Acronyms in This Presentation

- Against Medical Advice (AMA)
- Annual Payment Update (APU)
- Automated Submission and Processing (ASAP) System
- Brief Interview for Mental Status (BIMS)
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Certification and Survey Provider Enhanced Reports (CASPER)
- *Clostridium difficile* Infection (CDI)
Acronyms in This Presentation

- Improving Medicare Post-Acute Care Transformation (IMPACT) Act
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Inpatient Rehabilitation Validation and Entry System (jIRVEN)
- Methicillin-Resistant *Staphylococcus aureus* (MRSA)
Acronyms in This Presentation

- National Healthcare Safety Network (NHSN)
- National Quality Forum (NQF)
- Present on Admission (POA)
- Quality Improvement and Evaluation System (QIES)
- QIES Technical Support Office (QTSO)
- Quality Measure (QM)
- Quality Reporting Program (QRP)
- Validation Utility Tool (VUT)
Housekeeping

• This webinar is being recorded.
• Please click on the settings button near the top of your screen to enable closed captioning.
• If you have a question at any point throughout today’s presentation, please use the Electronic Question Submission Form or enter it in the chat panel.
How to Download the Handout Materials

• In the upper right corner of the window are two icons.
• Click on the first icon to show the MEDIA LIBRARY.
• The MEDIA LIBRARY will open on the right. Go to the SHARED FILES section.
• You can download the file by placing your mouse over the file and clicking on the green circle with the white arrow.
How to Enter Full Screen Mode

• Click on the PPT Presentation Title located above the presentation area.
• The option for FULL SCREEN will appear.
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- The “Fit to Screen” icon is the left icon located on the upper right corner of the Caption Stream box.
Polling Question

How many people (including yourself) are participating in this webinar together?

A. Just me—I am the only one participating.
B. Two people.
C. Three or four people.
D. Five or more people.
Electronic Question Submission

1. Visit
   https://docs.google.com/forms/d/e/1FAIpQLSf5gctioPYJlszTymwGqdтанGSZk8QmFBIH11HBDcaV9FJOLw/viewform?usp=sf_link.

2. Enter your full name, organization, and email address.
3. Using the drop-down menu, choose the section to which your question refers.

4. Type your questions and click “SUBMIT” to send your question to the presenter.
5. You may ask another question by clicking “Submit another response” after the page refreshes.
Today’s Presenters

Karen Prior-Topalis, R.N., B.S.N., M.B.A., CCM.
Manager of Quality and Outcomes
Mount Sinai Rehabilitation Hospital

Gina Waltos, COTA/L, B.S.
Team Leader, Quality and Outcomes
Mount Sinai Rehabilitation Hospital
Today’s Presenters

Anne Deutsch, R.N., Ph.D., CRRN
Senior Research Public Health Analyst
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Objectives

Upon completion of the training, the participant will be able to:

- Identify the resources available to guide understanding of the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).
- Demonstrate understanding of section-specific assessment items to correctly interpret and code the IRF-PAI Version 1.4.
- Discuss findings from data analysis on data submissions, including the new assessment items, effective October 1, 2016.
Live Demonstration

Karen Prior-Topalis
Gina Waltos
Mount Sinai Rehabilitation Hospital
Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.
IRF QRP Website

IRF Quality Reporting

IRF-PAI & IRF QRP Manual

Technical Information

Training

Measures Information

Spotlight & Announcements

Public Reporting

Data Submission Deadlines
IRF QRP Website

IRF-PAI & IRF QRP Manual
Technical Information
Training
Measures Information
Public Reporting
Data Submission Deadlines
Spotlight & Announcements
IRF Quality Reporting
IRF QRP Website: Spotlight & Announcements

- News
- Announcements
- Updates

IRF QRP Website: Measures Information

- IRF Quality Measure (QM) User Manual
- Measure Specifications.
- National Quality Forum (NQF) Measure Identification Numbers and Titles.
- IRF QRP Measures by Payment Determination Year.
- Current Definitions for IRF Quality Measures.
- List of IRF-PAI 1.4 Mandatory and Voluntary Items.

IRF QRP Website

IRF-PAI & IRF QRP Manual

Technical Information

Training

Measures Information

Public Reporting

IRF Quality Reporting

Spotlight & Announcements

Data Submission Deadlines
IRF QRP Website: IRF-PAI and IRF QRP Manual

- Current versions of the IRF-PAI, the Quality Indicator Section of the IRF-PAI Manual, and associated documents.
- Tool and Manual Updates.
- Change table(s).

Final IRF-PAI version 1.4, effective October 1, 2016.
Proposed IRF-PAI version 1.5, effective October 1, 2017.
Proposed IRF-PAI Version 2.0, effective October 1, 2018.
Change tables.
IRF QRP Website: Technical Information

- Technical Updates and Resources.
- Contacts for Technical Issues.
- IRF-PAI Submission Specifications.

IRF QRP Website: Training

- Training Updates.
- Training Registration.
- Training Presentations and Collateral Materials.
- Training Q&As.

IRF QRP Website: Training Downloads

- May 2017 Review and Correct Reports Webcast Recording & Q&A.
- August 2016 IRF QRP Provider Training Materials, Videos & Q&A.
- May 2016 IRF QRP Provider Training Materials, Videos & Q&A.
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act.
- Act & Interoperability Training Presentation.

Past in-person IRF QRP Provider Training materials are packaged into zipped folders.

Each section of the training has a zipped folder containing all related training materials.

CMS provides training materials (presentations, case studies, action plan templates, etc.) for reuse in your organization.
IRF QRP Website: Public Reporting

- Public Reporting Updates.
- Public Reporting Resources & Education Materials.
- Downloads.
  - IRF Compare Fact Sheet.
  - NHSN Rebaseline Guidance.
IRF QRP Website

IRF Quality Reporting

IRF-PAI & IRF QRP Manual

Technical Information

Training

Measures Information

Public Reporting

Spotlight & Announcements

Data Submission Deadlines
• Data Submission Updates.
• Data Collection & Final Submission Deadlines for FY 2018 Payment Update Determination.
• Downloads.
Federal Register

- Proposed Rules and Final Rules are published in the Federal Register and typically released each year in April and August.

- Proposed and Final Rules are posted on both of these web pages:
  - [http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientRehabFacPPS/List-of-IRF-Federal-Regulations.html](http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientRehabFacPPS/List-of-IRF-Federal-Regulations.html).
Stay Connected

• To receive mailing list notices and announcements about the IRF QRP, sign up at: https://public.govdelivery.com/accounts/USCMS/subscriber/new.

• CMS Open Door Forums and listening sessions. Notices about CMS Open Door Forums related to the IRF QRP are announced on the following webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/IRF-Quality-Reporting/Spotlights-Announcements.html.
IRF Help Desks
IRF Help Desks

IRF Vendor, with a question about:

IRF Vendor Issues
- IRF-PAI data technical specifications.
- VUT (vendor tool to ensure software meets CMS requirements and will pass ASAP edits).
- Technical questions related to IRF-PAI data specifications.

Email:
IRFTechIssues@cms.hhs.gov
IRF QRP Help Desk

IRF QRP
Email: IRF.Questions@cms.hhs.gov

Examples of issues:
• IRF QRP requirements, including data submission timelines.
• IRF-PAI Quality Indicator items.
• Calculation of Quality Measures.
• IRF QRP provider training materials.
• General IRF quality reporting questions.

If you are unsure which Help Desk to use, e-mail your question to this Help Desk for triage.
CDC/NHSN Help Desk

CDC National Healthcare Safety Network (NHSN)
Email: NHSN@cdc.gov

Examples of issues:
• Centers for Disease Control and Prevention (CDC) Quality Measures:
  o Catheter-Associated Urinary Tract Infections (CAUTIs).
  o Methicillin-Resistant *Staphylococcus aureus* Bacteremia.
  o *Clostridium difficile* Infection.
  o Influenza Vaccination Coverage Among Healthcare Personnel.
• National Healthcare Safety Network (NHSN) enrollment, reporting, and data analysis.
Data Submission and Data Validation

Help Desk

Email: Help@qtso.com
Phone: (800) 339-9313

Examples of issues:
- Accessing QIES (username and password).
- Data/record submissions.
- CMG Grouper classification.
- Submission/validation reports.
- Accessing Certification and Survey Provider Enhanced Reports (CASPER).
- Inpatient Rehabilitation Validation and Entry System (jIRVEN).
Examples of issues:

• Reporting periods for the CASPER Review and Correct reports.
• Interpretation of results for the CASPER Quality Measure reports.
• Measures included the Provider Preview reports.
• IRF Compare website: https://www.medicare.gov/inpatientrehabilitationfacilitycompare/
• IRF data available on Data.Medicare.gov.
IRF-PAI Clinical Items Help Desk

IRF-PAI Clinical Items
Email: Help@qtso.com
Phone: (800) 339-9313

Examples of issues:
• Identification information.
• Payer information.
• Medical information.
• Function modifiers and FIM® instrument.
• Discharge information.
IRF Medicare Policy Help Desk

IRF Medicare Policy
Email: IRFCoverage@cms.hhs.gov

Examples of issues:
- IRF Medicare reimbursement.
- Claims/billing.
- Eligibility and coverage requirements.
- Therapy information reporting.
- IRF-PAI requirements (for nonquality sections).
IRF Vendor Issues

Email: IRFTechIssues@cms.hhs.gov

Examples of issues:

• IRF-PAI data technical specifications.
• Validation utility tool (VUT) to ensure software meets CMS requirements and will pass Automated Submission and Processing (ASAP) System edits.
• Technical questions that are related to IRF-PAI data specifications.
Polling Question

How often do you visit the IRF QRP web page on the CMS website?

A. Very frequently (weekly).
B. Occasionally (monthly).
C. Rarely (a few times a year).
D. Never.
Knowledge Check 1

Which resource below is the best reference for guidance in coding the IRF-PAI assessment items?

B. IRF-PAI Change Table.
You have a question about coding an unstageable pressure ulcer on the IRF-PAI. Which Help Desk should you contact?

A. IRF Medicare Policy.
B. CDC/NHSN.
C. IRF Quality Reporting Program (QRP).
D. Data Submission and Data Validation.
Coding Reminders
Dash Use

• Instances where coding of the dash [–] does not impact Annual Payment Update (APU) determination:
  o Coding Section GG Discharge Goal items.
  o Coding Brief Interview for Mental Status (BIMS) items C0400A, C0400B, and C0400C when the interview is stopped because the patient did not answer the previous questions.
Dash Use: Section GG Discharge Goals

• Use the six-point scale to code GG0130. Self-Care and GG0170. Mobility Discharge Goal(s).
  o Do not use the “activity was not attempted” codes (07, 09, or 88) to code discharge goal(s).

• At least one discharge goal must be reported for either one self-care or one mobility activity.

• A dash [–] may be used if a goal is not reported for a specific activity.

• Using the dash in this allowed instance does not affect APU determination as long as at least one self-care or mobility goal is reported.
Dash Use: BIMS Interview Stopped

- Use a dash [–] to indicate that the BIMS interview was stopped.
  - Refer to the rules for stopping the interview before it is completed (Guidance Manual, page C-5).
- If the patient refuses to answer the BIMS (specifically C0200 & C0300A–C=0), then using the dash for items C0400A–C does not affect APU determination.
- In this case, where the BIMS is stopped, code C0500 as 99, code C0600 as 1, Yes and check C0900 items if they apply.
Checkbox Items

- For checkbox items, leaving an item unchecked is a valid response indicating that the condition is not present:
  - I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD).
  - OR
  - I7900. None of the above.
Checkbox Items

• Leaving an item unchecked is a valid response for:
  o O0100N. Total Parenteral Nutrition
Important Timeframes

• The **3-Day Assessment** period is 3 calendar days and is defined in the IRF-PAI Manual.
  - Admission Assessment Period: First day of admission and the following 2 days, ending at 11:59 PM.
  - Discharge Assessment Period: Day of discharge and the 2 calendar days prior to the day of discharge.
Important Timeframes

• J1750. History of Falls asks whether the patient has had two or more falls or any fall with major injury in the past year.

• J2000. Prior Surgery asks whether the patient had major surgery during the 100 days prior to admission.
Knowledge Check 3

If at least one self-care or mobility goal is entered on the IRF-PAI, using a dash for the remaining discharge goal items will not affect the APU determination.

A. True
B. False
Leaving an item unchecked is an allowable response for which of the assessment items below?

A. M0300A. Stage 1.
C. GG0170G2. Car Transfer Discharge Goal.
D. H0350. Bladder Continence.
Section-Specific Assessment Items
Sections B, C, H, J, M & O
Section B

Hearing, Speech, and Vision
Section B

• Section B is assessed on admission.
  
  o **BB0700.** Expression of Ideas and Wants.
  
  o **BB0800.** Understanding 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

1. Rarely/Never expresses self or speech is very difficult
2. Frequently exhibits difficulty with expressing needs and ideas
3. Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
4. Expresses complex messages without difficulty and with speech that is clear and easy to understand

Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)
BB0700 Coding Tips

• Complex messages would include:
  o Discussion about medication administration.
  o Discharge planning.
  o Caregiver issues.
BB0800 Coding Instructions

• Enter the code that best reflects the patient’s ability to understand verbal content, however able.
Q. Clarify the difference between “Code 3, Some Difficulty” and “Code 2, Frequently Exhibits Difficulty.”
Q. Clarify the difference between “Code 3, Some Difficulty” and “Code 2, Frequently Exhibits Difficulty.”

A. Not based on just the number of words or the number of gestures if the patient is nonverbal.

Coding should reflect the frequency of the difficulty the patient has expressing wants and ideas.

Observe interactions with others in different locations and circumstances and ask other clinicians during different shifts as well as family members.
Section C

Brief Interview for Mental Status (BIMS)

C0200–C0500
Section C: BIMS

- Consists of three components:
  - C0200. Repetition of Three Words.
  - C0300. Temporal Orientation.
  - 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

3. Be sure the patient can hear you.

4. Sit so that the patient can see your face.

5. Give an introduction before starting the interview.
Section C: BIMS Instructions

6. If the patient expresses concern, he or she may be more comfortable if you reply:
   
   o “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: BIMS Coding Tips

- Nonsensical responses should be coded as zero.

DEFINITION:

NONSENSICAL RESPONSE
Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated.
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 by patient after first attempt:**

3. Three
2. Two
1. One
0. None

After the patient’s first attempt say: “I will repeat each of the three words with a cue and ask you about them later: 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.
  o Repeating words in a sentence counts as repeating the words.
• Score the number of words repeated on the first attempt only.
  o Do not score the number of repeated words on the second or third attempt.
  o Do not record the number of attempts that the patient needed to complete.
• If the interviewer cannot say words clearly, have another staff member conduct the interview.
C0300: Temporal Orientation

- Assess ability to report the correct year, month, and day of the week.
- **Code 0** if the patient does not answer.

<table>
<thead>
<tr>
<th>C0300. Temporal Orientation: Year, Month, Day</th>
</tr>
</thead>
</table>
| **A. Ask patient:** "Please tell me what year it is right now."
  Patient’s answer is:
  3. Correct
  2. Missed by 1 year
  1. Missed by 2 to 5 years
  0. Missed by more than 5 years or no answer |
| **Enter Code** |
| **B. Ask patient:** "What month are we in right now?"
  Patient’s answer is:
  2. Accurate within 5 days
  1. Missed by 6 days to 1 month
  0. Missed by more than 1 month or no answer |
| **Enter Code** |
| **C. Ask patient:** "What day of the week is today?"
  Patient’s answer is:
  1. Correct
  0. Incorrect or no answer |
| **Enter Code** |
**C0400: Recall**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Ask patient: “Let’s go back to the first question. What were those three words that I asked you to repeat?” If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>A. Recalls “sock?”</strong></td>
</tr>
<tr>
<td></td>
<td>2. Yes, no cue required</td>
</tr>
<tr>
<td></td>
<td>1. Yes, after cueing (“something to wear”)</td>
</tr>
<tr>
<td></td>
<td>0. No, could not recall</td>
</tr>
<tr>
<td></td>
<td><strong>B. Recalls “blue?”</strong></td>
</tr>
<tr>
<td></td>
<td>2. Yes, no cue required</td>
</tr>
<tr>
<td></td>
<td>1. Yes, after cueing (“a color”)</td>
</tr>
<tr>
<td></td>
<td>0. No, could not recall</td>
</tr>
<tr>
<td></td>
<td><strong>C. Recalls “bed?”</strong></td>
</tr>
<tr>
<td></td>
<td>2. Yes, no cue required</td>
</tr>
<tr>
<td></td>
<td>1. Yes, after cueing (“a piece of furniture”)</td>
</tr>
<tr>
<td></td>
<td>0. No, could not recall</td>
</tr>
</tbody>
</table>
1. Ask the patient to repeat the words from the earlier question.
   - Read question as it appears on the IRF-PAI.
2. Allow up to 5 seconds for spontaneous recall of each word.
3. Provide category cues for any word not correctly recalled after 5 seconds.
4. Use category cues only after patient is unable to recall one or more words.
5. Allow up to 5 seconds after category cue for recall.
Section C: Stopping the BIMS Interview

• Stop the interview if necessary.

• 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

If the interview is stopped, 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 the Staff Assessment for Mental Status.
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.

Section C: BIMS and Program Interruptions

• If an IRF patient has an interrupted stay, the BIMS assessment that was conducted when the patient was first admitted to the IRF (prior to the program interruption) would be the patient’s BIMS assessment.

• No additional BIMS assessments are required for patients who have one or more program interruptions.
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 CMS YouTube Channel to view the BIMS video and other videos about interviewing techniques:

- [https://www.youtube.com/watch?v=DAj3TA5w11Y](https://www.youtube.com/watch?v=DAj3TA5w11Y)
Section H

H0350 & H0400
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 soiled.
H0350 Coding Instructions

- Code according to the amount and number of episodes of incontinence that occur during the assessment period.
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:
  o Coughing.
  o Sneezing.
  o Laughing.
  o Lifting heavy objects.
  o Exercise.
Stress Incontinence

• There does not need to be a physician diagnosis of stress incontinence.

• Based on the clinician’s assessment, patient or family reporting, or physician documentation, a patient can be coded as **1**, Stress incontinence only.

• Staff observations would be helpful in distinguishing incontinence (large amount) from stress incontinence (small amount) in nonverbal patients.
H0350 Coding Tips

• 3-day assessment period only.

• Review all documentation and discuss with staff to determine the frequency.

• 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.
H0350 Coding Tips

• If a patient has an indwelling catheter upon admission and the device is removed on day 2 of the stay and the patient has two incontinent episodes during the 3-day assessment period:
  o Code H0350. Bladder Continence as code 2, Incontinent less than daily.
H0400 Coding Instructions

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Bowel Continence - Select the one category that best describes the bowel pattern during the 3-day assessment period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Always continent</td>
</tr>
<tr>
<td>1</td>
<td>Occasionally incontinent (one episode of bowel incontinence)</td>
</tr>
<tr>
<td>2</td>
<td>Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement)</td>
</tr>
<tr>
<td>3</td>
<td>Always incontinent (no episodes of continent bowel movements)</td>
</tr>
<tr>
<td>9</td>
<td>Not rated, patient had an ostomy or did not have a bowel movement for the entire 3 days</td>
</tr>
</tbody>
</table>
H04000 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 a 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.
H04000 Coding Tips

• Patients 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 was in a commode, toilet, incontinence pad or bedpan.

• Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.
H04000 Coding Tips

• If the patient has a bowel program that has been developed to induce stool, and the bowel program is performed successfully as a scheduled event, then item H04000. Bowel Continence would be coded 0, Always continent.

• A bowel program does not have to occur using a toilet or bedpan.
• **Scenario:** Mrs. B usually has stress incontinence. During the 3-day assessment period, she experienced a large amount of urine leakage daily.

• 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.
• **Coding:** H0350 would be coded 3, Incontinent daily.

• **Rationale:**
  - The patient is incontinent of a large amount of urine daily during the Admission Assessment period.
  - Stress incontinence is coded if the patient has **only** stress incontinence. Stress incontinence refers to episodes of a small amount of urine leakage only associated with physical movement or activity, such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
Knowledge Check 6

- **Scenario:** Mr. T has an indwelling catheter in place during Day 1 of the assessment period. On Day 2, the catheter is removed, and Mr. T is incontinent on Days 2 and 3.

- **How would you code H0350?**
  A. Code 1, Stress incontinence only.
  B. Code 2, Incontinent less than daily.
  C. Code 3, Incontinent daily.
  D. Code 9, Not applicable.
• **Coding:** H0350 would be coded **2**, Incontinent less than daily.

• **Rationale:**
  - The patient is incontinent only on Days 2 and 3 of the Admission Assessment period.
  - The patient cannot be considered incontinent on Day 1 due to the use of an indwelling catheter.
Section J

Health Conditions (Falls)
Fall Definition

• Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface.
  o 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.
  o e.g., a patient pushes another patient.
Fall Definition

• An intercepted fall occurs when the patient:
  o Would have fallen if he or she had not caught him/herself.
  o 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.
Item Intent

• The intent of items J1800 and J1900 is to maximize patient safety and capture events that represent threats to patient safety.

• Only falls with “major injury” (item J1900C) are used in the calculation of the Quality Measure: Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674).
J1750 Steps for Assessment

1. Indicate whether the patient has had:
   - Two or more falls in the past year.
   - Any fall with injury in the past year.

2. Interview the patient if he or she is capable of reliably reporting fall history.

3. Speak with family members or significant others to obtain fall history.
J1750 Coding Instructions

- Complete at the time of admission.

0. No
1. Yes
8. Unknown
J1800 & J1900
Steps for Assessment

• Review IRF medical record:
  o Physician, nursing, therapy, and nursing assistant notes.
  o Incident reports.
  o Fall logs.
J1800 Coding Instructions

- Complete only at the time of discharge.

J1800. Any Falls Since Admission

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has the patient had any falls since admission?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No → Skip to M0210. Unhealed Pressure Ulcer(s)</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Continue to J1900. Number of Falls Since Admission</td>
</tr>
</tbody>
</table>
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.
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.
Knowledge Check 7

• **Scenario:** Mr. S has been working with his physical therapist on high-level balance activities. Today during therapy, Mr. S was asked to stand on one leg to challenge his balance. Mr. S leaned to the left, requiring the therapist to provide support and to “right” him.

• How would you code J1800. Any Falls Since Admission?
  A. Code 0, No.
  B. Code 1, Yes.
Knowledge Check 7

• **Coding**: J1800 would be coded 0, No.

• **Rationale**: Patient was participating in a therapy session where balance was being challenged in order to improve his mobility. Challenging the patient’s balance was part of the treatment session, and it was expected that the patient might need assistance to maintain balance.
Knowledge Check 8

• **Scenario:** 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.
Knowledge Check 8

• **Coding:** J1800 would be coded 1, Yes.

• **Rationale:** Patient was lowered to the bottom step by the therapist. An unintentional change in position coming to rest on a lower surface is considered a fall.

• How would you code J1900. Number of Falls Since Admission?
Knowledge Check 8

• **Coding:** J1900 would be coded as follows:
  
  A. No Injury: 0, None.
  
  B. Injury (except major): 1, One.
  
  C. Major Injury: 0, None.

• **Rationale:** Patient sustained a small superficial bruise on her elbow, which is considered an injury.
Knowledge Check 9

- **Scenario:** Mr. K has limited use of his left side and a left lateral lean due to a stroke. During a therapy session, Mr. K was standing at the parallel bars with the assistance of a therapist who was standing on his left side. Mr. K was using a mirror to help him monitor his balance. Mr. K began to lean heavily to his left side and was bearing some of his weight on the therapist as he attempted to right himself.

- How would you code J1800. Any Falls Since Admission?
  A. Code 0, No.
  B. Code 1, Yes.
Knowledge Check 9

• **Coding**: J1800 would be coded 0, No.

• **Rationale**: Mr. K was in a therapeutic session working on his balance and posture. The therapist was aware that he might list to the left and anticipated that he would require support to not fall.
Section M

Skin Conditions
Section M: Intent

Document the presence, appearance, and change in status of pressure ulcers.

PRESSURE ULCER:
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.
M0300. Current Number of Unhealed Pressure Ulcer(s)

Admission Assessment
• M0300A1-G1
  o Identifies number of unhealed pressure ulcers at each stage.
  o Establishes the patient’s baseline assessment.

Discharge Assessment
• M0300A1-G1
  o Identifies number of unhealed pressure ulcers at each stage.
• M0300A2-G2
  o At the time of discharge, identifies if the unhealed pressure ulcer(s) in M0300A1-G1 were present on admission or if the pressure ulcer(s) were acquired or worsened during the stay.
The present on admission (POA) items (M0300A2-G2) are coded at discharge.

Address whether the pressure ulcer(s) observed at discharge were:

1. Present on admission

2. Acquired or worsened during the stay
• A pressure ulcer reported at discharge and coded as **not Present on Admission** on the Discharge Assessment would be interpreted as new or worsened.

• A pressure ulcer reported at discharge and coded as **Present on Admission** on the Discharge Assessment would **not** be considered new or worsened.
**Present on Admission: Scenario 1**

- **Admission**: Stage 2 pressure ulcer.
- **Discharge**: Stage 2 pressure ulcer becomes unstageable due to slough/eschar.

This pressure ulcer was **Not Present on Admission**. It has worsened.
## Present on Admission: Scenario 1 Coding

<table>
<thead>
<tr>
<th>Item</th>
<th>Admission Assessment</th>
<th>Discharge Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M0300B1. Number of Stage 2 pressure ulcers</strong></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission</strong></td>
<td></td>
<td>Skip</td>
</tr>
<tr>
<td><strong>M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</strong></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>M0300F2. Number of these unstageable pressure ulcers that were present upon admission</strong></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>M0800A. Worsening in Pressure Ulcer Status Since Admission: Stage 2</strong></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>M0800E. Worsening in Pressure Ulcer Status Since Admission: Unstageable – Slough and/or eschar</strong></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
Present on Admission: Scenario 1
Coding Rationale

- A Stage 2 pressure ulcer, per definition, does not include slough and/or eschar, as these are signs of a deeper involvement of tissue damage.
- Even though the ulcer itself cannot be staged to a higher numerical stage, characteristically and clinically it is appropriate to assign a worsened status to this ulcer.
- The unstageable ulcer due to slough and/or eschar would not be coded as Present on Admission at the time of discharge, because the ulcer was observed at admission as a Stage 2 pressure ulcer, not as an unstageable ulcer due to slough and/or eschar.
- This ulcer would also be reported as worsened in M0800E Unstageable – Slough and/or Eschar.
Present on Admission: Scenario 2

Admission

Stage 3 pressure ulcer.

Discharge

Stage 3 pressure ulcer becomes unstageable due to slough/eschar.

This pressure ulcer was Present on Admission. It is not considered worsened.
Present on Admission: Scenario 2

<table>
<thead>
<tr>
<th>Item</th>
<th>Admission Assessment</th>
<th>Discharge Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0300C1. Number of Stage 3 pressure ulcers</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>M0300C2. Number of these Stage 3 pressure ulcers that were present upon admission</td>
<td>Skip</td>
<td></td>
</tr>
<tr>
<td>M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>M0300F2. Number of these unstageable pressure ulcers that were present upon admission</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>M0800B. Worsening in Pressure Ulcer Status Since Admission: Stage 3</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>M0800E. Worsening in Pressure Ulcer Status Since Admission: Unstageable – Slough and/or eschar</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Present on Admission: Scenario 2
Coding Rationale

- We cannot observe the tissues to differentiate between Stage 3 and 4.
- Because we cannot observe the tissues within the ulcer to appropriately numerically stage it, we cannot say whether the ulcer has worsened or not per our definition.
- Because this ulcer was not debrided and the assessor was unable to determine whether the ulcer remained a Stage 3 or had increased in numerical stage to a Stage 4, it would be considered present on admission (at the time of discharge).
- Clinicians should ensure that an ulcer is as clean as possible (and debrided, if necessary) prior to staging the ulcer and before simply choosing to code the ulcer as unstageable.
Unstageable Pressure Ulcers

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

• Pressure ulcers that have eschar or slough 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.
Unstageable Pressure Ulcers

• 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; do not code this as unstageable.

• Known pressure ulcers covered by a nonremovable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.
Unstageable Pressure Ulcers: Scenario 3

- **Scenario:** A patient is admitted to an IRF with an unstageable pressure ulcer. During the patient’s stay, the pressure ulcer opens, is reassessed and staged as a Stage 3. At discharge, the pressure ulcer is healed. There are no other pressure ulcers.

- How would you code this at discharge?
Unstageable Pressure Ulcers: Scenario 3
Coding Rationale

• **Coding:**
  
  M0210. Unhealed Pressure Ulcer(s) = 0, No
  M0900C. Healed Stage 3 Pressure Ulcer(s) = 1

• **Rationale:** When completing the discharge items, a pressure ulcer that was unstageable on admission and later becomes numerically stageable during the patient’s stay should be coded based on the stage at which it first becomes numerically stageable. This pressure ulcer is staged as a Stage 3 pressure ulcer before it heals. Thus, it would be considered a healed Stage 3 pressure ulcer at discharge.
Discharge: Scenario 4

- **Scenario:** Mr. J develops a Stage 2 pressure ulcer on his left heel while at the IRF. He is transferred to an acute care hospital for treatment of pneumonia. Mr. J returns to the IRF after 5 days with a Stage 3 pressure ulcer in the same anatomical location.

- How would you code this on the second Admission Assessment?
Discharge: Scenario 4
Coding Rationale

• **Coding:**
  M0300C1. Number of Stage 3 Pressure Ulcer(s) = 1

• **Rationale:** Even though the patient had a pressure ulcer in the same anatomical location prior to acute care transfer, because it increased in numerical staging to Stage 3 during hospitalization at another facility that lasted longer than 3 calendar days, M0300C1 should be coded as “1” on the second Admission Assessment to indicate that the Stage 3 pressure ulcer was present on the patient’s second admission to the IRF.
Interrupted Stay: Scenario 5

- **Scenario:** Ms. K is admitted to the IRF and has no pressure ulcers noted when the Admission Assessment is completed. She is emergently transferred to an acute care hospital for evaluation and returns to the IRF in less than 3 days with a Stage 2 pressure ulcer on her coccyx. This Stage 2 pressure ulcer was still present at discharge.

- How would you code this on the Discharge Assessment?
Interrupted Stay: Scenario 5
Coding Rationale

• Discharge Assessment Coding:
  M0300B1. Number of Stage 2 pressure ulcers = 1
  M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission = 0
  M0800A. Worsening Since Admission: Stage 2 = 1

• Rationale: Since the Stage 2 pressure ulcer acquired during the program interruption was still present at discharge, it would be considered a “new” pressure ulcer for that IRF stay.
Coding Tips

• Data reported on the IRF-PAI for Section M are pressure ulcers observed at time of admission and discharge only.
  
  o 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 a patient’s admission and discharge status.
  
  o 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.
Coding Tips

• Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made.
• Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity, etc.) should not be coded on the IRF-PAI Section M.
Section O

Influenza Vaccination Season
Influenza Vaccination Season

• Influenza Season:
  o Begins July 1 of the current year and ends June 30 of the following year.

• Influenza Vaccination Season:
  o Begins October 1 of the current year.
  o Ends March 31 of the following year.
Influenza Vaccination Season

• IRFs should document year-round, including when a patient has been vaccinated outside the influenza vaccination season.

• For the Quality Measure, only the records of patients in the IRF 1 or more days during the influenza vaccination season (at least 1 day between Oct 1 and Mar 31) are included in the calculation.
### O0250. Influenza Vaccine

- **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 |

- **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
  7. None of the above
Entire Stay is During the Influenza Vaccination Season

October 1

October 8
Patient admitted to IRF

October 10
Patient vaccinated by IRF

November 1
Patient discharged home

Influenza Vaccination Season
Admitted Before the End of the Influenza Vaccination Season

March 31
- Patient admitted to IRF

April 1
- Patient vaccinated by IRF

April 20
- Patient discharged home

Influenza Vaccination Season
Discharged During the Influenza Vaccination Season

- **September 3**: Patient vaccinated by primary care physician
- **September 15**: Patient admitted to IRF
- **October 1**: Patient discharged home

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Influenza Vaccination Season
IRF QRP

Findings from Data Analysis
Findings from Data Analysis

• Thank you for all the effort you have made to collect accurate data!

• We have examined the data, and much of the data patterns we observed are patterns we expected.
Section GG: Use of Code 07, Patient Refused

- Coding a self-care item as 07, Patient refused would indicate that the patient did not perform the activity and a helper did not perform the activity for the patient during the 3-day assessment period.

- A therapist would not code 07, Patient refused because the patient is not assessed performing the activity in therapy.
Section GG: GG0130. Self-Care

• Example:
  - A therapist is responsible for coding the oral hygiene item.
  - She/he does not assess this activity in therapy during the last 3 days of the patient’s stay.

• Coding:
  - The therapist should interview the patient and nurses to determine the patient’s level of independence with the activity and code 01-06, as appropriate.”
Section GG: Use of Code 09, Not Applicable

• Code **09, Not applicable**, indicates that:
  
  o the patient does not perform the activity, and a helper does not perform the activity for the patient and
  
  o the patient or a helper did not perform the activity prior to the current illness, injury, or exacerbation.

• We do not expect this code to be used frequently for most self-care or mobility items.
Section GG: Use of Code 09, Not Applicable

• Example:
  o The patient uses bilateral prosthetics with attached socks and shoes. The patient used both of these prosthetics prior to his acute care and IRF admission.

• Coding:
  o Code GG0130H. Putting on/taking off footwear as 09, Not applicable.
Section GG: Incomplete Stay

• If a patient has an incomplete stay, discharge self-care and mobility items can be coded 88, Not attempted due to medical condition or safety concern.
Section GG: Incomplete Stay

- Patients with incomplete stay records are identified based on:
  - Discharge to Acute Care: Discharge Destination (Item 44D).
    - 02 = Short-term General Hospital
    - 63 = Long-Term Care Hospital (LTCH)
    - 65 = Inpatient Psychiatric Facility
    - 66 = Critical Access Hospital
  OR
  - Discharged Against Medical Advice: Patient discharged against medical advice (Item 41 = 1).
  OR
  - Died while in IRF: Was the patient discharged alive? (Item 44C = 0).
  OR
  - Length of stay less than 3 days: ([Item 40. Discharge Date] minus [Item 12. Admission Date]) < 3 days.
Section M: Discharge

At the time of discharge, the skin assessment items are coded based on the following:

- If a pressure ulcer is observed at discharge, determine whether the pressure ulcer was observed at the time of admission.

- A pressure ulcer that is coded as “present on admission” on the Discharge Assessment refers to a pressure ulcer that has not worsened or is not new since the time of admission.

- If a pressure ulcer observed at admission worsens to a higher stage by discharge, it would not be coded as “present upon admission” at discharge.
Section O

- The influenza vaccination season starts October 1 and ends on March 31.
  - Communities may extend an influenza vaccination season.
- If the influenza vaccine was not received, code 1, “Patient not in this facility during this year’s influenza vaccination season,” only if the patient was not in the IRF 1 or more days during the influenza vaccination season.
• Example:
  o The patient was admitted to the IRF June 16, 2017, and discharged June 30, 2017.
  o The patient did not receive the influenza vaccination for the 2016–2017 season.
  o This patient was not in the IRF 1 or more days and did not receive the influenza vaccine.

• Coding:
  o Code 1, Patient was not in this facility during this year's influenza vaccination season.
Questions?