



IRF-PAI Quarterly Q&As, December 2020

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*This document is intended to provide guidance on IRF-PAI questions that were received by CMS help desks.
Responses contained in this document may be superseded by guidance published by CMS at a later date.*

25A

Question 1: How should height be reported for item 25A - Height on admission for a patient with bilateral lower extremity amputations? Should their current height or their height prior to amputation be reported?

Answer 1: Item 25A - Height on admission records the most recent height of measurement for the patient. Measure the patient's height in accordance with the facility's policies and procedures, which should reflect current standards of practice (shoes off, etc.).

When reporting height for a patient with bilateral lower extremity amputations, measure and record the patient's current height (i.e., height after bilateral amputations).

GG0110

Question 2: Should a transport chair be considered a "wheelchair" for GG0110 - Prior Device Use?

Answer 2: The intent of GG0110 - Prior Device Use is to indicate which devices and aids were used by the patient prior to the current illness, exacerbation, or injury. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how prior device use applies for each individual patient.

CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use.

GG0130A

Question 3: How would the following scenario for GG0130A - Eating be coded: A patient was admitted and on day 1 required only setup assistance for eating. On day 2 the patient was transferred to an acute care hospital and returned on day 3 with an overall decline in status and was made NPO due to dysphagia. Would we code 05 - Setup or clean-up assistance based on initial ability or 88 - Not attempted due to medical conditions or safety concerns because this is the new baseline following the decline?

Answer 3: 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.

At admission, the 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.

In the scenario provided, use code 05 - Setup or clean-up assistance for GG0130A - Eating if this represents the patient's baseline status.

Only use an "activity not attempted" code if the patient was not able to complete the activity 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.

Question 4: A patient is admitted to an Inpatient Rehabilitation Facility (IRF) with quadriplegia from a previous spinal cord injury. Once an occupational therapist applies a universal cuff to the patient's hand, the patient is able to eat the entire meal without further assistance. What is the performance code for GG0130A - Eating? Would this scenario be similar to the rationale for a Foley catheter that is coded as 04 - Supervision or touching assistance for lower body dressing, because someone had to help thread the tubing so that it was safe to perform the task?

Answer 4: 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.

In the scenario provided, if the patient only requires assistance to apply a universal cuff and no further assistance is required during the eating activity, then code 05 - Setup or clean-up assistance. This is because assistance is only required prior to or following the activity, but not during the activity.

Regarding the Foley catheter guidance referenced, code 05 - Setup or clean-up assistance would not be appropriate for that specific scenario. The helper is managing the catheter **during** the activity of lower body dressing and not only before or after the activity.

GG0130E

Question 5: If a patient requires assistance only to cover a brace/port/wound prior to a shower, but is able to bathe (wash, rinse, and dry) without assistance from a helper, how would GG0130E - Shower/bathe self be coded?

Answer 5: The intent of GG0130E - Shower/bathe self is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.

If the only help a patient requires is assistance to cover wounds or devices for water protection during bathing, then code 05 - Setup or clean-up assistance.

GG0170

Question 6: If a patient is dependent for all GG bed mobility activities would it be acceptable to code the patient as dependent for all other GG mobility activities even if those activities were not specifically assessed?

Answer 6: At Admission, the mobility 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. 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.

Each IRF-PAI item should be considered individually and coded based on the guidance provided for that item.

It is important to determine whether the appropriate code for each GG activity is a performance code (including 01 - Dependent) vs. an “activity not attempted” code.

It is also important to note that a helper cannot complete the walking activities for a patient. The walking activities cannot be considered completed without some level of patient participation that allows patient ambulation to occur the entire stated distance. For instance, if even with assistance a patient was not able to participate in walking a distance of 10 feet, an “activity not attempted” code (rather than 01 - Dependent) would be selected.

GG0170E

Question 7: We have a patient who at discharge requires max assistance to perform a transfer, so is coded as 02 - Substantial/maximal assistance for GG0170E - Chair/bed-to-chair transfer. This maximal assist transfer will not be safe for the patient and elderly family to attempt once at home, so two family members will be using a Hoyer lift to transfer the patient from bed to chair. At discharge, would the correct code for GG0170E be 02 - Substantial/maximal assistance, based on the patient’s performance in the facility; or would the correct code be 01 - Dependent, because that is what the patient’s “usual” status will be at home?

Answer 7: The intent of GG0170E - Chair/bed-to-chair transfer is to assess the patient’s ability to transfer to and from a bed to a chair (or wheelchair).

When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe.

If the patient performed the activity during the discharge assessment period, code based on that assessment. Use the GG 6-point scale codes to identify the patient’s usual performance on the discharge assessment.

If in your scenario, at discharge, when allowed to complete the activity as independently as possible, the patient was able to safely complete the transfer activity with max assist, then code 02 - Substantial/maximal assistance.

GG0170F

Question 8: A patient completes a toilet transfer requiring only supervision. As he was ambulating with contact guard assistance back to his bed he lost his balance and required assistance to steady himself. Would the contact guard assist and assistance to steady himself be considered in determining the performance code for GG0170F - Toilet transfer?

Answer 8: The intent of GG0170F - Toilet transfer is to assess the patient’s ability to get on and off a toilet (with or without a raised toilet seat) or commode once the patient is at the toilet or commode.

In the scenario described, the assistance provided while ambulating to or from the toilet should not be considered when coding the GG0170F - Toilet transfer activity.

Question 9: In the recent September Quarterly Q&A publication, it indicates that “assessment of similar activities” is acceptable for coding the IRF-PAI. Please provide clarification on if the following scenarios would be acceptable simulations for the GG0170F - Toilet transfer activity in situations where a patient does not need to use the toilet during an assessment:

- 1. An Occupational Therapist (OT) takes the patient to the toilet and simulates a toileting experience, with patient pulling down pants and transferring onto the toilet and then back to the chair.**
- 2. Using the functional performance of the patient’s chair/bed-to-chair transfer performance code to code toilet transfer.**
- 3. Using the functional performance of the patient’s ability to transfer on and off a bedside commode in the therapy gym to code toilet transfer.**

Answer 9: The intent of GG0170F - Toilet transfer is to assess the patient’s ability to get on and off a toilet or commode. Do not consider or include GG0130C - Toileting hygiene item tasks (managing clothing, undergarments, or perineal hygiene) when coding the toilet transfer item. The toilet transfer activity can be assessed and coded regardless of the patient’s need to void or have a bowel movement in conjunction with the toilet transfer assessment.

Use clinical judgment to determine if each situation described adequately represents the patient’s ability to transfer on and off the toilet or commode. 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.

In each scenario, if the patient was not able to transfer on/off the toilet or commode 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.

GG0170G

Question 10: Has CMS offered any new guidance on functional activities that can not be assessed due to a patient having COVID-19? Specifically interested in car transfers. We have our COVID-positive patients on isolation in their rooms and are unable to assess them using the car simulator. Are we able to simulate a car transfer using a mat to assess this item?

Answer 10: The intent of GG0170G - Car transfer is to assess the patient’s ability to transfer in and out of a car or van seat on the passenger side.

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.

If, using clinical judgment, simulating the car transfer using a mat adequately represents the patient's ability to transfer in and out of a car, code GG0170G - Car transfer based on the type and amount of assistance required to complete the activity.

For a COVID-19 patient on isolation, new guidance on coding the GG items is not necessary. The existing guidance allowing coding based on assessment of similar activities can be used, as well as the use of "activity not attempted" codes as needed.

GG0170R, GG0170S

Question 11: Regarding Section GG Wheelchair Items, does the activity of wheeling 50 feet with 2 turns need to be done independent of the activity of wheeling 150 feet?

Also the manual states the coding is based on an assessment completed before therapeutic intervention. Patients who had not used a wheelchair previously may not be able to complete both wheelchair activities. Would an "activity not attempted" code be used?

Answer 11: The intent of GG0170R - Wheel 50 feet with two turns is to assess the patient's ability, once seated in wheelchair/scooter, to wheel at least 50 feet and make two turns.

The intent of GG0170S - Wheel 150 feet is to assess the patient's ability, once seated in a wheelchair/scooter, to wheel at least 150 feet in a corridor or similar space.

Use clinical judgment to determine how the actual patient assessment of wheelchair mobility is conducted. If a clinician chooses to combine the assessment of multiple wheelchair activities, use clinical judgment to determine the type and amount of assistance needed for each individual activity.

At Admission, the 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. The item would then be coded 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.

H0350

Question 12: Please clarify the use of the code 4 - Always incontinent for H0350 - Bladder Continence. The coding instructions state that this code is used if during the 3-day assessment period the patient had no continent voids. What if during the 3-day assessment period the patient has no continent episodes because the patient was catheterized during some portion of the 3-day assessment period?

Answer 12: The intent of H0350 - Bladder Continence is to gather information on bladder continence. Code 4 - Always Incontinent is applicable when the patient had no continent voids and did not require the use of any type of catheter at any time during the 3-day assessment period.

Question 13: How would the following scenarios for H0350 - Bladder Continence be coded?

Scenario 1

Day 1: One intermittent catheterization, no other bladder episodes

Day 2: Foley was placed, no other bladder episodes

Day 3: Foley remained in place the entire day

Would this scenario be coded as 9 - Not applicable because the patient had a Foley in place for 2 of the 3 days or as 0 - Always Continent because there were no episodes of incontinence in between intermittent catheterization; even though there were no continent episodes either?

Scenario 2

Day 1: Intermittent catheterizations, no bladder episodes in between catheterizations

Day 2: Intermittent catheterizations, no bladder episodes in between catheterizations

Day 3: Intermittent catheterizations, no bladder episodes in between catheterizations

Answer 13: The intent of H0350 - Bladder Continence is to gather information on bladder continence. Incontinence refers to the involuntary loss of urine, when there is a loss of control of the evacuation of urine from the bladder, regardless of whether clothing or linens are soiled.

In both scenarios, if intermittent catheterization is used to empty the bladder and there are no episodes of incontinence between catheterizations, H0350 - Bladder Continence is coded 0 - Always continent (no documented incontinence). Code 09 - Not applicable would not apply for either scenario as the patient did not have a catheter in place for the entire 3-day assessment period.

M0300

Question 14: Is a pressure ulcer that was present when the first skin assessment was completed then healed during the stay and reopened at the same stage or less during the same stay, considered “present on admission” when completing the discharge assessment?

Answer 14: If a patient has a pressure ulcer that was documented on admission, and at discharge is documented at the same stage, it would be considered as “present on admission”. This guidance is true even if during the stay the original pressure ulcer healed and reopened.

In addition to coding the pressure ulcer as “present on admission”, a previously closed pressure ulcer that opens again should be reported at its worst stage.

Question 15: A patient is admitted Monday evening by the admissions nurse and no pressure ulcers/injuries are documented at that time. The next day the wound nurse assesses the patient’s spinal incision and notices a stage 2 pressure ulcer on coccyx. Is this pressure ulcer considered “present on admission” or facility acquired?

Answer 15: The intent of the items in Section M - Skin Conditions is to document the presence, appearance, and change of pressure ulcers/injuries.

The first skin assessment was conducted on Monday and no pressure ulcer was identified. Then during a subsequent skin assessment a pressure ulcer was identified. In this case the pressure ulcer would not be reported at admission or considered “present on 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.