INPATIENT REHABILITATION FACILITY (IRF) / LONG-TERM CARE HOSPITAL (LTCH) QUALITY REPORTING PROGRAM (QRP) PROVIDER TRAINING

Participant Questions From Provider Training

IRF AND LTCH UPDATED GUIDANCE VIRTUAL TRAINING PROGRAM

On June 15–16, 2022

Current as of July 2022

Acronym List

Acronym	Definition
A-Fib	Atrial Fibrillation
AIF	Annual Increase Factor
AMA	Against Medical Advice
AMB	Ambulation/Ambulatory
APU	Annual Payment Update
ARU	Acute Rehabilitation Unit
AVAPS	Average Volume Assured Pressure Support
BIMS	Brief Interview for Mental Status
BiPAP	Bilevel Positive Airway Pressure
CAH	Critical Access Hospital
CAM	Confusion Assessment Method
CMS	Centers for Medicare & Medicaid Services
CPAP	Continuous Positive Airway Pressure
DC	Discharge
DRR	Drug Regimen Review
DTI	Deep Tissue Injury
Dx	Diagnosis
EHR	Electronic Health Record
EMR	Electronic Medical Record
FY	Fiscal Year
H&P	History and Physical
HHA	Home Health Agency
HHCO	Home Health Care Organization
HIE	Health Information Exchange
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act of 2014
IRF	Inpatient Rehabilitation Facility
IRF-PAI	IRF Patient Assessment Instrument
IV	Intravenous
IVF	Intravenous Feeding
LCDS	LTCH Continuity Assessment Record and Evaluation (CARE) Data Set
LTCH	Long-Term Care Hospital
MAC	Medicare Administrative Contractor
MDS	Minimum Data Set
NDT	Neurodevelopmental Treatment/Therapy
OT	Occupational Therapy/Therapist
PAC	Post-Acute Care
PAC-PRD	Post-Acute Care Payment Reform Demonstration
PAS	Patient Assessment System
PASC	Patient Assessment Standards Coordinator
PEG	Percutaneous Endoscopic Gastrostomy

Acronym	Definition
PHQ	Patient Health Questionnaire
PI	Pressure Injury
PICC	Peripherally Inserted Central Catheter
PPS	Prospective Payment System
PRN	as needed
PT	Physical Therapy/Therapist
Pt	Patient
Q&A	Question and Answer
QRP	Quality Reporting Program
RN	Registered Nurse
SDOH	Social Determinants of Health
SLP	Speech Language Pathologist
SNF	Skilled Nursing Facility
TPN	Total Parenteral Nutrition
WB	Weight-bearing
WC	Wheelchair
WOCN	Wound, Ostomy, and Continence Nursing

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General Questions

These Q&As apply to both IRF and LTCH settings unless otherwise specified within the question and/or answer.

#	Topic	Question	Response
1	Admission	Can you please provide clarification on the term 'as close to admission as possible.'	The assessment period for admission is 3 calendar days. This includes the day of admission and the 2 days following the day of admission ending at 11:59 p.m. These 3 calendar days are the days during which the patient's clinical condition should be assessed. All items in the Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument (IRF-PAI) must be completed based on an assessment that occurs within the first 3 days of admission. The IRF-PAI items may be completed as early as possible within the 3-day admission assessment time period.
2	Assessment Corrections	Is there a timeframe for IRFs to conduct audits/corrections to ensure correct coding?	CMS strongly encourages all facilities to submit data several days prior to the deadline to allow time to address any submission issues and to provide opportunity to review submissions to ensure data are complete. Additional information about data submission deadlines can be found here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines. Providers are encouraged to correct incorrect data and should work directly with their Medicare Administrative Contractor (MAC) to ensure that any payment adjustments that may be necessary are made appropriately. You can contact your MAC by visiting the link copied here. Click on your state on the map or select it from the drop-down list below the map. Contact information for your state will then be displayed below the map. You can find your Regional Office at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/Index.

#	Topic	Question	Response
3	Miscellaneous	With the addition of the new items, will there be additional measures added to the QRP Care Compare site?	Two new quality measures were finalized in the fiscal year (FY) 2020 IRF Prospective Payment System (PPS) Final Rule; Transfer of Health Information to the Provider – Post Acute Care and Transfer of health to the Patient – Post Acute Care. Data Collection for both these measures begins on October 1, 2022. We encourage you to continue monitoring the IRF Quality Reporting Program (QRP) Measures Information web page for updates regarding new measures added to the IRF QRP: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information. The same two measures were finalized for LTCH in the FY 2020 IPPS/ Long-Term Care Hospital (LTCH) PPS Final Rule. We encourage you to continue monitoring the LTCH QRP Measures Information web page for updates regarding new measures added to the LTCH QRP: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.
4	Admission/ Discharge	What is the rationale behind collecting certain assessment items at both admission and discharge?	Thank you for your question. For information on the purpose and rationale for collection of these items, we refer you to the FY 2020 IRF PPS Final Rule (CMS-1748-F) at the following website: https://www.federalregister.gov/documents/2019/08/08/2019-16603/medicare-program-inpatient-rehabilitation-facility-irf-prospective-payment-system-for-federal-fiscal

#	Topic	Question	Response
5	Unplanned Discharge	Can you provide additional coding guidance for unplanned discharges from an IRF?	Patients who meet the criteria for unplanned discharges are: • Patients who are discharged to an acute care setting, such as a Short-stay acute hospital, Critical Access Hospital (CAH), Inpatient Psychiatric Facility, or LTCH; • Patients who die; and • Patients who leave an IRF against medical advice. If the patient meets the criteria for an unplanned discharge, complete the discharge IRF-PAI Quality Indicator items using the following discharge assessment guidance: If assessment of an item was not completed prior to the unplanned discharge, code the item using available documentation/information. When the patient is unable to respond and it is allowable, code 8 – Patient unable to respond or code X – Patient unable to respond. If assessment of an item was not completed prior to the unplanned discharge and no information is available, a dash is a valid response. Review guidance manual and Q&As for item-specific guidance. Please note that while the coding of a “dash” is an optional response value for some data elements, its use does not count toward meeting the Annual Increase Factor (AIF) minimum submission threshold. Failure to meet the minimum threshold may result in a two (2) percentage point reduction in the IRF’s AIF. CMS is aware of concerns brought forth by IRF providers as it relates to coding certain assessment items during an unplanned discharge. While we believe this to be an infrequent scenario, CMS will be very closely monitoring new assessment data submissions in this area, beginning October 1, 2022. As always, we will continue to partner with IRF providers to address compliance matters on a case-by-case basis.

#	Topic	Question	Response
6	Admission	For the Admission Assessment Period, do all of the following items require an answer only after a patient has been admitted to the inpatient rehab facility/during the Admission Assessment Period or can these responses be gathered in the acute setting and/or during the preadmission screening process? A1250. Transportation B0200. Hearing B1000. Vision B1300. Health Literacy D0150. Patient Mood Interview D0700. Social Isolation J0510. Pain Effect on Sleep J0520. Pain Interference with Therapy Activities J0530. Pain Interference with Day-to-Day Activities	Each IRF-PAI and LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) item should be considered individually and coded based on the guidance provided for that item at each assessment time period. If information used to complete the IRF-PAI/LCDS is gathered prior to the patient's admission, this information should be verified and coded following applicable coding guidance during an assessment that occurs during the 3-day admission assessment time period. A facility's software should not answer or generate the IRF-PAI or LCDS responses for the assessing clinician. Please note that based on coding guidance, the medical record should not be used as the data source for coding Health Literacy and Social Isolation. Also note that the medical record should not be used as the data source for coding Ethnicity, Race, Language, and Transportation unless the patient and proxy are unable to respond during the admission or discharge assessment time periods.

#	Topic	Question	Response
7	SDOH	Please provide guidance on how to collect the transportation (A1250) and health literacy (B1300) items at admission and discharge. Wouldn't the coding for these items be the same at both time points?	The intent of A1250 – Transportation is to identify if a lack of transportation has kept the patient from medical appointments, meetings, work, or from getting things needed for daily living over the past 6 to 12 months. The intent of B1300 – Health Literacy is to identify how often the patient needs to have someone help them when they read instructions, pamphlets, or other written material from their doctor or pharmacy. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how each item applies for each individual patient at both the admission and discharge time points. It is possible that the admission and discharge coding are the same. For further information on the purpose and rationale for collection of these items, we refer you to the respective IRF and LTCH FY 2020 Final Rules: the FY 2020 IRF PPS Final Rule (CMS-1710-F) at: https://www.federalregister.gov/documents/2019/08/08/2019-16603/medicare-program-inpatient-rehabilitation-facility-irf-prospective-payment-system-for-federal-fiscal or the FY 2020 LTCH PPS Final Rule (CMS-1716-F) at: https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf
8	SDOH	When does the assessment for the following new items, A1005 – Ethnicity, A1010 – Race, A1250 – Transportation, B1300 – Health Literacy, and D0700-Social Isolation need to occur? Does the assessment have to take place during the 3-day assessment time period or can they be assessed at any time during the admission?	A1005 – Ethnicity, A1010 – Race, and A1110 – Language must be based on an assessment that occurs within the 3-day admission assessment time period. A1250 – Transportation, B1300 – Health Literacy, and D0700 – Social Isolation should be completed based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.

#	Topic	Question	Response
9	Admission/ Discharge	Please provide guidance on how to assess the patient interview items such as B1300 – Health Literacy, C0200-C0500 – BIMS, C1310 – Signs and Symptoms of Delirium, and D0150 – Patient Mood Interview for pediatric patients.	To meet IRF QRP reporting requirements, providers must complete the IRF-PAI for each Medicare Part A fee-for-service patient and Medicare Part C patient. To meet the LTCH QRP reporting requirements providers must complete the LCDS for any patient who is admitted to a facility certified as a hospital and designated as an LTCH under the Medicare Program Each item should be considered individually, and coded based on the guidance provided for that item, regardless of the patient's age. For your question in regard to B1300 – Health Literacy: B1300 – Health Literacy is intended to be a self-report item. If the patient is unable to respond, then code 8 – Patient unable to respond. For your question in regard to the Brief Interview for Mental Status (BIMS). C0100 – Should Brief Interview for Mental Status (C0200–C0500) Be Conducted? identifies if the interview will be attempted. If the patient is rarely/never understood verbally, in writing, or using another method code 0 – No and skip to C0900 Memory/Recall Ability. This guidance applies to all patients who cannot communicate, regardless of age. For your question in regard to C1310 – Signs and Symptoms of Delirium observe patient behavior during the cognitive assessment, review medical record documentation to determine the patient's baseline status, fluctuations in behavior, and behaviors that might have occurred during the assessment period that were not observed during the cognitive assessment. Observe patient's behavior during patient interactions and consult with other staff, family members/caregivers, and other in a position to observe the patient's behavior during the assessment period. For your question in regard to Patient Mood Interview. Ask the first two questions (D0150A, D0150B). Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, code D0150A1 and D0150B1 as 9 (No response), leave D0150A2 and D0150B2 blank, end the Patient Health Questionnaire (PHQ)-2 interview, and skip D0160, Total Severity Score.

#	Topic	Question	Response
10	Miscellaneous	Can any or all of these questions be delivered to the patient visually? For example, can the question be written out and answers written out for them in addition to the verbal presentation from the staff member?	When completing items in the IRF-PAI or LCDS interact with the patient using their preferred language. Be sure the patient can hear you and/or has access to their preferred method of communication. Alternative approaches, such as writing, pointing, sign language, or cue cards, may be helpful communication approaches to consider for some items and some patients
11	Admission/ Discharge	If a patient is admitted to IRF in September and discharged October 1st or after, are we responsible to add the new admission information to the IRF PAI 4.0?	The IRF-PAI version at admission and discharge must be the same version. In your situation, you would be required to use the IRF-PAI 4.0.
12	Admission	Can information collected on day 4 of a patient's stay or later be used to code the IRF-PAI/LCDS items and still be considered compliant?	In order to be compliant, the admission assessment must be completed by the end of the 3-day assessment period (i.e., midnight of the third calendar day).

Section A

#	Topic	Question	Response
13	Race/Ethnicity	Do you need to verbally ask the patient their race and ethnicity if your EMR has a current way to obtain this information?	A facility's software should not answer or generate the IRF-PAI/LCDS responses for the assessing clinician. Please note that the medical record should not be used as the data source for coding Ethnicity and Race unless the patient and proxy are unable to respond during the admission or discharge assessment time periods.
14	Transportation	For A1250 – Transportation is the assessment timeframe 6 months to 1 year?	The intent of A1250 – Transportation is to identify if a lack of transportation has kept the patient from medical appointments, meetings, work, or from getting things needed for daily living over the past 6 to 12 months. At both admission and discharge ask the patient: • "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?" • "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?"

#	Topic	Question	Response
15	Transportation	For A1250: Transportation, if the patient is unable to go to medical appointments, it would stand to reason they cannot go to non-medical events as well. Why wouldn't we choose code A & B?	The intent of A1250 – Transportation is to identify whether a lack of transportation kept a patient from medical appointments, meetings, work, or from getting things needed for daily living. Patients should be offered the option of selecting more than one yes designation, if applicable. When coding A1250 – Transportation, check all that apply.
16	Transportation	Why is A1250 – Transportation asked on admission and discharge? It does not seem likely that the patient's response will be different at discharge than at admission?"	The intent of A1250. Transportation is to identify if a lack of transportation has kept the patient from medical appointments, meetings, work, or from getting things needed for daily living over the past 6 to 12 months. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how transportation applies for each individual patient at both the admission and discharge time points. It is possible that the admission and discharge coding are the same. For further information on the purpose and rationale for collection of these items, we refer you to the FY 2020 IRF PPS Final Rule (CMS-1710-F) at: https://www.federalregister.gov/documents/2019/08/08/2019-16603/medicare-program-inpatient-rehabilitation-facility-irf-prospective-payment-system-for-federal-fiscal. or the FY 2020 LTCH PPS Final Rule (CMS-1716-F) at: https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf
17	Miscellaneous	Why is the item – "Patient discharged against medical advice?" listed differently in the IRF-PAI (item 41) and LCDS (item A1990)? Will this alter the skip pattern when it comes to the other questions and discharge items?	The IRF-PAI 4.0 and LCDS 5.0 item sets are independent of each other. Some items appearing in the IRF PAI and LCDS may have different item numbers, such as the example you point out, while many other items have the same item numbers.

#	Topic	Question	Response
18	Transfer of Health Information	If a patient is not discharged to a subsequent provider listed in the guidance for A2121 – Provision of Current Reconciled Medication List to Subsequent Provider (e.g., the patient goes home with outpatient therapy), how is A2121 coded?	A2121 – Provision of Current Reconciled Medication List to Subsequent Provider at Discharge identifies if, at the time of discharge to another provider, your facility provides the patient's current reconciled medication list to the subsequent provider. As stated in the *Coding Instructions* for A2121, if at discharge the patient was not transferred to a subsequent provider listed in the guidance for A2121, then code 0 – No for A2121 and skip to A2123 – Provision of Current Reconciled Medication List to Patient at Discharge.
19	Transfer of Health Information	How is A2123. Provision of Current Reconciled Medication List to Patient coded at discharge when the Discharge Location is not 01 – Home/community or 99 – Not Listed?	A2123 – Provision of Current Reconciled Medication List to Patient at Discharge identifies if, at the time of discharge, your facility provided the patient's current reconciled medication list to the patient, family, and/or caregiver. As stated in the *Coding Tips* for A2123 if, at discharge, the patient was discharged to a subsequent provider then code A2123 as 0 – No.
20	Transfer of Health Information	Are A2121 **and** A2123 completed for all patients?	Yes, A2121 and A2123 are completed for all patients. Follow the coding guidance for each item in order to code accurately.
21	Discharge Destination	For item 44D, what is the most appropriate discharge destination for a patient going home with outpatient therapy?	Code 44D – Patient's discharge destination/living setting or A2105 – Discharge location based on the setting the patient is discharged to at the time of the discharge from the IRF/LTCH. If the patient is discharged from the IRF/LTCH to their home not under the care of an organized home health service organization then code 01 – Home (private home/apt., board/care, assisted living, group home, transition living, other residential care arrangement).
22	Race/Ethnicity	How should the Race/Ethnicity questions be coded if the patient is agreeable to participate/respond but due to aphasia or cognitive issues they provide a response that is in direct conflict with what is either a) documented in the medical record or b) provided by proxy?	A1005 – Ethnicity identifies the patient's self-reported ethnicity. A1010 – Race identifies the patient's self-reported race. Use clinical judgment to determine if the patient is able to respond. As stated in the *Coding Instructions* if the patient can provide a response, check the box(es) indicating category or categories identified by the patient. In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X – Patient unable to respond.

#	Topic	Question	Response
23	Race/Ethnicity	For items A1005 – Ethnicity and A1010 – Race, our admission department collects this data prior to patient's admission to the hospital, can we use that information in the patient's demographics or do these items s need to be assessed during the 3-day admission assessment time period?	If information used to complete the admission assessment is gathered prior to the patient's admission this information should be verified, following applicable coding guidance, during an assessment that occurs during the 3-day admission assessment time period. A facility's software should not answer or generate the assessment responses for the assessing clinician. Please note that based on coding guidance, the medical record should not be used as the data source for coding Health Literacy and Social Isolation. Also note that the medical record should not be used as the data source for coding Ethnicity, Race, Language, and Transportation unless the patient and proxy are unable to respond during the admission or discharge assessment time periods.
24	Language	For the new item A1110B – Language; Do you want or need an interpreter?, If a patient primarily speaks English according to a proxy and the medical record, but has new severe expressive and/or receptive aphasia, should code 0, No, or code 9, Unable to determine, be selected?	A1110 – Language identifies the patient's preferred language and if the patient needs or wants an interpreter. If the patient is unable to respond themselves to A1110A – What is your preferred language? or A1110B – Do you need or want an interpreter?, a proxy response is permitted. For A1110B Code 9 – No response should be used when no source can identify whether the patient wants or needs an interpreter.

#	Topic	Question	Response
25	Transfer of Health Information	For A2123 – Provision of Current Reconciled Medication List to Patient at Discharge, how is the item coded if patient is discharged to home with home care AND a reconciled medication list was provided to the patient? My understanding from the training if patient is discharged to home with home care it would be considered a subsequent provider and therefore A2123 would be coded as 0 – No even though patient did receive a reconciled medication list.	A2123 – Provision of Current Reconciled Medication list to Patient at Discharge indicates if, at the time of discharge, an IRF or LTCH provided the patient's current reconciled medication list to the patient, family, and/or caregiver. As stated in the Coding Instructions for A2123, if the patient was discharged to a subsequent provider, then code 0 – No to A2123. For the IRF-PAI 4.0, a subsequent provider is based on the discharge locations in 44D and defined as any of the following: 02- Short-term General Hospital 03- Skilled Nursing Facility (SNF) 04- Intermediate care 06- Home under care of organized home health service organization 50- Hospice (home) 51- Hospice (medical facility) 61- Swing bed 62- Another Inpatient Rehabilitation Facility 63- Long-Term Care Hospital (LTCH) 64- Medicaid Nursing Facility 65- Inpatient Psychiatric Facility 66- Critical Access Hospital (CAH) For the LCDS 5.0, A subsequent provider is based on the discharge locations in A2105 and defined as any of the following: 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing bed) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service organization
26	Transportation	Is A1250 – Transportation collected at both the admission and discharge time points?	Yes, A1250 – Transportation is collected at both admission and discharge.

#	Topic	Question	Response
27	Race/Ethnicity	For items A1005. Ethnicity, A1010. Race, and A1110. Language questions, please define "as close to admission as possible." Can these questions be completed as part of a pre-admission screen process, or do they have to be asked once the patient is physically in the IRF or LTCH?	If information used to complete the admission assessment is gathered prior to the patient's admission this information should be verified, following applicable coding guidance, during an assessment that occurs during the 3-day admission assessment time period. A facility's software should not answer or generate the assessment responses for the assessing clinician. The medical record should not be used as the data source for coding Ethnicity, Race, and Language unless the patient and proxy are unable to respond during the admission or discharge assessment time periods.
28	Transfer for Health Information	If a patient is discharged to a subsequent provider and the medication list is provided to that facility, can the facility be considered a caregiver? This would allow A2123 – Provision of Current Reconciled Medication List to Patient to be coded 1 – Yes.	If a patient is discharged to a subsequent provider as defined in the Coding instructions for A2121 – Provision of Reconciled Medication List to Subsequent Provider at Discharge then, A2123 – Provision of Reconciled Medication List to the Patient at Discharge would be coded 0 – No.
29	Miscellaneous	What is the difference between an Electronic Health Record (EHR) and a Health Information Exchange (HIE)?	An electronic health record (EHR), sometimes referred to as an electronic medical record (EMR), is an electronic version of a patient's medical history that is maintained by the provider over time. This may include key clinical data relevant to that person's care under a particular provider, including demographics, progress notes, medical conditions, diagnoses, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports (https://www.healthit.gov/faq/what-electronic-health-record-ehr). A Health Information Exchange (HIE) is an organization used by provider agencies to appropriately access and securely exchange patients' health information, including medical records, current reconciled medication lists, etc. (https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie).

#	Topic	Question	Response
30	Discharge Destination	If a patient discharges to home (for IRF: 44D = 01, Home or for LTCH: A2105 = 01 Home/Community), there is no subsequent provider to provide a reconciled medication list. If the day after discharge, the patient decides to get Home Health services, are we obligated to then provide the HHA with a reconciled medication list and change this data element?	For IRF, Code 44D – Patient's discharge destination/living setting or for LTCH A2105 – Discharge Location is based on the information known at discharge regarding where the patient will reside, and the services the patient is expected to receive after discharge from the facility.
31	Transfer of Health Information	If a patient is discharged to home with home health services and a reconciled medication list is given to the patient at discharge, would this be considered as provided to the subsequent provider for A2121 – Provision of Reconciled Medication List to Subsequent Provider at Discharge?	A2121 – Provision of Current Reconciled Medication List to Subsequent Provider at Discharge, identifies if the facility, at the time of discharge to another provider, provided the patient's current reconciled medication list to the subsequent provider. Code 0 – No, if at discharge to a subsequent provider, your facility did not provide the patient's current reconciled medication list to the subsequent provider, or the patient was not discharged to a subsequent provider. Code 1 – Yes, if at discharge to a subsequent provider, your facility did provide the patient's current reconciled medication list to the subsequent provider. See Question 25 for a list of subsequent providers based on the discharge location for both the IRF and LTCH.

Section B

#	Topic	Question	Response
32	Hearing/Vision	If the patient is unable to respond for the hearing or vision questions how should these items be coded?	The intent of B0200 – Hearing is to assess the patient's ability to hear (with hearing aid or hearing appliances if normally used). As stated in the Guidance Manual's Coding Tips, patients who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods. The patient can be observed in their normal environment. Do they respond (e.g., turn their head) when a noise is made at a normal level? Does the patient seem to respond only to specific noise in a quiet environment? Assess whether the patient responds only to loud noise or does not respond at all. The intent of B1000 – Vision is to assess the patient's ability to see in adequate light (with glasses or other visual appliances). As stated in the Guidance Manual's Coding Tips, if the patient is unable to communicate or follow your directions for testing vision, observe the patient's eye movements to see if their eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether or not the patient has any visual ability. For patients who appear to follow movement and objects, code 3, Highly impaired.

#	Topic	Question	Response
33	Vision	Please explain the differences between the codes for B1000 – Vision and give examples for each code (i.e., impaired, moderately impaired, highly impaired and severely impaired).	The intent of B1000 – Vision is to assess the patient's ability to see in adequate light (with glasses or other visual appliances). As stated in the Steps for Assessment ask family, caregivers, and/or direct care staff about the patient's usual vision patterns at admission. Ask the patient about their visual abilities. Test the accuracy of your findings by asking the patient to look at regular-size print in a book or newspaper. Ask the patient to read aloud, starting with larger headlines and ending with the finest small print. Code B1000 based on assessment that occurs during the 3-day assessment time period. If the patient sees fine detail, including regular print in newspapers/books, then code 0 – Adequate. If the patient sees large print, but not regular print in newspapers/books, then code 1 – Impaired. If the patient has limited vision and is not able to see newspaper headlines but can identify objects nearby in their environment, then code 2 – Moderately Impaired. If the patient's ability to identify objects in their environment is in question, but the patient's eye movements appear to be following object (especially people walking by), then code 3 – Highly Impaired. If the patient has no vision, sees only light, color or shapes, or does not appear to follow objects with eyes, then code 4 – Severely impaired.
34	Hearing/Vision	Is there a recommended individual (e.g., RN, SLP) that would be best suited for collecting data regarding hearing and vision?	Providers should refer to facility, federal, and state policies and procedures to determine which staff members may complete an assessment. Patient assessments are to be done in compliance with facility, federal, and state requirements.

#	Topic	Question	Response
35	Hearing/Vision	How would you code B0200 – Hearing and B1000 – Vision, if hearing or visual aids were unavailable to the patient at the time of assessment?	The intent of B0200 – Hearing is to assess the patient's ability to hear (with hearing aid or hearing appliances if normally used. The intent of B1000 – Vision is to assess the patient's ability to see in adequate light (with glasses or other visual appliances). The patient may not have their normal hearing appliances or visual aids available to them during the 3-day admission assessment period. In addition to observation, ask about hearing/vision function by interviewing the patient, family, caregivers, direct care staff, specialists, etc., and review the clinical record or other available documentation to determine the most accurate response for B0200 and B1000.
36	Vision	If the patient can read the larger headline of a newspaper, but cannot read the smaller newspaper print, how is B1000 – Vision coded? I understand that if a patient can read a larger print book, the score is a 1- Impaired.	For B1000 – Vision code 1 – Impaired, if the patient sees large print but not regular print in newspapers/books.

Section C

#	Topic	Question	Response
37	Delirium	If C1310A – Signs and Symptoms of Delirium; Acute Mental Status Change is 0 – No, do C1310B, C1310C, and C1310D have to be answered, or will there be a skip pattern applied?	As noted in the IRF-PAI 4.0 and LCDS V5.0 item set, there is no skip pattern associated with item C1310A. Per the Coding Instructions for C1310A, Acute Mental Status Change, Code 0 – No, if there is no evidence of acute mental status change from the patient's baseline. Code items C1310B, C1310C, and C1310D in accordance with the coding instructions provided in the manual.
38	Delirium	If the conditions are met for Item C1310 that may identify that the patient has signs and symptoms of delirium, what does CMS do with that information? Does the IRF or LTCH have a responsibility to take further action in this situation?	The purpose of the guidance manuals is to guide the user in completing the IRF-PAI and LCDS. C1310 – Signs and Symptoms of Delirium is used for determining IRF/LTCH QRP compliance and are included in the AIF/Annual Payment Update (APU) data completion threshold.

#	Topic	Question	Response
39	Delirium & Patient Mood Interview	Like many other inpatient rehab facilities, we are questioning the CAM and PHQ-2 to 9 assessments as they are published in the IRF-PAI 4.0. These two assessments are copyrighted from Pfizer and CAM, but these are not a 1:1 match with the IRF-PAI. This is causing extreme challenge to hospital systems in which these assessments are already being completed, but not in the way in which the IRF-PAI requires (because it isn't an exact match to the true copyrighted assessments). Can you please point me to where the published authoritative version of both the PHQ-2 to 9 and the Delirium/CAM screening is that exists in the IRF-PAI 4.0? This is causing additional documentation/assessment burden to facilities to do a duplicative (yet not exact match) assessment for both the CAM/Delirium and PHQ-2 to 9. Our higher-level administration is asking for the rationale behind this change. If you are unable to assist in answering this question, can you please direct me to the best contact to help?	As described in the National Beta Test Findings Executive Summary (Vol. 4), the Confusion Assessment Method (CAM) is under separate copyright protection. The Hospital Elder Life Program has granted permission to use the CAM in association with the PAC instruments. Versions of the CAM, adapted from Inouye, S.K., et al. ("Clarifying confusion: The Confusion Assessment Method: A new method for detection of delirium," *Annals of Internal Medicine,* Vol. 113, No. 12, December 1990, pp. 941–948), are currently used in the Minimum Data Set (MDS) 3.0 and LCDS. As mentioned in the Final Specifications for IRF QRP Quality Measures and standardized patient assessment data elements, although multiple versions of the CAM have been developed, CMS finalized that the short version be adopted for standardized patient assessment data elements. The Short CAM contains only four items (i.e., items 1 to 4) from the original CAM (Long CAM). These items focus on an acute change in mental status, inattention, disorganized thinking, and altered level of consciousness. Pfizer Inc. holds the copyright for all the PHQ screeners, including the PHQ-9. As described in the National Beta Test Findings Executive Summary (Vol 5), Pfizer, Inc., has granted permission to use this instrument in association with the PAC assessment instruments. You can find all of the above mentioned resources on the IMPACT Act Downloads and Videos webpage here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos. Your concern about the differences between the item in the IRF-PAI and your internal systems has been forwarded to CMS for future consideration.
40	BIMS	Who is qualified to conduct the BIMS interview in section C? Does the same clinician need to complete the assessments at admission and discharge?	Providers should refer to facility, federal, and state policies and procedures to determine which staff members may complete an assessment. Patient assessments are to be done in compliance with facility, federal, and state requirements.

#	Topic	Question	Response
41	BIMS & Delirium	Does the C1310. Signs and Symptoms of Delirium (from CAM©) need to be completed immediately following the Brief Interview for Mental Status (BIMS)?	Each assessment item should be considered individually and coded based on the guidance provided for that item. C1310 – Signs and Symptoms of Delirium (from CAM©) should be completed based on an assessment that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period. C1310 – Sign and Symptoms of Delirium (from CAM©) is to be coded after completing the Brief Interview for Mental Status or Staff Assessment and reviewing medical record. As stated in the Steps for Assessment for C1310: 1. Observe patient behavior during the cognitive assessment (BIMS items (C0200–C0400), Staff Assessment for Mental Status (C0900) or other cognitive assessment for the signs and symptoms of delirium). 2. Review medical record documentation to determine the patient's baseline status, fluctuations in behavior, and behaviors that might have occurred during the assessment period that were not observed during the cognitive assessment (e.g., BIMS). 3. Observe patient's behavior during patient interactions and consult with other staff, family members/caregivers, and others in a position to observe the patient's behavior during the assessment period.

#	Topic	Question	Response
42	Delirium	C1310A – Signs and Symptoms of Delirium; Acute onset of mental status changes (from CAM©) asks if there is a change in mental status from baseline. How do you determine the patient's baseline?	C1310 – Signs and Symptoms of Delirium (from CAM©) should be completed based on an assessment that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period. C1310 – Signs and Symptoms of Delirium (from CAM©) is to be coded after completing the Brief Interview for Mental Status or Staff Assessment and reviewing medical record. As stated in the Steps for Assessment for C1310: 1. Observe patient behavior during the cognitive assessment (BIMS items (C0200–C0400), Staff Assessment for Mental Status (C0900) or other cognitive assessment for the signs and symptoms of delirium). 2. Review medical record documentation to determine the patient's baseline status, fluctuations in behavior, and behaviors that might have occurred during the assessment period that were not observed during the cognitive assessment (e.g., BIMS). 3. Observe patient's behavior during patient interactions and consult with other staff, family members/caregivers, and others in a position to observe the patient's behavior during the assessment period. Code 1, Yes, if patient has an alteration in mental status observed in the assessment period or in the cognitive assessment (e.g., BIMS) that represents an acute change from baseline.
43	BIMS	Where can the validation study For C0200–C0500 – Brief Interview for Mental Status be found for admission and discharge?	The BIMS was discussed in both the FY 2018 and FY 2020 rulemaking cycles. The rules describe the testing of the BIMS in the Post-Acute Care Payment Reform Demonstration (PAC-PRD). You can find these discussions, as well as the literature to support these proposals, in the Federal Register. The FY 2018 IRF rule discussion can be found here: https://www.federalregister.gov/d/2017-16291/p-736. The FY 2020 IRF rule discussion can be found here: https://www.federalregister.gov/d/2019-16603/p-644. The FY 2018 LTCH rule discussion can be found here: https://www.federalregister.gov/d/2017-16434/p-5516. The FY 2020 LTCH rule discussion can be found here: https://www.federalregister.gov/d/2019-08330/p-3422.

#	Topic	Question	Response
44	BIMS	How should C0200–C0500 be coded at discharge if the facility is unable to complete the interview prior to discharge?	The BIMS should be attempted with all patients during the 3-day discharge assessment period. If the patient should have been interviewed but the facility did not complete the interview during the 3-day assessment period and based on interactions with the patient, it is determined that the patient is at least sometimes understood verbally, in writing or using another method, code Section C as follows: 1. Indicate that the BIMS should have been conducted by coding C0100 as 1, Yes. 2. Enter dashes for each of the BIMS items (C0200, C0300ABC, C0400ABC). 3. Enter a 99 for C0500 – BIMS Summary Score.

#	Topic	Question	Response
45	Unplanned discharge	Will the Section C: Cognitive Status items be required at discharge for patients who are discharged unexpectedly?	Patients who meet the criteria for unplanned discharges are: • Patients who are discharged to an acute care setting, such as a Short-Stay Acute Hospital, CAH, Inpatient Psychiatric Facility, or LTCH; • Patients who die; and • Patients who leave an IRF against medical advice. If the patient meets the criteria for an unplanned discharge, complete the discharge IRF-PAI Quality Indicator items using the following discharge assessment guidance: If assessment of an item was not completed prior to the unplanned discharge, code the item using available documentation/information. When the patient is unable to respond and it is allowable, code 8 – Patient unable to respond or code X – Patient unable to respond. If assessment of an item was not completed prior to the unplanned discharge and no information is available, a dash is a valid response. Review guidance manual and Q&As for item-specific guidance. Please note that while the coding of a “dash” is an optional response value for some data elements, its use does not count toward meeting the AIF minimum submission threshold. Failure to meet the minimum threshold may result in a two (2) percentage point reduction in the IRF’s AIF. CMS is aware of concerns brought forth by IRF providers as it relates to coding certain assessment items during an unplanned discharge. While we believe this to be an infrequent scenario, CMS will be very closely monitoring new assessment data submissions in this area, beginning October 1, 2022. As always, we will continue to partner with IRF providers to address compliance matters on a case-by-case basis.

Section D

#	Topic	Question	Response
46	Social Isolation	For item D0700. Social Isolation, is there a timeframe to use as a reference (for example, within the past 6 months)?	The intent of D0700 – Social Isolation is to identify and report how often the patient felt lonely or isolated from those around them. This item is intended to be a patient self-report item. Ask the patient "how often do you feel lonely or isolated from those around you?" Coding should be solely based on the patient's actual or perceived lack of contact with other people.
47	PHQ 2-9	We understand the intent of the PHQ-2 to 9 is to screen for depression and subsequent follow up interventions as appropriate. Many individuals that are admitted to a PAC setting are in acute crisis, and a large majority have neuro related injuries. How are we to accurately screen for depression, when the majority of the questions are typical symptoms of acute trauma, particularly neuro related trauma? Why was this screening tool chosen specifically for the PAC setting where there are much more applicable, relevant, and effective screening tools available?	We recognize the challenges faced by patients receiving care from PAC providers. As we stated in the FY 2020 IRF PPS and the FY 2020 IPPS/ LTCH PPS Final Rule when the item was finalized, we believe that the PHQ-2 to 9 is the most accurate and appropriate depression screening for the PAC population, and that assessing for depression is necessary for high-quality clinical care. The PHQ-2 has performed well as a screening tool for identifying depression, to assess depression severity, and to monitor patient mood over time. The PHQ-2 and PHQ-9 instruments have been validated in primary care populations against a gold standard diagnostic interview, and we believe this prior validation research generalizes to the PAC population. If a patient self-reports a significant number of depressive symptoms, we do not believe that they should be considered to be a "false positive" because of, for example, a recent trauma or neuro related injury. As a screening tool, the PHQ-2 to 9 is intended to capture likely depression and then to have those patients referred for further evaluation, which will ascertain if their condition is consistent with the full diagnostic criteria for a major depressive disorder. Moreover, standardized screening for the signs and symptoms of depression with the PHQ-2 to 9 does not preclude or provide a substitute for assessment by rehabilitation psychologist or other clinicians, as deemed appropriate by a patient's care team. For a more extensive summary of the rationale for adopting the PHQ-2 to 9, comments received and CMS responses to comments, we refer you to the FY 2020 IRF PPS final rule (https://www.federalregister.gov/d/2019-16603/p-703) and the FY 2020 LTCH PPS final rule (https://www.federalregister.gov/d/2019-16762/p-4745).

Section GG

#	Topic	Question	Response
48	Mobility	For the rolling in bed scenario provided during the training, can a CNA be considered as the assessing clinician?	In the scenario you are referring to, the assessing clinician is not the CNA. Providers should refer to facility, federal, and state policies and procedures to determine which staff members may complete an assessment. Patient assessments are to be done in compliance with facility, federal, and state requirements.
49	Self-Care/Mobility	Please provide a scenario of scoring an item that was not assessed but is similar to another activity.	For the GG0130 Self-Care and GG0170 – Mobility items, clinicians may use clinical judgment to determine if assessment of a similar activity adequately represents the patient's ability to complete the activity and meets the intent of the target activity. This practice will serve to minimize the use of an "activity not attempted" code in favor of a performance code determined to represent the patient's status in the given self-care or mobility activity. While CMS does not provide specific parameters or a complete list of what is and is not an acceptable similar activity, providers are expected to use clinical judgment in determining if the "similar activity" is a reasonable substitute when making a coding determination.

#	Topic	Question	Response
50	Mobility	Could you explain why, for Practice Coding Scenario 5 (that included an example of coding GG0170A. Roll left and right), the patient was scored low on the rolling task when there was no lifting assistance needed?	The correct code for this scenario is 03 – Partial/moderate assistance. The patient needed physical assistance from a helper to provide less than half the effort needed for the patient to complete the entire activity of rolling left and right. When coding any of the activities in Section GG, clinicians should code what occurs at the time of the assessment and allow the patient to perform the activity as independently as possible, as long as the patient is safe, regardless of how the patient performed the activity prior to the current illness, exacerbation, or injury and code based on the type and amount of assistance required to complete the entire activity. The intent of GG0170A – Roll left and right, is to assess the patient's ability to roll from lying on back to left and right side and return to lying on back on the bed. Clinical judgment should be used to determine what is considered a "lying" position for the patient for all these activities. For example, a clinician could determine that a patient's preferred slightly elevated resting position is "lying" for a patient.
51	Mobility	Please explain why a patient ambulating 6' out of 10' (GG0170I. Walk 10 feet) is coded with an "activity not attempted" code but and a patient being able to propel 60' out of 150' in manual WC is coded as 02 – Substantial/maximal assist (for GG0170S. Wheel 150 feet)?	For the GG walking activities, a walking activity cannot be completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a patient. Therefore, when a patient cannot complete the entire stated distance for one of the walking items, the item is coded with the appropriate "Activity Not Attempted" code. However, a helper can assist a patient to complete the wheelchair distance or make turns if required. When a patient is unable to wheel the entire distance themselves, the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.

#	Topic	Question	Response
52	Self-Care	If the GG0130C – Toileting hygiene activity was simulated for therapy, can that be used to assess and code the patient's performance score?	The intent of GG0130C – Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement. The toileting hygiene activity can be assessed and coded regardless of the patient's need to void or have a bowel movement at the time of the assessment. If the patient did not void or have a bowel movement during the assessment timeframe the code for toileting hygiene may still be determined based on patient/family report, collaboration with other facility staff, or assessment of similar activities. If the patient only simulates the activity and does not complete the entire activity during the assessment time period, use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines simulating the activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code.
53	Mobility	Regarding the wheelchair items, if a patient is transported to the therapy gym by wheelchair from another floor, should we code the patient for WC use even if this is only use of the wheelchair?	The intent of the wheelchair mobility items is to assess the ability of patients who ***are using*** a wheelchair under any condition. The intent of GG0170Q – Does the patient use a wheelchair and/or scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. Only code 0 – No to GG0170Q if, at the time of the assessment, the patient does not use a wheelchair or scooter under any condition.

#	Topic	Question	Response
54	Mobility	Regarding Practice Coding Scenario 12 for GG0170P. Picking up object, would this scenario represent the coding 04-steadying assistance for this activity?	This scenario included a video of a patient picking up an object from the floor. In the video vignette, the patient uses a reacher to complete GG0170P – Picking up object. The patient required the helper to provide less than half the effort needed to keep the patient from falling on her first attempt to pick up the object from the floor safely. Coding would be based on the type and amount of assistance the patient requires to complete the activity. GG0170P – Picking up object, includes the patient bending/stooping from a standing position to pick up a small object, such as a spoon, from the floor. Activities may be completed with or without an assistive device. Use of a device or equipment may result in the patient needing less assistance from a helper.
55	Mobility	In the IRF-PAI Q&A, it states that once the patient starts the activity of stairs, they must be able to ascend (or descend) all the steps without taking more than a brief rest break. It does not specify standing vs. seated. Why would a patient be allowed to take a seated rest break for the stair activity but not for the ambulation activity?	During a walking activity (GG0170I – Walk 10 feet, GG0170J – Walk 50 feet with two turns, GG0170K – Walk 150 feet, and/or GG0170L – Walk 10 feet on Uneven Surface), a patient may take a brief standing rest break. If the patient needs to sit to rest during a GG walking activity, consider the patient unable to complete that walking activity and code using the appropriate “activity not attempted” code. For GG0170M. 1 Step (Curb), GG0170N. 4 Steps, and GG0170O. 12 Steps, completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (including cane, walker, railing or stair lift) and with or without some level of assistance. Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up and down stairs, by any safe means, occurs sequentially, the patient may take a rest break between ascending and descending the 4 steps or 12 steps. While a patient may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means without taking more than a brief rest break in order to consider the stair activity completed.

#	Topic	Question	Response
56	Mobility	Is the patient allowed to take a sitting or standing rest break to complete the 10, 50, or 150 feet walking distances?	The intent of the walking items (GG0170I, GG0170J, GG0170K, and GG0170L) is to assess the patient's ability to ambulate the **stated** distances once in a standing position. During a walking activity a patient may take a brief standing rest break. If the patient needs to sit to rest during a GG walking activity and the entire stated distance in the item was not walked by the patient, with or without some level of assistance consider the patient unable to complete that walking activity and code using the appropriate "activity not attempted" code.
57	Mobility	If a patient uses a power wheelchair and a ramp to get into a wheelchair van, how would we score the car transfer?	The intent of item GG0170G – Car transfer focuses on transferring into and out of a car or van seat. If the patient remains in the wheelchair and does not transfer into or out of a car or van seat, then the activity is not completed. In your scenario select the appropriate "activity not attempted" code depending on if the patient was able to complete the car transfer prior to the current illness, exacerbation, or injury. Code 09 – Not applicable if the patient did not perform the activity prior to the current illness, exacerbation, or injury and the patient does not perform the activity at the time of assessment. Code 88, Not attempted due to medical condition or safety concerns, if the activity was not attempted due to medical condition or safety concerns, but the patient could perform the activity prior to the current illness, exacerbation, or injury.
58	Mobility	Can we code the Walking items in Section GG0170. Mobility with a neuro-development treatment (NDT) pole?	Do not code mobility activities with use of a device that is restricted to patient use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems). CMS does not provide an exhaustive list of assistive devices that may be used when coding mobility performance. Clinical assessments may include any device or equipment that the patient can use to allow them to safely complete the activity as independently as possible.

#	Topic	Question	Response
59	Mobility	Can you clarify the coding for the GG0170 walking and step items regarding whether clinical judgement can be applied for all distances and ability to perform those tasks?	The GG walking activities cannot be completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a patient. Therefore, when a patient cannot complete the entire stated distance for one of the walking items, the item is coded with the appropriate “activity not attempted” code. For the GG0170 items that assess going up and down stairs (GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps, completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (e.g., railing or stair lift), and with or without some level of assistance. Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up the stairs and then down the stairs occurs sequentially, the patient may take a standing or seated rest break between ascending and descending the 4 steps or 12 steps.

#	Topic	Question	Response
60	Self-Care/ Mobility	For GG0130 and GG0170, why is less than half assistance considered moderate assistance?	We interpret your question to be about the coding scale for Section GG0130 and GG0170. Functional Abilities and Goals. The items included in Section GG were extensively evaluated and tested during the PAC-PRD development process and in specific reliability tests conducted thereafter (2008 through 2013). Participant feedback on the items was generally positive. Clinicians in all five settings (acute care hospital, SNFs, IRFs, LTCHs, and home health agencies) appreciated the use of standard items. Therapists consistently commented that the items were easy to use and provided greater specificity for measuring severity and change in function than the items that had been on assessment tools they were currently using. They also commented positively about the coding approach of determining whether a patient could do at least half the task or not; and if they could, whether they could safely leave the patient to complete the task without supervision. The staff appreciated being able to note small changes from complete dependence to being able to complete a task with much assistance (over half the task was completed by the helper), particularly for the most impaired populations. For more information about the PAC-PRD, visit the website: https://innovation.cms.gov/medicare-demonstrations/post-acute-care-payment-reform-demonstration.

#	Topic	Question	Response
61	Mobility	For GG0170D – Sit to stand, if a patient is able to transfer using a sit/stand lift and assistance from 1-person, should we score according to amount of assistance needed from the clinician or would it be an automatic 01 – Dependent?	The intent of GG0170D – Sit to stand is to assess the patient's ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe. Activities may be completed with or without an assistive device. This includes the use of any new or previously utilized assistive device(s) or equipment. Use of a device or equipment may result in the patient needing less assistance from a helper. CMS does not provide an exhaustive list of assistive devices that may be used when coding mobility performance. Clinical assessments may include any device or equipment that the patient can use to allow them to safely complete the activity as independently as possible. However, do not code mobility activities with use of a device that is restricted to patient use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems). If the assistance of one helper is required, and the patient contributes some effort (less than half), code 02 – Substantial/maximal assistance. If the helper does all the effort and the patient does none of the effort to complete the activity or the assistance of two people is required, code 01 – Dependent.

#	Topic	Question	Response
62	Self-Care/ Mobility	If a patient is provided with a new assistive device on the PT initial eval and the PT is providing verbal cues and /or physical assistance to safely to complete an ambulation activity – how should this be coded? Wouldn't the patient be benefiting from therapy services if the PT is providing verbal cues or physical assistance to complete the ambulation activity?	At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff. For the admission assessment, the patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. Introducing a new device should not automatically be considered as "providing a service." Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility/staff. "Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required. Communicating the activity request (e.g., "Can you walk up the stairs?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity (e.g., "Hold on to the railing"), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.
63	Mobility	Clinically, the activity of bumping up and down the stairs includes the ability of the person to sit down and stand up from the steps in order to complete stair negotiation. Should the assistance provided for the complete task be coded, or is the intent to score only bumping up and down the steps?	The intent of the GG stair items (GG0170M, GG0170N, and GG0170O) is to assess the patient's ability to go up and down a curb and/or one step, 4 steps, and 12 steps respectively. Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (for example, a railing or stair lift) and/or with or without some level of assistance. Going up and down stairs by any safe means includes the patient walking up and down stairs on their feet or bumping/scooting up and down stairs on their buttocks. In your scenario, the patient's safe means of going up and down stairs is scooting up/down on their buttocks. Do not consider the stand-to-sit or sit-to-stand transfer or transfers to or from the step/floor when coding the stairs activity.

#	Topic	Question	Response
64	Self-Care	If a patient does not eat or drink by mouth, but is able to "eat" ice chips, can item GG0130A – Eating be assessed and coded?	The intent of GG0130A – Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient. Use clinical judgment to determine if the situation of eating ice chips allows the clinician to adequately assess the patient's ability to complete the GG0130A activity. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines this situation does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code. Use of an "activity not attempted" code should occur only after determining that the activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.
65	Self-Care/ Mobility	If an activity is completed during the assessment period but the patient is breaking their precautions and requiring intervention in order to complete the activity safely, is that item considered completed or is it considered an intervention due to the instruction by a skilled clinician?	For GG0130 – Self-Care and GG0170 – Mobility in Section GG, allow the patient to complete each activity as independently as possible, as long as they are safe. At Admission, the self-care or mobility performance code is to be based on a functional assessment that occurs at or soon after the patient's admission and reflects the patient's baseline ability to complete the activity prior to the benefit of services provided by your facility staff. "Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding. If helper assistance is required because the patient's performance is unsafe or of poor quality, score according to the type and amount of assistance provided. Only use an "activity not attempted" code after determining that the activity is not completed prior to the benefit of services, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.

#	Topic	Question	Response
66	Self-Care/Mobility	Is it possible to simulate a patient's "preferred or necessary sleeping surface" during assessment, if the preferred or necessary sleeping surface is not available?	Use clinical judgment to determine if simulating a GG self-care or mobility activity allows the clinician to adequately assess the patient's ability to complete the activity. If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the activity. If the clinician determines that simulating an activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code. Use of an "activity not attempted" code should occur only after determining that the activity is not completed prior to the benefit of services, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.
67	Mobility	If GG0170Q – Does patient use wheelchair/scooter was coded 1 – Yes during the admission assessment but now at discharge they no longer require a wheelchair should the wheelchair items be assessed and coded on the discharge assessment?	Each assessment item should be considered individually and coded based on the guidance provided for that item during each assessment timeframe regardless of how the patient performed the activity at a prior assessment time point The intent of GG0170Q – Does the patient use a wheelchair and/or scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. Only code 0 – No if, at the time of the assessment, the patient does not use a wheelchair or scooter under any condition.
68	Mobility	For GG0170M – 1 step/curb, if both one step and stairs are assessed upon admission, do they both need to be re-assessed at discharge?	When coding any of the self-care or mobility activities in Section GG, clinicians should code what occurs at the time of the assessment, regardless of how the patient performed the activity at a prior assessment time point. The intent of GG0170M – 1 step (curb), is to assess the patient's ability to go up and down a curb and/or up and down one step. This activity can be assessed using a curb or a step of a staircase, with or without railing(s). There is no requirement to assess a patient going up and down both a curb and a step. However, since coding GG0170M – 1 step (curb) with a 07, 09, 10 or 88 results in skipping GG0170N – 4 Steps and GG0170O – 12 Steps, when a patient is unable to go up and down a curb, you may want to consider assessing the patient's ability to go up and down 1 step in order to possibly capture performance codes of 06 through 01 for one or more of the stair items, if that patient can complete them with help and/or a railing.

#	Topic	Question	Response
69	Mobility	In the IRF-PAI Change Table, the guidance states that 04 – Supervision or touching assistance is coded if the patient requires only verbal cueing to complete the activity safely. However, the IRF-PAI manual states that the patient may require only contact guard or steadying assistance. Please advise as contact guard is more physical assistance than touching assistance.	As stated in the Coding Instructions for Section GG of the IRF-PAI V4.0 Guidance Manual code 04 – Supervision or touching assistance, if the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or patient may require only contact guard or steadying assistance during the activity. Code 04 – Supervision or touching assistance may also be coded if the patient requires only verbal cueing to complete the actively safely. Please note the change table summarizes the substantive changes made in the IRF-PAI V4.0 Guidance Manual. It does not contain the entire guidance from the manual.
70	Self-Care/ Mobility	When does the provision of assistance as needed become actual providing beneficial services? If a patient has to be “assisted” to use a piece of equipment safely by a skilled clinician, how is that capturing baseline function prior to the patient benefiting from services? This sounds like contradictory instruction; “clinician could provide assistance” and “prior to the benefit of services.” Please provide clarification and distinction examples.	At Admission, the self-care or mobility performance code is to reflect the patient’s baseline ability to complete the activity, prior to the benefit of services provided by your facility staff. The patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, prior to the benefit of services provided by your facility/staff. “Prior to the benefit of services” means prior to provision of any care by your facility staff that would result in more independent coding. Introducing a new device should not automatically be considered as “providing a service.” Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility/staff.

#	Topic	Question	Response
71	Miscellaneous	We have noticed the increased instruction in the manual to use clinical judgment, similar items, collaboration and report instead of using an activity not attempted code. If the report from family, patient, and/or similar items and clinical judgment is used instead of a not attempted code and proves to be incorrect, which impacts a quality indicator reporting item, can that code or score be adjusted after the assessment period? Does a patient no longer need to complete all of a task, i.e. gait and stairs in order to be scored on that item?	The performance code is to reflect the patient's baseline ability to complete the activity, and is based on observation of activities, to the extent possible. The assessing clinician may, as needed, combine general observation, assessment of similar activities, patient/caregiver report, collaboration with other facility staff, and other relevant strategies to complete all GG items. While CMS does not provide specific parameters or a complete list of what is and is not an acceptable similar activity, providers are expected to use clinical judgment in determining if the "similar activity" meets the intent of the target activity to make it a reasonable substitute when making a coding determination. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines the performance of a similar activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code. Use of an "activity not attempted" code should occur only after determining that an activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities. The assessment timeframe is 3 calendar days. At the admission assessment, the self-care or mobility performance code is to be based on afunctional assessment that occurs soon after the patient's admission and reflects the patient's baseline ability to complete the activity. This functional assessment must be completed within the first 3 days (3 calendar days).
72	Mobility	For GG0170 Mobility – Wheel 50 feet with 2 turns and Wheel 150 feet, if a patient is only using a wheelchair for transportation while at the IRF and the goal for discharge is ambulation, why is it necessary to evaluate and score the wheelchair items?	The intent of GG0170Q – Does the patient use a wheelchair and/or scooter? is to document whether ***a patient uses*** a wheelchair or scooter at the time of the assessment. Only code 0 – No if, at the time of the assessment, ***the patient does not*** use a wheelchair or scooter under any condition.

#	Topic	Question	Response
73	Self-Care	When assessing upper body dressing, item GG0130F, if the patient dons only a hospital gown during the assessment, should this be coded with an "activity occurred" code? Does it matter whether there was or was not an undershirt, T-shirt, button-down shirt, pullover shirt, dress. sweatshirt, sweater, or pajama top available during the assessment time frame?	The intent of GG0130F – Upper body dressing is to assess the patient's ability dress and undress above the waist; including fasteners, if applicable. Clinicians should use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity of upper body dressing. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the activity. If the clinician determines that this observation is not adequate and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities, use the appropriate "activity not attempted" code.
74	Mobility	Can GG items be scored based on modified activities, the patient or caregiver self-report, other staff report, or based on how a patient performed other similar activities that required similar functioning?	Clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient and/or family, assessment of similar activities, collaboration with other facility staff, and other relevant strategies to complete all GG items. While CMS does not provide specific parameters or a complete list of what is and is not an acceptable "similar activity," providers are expected to use clinical judgment in determining if the "similar activity" meets the intent of the target activity to make it a reasonable substitute when making a coding determination. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines the performance of a similar activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code. If the patient only completes a portion of the activity (e.g., performs a partial bath or transfers into but not out of a vehicle) and does not complete the entire activity during the assessment time period, use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines the partial activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code.

Section H

#	Topic	Question	Response
75	Bladder/Bowel	For H0350 – Bladder Incontinence, what is the coding for a person always incontinent but also catheterized (no continent episodes)?	The intent of H0350 – Bladder Continence is to gather information on bladder continence. If the use of a catheter is intermittent (e.g., the indwelling catheter is not used for the entire 3-day assessment period), code continence level when the catheter is not in use during the 3-day assessment period. Code 3 – Incontinent daily if the patient had at least one episode of incontinence on each of the 3 days AND catheterization at any time during the 3-day assessment time period. 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.
76	Bladder/Bowel	The IRF PAI Manual 4.0 instructs that code 4 is to be used “if during the 3-day assessment period the patient had no continent voids and no catheterization.” The guidance also supplies the coding tip, “If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.” Since the manual instructs not to code ‘4, always incontinent’ when there have been catheterization, and to code continence level based on continence between catheterizations, what code should be entered when a patient is always incontinent of urine and requires intermittent catheterization during the entire 3-day assessment period for bladder elimination?	The intent of H0350 – Bladder Continence is to gather information on bladder continence. Code 3 – Incontinent daily if the patient had at least 1 episode of incontinence on each of the 3 days AND catheterization at any time during the 3-day assessment time period.

#	Topic	Question	Response
77	Bladder/Bowel	For H0400 – Bowel Continence, if a patient had ONE episode of bowel incontinence but no continent episode during admission period, how would this be coded?	The intent of H0400 – Bowel Continence is to report the level of bowel continence. If during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements) then code 3 – Always incontinent.

Section J

#	Topic	Question	Response
78	Pain	For the pain interview questions at discharge, if a patient is in the PAC setting for less than 5 days, would we include the acute care stay as part of the discharge 5-day window?	The intent of the pain interview items J0510–J0530, is to assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities. For each pain item, J0510, J0520, and J0530, the lookback is the past 5 days. This is true at both the admission and discharge time points.
79	Pain	For items J0510 through J0530, if a patient is not cognitively intact, do we still use their sensical/nonsensical responses or base it on chart review or nurse communication?	J0510–J0530 – Pain Interview should be coded based on the patient's interpretation of the provided response options for frequency. Code 8 – Unable to answer if the patient is unable to answer the question, does not respond, or gives a nonsensical response
80	Pain	For the pain interview item, J0530, what is included in day-to-day activities?	The intent of J0530 is to assess the effect of pain interference with a patient's day-to day activities. Day-to-day activities include activities that occur outside of rehabilitation therapy sessions. Directly ask the patient whether over the past 5 days, pain has interfered with their day-to-day activities. If the patient is unsure about whether the pain effect or interference occurred in the 5-day time interval, prompt the patient to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.
81	Pain	Are patients supposed to answer the pain questions based on acute pain or chronic pain?	As stated in Section J of the Guidance Manuals, pain is any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous, or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever they say it does.

#	Topic	Question	Response
82	Falls	For J1800 and J1900, if a patient has an interrupted stay during IRF admission, and then is transferred to acute hospital, falls in the hospital and is transferred back to the IRF within 3 midnights, does the fall in the hospital setting get included in J1800 and J1900?	Items J1800 and J1900 include all falls that occurred since the time of admission. This would include any falls that occurred outside of the facility during a program interruption.
83	Pain	Are we allowed to use cue cards with the responses to the pain questions that are asked of the patient exactly as written on the IRF-PAI for the following: Pain's Effect on Sleep, Pain's Effect on Rehab Therapy, and Pain's Effect on Day-To-Day Activities?	When completing items in the IRF-PAI or LCDS, interact with the patient using their preferred language. Be sure the patient can hear you and/or has access to their preferred method of communication. Alternative approaches, such as writing, pointing, sign language, or cue cards, may be helpful communication approaches to consider for some items and some patients.
84	Pain	Will the pain assessment questions: J0510. Pain Effect on Sleep, J0520. Pain Interference with Therapy Activities, and J0530. Pain Interference with Day-to-Day Activities, need to be completed at discharge on the IRF-PAI for patients that have an unplanned discharge?	Patients who meet the criteria for unplanned discharges are: • Patients who are discharged to an acute care setting, such as Short-stay Acute Hospital, CAH, Inpatient Psychiatric Facility, or LTCH; • Patients who die; and • Patients who leave an IRF against medical advice. If the patient meets the criteria for an unplanned discharge, complete the discharge IRF-PAI Quality Indicator items using the following discharge assessment guidance: If assessment of an item was not completed prior to the unplanned discharge, code the item using available documentation/information. When the patient is unable to respond and it is allowable, code 8 – Patient unable to respond or code X – Patient unable to respond.

#	Topic	Question	Response
85	Pain	For items J0510, J0520, and J0530, will we need to do a chart review from previous settings if the patient is unable to recall how much pain has interfered with sleep, participation in therapy and day to day activities, or is it purely based on a patient's response?	J0510 – Pain Effect on Sleep, J0520 – Pain Interference with Therapy Activities, and J0530 – Pain Interference with Day-to-Day Activities should be coded based on the patient's interpretation of the provided response options for frequency. As stated in the Steps for Assessment for J0510–J0530: 1. Directly ask the patient each item in J0510, Pain Effect on Sleep through J0530, Pain Interference with Day-to-Day Activities in the order provided. ○ Use other terms for pain or follow-up discussion if the patient seems unsure or hesitant. Some patients avoid use of the term "pain" but may report that they "hurt." Patients may use other terms such as "aching" or "burning" to describe pain. 2. If the patient chooses not to answer a particular item, accept their refusal, code 8, Unable to Answer, and move on to the next item. 3. If the patient is unsure about whether the pain effect or interference occurred in the 5-day time interval, prompt the patient to think about the most recent episode of pain and try to determine whether it occurred within the look-back period. And as stated in the Steps for Assessment for J0510, Pain Effect on Sleep: 1. Read the question and response choices as written. 2. No pre-determined definitions are offered to the patient. The response should be based on the patient's interpretation of frequency response options. 3. If the patient's response does not lead to a clear answer, repeat the patient's response and then try to narrow the focus of the response.
86	Pain	Regarding item J0510 on discharge, can you clarify the difference between response options code 0, Does not apply and code 1, Rarely or not at all?	The intent of J0510. Pain Effect on Sleep is to assess the effect of pain on the patient's sleep. The key difference between code 0 – Does not apply and code 1 – Rarely or not at all is that for code 0, the patient has NO pain/hurting in the last 5 days and for code 1, the patient reports pain/hurting HAS been present in the past 5 days but has rarely or not at all impacted sleep.

Section K

#	Topic	Question	Response
87	Nutritional approaches	For item K0520 – Nutritional Approaches, does "At Discharge" ask what the diet was on the day of discharge or is it asking what was ordered for the patient to continue on after they are discharged?	The intent of item K0520 – Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or were being received in the last 7 days and at discharge. At discharge, check all of the listed nutritional approaches that were received during the last 7 days and during the 3-day discharge assessment time period, and not what is expected to occur after discharge.
88	Nutritional approaches	Are IV fluids considered parenteral feeding, if needed and documented for nutrition ***and*** hydration, for K0520A. Parenteral/IV feeding, OR if needed and documented for nutrition ***or*** hydration?	As described in the Guidance Manuals, IV fluids can be coded in K0520A when there is supporting documentation that reflects the need for additional fluid intake to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration.
89	Nutritional approaches	For item K0520 – Nutritional Approaches, is the discharge assessment timeframe the last 3 days as it is for several other measures or just the day of discharge?	The intent of K0520 – Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or were being received in the last 7 days and at discharge. At discharge for Column 5 check all of the listed nutritional approaches that were being received during the 3-day discharge assessment time period.
90	Nutritional approaches	If the length of stay is less than 7 days, does the 7-day lookback period for K0520 – Nutritional Approaches "at Discharge," go back into the preadmission period?	As stated in the Coding Instructions for K0520 – Nutritional Approaches, review the medical record to determine if any of the listed nutritional approaches were received in the last 7 days and at discharge.

Section M

#	Topic	Question	Response
91	Pressure Ulcer	What if your facility has Wound, Ostomy, Continence, Nursing (WOCN) certified nurses that stage pressure ulcers/injuries? Our nurses don't stage, so would we just use the prior staging from notes and wait for the WOCN nurse consult note on admission to use that stage for admission assessment? Same at discharge?	Providers should refer to facility, federal, and state policies and procedures to determine which staff members may complete an assessment. Patient assessments are to be done in compliance with facility, federal, and state requirements. At admission the pressure ulcer items should be coded based on findings from the first skin assessment that is conducted on or after, and as close to the admission as possible. At discharge the pressure ulcer items should be coded based on findings from the last skin assessment that is conducted as close to discharge as possible.
92	Pressure Ulcer	What will be the coding if there's no skin assessment during the 3-day window for the pressure ulcer?	The intent of Section M – Skin Conditions, is to document the presence, appearance, and change of pressure ulcer/injuries. If the skin assessment was not completed during the 3-day assessment period, then code the Section M – Skin Condition items to the best of your abilities. If there is no information available, enter a dash (-) for M0210 – Unhealed Pressure Ulcers/Injuries and M0300 – Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Please note that while the coding of a "dash" is an optional response value for these data elements, its use does not count toward meeting the AIF/APU minimum submission threshold. Failure to meet the minimum threshold may result in a 2-percentage point reduction in the IRF's AIF and the LTCH's APU.

#	Topic	Question	Response
93	Pressure Ulcer	For Practice Coding Scenario 6, would you change the admission pressure injury in Practice Scenario 6 from a deep tissue injury to a stage 3?	Practice scenario 6 described a patient admitted to the IRF/LTCH with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, the nurse documents on the first skin assessment that the heel blister is a deep tissue injury (DTI). Four days after admission, the right heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is staged as a Stage 3 pressure ulcer. The nurse completes the last skin assessment the day before discharge and documents that the right heel remains at a Stage 3. At admission, M0300G1 (Unstageable – DTI) is coded '1.' The rationale for selecting '1' is that after a thorough clinical and skin examination, an assessment of the right heel and surrounding tissues revealed a skin injury consistent with what constitutes a DTI, and this was observed at the time of the first complete skin assessment. To support consistency of data collection related to pressure ulcers/injuries data across all PAC providers, cross-setting guidance directs coding for pressure ulcers/injuries to be based on the "first skin assessment." At discharge, M0300C1 (Stage 3) would be coded as 1 and M0300C2 (Stage 3, Present on Admission) would be coded as 1. The rationale for coding at discharge is that the DTI heel blister (staged at admission M0300G1 – Unstageable – DTI) has been drained and the tissue debrided. It was subsequently numerically staged as a Stage 3. Because this was the first time the ulcer was able to be assessed and numerically staged, and it remained at that stage at the time of discharge, it is considered to have been present on admission.
94	Pressure Ulcer	If a patient has a stage 3 or 4 pressure ulcer on admission which then becomes unstageable with slough on discharge, how do you code upon discharge?	Any pressure ulcer that is observed to be unstageable due to slough and/or eschar at the time of discharge, but was previously numerically stageable, is considered new, and not coded as present at admission on the discharge assessment.
95	Pressure Ulcer	What is the recommendation for reporting when a wound has been clinically assessed as mixed etiology of multiple factors, such as of moisture, pressure, and shear?	As stated in the Coding Tips for M0210 – Unhealed Pressure Ulcers/ Injuries if an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the ulcer/injury should be included in Section M: Skin Conditions as a pressure ulcer/injury.

Section N

#	Topic	Question	Response
96	High-Risk Drug Classes	For N0415 – High Risk Drug Classes: Use and Indication, can pharmacy notes be reviewed to determine the indications for specific medications?	The intent of N0415 – High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any medications in specified drug classes and whether the patient-specific indication was noted for taking the prescribed medications Review patient documentation to determine if there is a patient-specific indication noted for all medications in the drug class.
97	Drug Regimen Review	For N2001 – 2005, please clarify why a physician in the facility contacting another physician regarding a medication issue would need to be reported for the drug regimen items. It was my understanding that the Drug Regimen Review (DRR) items only capture when a nurse would contact a physician regarding a potential clinically significant issue, is that not correct?	The drug regimen review in post-acute care is generally considered to include (1) a medication reconciliation (that is, a review of all medications a patient is currently using), and (2) a review of the drug regimen to identify and, if possible, prevent potential clinically significant medication issues. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. If the facility (i.e., facility physician) identified a potential or actual clinically significant medication issue and contacted another physician or pharmacist, then this meets the definition of a potential clinically significant medication issue.
97	Drug Regimen Review	For the DRR items, is hyper or hypoglycemia considered an adverse reaction in a patient that is prescribed insulin?	An adverse drug reaction is defined as any unexpected, unintended, undesired, or excessive response to a drug that: requires discontinuing the drug (therapeutic or diagnostic), requires changing the drug therapy, requires modifying the dose (except for minor dosage adjustments), necessitates admission to a hospital, prolongs stay in a healthcare facility, necessitates supportive treatment, significantly complicates diagnosis, negatively affects prognosis, or results in temporary or permanent harm, disability, or death.

#	Topic	Question	Response
99	High-Risk Drug Classes	Will there be a penalty if the high-risk drug indication (for N0415, column 2) is not completed?	The intent of the High-Risk Drug Classes items in this section is to record whether the patient is taking any medications in specified drug classes and whether the indication was noted for taking the prescribed medications. Patients taking medications in these medication categories and drug classes are at risk for side effects that can adversely affect health, safety, and quality of life. Addressing Column 2 (Indication noted) is required only when Column 1 is checked indicating the patient is taking the medication in that drug classification. N0415. High-Risk Drug Classes: Use and Indication are standardized patient assessment data elements. Effective October 1, 2022, IRFs and LTCHs are required to submit these items to meet the AIF minimum data completion threshold for the IRF QRP and the Annual Update (i.e., the APU for the LTCH QRP. Successful data completion means that the assessment does not contain non-informative responses, i.e., “dash” (-) for these required data elements. Please note that while the coding of a “dash” is an optional response value for many data elements, its use does not count toward meeting the AIF and APU minimum data completion thresholds. Failure to meet the minimum threshold may result in a two (2) percentage point reduction in the IRF’s AIF/APU. For a full list of data elements required to meet the AIF minimum data completion threshold for the IRF QRP, see the document titled FY-2024-IRF-QRP-AIF-Table-for-RABM-and-Standardized-Patient-Assessment-Data-Elements (PDF) in the Downloads section of the IRF QRP Measures Information web page at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information. For a full list of data elements required to meet the APU minimum data completion threshold for the LTCH QRP, see the document titled FY-2024-LTCH-QRP-APU-Table-for-RABM-and-Standardized-Patient-Assessment-Data-Elements (PDF) in the Downloads section of the LTCH QRP Measures Information web page at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.

#	Topic	Question	Response
100	High-Risk Drug Classes	Can you please clarify what the assessment reference period is for N0415 – High-Risk Drug Classes: Use and Indication. Additionally, please clarify the definition of 'taking'? Does this mean prescribed or administered?"	The intent of N0415 – High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any medications in specified drug classes and whether the indication was noted for taking the prescribed medications. Determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). If Column 1 is checked (patient is taking a medication in drug classification), review patient documentation to determine if there is a documented patient specific indication for all medications in the drug class (Column 2). When coding N0415, consider a medication that is included in the patient's prescribed drug regimen even if it is not taken during the 3-day admission (or discharge) assessment period.
101	High-Risk Drug Classes	For N0415. High-Risk Drug Classes: Use and Indication, is Venlafaxine hydrochloride considered an antipsychotic medication?	We interpret your question to be related to N0415. High-Risk Drug Classes: Use and Indication. The intent of the High-Risk Drug Classes items in this section is to record whether the patient is taking any medications in specified drug classes and whether the indication was noted for taking the prescribed medications. Code medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it. Medications that have more than one therapeutic category and/or drug classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used. CMS does not specify a source for identifying the therapeutic category and/or pharmacological classification.

#	Topic	Question	Response
102	Drug Regimen Review	For N2005 – Medication Intervention at discharge, are issues found on admission included? Previous guidance states to include only admission DRR on admission and anything after admission through discharge on the discharge assessment. However, the rationale slide (slide 40) states, “All clinically significant medication issues identified admission through discharge.”	The intent of N2005. Medication Intervention is to document whether clinically significant medication issues were addressed in a timely manner when identified throughout the patient stay. Review the patient’s medical record to determine whether any potential and actual clinically significant medication issues were identified **upon admission** and throughout the patient’s stay. Code 0, No, if the facility did not contact the physician (or physician-designee) and complete prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified at admission or at any time throughout the patient stay (admission through discharge). Code 1, Yes, if the facility contacted the physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential or actual clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge). Code 9, Not applicable, if there were no potential or actual clinically significant medication issues identified at admission nor throughout the patient’s stay, or the patient was not taking any medications, by any route, at admission or throughout the stay.

Section O

#	Topic	Question	Response
103	Special Treatments, Procedures, and Programs	For items O0110O1. IV access and O0110O2. Peripheral, if a patient is admitted with peripheral IV access for seizure precautions or PRN use for hypertensive medications only (necessitating saline flushes), is it correct to code both O1, IV access and O2, peripheral?	The intent of O0110 – Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient. O0110O1, IV Access refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure. When a patient has a peripheral IV access, O0110O1 (IV Access) and O0110O2 (Peripheral) should be checked even when it may not be accessed.
104	Special Treatments, Procedures, and Programs	For O0110C – Special Treatments, Procedures, and Programs; Oxygen therapy: If the oxygen is ordered PRN, is that considered intermittent because it is ordered PRN or only if the patient uses it PRN during the 3-day assessment period? Additionally, the guidance manual specifically states, “delivered to relieve hypoxia.” If there is no documentation of hypoxia but the patient reported shortness of breath and the oxygen was used, can oxygen still be marked?	The intent of O0110 – Special Treatments, Procedures, and Programs identifies if any of the listed special treatments, procedures, and programs apply to the patient. O0110 should be completed based on an assessment that occurs within the 3-day admission assessment period or the 3-day discharge assessment period. Check all treatments, programs, and procedures that are part of the current care/treatment plan during the 3-day admission assessment or the 3-day discharge assessment period. If the oxygen is part of the patient’s current care/treatment plan regardless of reason for its use, O0110C1 – Oxygen therapy should be checked. Regardless of whether the oxygen is ordered continuously or intermittently, apply the IRF-PAI/LCDS specific definitions in determining whether oxygen is coded as continuous (delivered for greater than/equal to 14 hours per day) or intermittent (oxygen was not delivered continuously for at least 14 hours per day).

#	Topic	Question	Response
105	Special Treatments, Procedures, and Programs	For Special Treatments, Procedures, and Programs: Non-invasive Mechanical Ventilator O0110G2 – BiPAP and O0110G3 – CPAP, are these only selected if the BiPAP/CPAP was used during the assessment window? Sometimes a treatment may be ordered and available, but the patient will refuse to wear it.	If the BiPAP or CPAP is part of the patient's current care/treatment plan, then code O0110G1 – Non-Invasive Mechanical Ventilator and O0110G2 – BiPAP or O0110G3 – CPAP.
106	Special Treatments, Procedures, and Programs	If a patient is receiving chemotherapy not related to cancer, how is this item coded (e.g., oral/injection chemotherapy for autoimmune diseases)?	As stated in the Coding Tips in the IRF-PAI V4.0 and the LCDS V5.0 Guidance Manual for O0110A1, Chemotherapy, code any type of chemotherapy medication administered as an antineoplastic for cancer treatment given by any route in this item. Medications coded here are those actually used for cancer treatment. Each medication should be evaluated to determine its reason for use before coding it here.
107	Special Treatments, Procedures, and Programs	Please provide clarification on the new guidance provided for coding Chemotherapy medications given through a PEG as "oral" route. It is NOT an "oral" route but rather enteral administration. Thank you.	As stated in the Coding Instructions in the Guidance Manuals, O0110A3 – Chemotherapy; Oral is checked if chemotherapy was administered orally. For the purposes of this item, this sub-element (O0110A3) also applies if the chemotherapy is administered through a feeding tube/PEG.
108	Special Treatments, Procedures, and Programs	Can you please clarify the assessment time period for both admission and discharge for O0110?	The intent of O0110 – Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient. Check all treatments, programs, and procedures that are part of the patient's current care/treatment plan during the 3-day admission (or 3-day discharge) assessment time period. Include treatments, programs, and procedures performed by others and those the patient performed themself independently or after setup by facility staff or family/caregivers. Check treatments, procedures, and programs that are performed in the care setting, or in other settings (e.g., dialysis performed in a dialysis center). At discharge O0110 considers special treatment, procedures, and programs that are part of the patient's current care/treatment plan during 3-day discharge assessment time period, and not what is expected to occur after discharge.

#	Topic	Question	Response
109	Special Treatments, Procedures, and Programs	Regarding item O0110 – Special Treatments, Procedures, and Programs, would a Vas Cath (large bore central venous catheter used for dialysis placed in the jugular or femoral vein) be classified as a central line?	O0110 – Special Treatments, Procedures, and Programs identifies any special treatments, procedures, and programs that apply to the patient. O01101O1 – IV Access identifies a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, TPN, or in some instances the measurement of central venous pressure. Check O0110O4 – Central (e.g., PICC, tunneled, port) when IV access was centrally located (e.g., PICC, tunneled, port).
110	Special Treatments, Procedures, and Programs	If the plan for a patient is to go out of house for chemo/radiation during the middle of their stay but then does not return until 4 days later, as a new admission, would this be considered part of the original plan of care, for the O0110 chemotherapy and radiation items? Or in order for this to be part of the plan of care, does this treatment need to occur during the length of stay?	The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient during the current stay. For O0110 check all treatments, programs, and procedures that are part of the patient's current care/treatment plan during the 3-day admission (or 3-day discharge) assessment time period. Include treatments, programs, and procedures performed by others and those the patient performed themself independently or after setup by facility staff or family/caregivers. Check treatments, procedures, and programs that are performed in the care setting, or in other settings (e.g., dialysis performed in a dialysis center).