SECTION IV
MEDICAL NEEDS/QUALITY INDICATORS

MEDICAL NEEDS

Completion of the "Medical Needs" items is voluntary.

25. Is patient comatose at admission? Has the patient been diagnosed as comatose or in a persistent vegetative state? Enter the appropriate code at the time of admission.

0 No
1 Yes. Record ICD-9-CM diagnosis code(s) of coma or persistent vegetative state in Comorbid Conditions (Item 24).

26. Is patient delirious at admission? Has the patient exhibited symptoms of delirium? Delirium may be manifested as disoriented thinking, being easily distracted, disorganized speech, restlessness, lethargy, or altered perceptions or awareness of surroundings. Enter the appropriate code at the time of admission.

0 No
1 Yes. Record ICD-9-CM diagnosis code(s) of delirium in Comorbid Conditions (Item 24).

27. Swallowing Status. Use the following codes to describe the patient's swallowing status. Enter the appropriate code at the time of admission and discharge.

3 Regular Food: Solids and liquids are swallowed safely without supervision or modified food or liquid consistency.

2 Modified Food Consistency/Supervision: Patient requires modified food or liquid consistency, such as a pureed diet, or the patient requires supervision during eating for safety reasons.

1 Tube/Parenteral Feeding: Tube/parenteral feeding used wholly or partially as a means of sustenance. This includes patients who are unable to have any food by mouth (i.e., NPO).

28. Clinical signs of dehydration. Does the patient exhibit signs of clinical dehydration? Signs of clinical dehydration may include oliguria, dry skin, orthostatic hypotension, somnolence, agitation, sunken eyes, poor skin turgor, very dry mucous membranes, cyanosis, poor fluid intake, or excessive loss of fluid through vomiting or excessive urine, stools, or sweating (whereby the amount of output exceeds the amount of intake). Enter the appropriate code at the time of admission and discharge.

0 No
1 Yes. Record ICD-9-CM diagnosis code(s) related to dehydration in Comorbid Conditions (Item 24), or Complications (Item 47), or Both.

Quality Indicators – Questions 48A – 50D

The August 5, 2011 IRF PPS Final Rule (76 FR 47836) established a quality reporting program for IRFs. Although an IRF may decide not to submit data on Quality Indicators section (Items 48A through 50D), failure to complete such items may result in payment reduction of two percentage points starting in Fiscal Year 2014.

Definitions

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. Healed Pressure Ulcer - Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.

Current clinical standards do not support reverse staging or backstaging. For example, over time, a stage 4 pressure ulcer has been healing such that it is less deep, wide, and long. Previous standards using reverse or backstaging would have permitted identification of the pressure ulcer as a Stage 2 pressure ulcer when it reached a depth consistent with Stage 2 pressure ulcers. Current standards require that it continue to be documented as a Stage 4 pressure ulcer until it has completely healed.

C. 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. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

D. Tunneling - A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

E. 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.

F. Unstageable Pressure Ulcers - There are 3 types of unstageable pressure ulcers;

1. **Unstageable Pressure Ulcer - Deep Tissue Injury**
   a. Localized area of discolored (darker than surrounding tissue) intact skin.
   b. Related to damage of underlying soft tissue from pressure and/ or shear.
   c. Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
   d. Deep tissue injury may be difficult to detect in individuals with dark skin tones
2. **Unstageable Pressure Ulcer - Slough and/ or Eschar**
   a. Known but not stageable related to coverage of wound bed by slough and/ or eschar.
   b. Full thickness tissue loss.
   c. Base of ulcer covered by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed
3. **Unstageable Pressure Ulcer - Non-Removable Dressing**
   Known but not stageable because of the non-removable dressing

IRF-PAI Quality Indicator Pressure Ulcer Questions:

The observation period for the admission and discharge pressure ulcer items (items 48A through 50D) is three calendar days.

Proper Method of Assessment of Pressure Ulcers:

- For **each** pressure ulcer, determine if the pressure ulcer was present at the time of admission **or** acquired while the patient was in the care of the IRF.
- Consider current and historical levels of tissue involvement. Review the medical record for the history of the ulcer.
- Review for location and stage at the time of admission and discharge.
- You cannot assign a stage to a pressure ulcer that cannot be fully assessed.

DO NOT report unstageable pressure ulcers on the IRF-PAI. If the pressure ulcer was unstageable on admission, but becomes stageable later, it should be considered as present at the time of admission at the stage at which it first becomes stageable.

We recognize that the number of pressure ulcers reported in the patient's medical record and ICD-9-CM codes reported on the IRF-PAI or on the UB-04 may not match the number of pressure ulcers reported in the IRF-PAI.

Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

48A. Stage 2. Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, **without slough.** May also present as an intact or open/ruptured blister.

Steps for Assessment:

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, greater trochanters (hips), heels, ankles, elbows, etc).

2. 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.
3. 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 deep tissue injury rather than a Stage 2 Pressure Ulcer.
4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.

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

Discharge: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 2, that were present at discharge and note the number under the discharge assessment. Enter 0 if no Stage 2 pressure ulcers are noted at the time of discharge.

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, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury here.

- When a lesion that is related to pressure presents with 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.

48B. 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 or tunneling.

Steps for Assessment:

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, greater trochanters, heels, ankles, elbows, etc).
2. 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.

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

Discharge: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 3, that were present at discharge and note the number under the discharge assessment. Enter 0 if no Stage 3 pressure ulcers are noted at 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.

48C. 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.

Steps for Assessment:

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).

2. 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.

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

Discharge: Enter the number of unhealed pressure ulcers, whose deepest anatomical stage is Stage 4, that were present at discharge and note the number under the discharge assessment. Enter 0 if no Stage 4 pressure ulcers are noted at 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.

Worsening in Pressure Ulcer Status Since Admission

49A. Stage 2. Indicate the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage 2, that were not present or were at a lesser stage on admission. If no pressure ulcers have worsened or there are no new pressure ulcers, enter 0. If no current pressure ulcer is present, enter 0.

49B. Stage 3. Indicate the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage 3, that were not present or were at a lesser stage on admission. If no pressure ulcers have worsened or there are no new pressure ulcers, enter 0. If no current pressure ulcer is present, enter 0.

49C. Stage 4. Indicate the number of current pressure ulcers at discharge, whose deepest anatomical stage is Stage 4, that were not present or were at a lesser stage on admission. If no pressure ulcers have worsened or there are no new pressure ulcers, enter 0. If no current pressure ulcer is present, enter 0.

Coding Tips:

- Coding this item will be easier for facilities that document and follow pressure ulcer status on a routine basis.

- Coding unstageable pressure ulcers:
  - If an ulcer was unstageable on admission, do not consider it to be worse at discharge. If the ulcer became stageable, it should be considered present at the time of admission at the stage at which it first became stageable. However, if it worsens after it becomes stageable as noted on the admission assessment, it should be included.
  - If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened.
  - If a previously staged pressure ulcer becomes unstageable and then is debrided sufficiently to be staged, compare its stage before and after it was unstageable. If the pressure ulcer's stage has worsened, code it as such.

Healed Pressure Ulcers

50A. Were unhealed pressure ulcers present on admission? Enter 0 for no and leave items 50B-50D blank. Enter 1 for yes if any unhealed, stage 2 or greater, pressure ulcers were present at the time of admission.

50B. Stage 2. Indicate the number of pressure ulcers, whose deepest anatomical stage was Stage 2 on admission, that have completely closed (resurfaced with epithelium) at discharge. If no healed pressure ulcer is present at discharge, enter 0. **Only code this item if 50A is 1 (yes).**

50C. Stage 3. Indicate the number of pressure ulcers, whose deepest anatomical stage was Stage 3 on admission, that have completely closed (resurfaced with epithelium) at discharge. If no healed pressure ulcer is present at discharge, enter 0. **Only code this item if 50A is 1 (yes).**

50D. Stage 4. Indicate the number of pressure ulcers, whose deepest anatomical stage was Stage 4 on admission, that have completely closed (resurfaced with epithelium) at discharge. If no healed pressure ulcer is present at discharge, enter 0. **Only code this item if 50A is 1 (yes).**