Inpatient Rehabilitation Facility
Quality Reporting Program Provider Training

FAQs:
Sections B, H, I, K, and O

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Objectives

- Demonstrate a working knowledge of Sections B, H, I, K, and O.
- Articulate the intent of Sections B, H, I, K, and O.
- Interpret the coding options for each item in Sections B, H, I, K, and O.
- Interpret FAQs about Sections B, H, I, K, and O.

Section B

Hearing, Speech, and Vision

Section B: New Items

- All items in Section B are **new.**
  - **BB0700,** Expression of Ideas and Wants.
  - **BB0800,** Understanding Verbal Content.

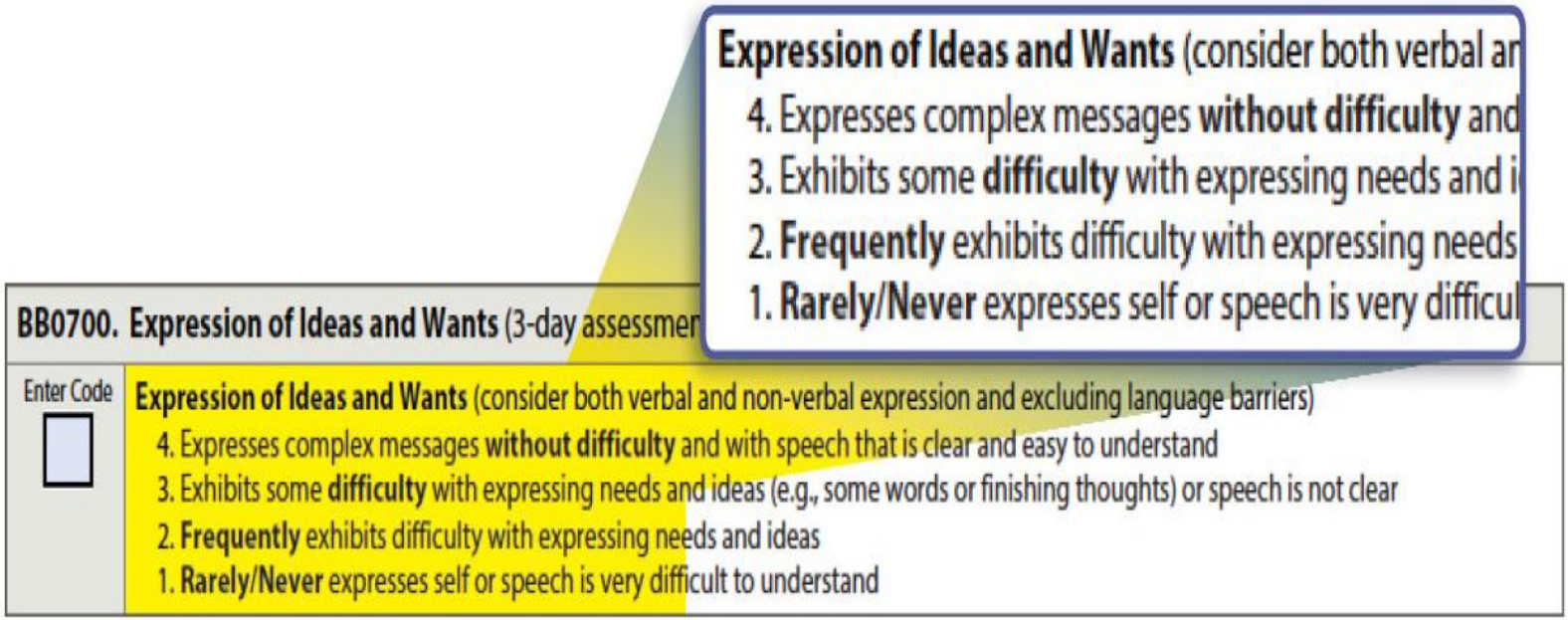
- Section B is assessed on admission.

Section B: Intent

Document the patient's ability to understand and communicate with others.

BB0700 Coding Instructions

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

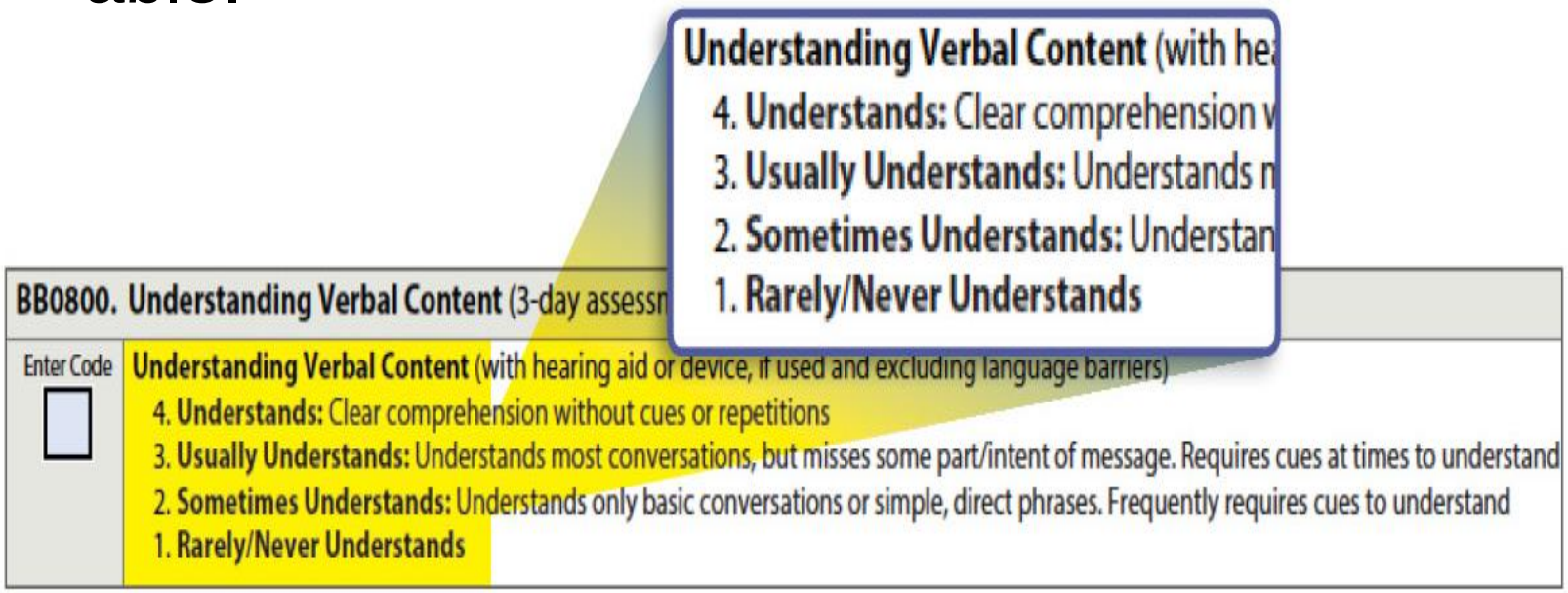


BB0700 Coding Tips

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

BB0800 Coding Instructions

- Enter the code that best reflects the patient's ability to understand verbal content, however able.



Section B Question No. 1

Q. Clarify the difference between “Code 3, Some Difficulty” and “Code 2, Frequently Exhibits Difficulty.”

Section B Question No. 1

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 B Question No. 2

Q. What do you do if a patient utilizes a Passy Muir Valve or an Electrolarynx, but is difficult to understand?

Section B Question No. 2

Q. What do you do if a patient utilizes a Passy Muir Valve or an Electrolarynx, but is difficult to understand?

A. In this situation, Section B can be assessed using alternative electronic devices (e.g., smart phone, tablet, laptop), writing, pointing, nodding, or using cue cards.

Section B Question No. 3

Q. If a patient is deaf and utilizes sign language to communicate, can you use sign language or do you need to use written communication?

Section B Question No. 3

Q. If a patient is deaf and utilizes sign language to communicate, can you use sign language or do you need to use written communication?

A. When coding items BB0700 and BB0800, sign language may be used in the event that a patient is deaf.

Section H

Bladder and Bowel

Section H: New Items

- All items in Section H are **new.**
  - **H0350,** Bladder Continence.
  - **H0400,** Bowel Continence.

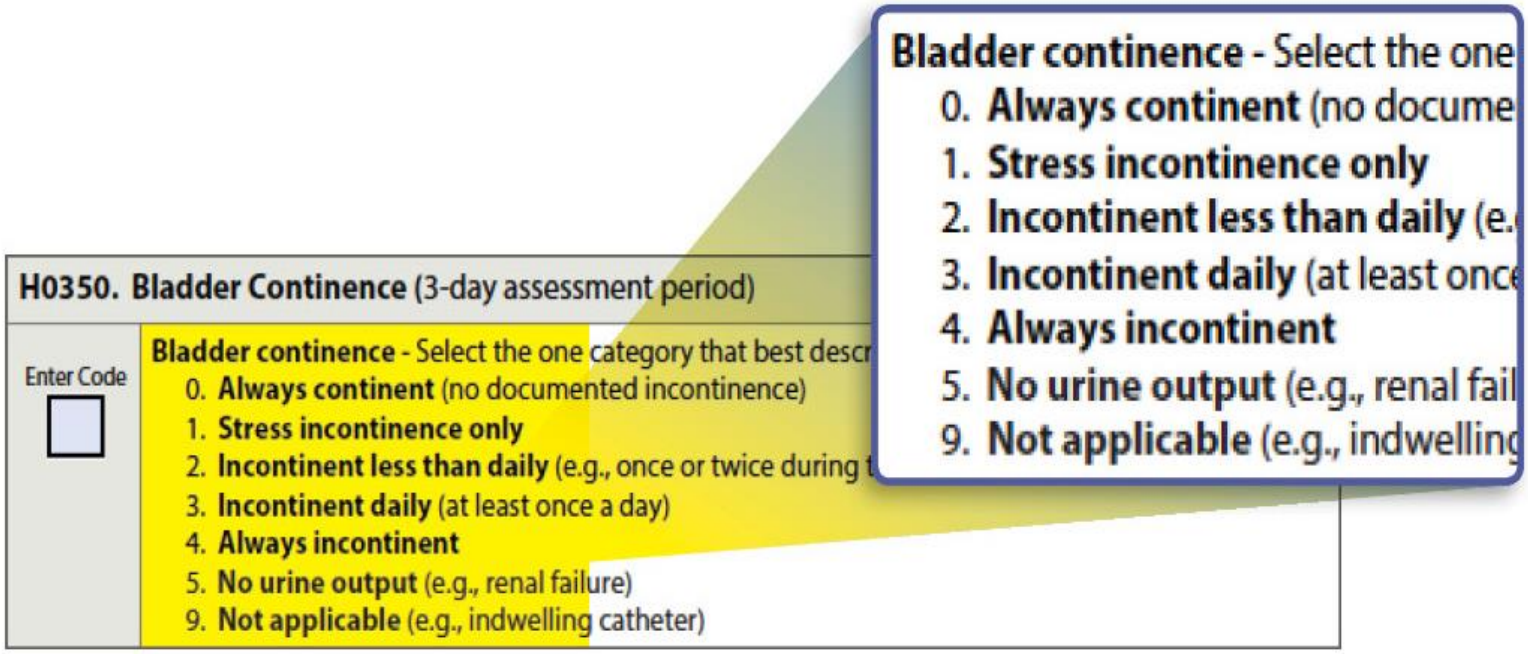
- Section H is assessed on admission.

Section H: Intent

To gather information on bladder and bowel continence.

H0350 Coding Instructions

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



H0350 Coding Instructions

- **Code 0, Always continent,** if throughout the 3-day assessment period, the patient was continent of urine, without any episodes of incontinence.
- **Code 1, Stress incontinence only,** if during the 3-day assessment period, the patient had episodes of incontinence only associated with physical movement or activity, such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
- **Code 2, Incontinent less than daily,** if during the 3-day assessment period, the patient was incontinent of urine once or twice.

H0350 Coding Instructions

- **Code 3, Incontinent daily,** if during the 3-day assessment period, the patient was incontinent of urine at least once a day.
- **Code 4, Always incontinent,** if during the 3-day assessment period, the patient had no continent voids.
- **Code 5, No urine output,** if during the 3-day assessment period, the patient had no urine output (e.g., renal failure, on chronic dialysis with no urine output) for the entire 3 days.
- **Code 9, Not applicable,** if during the 3-day assessment period, the patient had an indwelling bladder catheter, condom catheter, or ostomy for the entire 3 days.

Stress Incontinence

- Stress incontinence has its own code.
- Associated with physical movement or activity such as:
  - Coughing.
  - Sneezing.
  - Laughing.
  - Lifting heavy objects.
  - Exercise.
- Staff observations would be helpful in distinguishing incontinence from stress incontinence in nonverbal patients.

H0350 Coding Tips

- 3-day assessment period only.
- Incontinence is the same as leakage.
- Review all documentation and discuss with staff to determine the frequency.

Section H Question No. 1

Q. Can you please review your point about someone who has a history of stress incontinence and why it might be different?

Section H Question No. 1

Q. Can you please review your point about someone who has a history of stress incontinence and why it might be different?

A. Stress incontinence refers to episodes in which there is a small amount of urine leakage only associated with physical movement or activity, such as coughing, sneezing, laughing, lifting heavy objects, or exercise.

Section H Question No. 2

Q. If a condom catheter falls off and the patient is incontinent, how is it coded?

Section H Question No. 2

Q. If a condom catheter falls off and the patient is incontinent, how is it coded?

A. Code 9 should be used for indwelling bladder catheter, condom catheter, or ostomy that is in place for the entire 3 days.

If the condom catheter falls off and the patient is incontinent, the episode of incontinence should be coded.

Section H Question No. 3

Q. If a patient has an indwelling catheter or ostomy that leaks, do you consider this incontinence? Would you not use code 9?

Section H Question No. 3

Q. If a patient has an indwelling catheter or ostomy that leaks, do you consider this incontinence? Would you not use code 9?

A. A leaking catheter or ostomy is not considered incontinence.

Code 9, Not applicable, is coded if during the 3-day assessment period, the patient had an indwelling bladder catheter, condom catheter, or ostomy for the entire 3 days.

Section H Question No. 4

Q. How do we code if the patient has stress incontinence ***usually,*** but during the assessment period, the patient had bladder incontinence ***daily?***

Section H Question No. 4

Q. How do we code if the patient has stress incontinence ***usually,*** but during the assessment period, the patient had bladder incontinence ***daily?***

A. If the patient is incontinent daily during the admission assessment period, code 3, Incontinent daily. Stress incontinence is coded if the patient has only stress incontinence.

Stress incontinence refers to episodes in which there is a small amount of urine leakage only associated with physical movement or activity, such as coughing, sneezing, laughing, lifting heavy objects, or exercise.

Section H Question No. 5

Q. A patient uses a urinal successfully, but tends to spill urine when removing it and linens get wet. Is this considered an incontinent episode?

Section H Question No. 5

Q. A patient uses a urinal successfully, but tends to spill urine when removing it and linens get wet. Is this considered an incontinent episode?

A. If the urine spills from a urinal after the patient uses it, this is not considered an incontinent episode.

For the bladder continence item, incontinence refers to the involuntary loss of urine, where there is a loss of control of the evacuation of urine from the bladder, regardless of whether clothing or linens are soiled.

Section H Question No. 6

Q. What if a patient only has intermittent catheterizations within the 3-day assessment, with no voids between episodes?

Section H Question No. 6

Q. What if a patient only has intermittent catheterizations within the 3-day assessment, with no voids between episodes?

A. If the patient has maintained continence due to the use of intermittent straight catheterizations, then the patient is continent and item H0350 would be coded 0, Always continent.

Section H Question No. 7

Q. Please clarify the example of the patient who has a Foley catheter on day 1 that is removed on day 2. The patient has at least one incontinent episode on day 2 and 3.

Should this be coded a 3, since there was no incontinence on day 1?

Section H Question #7

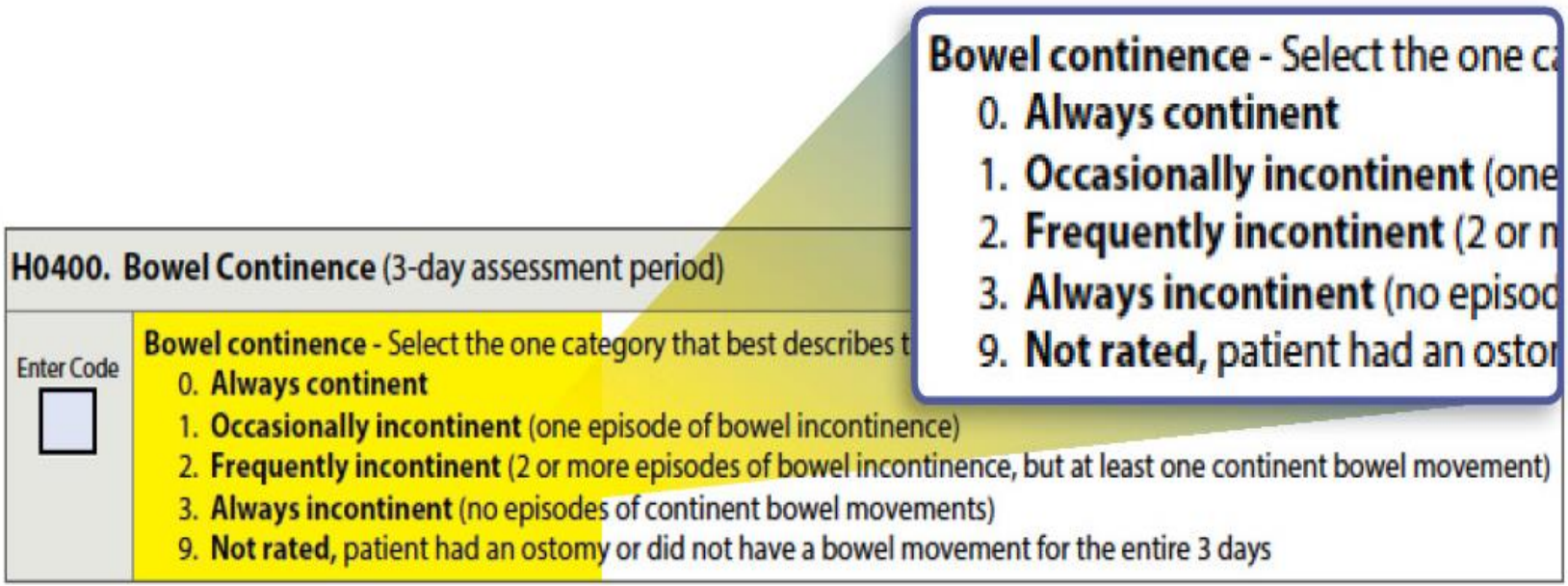
Q. Please clarify the example of the patient who has a Foley catheter on day 1 that is removed on day 2. The patient has at least one incontinent episode on day 2 and 3.

Should this be coded a 3, since there was no incontinence on day 1?

A. You would code the assessment a 2, Incontinent less than daily, since the patient cannot be considered incontinent on day 1 due to the use of a Foley catheter.

H0400 Coding Instructions

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



H0400 Coding Instructions

- **Code 0, Always continent,** if during the 3-day assessment period, the patient was continent for all bowel movements, without any episodes of incontinence.
- **Code 1, Occasionally incontinent,** if during the 3-day assessment period, the patient was incontinent for one bowel movement. This includes incontinence of any amount of stool at any time.
- **Code 2, Frequently incontinent,** if during the 3-day assessment period, the patient was incontinent of bowel at least twice, but also had at least one continent bowel movement. This includes incontinence of any amount of stool at any time.

H0400 Coding Instructions

- **Code 3, Always incontinent,** if during the 3-day assessment period, the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).
- **Code 9, Not rated,** if during the 3-day assessment period, the patient had an ostomy or other device, or the patient did not have a bowel movement during the entire 3 days. Note that patients who have not had a bowel movement for 3 days should be evaluated for constipation.

H0400 Coding Tips

- Being continent has to do with the ability to voluntarily release stool in a commode, toilet, or bedpan or as a result of prompted toileting, assisted toileting, or scheduled toileting.
- If the patient *cannot* voluntarily control the passage of stool, which results in involuntary passage of stool, then he or she is considered incontinent.

H0400 Coding Tips

- Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, enema) would be considered *continent* of bowel as long as the result of releasing the stool was in a commode, toilet, or bedpan.
- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

Section H Question No. 8

Q. If a patient is on a bowel program using a suppository and they do this in bed and release into a disposable pad, is this considered incontinent?

Section H Question No. 8

Q. If a patient is on a bowel program using a suppository and they do this in bed and release into a disposable pad, is this considered incontinent?

A. If the patient is unable to use a bedside commode, toilet, or bedpan for skin or safety reasons, and the bowel program includes the use of a suppository and a disposable pad, a bowel movement following soon after the suppository would not be considered an incontinent episode.

Any unplanned stool would be considered an incontinent episode.

Important Distinctions

Section H Items:

- 3-day assessment period.
- Codes according to the number of episodes of incontinence.

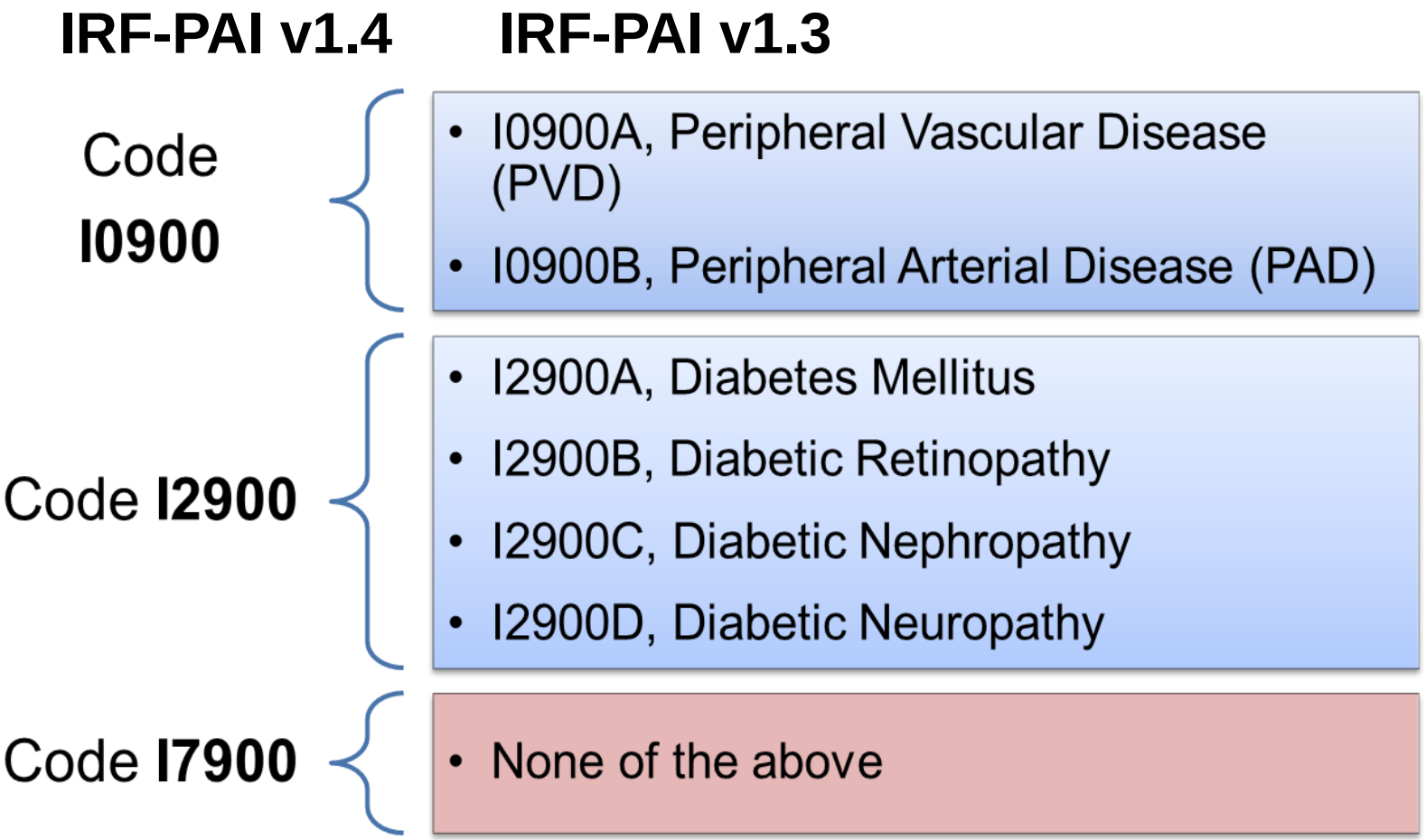
FIM®:

- 7-day assessment period.
  - 3-day assessment period at the inpatient rehabilitation facility (IRF) and 4-day assessment prior to IRF admission.
- Scores accidents.

Section I

Active Diagnoses

Section I: Overview of Changes



Section I: Intent

Indicate the presence of select diagnoses that influence a patient's risk for the development or worsening of a pressure ulcer(s).

Coding Instructions

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

I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
I7900. None of the above

Comorbidities and Co-existing Conditions	
↓	**Check all that apply**
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
☐	**I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
☐	**I7900. None of the above**

Identify Diagnoses Assessment

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

Identify Diagnoses Assessment

- Specific documentation areas in the medical record may include:
  - Progress notes.
  - Admission history and physical.
  - Transfer notes.
  - Hospital discharge summary.
- A diagnosis should not be inferred by association with other conditions.

Section I Question No. 1

Q. If a patient undergoes amputation due to PVD/PAD, and the PVD/PAD condition is resolved with the amputation, do we still code it?

Section I Question No. 1

Q. If a patient undergoes amputation due to PVD/PAD, and the PVD/PAD condition is resolved with the amputation, do we still code it?

A. If the physician does not document that the diagnosis is active, then it cannot be coded.

Section I Question No. 2

Q. Physicians can correct the History and Physical Examination (H&P) during a patient's entire stay.

Can Section I be corrected after the first 3 days if the H&P has been corrected?

Section I Question No. 2

Q. Physicians can correct the History and Physical Examination (H&P) during a patient's entire stay.

Can Section I be corrected after the first 3 days if the H&P has been corrected?

A. If the original H&P was incorrect and the physician corrected it after the 3-day assessment period, you may correct Section I data up until the data submission deadline for the applicable quarter.

Section I Question No. 3

Q. What would be an example of PVD, PAD, or diabetes reported in Item 24 (Comorbid Conditions) but not in Section I?

Section I Question No. 3

Q. What would be an example of PVD, PAD, or diabetes reported in Item 24 (Comorbid Conditions) but not in Section I?

A. Example: If a patient was found to have an active diagnosis after the 3-day assessment period, but not on the day of discharge or the day before the day of discharge:

- Item 24 would have an ICD-10 code.
- Section I, I7900, None of the above would be checked.

Section K

Swallowing/Nutritional Status

Section K: New Items

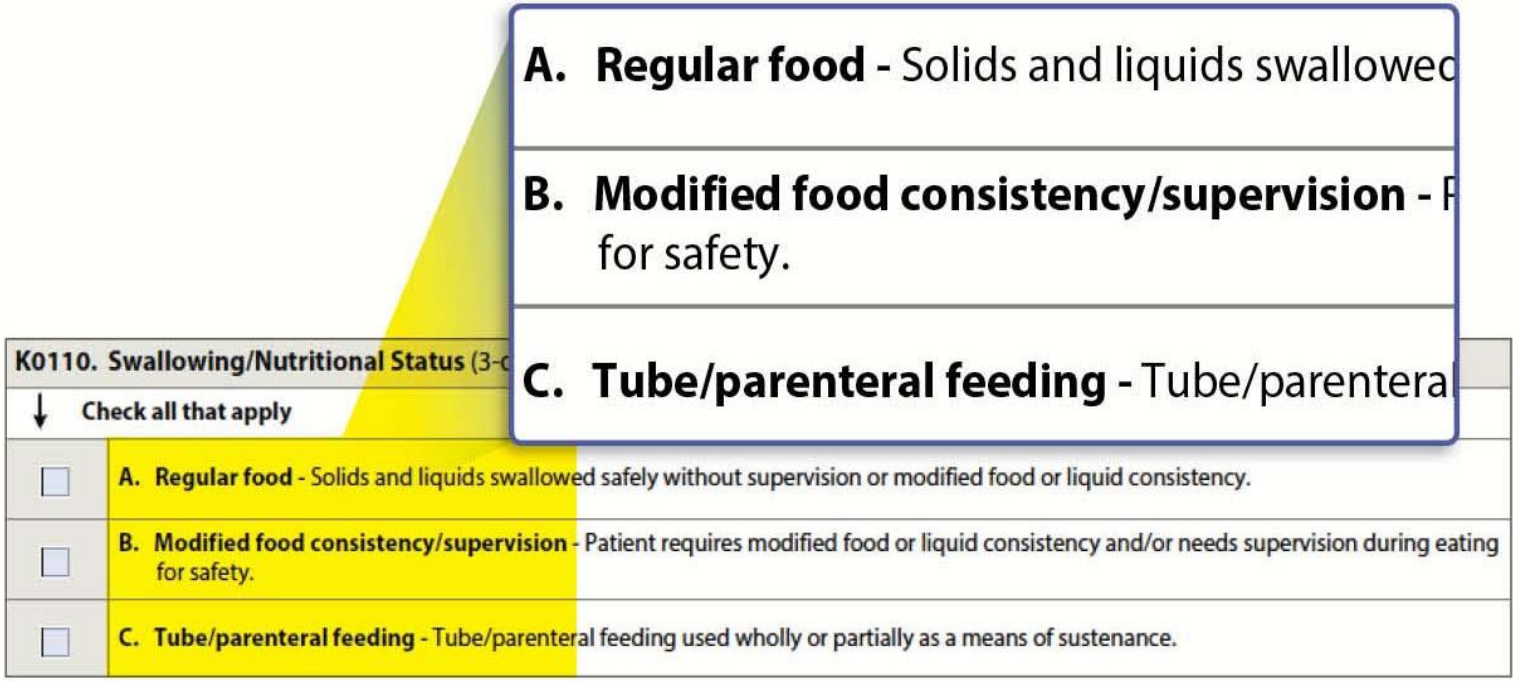
- Section K is **new.**
  - **K0110,** Swallowing/Nutritional Status.
- Section K is assessed on admission.

Section K: Intent

Assess the patient's swallowing/nutritional status.

K0110 Coding Instructions

- Check **all** that apply.



Section K Question No. 1

Q. During the 3-day assessment period, the patient initially was on a modified diet and then was placed on a regular diet.

Do you check both boxes?

Section K Question No. 1

Q. During the 3-day assessment period, the patient initially was on a modified diet and then was placed on a regular diet.

Do you check both boxes?

A. If a diet starts as modified and is changed to regular within the first 3 days, it is appropriate to check both A and B.

Section K Question No. 2

Q. A patient has a percutaneous endoscopic gastrostomy (PEG) tube and is eating a modified diet by mouth. The orders are to flush the PEG tube every shift with water to keep the tube patent. Do you code both the modified diet and PEG tube?

Section K Question No. 2

Q. A patient has a PEG tube and is eating a modified diet by mouth. The orders are to flush the PEG tube every shift with water to keep the tube patent. Do you code both the modified diet and PEG tube?

A. No, you would only code the modified diet. The tube feeding is not being used wholly or partially as a means of sustenance.

Section O

Special Treatments, Procedures, and Programs

Section O: New Items

New:

- **O0100,** Special Treatments, Procedures, and Programs.
  - Assessed on admission.

Existing:

- **O0250,** Influenza Vaccine.
  - Assessed by discharge.

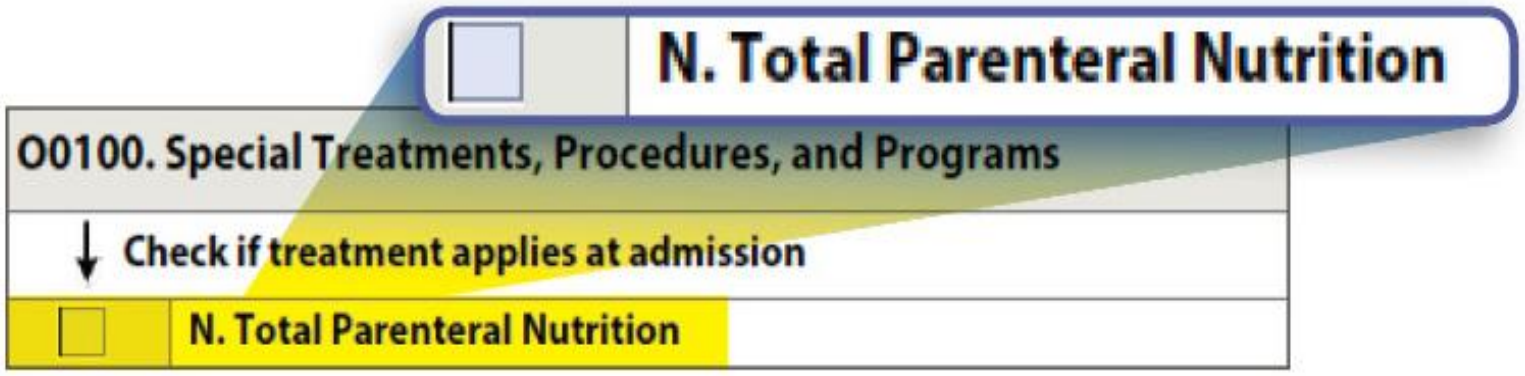
Section O: Intent

Identify any special treatments, procedures, and programs the patient received during the stay, including:

- Total parenteral nutrition (TPN).
- Influenza vaccination status.

O0100 Coding Instructions

- Complete only at the time of admission.
- **Check O0100N, Total Parenteral Nutrition,** if the patient receives parenteral/intravenous feeding.



Section O Question No. 1

Q. What is the timeframe for special treatments? Pre-admit, on admit, or 3-day assessment?

Section O Question No. 1

Q. What is the timeframe for special treatments? Pre-admit, on admit, or 3-day assessment?

A. If the patient received total parenteral nutrition (TPN) during the 3-day assessment period, it should be coded.

O0250, Influenza Vaccine

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

Enter Code ☐

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

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

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

☐☐ ☐☐ ☐☐☐☐

M M D D Y Y Y Y

Enter Code ☐

C. If influenza vaccine not received, state reason:

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

Influenza Vaccination Season

- **Influenza season** is July 1, 2016–June 30, 2017.
- **Influenza vaccination season (IVS)** is October 1, 2016 (or when vaccine becomes available) to March 31, 2017.

Influenza Vaccination Season

- IRFs are encouraged to document when a patient has been vaccinated outside the IVS.
  - The vaccine is usually available in September and generally does not expire until late spring.
- For the quality measure, only the records of patients in the IRF 1 or more days during the IVS are included in the calculation.

O0250 Coding

Documents three aspects of the administration of the vaccine:

- **O0250A:** Whether a vaccine for the current influenza season was administered in the facility.
- **O0250B:** Date the patient received the vaccine if administered in the facility.
- **O0250C:** Reason the patient did not receive the vaccine.

Section O Question No. 2

Q. If a patient received the influenza vaccine in the acute care hospital, but then was discharged and admitted to the IRF in the same hospital, do you code O0250A as "01, Yes?"

Section O Question No. 2

Q. If a patient received the influenza vaccine in the acute care hospital, but then was discharged and admitted to the IRF in the same hospital, do you code O0250A as "01, Yes?"

A. If the patient received the vaccine during the acute care stay, prior to the IRF stay, you would code:

- O0250A: 0, No.
- O0250B: Skip.
- O0250C: 2, Received outside of **this** facility.

The facility refers to the IRF, not the acute care hospital.

Action Plan

- Evaluate current documentation to ensure terminology aligns with items in IRF-PAI v1.4.
- Review current processes to identify opportunities for improvement.
- Determine where in your medical record the information will be captured.
- Identify who on your team will complete each section.
- Practice coding a variety of scenarios.
- Review the FAQs for each section to assist in understanding the rationale.