

For the list of current quality measures: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html

The quality items on the IRF-PAI are Height and Weight on admission (Items 25A and 26A) and the items on the Quality Indicators section (Items M0210 through O0250). Although an IRF may decide not to submit data on the quality items, failure to submit data on the mandatory items may result in a payment reduction of two percentage points starting in Fiscal Year 2016 or 2017. A table listing the voluntary and mandatory quality reporting items is provided in this Manual.

Use of Dashes for Quality Items

If a quality item has not been assessed, record and submit a dash ("-") value for the item.

For example, if a skin assessment has not been completed, use dashes ("-") for the pressure ulcer items. CMS expects that this will be a rare occurrence. Use of dashes ("-") may result in a payment reduction. Some circumstances where CMS expects dashes to be utilized are as follows:

- A patient is admitted to and discharged from an IRF before the facility has completed the admission skin assessment;
- A patient is discharged unexpectedly and the clinicians have not completed a skin assessment within the 3 days before discharge.

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Quality Indicator Pressure Ulcer Items (M0210 through M0900, I0900):

The pressure ulcer quality indicator items document the risk, presence, appearance, and change of pressure ulcers. If warranted by additional quality measures finalized by CMS for the IRF QRP through future rulemaking cycles, CMS may add additional items to this section to address other skin ulcers, wounds, or lesions, and to document treatment categories related to skin injury or avoiding skin injury.

CMS recognizes that, in addition to the pressure ulcer items included in this section of the IRF-PAI, a complete and ongoing assessment of patient's skin, guided by clinical standards, is essential to an effective pressure ulcer prevention and skin management program for all patients. Therefore, completion of this section does not replace a thorough assessment of each patient's risk factors for developing skin ulcers, wounds, or lesions. It is imperative to identify and evaluate each patient's risk factors and all areas at risk of constant pressure. It is also imperative to determine the etiology of all skin ulcers, wounds and lesions. This should determine and direct the proper treatment and appropriate skin management interventions for all patients.

Rationale for Quality Indicator Pressure Ulcer Items

Pressure ulcers occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force and friction are important contributors to pressure ulcer development. The underlying health of a patient's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers. Additional external factors, such as excess moisture and tissue exposure to urine or feces, can increase risk. Pressure ulcers affect quality of life for patients because they may limit activity, be painful, require time-consuming treatments and dressing changes, and can pose a risk of infection and sepsis. An existing pressure ulcer also identifies patients at risk for further complications or skin injury.

Helpful Terminology and Information

A. Pressure Ulcer—A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

B. Pressure Ulcer Staging—Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging also informs expectations for healing times.

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The pressure ulcer staging definitions used in the *IRF-PAI Training Manual* have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2007 Pressure Ulcer Stages. IRFs may adopt the NPUAP guidelines in their clinical practice and documentation. However, because CMS has *adapted* the NPUAP guidelines for IRF-PAI purposes, the definitions do not perfectly correlate with each stage as described by the NPUAP. Therefore, IRFs cannot use the NPUAP definitions to code the IRF-PAI. IRFs must code the IRF-PAI according to the instructions in this manual.

C. Healed Pressure Ulcer—A pressure ulcer that is completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.

Throughout this section, terminology referring to "healed" vs. "unhealed" ulcers refers to whether or not the ulcer is "closed" vs. "open." For Stage 1, Suspected Deep Tissue Injury (sDTI), and unstageable pressure ulcers (defined below), closed (i.e., may be covered with tissue, eschar, slough) would not be considered healed.

D. Pressure Ulcer "Worsening"—Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1–4 (using the staging assessment determinations assigned to each stage; starting at the Stage 1 and increasing in severity to Stage 4) on an assessment as compared to a previous assessment.

E. Slough Tissue—Nonviable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

F. Eschar Tissue—Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Eschar tissue is usually firmly adherent to the base of the wound and often the sides/edges of the wound.

G. Tunneling—A passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

H. Undermining—The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the surface.

I. Non-blanchable—Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

J. Fluctuance —The term used to describe the texture of wound tissue indicative of underlying unexposed fluid

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K. Mucosal Pressure Ulcers—Mucosal pressure ulcers are not staged using the pressure ulcer staging system because anatomical tissue comparisons cannot be made. Mucosal ulcers are also not described as partial or full thickness ulcers because tissue comparisons cannot be made. Therefore, mucosal ulcers (e.g., those related to rectal tubes) should not be reported in this section.

L. Reverse or Back Staging—Current clinical standards do not support reverse or back staging. For example, a Stage 4 pressure ulcer that has been healing such that it is less deep, wide, and long should continue to be documented as a Stage 4 pressure ulcer until it has completely healed.

Observation Period

The observation period for the admission and discharge pressure ulcer items is three calendar days. While CMS allows a 3-day observation period, the admission and discharge assessments should be completed as close to the time of admission and discharge as possible, to most accurately represent patients' admission and discharge status.

Clinical assessments performed on patients in IRFs should be completed according to accepted clinical practice and comply with facility policy, and State and Federal regulations.

The data reported on the IRF-PAI admission sections that involve patient assessment should be consistent with the initial admission clinical assessment. If a patient who is clinically assessed upon admission has a pressure ulcer identified and staged, that initial clinical assessment should be used when coding the IRF-PAI admission pressure ulcer items. If the pressure ulcer that is identified on admission increases in numerical staging (i.e., worsens) within the 3-day IRF-PAI assessment period, the IRF-PAI admission assessment would not be changed, and the **initial identified** stage of the pressure ulcer would continue to be documented on the IRF-PAI admission items. This pressure ulcer would be captured on the IRF-PAI discharge assessment as worsened (unless it heals).

General Steps for Assessment and Coding Tips for Items M0210 through M0900

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse or wound care specialist to confirm conclusions and clarify any questions from the medical record review.

3. Examine the patient and determine whether any skin ulcers are present.
    - Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers.
    - Conduct a full-body head-to-toe skin assessment to ensure no pressure ulcers are missed. Focus on bony prominences and pressure-bearing areas (sacrum, buttocks, greater trochanters (hips), heels, ankles, elbows, etc.), as well as other areas at risk for pressure ulcers.
    - Examine the patient in a well-lit room. Adequate lighting is important for detecting skin changes.
    - For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is NOT the primary cause, do not code here. If an ulcer arises from a combination of factors and the primary cause is pressure, then the ulcer should be included in this section as a pressure ulcer.
4. Patients with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a person with diabetes has an ulcer that is caused by pressure or other factors.
5. If a pressure ulcer is surgically closed with a flap or graft, it should be considered a surgical wound, not a pressure ulcer. If the flap or graft fails, it should be considered a surgical wound until healed. It should not be reported as a pressure ulcer on the IRF-PAI.
6. Skin ulcers that develop in patients who have terminal illness or are at the end of life should be assessed and staged as pressure ulcers until it is determined that the ulcer is part of the dying process (also known as Kennedy ulcers). Kennedy ulcers can develop from 6 weeks to 2 to 3 days before death. These ulcers present as pear-shaped purple areas of skin with irregular borders that are often found in the sacrococcygeal areas. When an ulcer has been determined to be a Kennedy Ulcer, it should not be coded as a pressure ulcer.
7. Note that pressure ulcers should generally show some evidence of healing within 14 days. Pressure ulcers that fail to show some evidence toward healing within 14 days could indicate that there are potential complications. In this situation, the patient's overall clinical condition ought to be reassessed.

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Proper Method of Assessment of Pressure Ulcers

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

Step 1: Determine Deepest Anatomical Stage

1. Observe or palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved. Assessment should be done in accordance with facility, State, and Federal requirements on which IRF staff members may complete patient assessments.

2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see items M0300E-M0300G below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage.

3. IRFs that carefully document and track pressure ulcers will be able to code the pressure ulcer items more accurately.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.

2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green, or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed should be classified as unstageable as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg

3. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.

4. A pressure ulcer with intact skin that is a sDTI should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg

5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) are classified as unstageable. "Known" refers to when

documentation is available that says a pressure ulcer exists under the non-removable dressing/device.

Step 3: Determine "Present on Admission"

*For **each** pressure ulcer, determine if the pressure ulcer was present at the time of admission and **not** acquired while the patient was in the care of the IRF. Consider current and historical levels of tissue involvement.*

1. Review the medical record for the history of the ulcer.

2. Review for location and stage at the time of admission. If the pressure ulcer was present on admission and subsequently increased in numerical stage during the patient's stay, that higher stage **should *not* be coded as "present on admission."**

3. If a patient is transferred to an acute care facility, and an existing pressure ulcer increases in numerical stage at the acute care facility, and the patient returns to the IRF within three days (interrupted stay), the pressure ulcer should **not** be coded as "present on admission" at the higher stage. The pressure ulcer would be reported as a 'worsened' pressure ulcer on discharge due to the progression in numerical stage, unless the pressure ulcer has healed by discharge. CMS considers acute care facilities and post-acute care facilities as having shared responsibility for patients' health, and encourages all healthcare providers to coordinate patient care in order to achieve the highest quality of care.

Unplanned Discharges

If a patient experiences an unplanned discharge (e.g., discharge to an acute care facility) and a full skin assessment was completed within the three days prior to the patient's unplanned discharge, that assessment may be used to complete the IRF-PAI discharge pressure ulcer items. However, if a full skin assessment had not been done within three days of the patient's unplanned discharge, dashes ("-") may be entered for the IRF-PAI discharge pressure ulcer items. Report the status of any known pressure ulcer that was assessed within the last three days.

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Quality Indicator Pressure Ulcer Items—Admission Assessment

M0210: Unhealed Pressure Ulcer(s)—Admission

Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher at Admission?

> **Code 0** (**No)** If patient does not have any unhealed pressure ulcer(s) at Stage 1 or higher or unstageable at admission, and then skip to question I0900 on Admission Assessment.
>
> **Code 1** (**Yes)** If patient has one or more unhealed pressure ulcer(s) at Stage 1 or higher or unstageable at admission, and then continue to question M0300A on Admission Assessment.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage—Admission

M0300A. Stage 1. Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones it may appear with persistent blue or purple hues. (*Non-blanchable*: reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device).

A Stage 1 pressure ulcer is defined as an observable, pressure-related alteration of intact skin, whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

Item Rationale

- Stage 1 pressure ulcers may deteriorate to more severe pressure ulcers without adequate intervention; as such, they are an important risk factor for further tissue damage.

Steps for Assessment:

- Distinguish Stage 1 pressure ulcers from suspected deep tissue injury (see M0300G) and moisture-associated skin damage.
- Reliance on only one descriptor is inadequate to distinguish Stage 1 and suspected deep tissue ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature [warmth or coolness], tissue consistency [firm or boggy]).

- Check any reddened areas for the ability to blanch by firmly pressing a finger into the reddened tissues and then releasing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.
- Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared with adjacent tissue. Stage 1 pressure ulcers may be difficult to detect in individuals with dark skin tones. Assess for temperature or color changes.

Coding Instructions:

M0300A1: Enter the number of Stage 1 pressure ulcers noted at the time of admission. Enter 0 if no Stage 1 pressure ulcers are noted.

M0300B. Stage 2. Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

Item Rationale

- Stage 2 pressure ulcers may worsen without proper interventions.
- These patients are at risk for further complications or skin injury.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher-stage pressure ulcers.

Steps for Assessment:

1. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury rather than a Stage 2 Pressure Ulcer. See M0300G for further description of suspected deep tissue injury. When a deep tissue injury is determined, do NOT code as a Stage 2.

2. Stage 2 pressure ulcers will *generally* lack the surrounding characteristics found with a deep tissue injury.

Coding Instructions:

M0300B1: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 2, that were present on admission. Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission.

Coding Tips:

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.
- Do NOT code skin tears, tape burns, moisture-associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2.

M0300C. Stage 3. Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present, but does not obscure the depth of tissue loss. May include undermining and/or tunneling.

Item Rationale

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.
- An existing pressure ulcer may put patients at risk for further complications or skin injury.

Coding Instructions:

M0300C1: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 3, that were present on admission. Enter 0 if no Stage 3 pressure ulcers were first noted at the time of admission.

Coding Tips:

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

M0300D. Stage 4. Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

Item Rationale

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and care that may be more time or staff intensive.
- An existing pressure ulcer may put patients at risk for further complications or skin injury.

Coding Instructions:

M0300D1: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 4, that were present on admission. Enter 0 if no Stage 4 pressure ulcers were first noted at the time of admission.

Coding Tips:

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- In Stage 4 pressure ulcers, exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, non-mucosal pressure ulcers that have exposed cartilage should be classified as Stage 4 pressure ulcers.

M0300E. Unstageable Pressure Ulcers due to non-removable dressing/device.
Pressure ulcers should be coded as unstageable when the wound bed cannot be visualized due to a non-removable dressing/device, and the pressure ulcer can thus not be numerically staged. Examples of non-removable dressing or device include a primary surgical dressing that cannot be removed, an orthopedic device, or a cast.

Item Rationale

- Although the wound bed cannot be visualized due to the non-removable dressing/device, and hence the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit their activity and be painful.

- Although the pressure ulcer itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to the touch, and the patient is monitored for adequate pain control.

Steps for Assessment:

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing/device. Do not assume that there is a pressure ulcer that is covered by a non-removable dressing/device.
2. Determine the number of unstageable pressure ulcers related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order (such as those used in negative pressure wound therapy [NPWT]), an orthopedic device, or a cast.

Coding Instructions:

M0300E1: Enter the number of unstageable pressure ulcers due to non-removable dressing/device that were present on admission. Enter 0 if no unstageable pressure ulcers due to non-removable dressing/device were first noted at the time of admission.

M0300F. Unstageable Pressure Ulcers due to slough and/or eschar. Pressure ulcers that are known but not stageable due to coverage of the wound bed by slough and/or eschar.

Item Rationale

- Although the wound bed cannot be visualized and the pressure ulcer cannot be numerically staged, the pressure ulcer may affect quality of life for patients because it may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Visualization of the wound bed is necessary for accurate numerical staging.
- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.

Coding Instructions:

M0300F1: Enter the number of unstageable pressure ulcers due to slough and/or eschar that were present on admission. Enter 0 if no unstageable pressure ulcers due to slough and/or eschar were first noted at the time of admission.

Coding Tips:

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore, the numerical stage) cannot be determined. Only until enough slough and/or eschar are removed to expose the anatomic depth of soft tissue damage involved can the numerical stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and in consultation with the patient's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. (*Fluctuance* is the term used to describe the texture of wound tissue indicative of underlying unexposed fluid).
- Once the pressure ulcer is debrided of enough slough and/or eschar such that the anatomic depth of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for restaging of the ulcer to occur.

M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (sDTI) in evolution. Pressure ulcers that are unstageable due to suspected deep tissue injury in evolution. Pressure ulcers with sDTI present as a purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones.

Item Rationale

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer, even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a patient's ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe tissue damage. Identification and management of a sDTI is imperative.
- Pressure ulcers that are unstageable due to sDTI require vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

Steps for Assessment:

1. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister *does not show* signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), **do not code as sDTI**.
2. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.

Coding Instructions:

M0300G1: Enter the number of unstageable pressure ulcers with sDTI that were present on admission. Enter 0 if no unstageable pressure ulcers with sDTI were first noted at the time of admission.

Coding Tips:

- Once a sDTI has opened to an ulcer, the ulcer should be reassessed, staged numerically, and documented in the discharge IRF-PAI assessment at the appropriate stage.

I0900. Pressure Ulcer Risk Conditions—Admission

These items document the presence of pressure ulcer risk conditions. For any pressure ulcer risk conditions documented, you must also document the appropriate ICD code(s) in Item 24 "Comorbid Conditions."

I0900A. Peripheral Vascular Disease (PVD)
Code '0' for 'No' if the patient does not have Peripheral Vascular Disease (PVD) as a risk condition.
Code '1' for 'Yes' if the patient has PVD.

I0900B. Peripheral Arterial Disease (PAD)
Code '0' for 'No' if the patient does not have Peripheral Arterial Disease (PAD) as a risk condition.
Code '1' for 'Yes' if the patient has PAD.

I2900A. Diabetes Mellitus (DM)
Code '0' for 'No' if the patient does not have Diabetes Mellitus (DM) as a risk condition, and skip items I29000B-D.
Code '1' for 'Yes' if the patient does have DM.

I2900B. Diabetic Retinopathy
Code '0' for 'No' if the patient does not have Diabetic Retinopathy.
Code '1' for 'Yes' if the patient does have Diabetic Retinopathy.

I2900C. Diabetic Nephropathy
Code '0' for 'No' if the patient does not have Diabetic Nephropathy.
Code '1' for 'Yes' if the patient does have Diabetic Nephropathy.

I2900D. Diabetic Neuropathy
Code '0' for 'No' if the patient does not have Diabetic Neuropathy.
Code '1' for 'Yes' if the patient does have Diabetic Neuropathy.

Quality Indicator Pressure Ulcer Items—Discharge Assessment

M0210: Unhealed Pressure Ulcer(s)—Discharge

Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher on Discharge?

Code 0 (No) - If patient does not have any unhealed pressure ulcer(s) at Stage 1 or higher or unstageable at discharge, and skip to question M0900A on Discharge Assessment.

Code 1 (Yes) - If patient has one or more unhealed pressure ulcer(s) at Stage 1 or higher or unstageable at discharge, and continue to question M0300A on Discharge Assessment.

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage—Discharge

Item Rationale:

- This item documents whether skin status, overall, has worsened since the admission assessment. To track increasing skin damage, this item documents the number of new pressure ulcers, and whether any pressure ulcers have increased in numerical stage (worsened) since the admission assessment. Such tracking of pressure ulcers is consistent with good clinical care.
- The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop and/or pressure ulcers worsen.

Steps for Assessment:

1. Review the history of each current pressure ulcer. Specifically, compare the current stage to the admission stage to determine whether any pressure ulcer on

the current assessment is new or at an increased numerical stage when compared with the admission assessment.

2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the admission assessment was completed.

Coding Tips:

1. Coding this item will be easier for facilities that document and follow pressure ulcer status on a routine basis.
2. If a numerically staged admission pressure ulcer increases in numerical staging at the time of discharge, it is considered worsened.
3. If two pressure ulcers at the same numerical stage merge into a single pressure ulcer also at the same stage, do not considered worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, the ulcer would need to have increased in numerical staging in order for it to be considered worsened.

M0300A. Stage 1. Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones it may appear with persistent blue or purple hues. (*Non-blanchable*: reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device).

A Stage 1 pressure ulcer is defined as an observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

Steps for Assessment:

- Distinguish Stage 1 pressure ulcers from suspected deep tissue injury (see M0300G) and moisture-associated skin damage.
- Reliance on only one descriptor is inadequate to distinguish Stage 1 and suspected Deep Tissue Injury ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature [warmth or coolness], tissue consistency [firm or boggy]).
- Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then releasing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.

- Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared with adjacent tissue. Stage 1 pressure ulcers may be difficult to detect in individuals with dark skin tones. Assess for temperature or color changes.

Coding Instructions:

M0300A1: Number of Stage 1 Pressure Ulcers at Discharge
Enter the total number of pressure ulcers currently (present at discharge) at Stage 1. Enter 0 if no Stage 1 pressure ulcers are noted at the time of discharge, and skip to item M0300B1.

M0300A2: Number of Stage 1 Pressure Ulcers at Discharge that were Present on Admission
Of these Stage 1 pressure ulcers present at discharge (reported in M0300A1), enter the number that were: (a) present on admission at Stage 1, and (b) remained at Stage 1 at discharge.

M0300A3: Number of Stage 1 Pressure Ulcers at Discharge that are New Since Admission
Of these Stage 1 pressure ulcers present at discharge (reported in M0300A1), enter the number that were not present on admission (i.e., new Stage 1 pressure ulcers that developed during the IRF stay).

M0300B. Stage 2. Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

Steps for Assessment:

1. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury rather than a Stage 2 Pressure Ulcer. When a deep tissue injury is determined, do NOT code as a Stage 2.
2. Stage 2 pressure ulcers will *generally* lack the surrounding characteristics found with a deep tissue injury.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Coding Instructions:

M0300B1: Number of Stage 2 Pressure Ulcers at Discharge
Enter the total number of pressure ulcers currently (present at discharge) at Stage 2. Enter 0 if no Stage 2 pressure ulcers are noted at the time of discharge, and skip to item M0300C1.

M0300B2: Number of Stage 2 Pressure Ulcers at Discharge that were Present on Admission
Of these Stage 2 pressure ulcers present at discharge (reported in M0300B1), enter the number that were: (a) present on admission at Stage 2, and (b) remained at Stage 2 at discharge.

M0300B3: Number of Stage 2 Pressure Ulcers at Discharge that were Unstageable at Admission
Of these Stage 2 pressure ulcers present at discharge (reported in M0300B1), enter the number that were: (a) present on admission as unstageable pressure ulcer due to the presence of a non-removable dressing/device, and (b) when it became stageable, were staged as Stage 2, and (c) remained at Stage 2 at the time of discharge.

M0300B4: Number of Stage 2 Pressure Ulcers at Discharge that are New or Worsened Since Admission
Of these Stage 2 pressure ulcers present at discharge (reported in M0300B1), enter the number that were: (a) not present on admission, or (b) were at a lesser stage at admission and worsened to a Stage 2 during the IRF stay.

Coding Tips:

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.
- Do NOT code skin tears, tape burns, moisture-associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2.

M0300C. Stage 3. Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and/or tunneling.

Coding Instructions:

M0300C1: Number of Stage 3 Pressure Ulcers at Discharge
Enter the total number of pressure ulcers currently (present at discharge) at Stage 3. Enter 0 if no Stage 3 pressure ulcers are noted at the time of discharge, and skip to item M0300D1.

M0300C2: Number of Stage 3 Pressure Ulcers at Discharge that were Present on Admission
Of these Stage 3 pressure ulcers present at discharge (reported in M0300C1), enter the number that were: (a) present on admission at Stage 3, and (b) remained at Stage 3 at discharge.

M0300C3: Number of Stage 3 Pressure Ulcers at Discharge that were Unstageable at Admission
Of these Stage 3 pressure ulcers present at discharge (reported in M0300C1), enter the number that were: (a) present at admission as an unstageable pressure ulcer, and (b) when they became stageable, was staged as a Stage 3, and (c) it remained at Stage 3 at the time of discharge.

M0300C4: Number of Stage 3 Pressure Ulcers at Discharge that are New or Worsened Since Admission
Of these Stage 3 pressure ulcers present at discharge (reported in M0300C1), enter the number that were: (a) not present on admission, or (b) were at a lesser stage at admission and worsened to a Stage 3 during the IRF stay, or (c) were unstageable due to a non-removable dressing/device at admission, initially became stageable at a lesser stage, but then progressed to a Stage 3 by the time of discharge.

Coding Tips:

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

M0300D. Stage 4. Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

Coding Instructions:

M0300D1: Number of Stage 4 Pressure Ulcers at Discharge
Enter the total number of pressure ulcers currently (present at discharge) at Stage 4. Enter 0 if no Stage 4 pressure ulcers are noted at the time of discharge, and skip to item M0300E1.

M0300D2: Number of Stage 4 Pressure Ulcers at Discharge that were Present on Admission
Of these Stage 4 pressure ulcers present at discharge (reported in M0300D1), enter the number that were: (a) present on admission at Stage 4, and (b) remained at Stage 4 at discharge.

M0300D3: Number of Stage 4 Pressure Ulcers at Discharge that were Unstageable at Admission
Of these Stage 4 pressure ulcers present at discharge (reported in M0300D1), enter the number that were: (a) present at admission as an unstageable pressure ulcer, and (b) when it became stageable, it was staged as a Stage 4, and (c) remained at Stage 4 at the time of discharge.

M0300D4: Number of Stage 4 Pressure Ulcers at Discharge that are New or Worsened Since Admission
Of these Stage 4 pressure ulcers present at discharge (reported in M0300D1), enter the number that were: (a) not present on admission, or (b) were at a lesser stage at admission and worsened to a Stage 4 by discharge, or (c) were unstageable on admission, initially became stageable at a lesser stage, and then progressed to a Stage 4 by the time of discharge.

Coding Tips:

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.

- Cartilage serves the same anatomical function as bone. Therefore, non-mucosal pressure ulcers that have exposed cartilage should be classified as a Stage 4 pressure ulcer.

M0300E. Unstageable Pressure Ulcers due to non-removable dressing/device.
Pressure ulcers should be coded as unstageable when the wound bed cannot be visualized due to a non-removable dressing/device, and the pressure ulcer can thus not be numerically staged. Examples of non-removable dressing or device include a primary surgical dressing that cannot be removed, an orthopedic device, or a cast.

Steps for Assessment:

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing/device. *Documentation of an existing pressure ulcer is needed to complete this item*. Do not assume that there is a pressure ulcer that is covered by a non-removable dressing/device.
2. Determine the number of unstageable pressure ulcers related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order (such as those used in negative pressure wound therapy [NPWT]), an orthopedic device, or a cast.

Coding Instructions:

M0300E1: Number of Unstageable Pressure Ulcers Due to Non-removable Dressing/Device at Discharge
Enter the total number of pressure ulcers currently (at discharge) unstageable due to a non-removable dressing or device. Enter 0 if the patient has no pressure ulcers unstageable due to a non-removable dressing/device at discharge, and skip to item M0300F1.

M0300E2: Number of Unstageable Pressure Ulcers Due to Non-removable Dressing/Device at Discharge that were Present on Admission
Of these pressure ulcers unstageable due to non-removable dressing/device present at discharge (reported in M0300E1), enter the number that were: (a) present on admission as an unstageable pressure ulcer due to non-removable dressing or device, and (b) remained unstageable due to non-removable dressing or device until discharge.

M0300E3: Number of Unstageable Pressure Ulcers Due to Non-removable Dressing/Device at Discharge that were Stageable at Admission
Of these pressure ulcers unstageable due to non-removable dressing/device present at discharge (reported in M0300E1), enter the number that were: (a)

present on admission as a stageable pressure ulcer and became unstageable due to non-removable dressing or device during the IRF stay, and (b) remained unstageable due to non-removable dressing or device until discharge.

M0300F. Unstageable Pressure Ulcers due to slough or eschar. Pressure ulcers that are known but not stageable due to coverage of the wound bed by slough and/or eschar.

Coding Instructions:

M0300F1: Number of Unstageable Pressure Ulcers Due to Slough or Eschar at Discharge
Enter the total number of pressure ulcers currently (at discharge) that are unstageable due to Slough and/or Eschar. Enter 0 if the patient has no pressure ulcers unstageable due to slough and/or eschar at discharge, and skip to item M0300G1.

M0300F2: Number of Unstageable Pressure Ulcers Due to Slough or Eschar at Discharge that were Present on Admission
Of these pressure ulcers unstageable due to slough and/or eschar present at discharge (reported in M0300F1), enter the number that were: (a) present on admission as an unstageable pressure ulcer due to slough and/or eschar, and (b) remained unstageable due to slough and/or eschar until discharge.

M0300F3: Number of Unstageable Pressure Ulcers Due to Slough or Eschar at Discharge that were Stageable at Admission
Of these pressure ulcers unstageable due to slough and/or eschar present at discharge (reported in M0300F1), enter the number that were: (a) present on admission as a stageable pressure ulcer and became unstageable due to slough and/or eschar during the IRF stay, and (b) remained unstageable due to slough and/or eschar until discharge.

Coding Tips:

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore, the numerical stage) cannot be determined. Only until enough slough and/or eschar are removed to expose the anatomic depth of soft tissue damage involved can the numerical stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and in consultation with the patient's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. (*Fluctuance* is

the term used to describe the texture of wound tissue indicative of underlying unexposed fluid).

- Once the pressure ulcer is debrided of enough slough and/or eschar such that the anatomic depth of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for restaging of the ulcer to occur.
- If a sDTI is identified as present on admission, opens to an ulcer during the IRF stay, and becomes unstageable due to slough/eschar prior to discharge, it is documented in M0300F1 at discharge. In this specific scenario, both items M0300F2 and M0300F3 in the discharge IRF-PAI assessment would be coded as "0."

M0300G. Unstageable Pressure Ulcers with Suspected Deep Tissue Injury (sDTI) in evolution. Pressure ulcers that are unstageable due to suspected deep tissue injury in evolution. Pressure ulcers with sDTI present as a purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones.

Steps for Assessment:

1. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister *does not show* signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), **do not code as a sDTI.**
2. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.

Coding Instructions:

M0300G1: Number of Unstageable Pressure Ulcers Due to Suspected Deep Tissue Injury
Enter the total number of pressure ulcers at discharge that are unstageable due to suspected deep tissue injury. Enter 0 if the patient has no unstageable pressure ulcers with suspected deep tissue injury at discharge, and skip to item M0900A.

M0300G2: **Number of** Uns**tage**able **Pressure Ulcers** Due to **Suspected Deep Tissue Injury that were Present on Admission**
Of the number of unstageable pressure ulcers with sDTI reported in M0300G1, enter the number that were: (a) present on admission as an unstageable pressure ulcer due to suspected DTI, and (b) remained unstageable due to suspected DTI until discharge.

M0900. Healed Pressure Ulcers—Discharge

This item documents the number of pressure ulcers that were present on admission and have healed by discharge.

Coding Instructions:

M0900A. Stage 1: Enter the number of Stage 1 pressure ulcers that were: (a) present on admission; and (b) have completely healed/closed upon discharge. Enter 0, if there were no admission Stage 1 pressure ulcers that have healed by discharge.

M0900B. Stage 2: Enter the number of Stage 2 pressure ulcers that were: (a) present on admission; and (b) have completely healed/closed upon discharge. Enter 0, if there were no admission Stage 2 pressure ulcers that have healed by discharge.

M0900C. Stage 3: Enter the number of Stage 3 pressure ulcers that were: (a) present on admission; and (b) have completely healed/closed upon discharge. Enter 0, if there were no admission Stage 3 pressure ulcers that have healed by discharge.

M0900D. Stage 4: Enter the number of Stage 4 pressure ulcers that were: (a) present on admission; and (b) have completely healed/closed upon discharge. Enter 0, if there were no admission Stage 4 pressure ulcers that have healed by discharge.

Coding Tips:

- If a sDTI is identified as present on admission, opens to an ulcer during the IRF stay, and heals prior to discharge, it is documented in Item M0900 - Healed Pressure Ulcers -- Discharge as the highest stage it was prior to its healing.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Quality Indicator Influenza Vaccine Item (O0250):

O0250. Influenza Vaccine—Discharge

This item assesses the influenza vaccination status of patients at discharge.

Item Rationale

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional influenza A outbreak can result in up to 60 % of the population becoming ill, with 25% of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immune-compromising diseases that can be exacerbated by influenza.
- As of 2013, the Advisory Committee on Immunization Practices (ACIP) continues to recommended annual influenza vaccination for all persons aged ≥6 months in the United States http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm

Influenza Vaccination Season Definitions:

- For the 2014–2015 influenza season, the influenza vaccination season is defined as beginning October 1st 2014 or when the influenza vaccine becomes available (whichever comes first) through March 31st 2015.
- For the 2015–2016 influenza season, the influenza vaccination season is defined as beginning October 1st 2015 or when the influenza vaccine becomes available (whichever comes first) through March 31st 2016.
- For subsequent influenza seasons, the influenza vaccination season is defined as beginning October 1st or when the influenza vaccine becomes available (whichever comes first) through March 31st.

Steps for Assessment:

1. Review the patient's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. . If the patient received the vaccine during a previous stay at the facility during the current influenza vaccination season, report the date of that vaccination. If vaccination status is unknown, proceed to the next step. Please also review (when

available) the patient's medical record from previous setting(s) (e.g., short-stay acute care hospital medical records).

2. Ask the patient if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. If influenza vaccination status is still unknown, proceed to the next step.
3. If the patient is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.
4. If vaccination status cannot be determined, please refer to the standards of clinical practice to determine whether or not to administer the vaccine to the patient.

O0250A. Did the patient receive the influenza vaccine in this facility for this year's influenza vaccination season?

Code 0 (No) - If the patient did not receive the influenza vaccine in this facility for this year's influenza vaccination season, and skip to O0250C.

Code 1 (Yes) - If the patient did receive the influenza vaccine in this facility for this year's influenza vaccination season, and continue to O0250B.

Code with a dash, ("-") - If the patient's influenza vaccination status cannot be determined. (**"-"** denotes that the information is not available/accessible or is unknown).

O0250B. Date influenza vaccine received.

- Enter the date the influenza vaccine was received in the facility and skip to Z0400A.
- Do not leave any boxes blank. If the month contains only a single digit, fill in the first box of the month with a "0." If the day contains only a single digit, then fill the first box of the day with the "0." For example, October 6, 2014, should be entered as 10-06-2014, and January 7, 2015, should be entered as 01-07-2015. A full 8-character date is required. If the date is unknown or the information is not available, a single dash needs to be entered in the first box.

O0250C. If influenza vaccine was not received, state reason why it was not received.

Code 1 - If the patient was not in this facility during this year's influenza vaccination season (October 1st through March 31st).

Code 2 - If the influenza vaccine was received outside of this facility, (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season.

Code 3 - If the patient was not eligible due to medical contraindications, including (1) allergic reaction to eggs or other vaccine component(s), (2) a physician order not to immunize, or (3) an acute febrile illness is was present. However, the patient should be vaccinated if contraindications end.

Code 4 - If patient or responsible party/legal guardian had been informed that the influenza vaccine was being offered and chose not to accept the influenza vaccine.

Code 5 - If the patient or responsible party/legal guardian was not offered the influenza vaccine.

Code 6 - If the influenza vaccine was unavailable at the facility due to declared vaccine shortage. However, the patient should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year.

Code 9 - If none of the above listed reasons describe why the influenza vaccine was not administered.

Code dash ("-") If the reason the vaccine was not administered is unknown or the information is not available.

Coding Tips and Special Populations:

- The influenza season varies annually. Information about the current Influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) Web site: http://www.cdc.gov/flu.
- Facilities should follow current ACIP recommendations to inform standard of practice and applicable patients. Annual influenza vaccination of all persons aged ≥6 months continues to be recommended.

Examples

1. Mrs. J. received the influenza vaccine in this IRF during this year's influenza vaccination season, on October 2, 2014.

   Coding: O0250A would be coded 1, yes; O0250B would be coded 10-02-2014, and O0250C would be skipped.

Rationale: Mrs. J. received the vaccine in the IRF on October 2, 2014, during this year's influenza vaccination season.

2. Mr. R. did not receive the influenza vaccine in the IRF during this year's influenza vaccination season because of his known allergy to egg protein.

   Coding: O0250A would be coded 0, no; O0250B is skipped, and O0250C would be coded 3, not eligible-medical contraindication.

   Rationale: Allergies to egg protein is a medical contraindication to receiving the influenza vaccine, therefore, Mr. R. did not receive the vaccine.

3. Mrs. T. received the influenza vaccine at her doctor's office during this year's influenza vaccination season. Her doctor provided documentation of Mrs. T.'s receipt of the vaccine to the IRF to place in Mrs. T.'s medical record. He also provided documentation that Mrs. T. was explained the benefits and risks for the vaccine prior to administration.

   Coding: O0250A would be coded 0, no; and O0250C would be coded 2, received outside of this facility.

   Rationale: Mrs. T. received the influenza vaccine at her doctor's office during this year's influenza vaccination season.

4. Mrs. W. received the influenza vaccine during her acute care stay immediate prior to the IRF stay. The IRF staff should review her acute care record as part of the admission process and document in the IRF record that Mrs. W. has already received the influenza vaccine prior to admission.

   Coding: O0250A would be coded 0, no; and O0250C would be coded 2, received outside of this facility.

   Rationale: Mrs. W. received the influenza vaccine in the acute care hospital prior to the IRF stay during this year's influenza vaccination season.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

MEASURE SPECIFICATIONS FOR QUALITY MEASURES REPORTED USING IRF-PAI

QUALITY MEASURE RECORD SELECTION METHODOLOGY

The purpose of this section is to describe the methodology employed to select assessment records that are used to compute the quality measures (QMs) from data collected by IRFs and submitted to the CMS using the IRF-PAI under the IRF Quality Reporting Program.

Definitions

Target period. The span of time that defines the QM reporting period.

Target date. The target date for an assessment is defined as follows:

- The **admission target date** is equal to the admission date on IRF-PAI (Item 12).
- The **discharge target date** is equal to the discharge date on IRF-PAI (Item 40).

Patient data stream. The patient's data stream consists of all records that have target dates within the target period and that are for the specific patient at a specific IRF.

Sort order. The records in a patient's data stream must be sorted by target discharge date (descending). This will cause records to appear in reverse chronological order so that the most recent records appear first in the data stream.

Stay. The period of time between a patient's date of admission into an IRF and date of discharge from the IRF. A stay, thus defined, will include a patient stay during a set of contiguous days in an IRF, and will include program interruptions lasting up to 3 calendar days.

QM sample. The set of patient records that is selected in order to calculate a particular QM.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Record Selection

The QM is calculated by selecting eligible records from patient data streams and applying the QM definitions to the selected records. The purpose of this section is to describe how records are selected for each QM for the IRF QRP.

Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)

The eligible records for this QM are selected as follows:

1. Define the target period for the measure.
2. Select all IRF-PAI records with a discharge date (Item 40) within the target period.
3. Exclude all records in which the patient is not discharged alive (44C = 0).
4. For each record within each IRF, do the following:
    a. Sort the records according to the sort order defined on the previous page.
    b. Scan the sorted records in reverse chronological order.
    c. Select all records that meet the patient stay definition on previous page. These are ***target patient stay records***. If a patient has multiple patient stay records with a discharge target date within the target period, then include each qualifying patient stay in the measure.
5. Apply the QM definition (Table 1) to the eligible target patient stay records.

Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)
(NQF #0680)

The sample for this QM is selected as follows:

1. The target period for this measure is the influenza vaccination season: October 1 through March 31 (i. e., October 1, 2014 through March 31, 2015 for the 2014-2015 influenza vaccination season).
2. The measure includes all patients with one or more days in the IRF during the target period. Select all IRF -PAI records with an admission date (Item 12) ***or*** a discharge date (Item 40) within the target period. For example, the record of a patient admitted to an IRF on March 31st will be selected based on the admission date, regardless of the discharge date. The record of a patient discharged from an IRF on October 1st will be selected based on the discharge date, regardless of the admission date.

3. For each patient within each IRF, do the following:
    a. Sort the stay-level records according to the sort order defined above.
    b. Scan the sorted records in reverse chronological order.
    c. Select the patient stay-level records that meet all of the following conditions:
        i. Patient was in the IRF one or more days during the target period based on admission date ***or*** discharge date (i.e., either the admission date, the discharge date or both the admission and discharge date fall within the target period of October 1st to March 31st)
        ii. One or both the following apply:
            a. The discharge target date is on or after October 1st of the most recently completed influenza vaccination season OR on or before March 31st of the most recently completed influenza vaccination season
            b. The admission target date is on or after October 1st of the most recently completed influenza vaccination season OR on or before March 31st of the most recently completed influenza vaccination season.
        iii. A qualifying patient stay record is called an ***influenza vaccination assessment***. If the patient has multiple patient stay records during the target period, then include each influenza vaccination assessment from all qualifying patient stays in the measure.
    d. If no qualifying record is found for a patient, then the patient is excluded from the measure.
4. Apply the QM definition to the qualifying influenza vaccination assessment records.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Table 4-1

Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)[1]

Measure Description	Measure Specifications[2]	Covariates
This measure reports the percentage of patients with stage 2, stage 3 or stage 4 pressure ulcers that are new or worsened pressure ulcers since admission. The measure is calculated by reviewing a patient's IRF-PAI pressure ulcer discharge assessment data for reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage at the time of the admission assessment.	***Numerator*** Patients for whom the discharge assessment indicates one or more new or worsened stage 2, stage 3 or stage 4 pressure ulcers: 1. M0300B4 (new or worsened Stage 2 pressure ulcers) > 0 OR 2. M0300C4 (new or worsened Stage 3 pressure ulcers) > 0 OR 3. M0300D4 (new or worsened Stage 4 pressure ulcers) > 0. ***Denominator*** Patients with IRF-PAI patient stay records during the target period, except those with exclusions. Note: IRF-PAI records are only submitted to CMS for Medicare patients. ***Exclusions*** 1. Patient stay is excluded if M0300B4=[-] and M0300C4=[-] and M0300D4=[-] on the discharge assessment. 2. Patient stay that ends with patient expiration (Item 44C=[0]) is excluded from the measure. 3. Patient stay is excluded if there is no admission risk adjustment data (covariates). ***Additional Exclusion for Future Public Reporting Program*** IRFs with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.	Data for each covariate is derived from the IRF-PAI admission assessment data included in the target patient stay records. 1. Indicator of minimal assistance or more assistance for the functional mobility item Transfers: Bed, Chair, Wheelchair (FIM® item 39I): Covariate = [1] (yes) if 39I = [0, 1,2,3,4] ([0]=Activity did not occur, [1]=Total assistance, [2]= Maximal assistance, [3]=Moderate assistance, [4]=Minimal assistance) Covariate = [0] (no) if 39I = [5, 6, 7, -] ([5]=Supervision, [6]=Modified Independence (Device), [7]=Complete Independence (Timely, Safely), [-]=No response available) 2. Indicator of any bowel incontinence in the past 7 days (Item 30): Covariate = [1] (yes) if item 30= [1, 2, 3, 4, 5] ([1]=Five or more accidents in the past 7 days, [2]=Four accidents in the past 7 days, [3]=Three accidents in the past 7 days, [4]=Two accidents in the past 7 days,[5]=One accident in the past 7 days) Covariate = [0] (no) if item 30 = [6, 7, -] ([6]=No accidents; uses device such as catheter, [7]=No accidents, [-]=No response available) 3. Have peripheral vascular disease or peripheral arterial disease or diabetes: Covariate = [1] (yes) if one or more of the following are true: a. I0900A = [1] b. I0900B = [1] c. I2900A = [1] Covariate = [0] (no) if I0900A = [0,-] AND I0900B = [0,-] AND I2900 = [0,-] ([0]=No, [-]=No response available) 4. Indicator of Low Body Mass Index, based on Height (Item 25A) and Weight (Item 26A): Covariate = [1] (yes) if BMI ≥ [12.0] AND ≤ [19.0] Covariate = [0] (no) if BMI > [19.0] Covariate = [0] (no) if 25A = [-] OR 26A = [-] OR BMI < [12.0] ([-]=No response available) Where: BMI = (weight * 703 / height^2) = ([26A] * 703) / (25A^2) and the resulting value is rounded to one decimal.

[1] This measure is NQF-endorsed for use in the Inpatient Rehabilitation Facility (IRF) setting (http://www.qualityforum.org/QPS/0678) (in addition to Long Term Care Hospital and Skilled Nursing Facility/Nursing Home (SNF/NH) settings) and finalized for reporting by IRFs under the IRF Quality Reporting Program (*Federal Register* 78 (6 August 2013): 47903-47919. Web. http://www.gpo.gov/fdsys/pkg/FR-2013-08-06/pdf/2013-18770.pdf and *Federal Register* 79 (6 August 2014): 45908-45918. Web. http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18447.pdf). The use of the words "resident" and "short-stay" in the title of this measure refer to the use of this measure in the SNF/NH setting. CMS's use of these words does not imply that the IRF patient is a "resident" or that a stay in an IRF is a "short stay".

[2] Beginning on October 1, 2012, IRFs began to use the "Inpatient Rehabilitation Facility - Patient Assessment Instrument" IRF as the vehicle by which to collect and submit the pressure ulcer data for the IRF Quality Reporting Program. An updated version of the IRF-PAI will become effective on October 1st, 2014. A copy of IRF -PAI V 1.2 is included in Section 8 of the IRF PAI Training Manual l V 1.2.

SECTION 4: QUALITY INDICATORS AND QUALITY MEASURE SPECIFICATIONS

Table 4-2
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)[1]

Measure Description	Measure Specifications	Covariates
This measure reports the percentage of residents or patients who are assessed and appropriately given the influenza vaccine during the most recent influenza vaccination season. The measure score is computed and reported for the three numerator components separately. The Patient Influenza Vaccination measure is calculated only once per year.	***Numerator*** Patients meeting any of the following criteria on the selected influenza vaccination assessment: 1. Patient received the influenza vaccine during the most recent influenza vaccination season, either in the facility (O250A=1) or outside the facility (O0250C=2) (computed and reported separately); or 2. Patient was offered and declined the influenza vaccine (O0250C=4) (computed and reported separately); or 3. Patient was ineligible due to contraindication(s) (O0250C=3) (computed and reported separately). ***Denominator*** 1. All patients with a selected influenza vaccination assessment during the target period (i.e., influenza vaccination period), except those with exclusions. Note: IRF-PAI assessments are only submitted to CMS for Medicare patients. ***Exclusions*** Patient's age on target date of selected influenza vaccination assessment is 179 days or less. ***Additional Exclusion for Future Public Reporting Program*** IRFs with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.	Not applicable.

[1] This measure is NQF-endorsed for use in the Inpatient Rehabilitation Facility (IRF) setting (http://www.qualityforum.org/QPS/0680) (in addition to Long Term Care Hospital and Skilled Nursing Facility/Nursing Home (SNF/NH) settings) and finalized for reporting by IRFs under the IRF Quality Reporting Program (*Federal Register* 78 (6 August 2013): 47903-47919. Web. http://www.gpo.gov/fdsys/pkg/FR-2013-08-06/pdf/2013-18770.pdf and *Federal Register* 79 (6 August 2014): 45908-45918. Web. http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18447.pdf). The use of the words "resident" and "short-stay" in the title of this measure refer to the use of this measure in the SNF/NH home setting. CMS's use of these words does not imply that the IRF patient is a "resident" or that a stay in a IRF is a "short stay."

[2] A copy of IRF -PAI V 1.2, including items for patient influenza vaccination measure, is included in Section 8 of the IRF PAI Training Manual.