Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Quarterly Q&As

June 2023

Consolidated June 2020 to June 2023

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Introduction

The Centers for Medicare & Medicaid Services (CMS) is publishing the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Quarterly Q&As, so that all IRF providers have the benefit of the clarifications to existing guidance. Through inquiries to the IRF Post-Acute Care (PAC) Quality Reporting Program (QRP) Help Desk, CMS identifies the opportunity to clarify or refine guidance.

CMS has updated the Quarterly Q&A document in light of the release of the CMS IRF-PAI 4.0 Manual on April 1, 2022, effective October 1, 2022. CMS has archived Q&As reflected in the IRF-PAI 4.0 Manual, and where items are not included in the IRF-PAI 4.0.

The archived Q&As can be found in the IRF Quality Reporting Archives here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Archives

New Q&As Added in June 2023

1. Quality Indicators (QI): General Information

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Quality Indicators (QI): General Questions

Question 1: Archived June 2022

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Question 3: How do I complete the IRF Quality Indicators Sections if a patient has an unplanned discharge?

Answer 3: Patients who meet the criteria for unplanned discharges are:

- Patients who are discharged to an acute care setting, such as Short-stay acute hospital, critical access hospital, inpatient psychiatric facility, or Long-term Care Hospital;
- 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 they relate 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.

Added: September 2022

Question 4: Several of the new items have a copyright. Does a facility need to get permission to include the items in the IRF medical record for data collection?

Answer 4: The IRF-PAI includes a few copyright items such as D0150 - Patient Mood Interview (PHQ-2 to 9). CMS has obtained permission to use these items in the IRF-PAI 4.0. Your facility has permission to use these items within the IRF-PAI assessment only.

Added: September 2022

Question 5: Can information collected prior to admission to an IRF be used when completing items such as A1005 - Ethnicity, A1010 - Race, A1110 - Language, A1250 - Transportation, B1300 - Health Literacy, and D0700 - Social Isolation? Our EMR is able to pull this information directly into the IRF-PAI from the information collected during the preadmission screening.

Answer 5: If information used to complete the IRF-PAI 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 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.

Added: September 2022

Question 6: If a patient has an unplanned discharge within the first 3 days of admission, would it be acceptable for some of the Quality Indicator items such as the C0200-C0500 - Brief Interview for Mental Status (BIMS), C1310 - Signs and Symptoms of Delirium, D0150 - Patient Mood Interview (PHQ-2 to 9), or J0510-J0530 - Pain Interview to have the same score on admission and discharge since the assessment time periods overlap?

Answer 6: Each IRF-PAI item should be considered individually and coded based on the guidance provided for that item at each assessment time period.

It is possible that the admission and discharge coding for items will be the same when an unplanned discharge occurs within the first 3 days of admission.

Added: March 2023

[NEW] Question 7: Can CMS provide clarification on when item 14 - Admission Class should be coded as 4 - Unplanned Discharge? We thought that 4 was coded when there was an unplanned discharge in the first 3 days of admission to the IRF. However, the definition of an unplanned discharge in recent guidance only includes the following situations:

- **Patients who are discharged to an acute care setting, such as short-stay acute hospital critical access hospital, inpatient psychiatric facility, or Long-term Care Hospital;**
- **Patients who die; and**
- **Patients who leave an IRF against medical advice.**

Does this mean any time a patient is discharged from the IRF for one of these reasons, item 14 should be coded as an unplanned discharge?

Answer 7: For the purposes of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) V4.0, an unplanned discharge is defined as:

- Patients who are discharged to an acute care setting, such as Short-stay acute hospital critical access hospital, inpatient psychiatric facility, or Long-term Care Hospital;
- Patients who die; and
- Patients who leave an IRF against medical advice.

For item 14 - Admission Class, response 4 - Unplanned Discharge specifically states this is a stay that lasts less than 3 calendar days because of an unplanned discharge.

Any of the scenarios from the unplanned discharge definition that occur within the first 3 days of the IRF stay would meet the intent of reporting an unplanned discharge for item 14 - Admission Class.

If the patient's stay is more than 3 days and any of the scenarios from the unplanned discharge definition occur, then the IRF stay would be considered an unplanned discharge for purposes of utilizing general unplanned discharge coding guidance. The stay would not meet the intent of reporting an unplanned discharge for item 14 - Admission Class.

Added: June 2023

Section A: Administrative Information

25A, 26A

Question 1: Archived June 2022

Question 2: If a patient's height and/or weight was not measured within the 3-day admission assessment period for 25A - Height on admission and 26A - Weight on admission, is it okay to use a height and/or weight that was measured day 5?

Answer 2: 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). If a patient's height and/or weight cannot be measured during the 3-day assessment period, enter a dash (–) to indicate "no information" for 25A - Height on admission and/or for 26A - Weight on admission. CMS expects dash use to be a rare occurrence.

Added: June 2021

25A

Question 1: Archived June 2022

44D

Question 1: Archived June 2022

Question 2: A patient who was admitted to IRF was planning on being discharged to a SNF on 2/14/22 however prior to discharge the patient was sent to the emergency department (ED). The ED then discharged the patient home with home care services the following day, on 2/15, rather than sending them to the SNF. How do we code 44D - Discharge Disposition for this scenario?

Answer 2: When a patient is transported from the IRF to an emergency department (ED) or observation status, and they do not return to the IRF within 3 days, complete a discharge assessment and code the discharge destination as the first subsequent provider setting the patient is admitted to immediately following the ED and/or observation stay. If a patient remains in ED and/or observation status for > 3 days, code the discharge destination as Code 99 - Not listed.

A subsequent provider is defined as a short-term general hospital, a SNF, intermediate care, home under care of an organized home health service organization or hospice (home), hospice in an institutional facility, an IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a Critical Access Hospital (CAH).

In the scenario, if the patient was transported from the IRF to an ED and within 3 days is discharged home from the ED to receive home care from a Medicare-certified home health agency, code 06 - Home under care of an organized home health service organization.

Added: March 2022

A1005, A1010, A1110, A1250

Question 1: Please provide an example of where the codes for A1250 - Transportation change from admission to discharge.

Answer 1: 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 this 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.

Added: September 2022

Question 2: In Section A: Administrative Information a few of the items state that a proxy can be used. Who would be considered a proxy? Can it be a caregiver, family member, friend or can it only be the Power of Attorney (POA), or health care representative?

Answer 2: For the items in section A that reference use of a proxy, based on item-specific guidance and the patient's unique circumstances, use facility policy to determine who is an appropriate proxy. This can include but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.

Added: December 2022

A2122, A2124

Question 1: Can CMS provide a definition of a "Health Information Exchange" organization for the purposes of coding A2122 - Route of Current Reconciled Medication List Transmission to Subsequent Provider and A2124 - Route of Current Reconciled Medication List Transmission to Patient?

Answer 1: A Health Information Exchange (HIE) is an organization used by provider facilities to electronically exchange patients' health information, including medical records, current reconciled medication lists, etc.

Added: March 2023

Section B: Hearing and Vision

B0200, B1000

Question 1: For B0200 - Hearing and B1000 - Vision what if aids (glasses, hearing aids, etc.) are unavailable to patient at the time of assessment? For example, if the patient reports they can read newspaper headlines with their glasses on but they do not have their glasses and are unable to read that size print when provided upon assessment, what should be coded?

Answer 1: 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.

Added: September 2022

B1300

Question 1: Please provide an example of where the codes for B1300 - Health Literacy change from admission to discharge.

Answer 1: 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 this 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.

Added: September 2022

Section C: Cognitive Patterns

Brief Interview for Mental Status (BIMS) C0100, C0200, C0300, C0400, C0500

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: I know we can administer the BIMS either verbally or written and there are specific directions around this. My question is, when administering it in writing can we present the cue card questions via laptop rather than an actual paper form for those patients who are hearing impaired etc., or does it need to be given in paper or card format?

Answer 3: Facilites may develop their own process for administering the BIMS. However, regardless of processes used, facilities must follow the exact language from the IRF-PAI 4.0 assessment instrument.

Added: December 2022

Question 4: Please clarify when C0500 - BIMS Summary Score should be coded as 99 - Unable to complete interview versus coded with a dash. The guidance manual says to code 99 if any of the BIMS items are coded with a "-" dash. However, the technical data specifications say if all BIMS items (C0200-C0400) are coded with a dash then C0500 must be dashed.

Answer 4: If some, but not all, of the BIMS items (C0200-C0400) are coded with a dash then C0500 - BIMS Summary Score should be coded as 99 - Unable to complete interview.

If all of the BIMS items are coded with a dash then C0500 - BIMS Summary Score must also be coded with a dash.

Added: December 2022

Question 5: As a vendor, when configuring C0200-C0500 - Brief Interview for Mental Status (BIMS) in our EMR system, would it be compliant if additional prompts were added to clarify the reason for coding a 0 response to each BIMS item? The 0 can have different meanings and the reason for coding the 0 may influence the scoring of C0500 - BIMS Summary Score.

Answer 5: The intent of C0200-C0500 - Brief Interview for Mental Status (BIMS) is to determine the patient's attention, orientation, and ability to register and recall information.

As stated in the coding tips for C0200-C0500, the interviewer should track the reason for coding answers as zero because this information will be used later for the coding of the summary score in C0500.

IRFs are required to incorporate the IRF-PAI data items exactly as written.

In addition to any required IRF-PAI items, a facility may determine what other assessment items will be included in the patient assessment to meet regulatory, coverage, and clinical needs.

In the development and maintenance of the IRF-PAI assessment user tools, vendors are advised to reference the Data Specifications (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/DataSpecs).

While the Data Specifications dictate the assessment instrument items, their applicable time point(s) in the assessment instrument, the exact language of the items, and each item's allowable response options, the Data Specifications do not dictate the presentation of the items in the assessment instrument. While the item language and response options may not be modified, reformatting of the presentation of the item is left to the user's discretion, as long as such modification does not impact the accuracy of the item scoring, and is presented in a way that makes it clear which items (assessment questions and response options) are part of the IRF-PAI, and which are not.

Added: March 2023

C0600

Question 1: Please clarify how C0600 - Should the Staff Assessment for Mental Status (C0900) be Conducted? should be coded, when C0100 - Should Brief Interview for Mental Status (C0200-C0500) be Conducted? is coded as 0 - No.

Answer 1: When C0100 - Should Brief Interview for Mental Status (C0200-C0500) be Conducted? is coded as 0 - No, skip C0200-C0600.

Added: June 2022

C1310

Question 1: If the Brief Interview for Mental Status (BIMS) is not completed, are we allowed to skip C1310 - Signs and Symptoms of Delirium? There is language in C1310 that states to complete after the BIMS is completed.

Answer 1: Each IRF-PAI item should be considered individually and coded using all available guidance provided for that item. There is no guidance or data specification edit directing providers to skip C1310A, C1310B, C1310C, and/or C1310D when the BIMS interview was not completed.

As stated in the Steps for Assessment for C1310, code C1310 after:

1. Observing the patient behavior during the cognitive assessment (BIMS items (C0200-C0400), Staff Assessment (C0900), if completed, or other cognitive assessment) for the signs and symptoms of delirium.

2. Reviewing 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. Observing 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.

Added: December 2022

Question 2: How is "baseline" defined for C1310A - Acute Onset Mental Status Change at discharge?

Answer 2: The intent of C1310 - Sign and Symptoms of Delirium is to identify any signs or symptoms of acute mental status changes as compared to the patient's baseline status.

As stated in the Coding Instructions for C1310A - Acute Onset Mental Status Change, 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.

Examples of acute mental status changes:

- A patient who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
- A patient who is normally quiet and content suddenly becomes restless or noisy.
- A patient who is usually able to find their way around their living environment begins to get lost.

At discharge, compare the patient's current mental status to their baseline mental status (prior to the discharge assessment time period).

Added: December 2022

Section D: Mood

D0150

[NEW] Question 1: Please clarify when the entire Patient Mood Interview should be completed for D0150 - Patient Mood Interview (PHQ-2 to 9). The instruction in the IRF-PAI Guidance Manual Section D-Errata appears to conflict with the language in the D0150 item.

Answer 1: At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance. Related to the Patient Mood Interview, please disregard the statement in the IRF-PAI item that states "If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview." This statement is outdated due to refinements in IRF-PAI guidance.

Please use the instructions found in the Steps for Assessment for D0150 in the IRF-PAI Guidance Manual Section D-Errata, which reflects the most recent guidance. As stated in the errata, whether or not further evaluation of a patient's mood is needed depends on the patient's responses to the PHQ-2 (D0150A and D0150B). If **both** D0150A1 and D0150B1 are coded 9, OR, **both** D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise continue. For all other scenarios proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9 and complete D0160, Total Severity Score.

Added: June 2023

Section GG: Functional Abilities and Goals

GG0100C

Question 1: Archived June 2022

GG0100C, GG0170M, GG0170N, GG0170O

Question 1: Archived June 2022

GG0100, GG0110

Question 1: We have questions regarding prior level of functioning and prior device use. A patient is admitted to our facility for rehab, has a medical issue, and is discharged to an acute care hospital for a week. When the patient returns to our facility, would the prior level of functioning reported in GG0100B - Prior Functioning: Indoor Mobility reflect the patient's ambulation status prior to the original admission (which is the reason we are still treating the patient) or is the prior level of functioning based on what the patient was doing during the hospital stay? Would this also apply to GG0110 - Prior Device Use?

Answer 1: The intent of GG0100B - Prior Functioning: Indoor Mobility is to report the patient's need for assistance with walking from room to room, with or without a device such as a cane, crutch, or walker, prior to the current illness, exacerbation, or injury. 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 functioning and prior device use apply for each individual patient.

In responding to GG0100 - Prior Functioning: Everyday Activities, the activities should be reported based on the patient's usual ability prior to the current illness, exacerbation, or injury. This is the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is most recent, that initiated this episode of care. Clinicians should use clinical judgment within these parameters in determining the timeframe that is considered "prior to the current illness, exacerbation, or injury."

The same approach should be used in determining Prior Device Use for GG0110.

Added: September 2020

GG0110

Question 1: Archived June 2022

GG0130, GG0170

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: I am seeking clarification on how to accurately code the admission assessments for Section GG0130 Self-care and GG0170 Mobility when a patient leaves AMA before the admission assessment is completed.

Would it be appropriate to use Code 07 - Patient refused if an assessment was not done because of the patient leaving AMA?

Answer 3: Patients who meet the criteria for incomplete stays include patients who are discharged to an acute care setting (such as short-stay acute hospital, critical access hospital, inpatient psychiatric facility, or long-term care hospital), patients who die while in the IRF, patients who leave the IRF against medical advice (AMA), and patients with a length of stay less than 3 days.

If the patient's IRF stay is less than 3 days, and ends before the admission assessment was completed, code GG0130 and GG0170 performance to the best of your abilities. If the patient refused rehab at the IRF and left AMA before the admission assessment was completed, use Code 07 - Patient refused.

Added: June 2020

Question 4: Archived June 2022

Question 5: Archived June 2022

Question 6: We understand that if a patient initially refuses to attempt an activity during the assessment period, but later agrees to perform the activity, the code that represents the patient's actual performance supersedes the refusal code (07). What if on day 1 or day 2 a safety or medical issue prevents the patient from attempting an activity, but on day 3, after benefiting from therapeutic intervention, the patient can now perform the activity? Which code should be reported on the IRF-PAI: Code 88 - Not attempted due to medical condition or safety concerns, or one of the performance codes, 01-06?

Answer 6: 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. "*Prior to the benefit of services*" means prior to provision of any care by your facility staff that would result in more independent coding.

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.

If this is the case in your scenario, code 88 - Not attempted due to medical condition or safety concerns even if the patient's status changes and the patient is able to complete the activity on a later day during the assessment period.

Added: September 2020

Question 7: Archived June 2022

Question 8: How should the following situation be coded for the GG0130 - Self-Care and GG0170 - Mobility items? On discharge a patient was nonadherent with spinal precautions. The patient was able to demonstrate completing functional tasks independently with good balance and strength, and was cognitively intact. By the patient's report, they were choosing not to routinely adhere to spinal precautions in their day-to-day activities, although they were aware of the precautions and risks. Should the GG activities be coded based on the patient's ability, which is independent, or based on the fact that they knowingly break their precautions?

Answer 8: The GG activities focus on the patient's ability to complete the activities as independently as possible as long as they are safe; willingness and nonadherence are not the focus of the coding.

If, in your scenario, you have assessed the patient being able to independently complete the GG activities safely, code 06 - Independent.

Added: June 2021

Question 9: For GG0130 - Self-Care and GG0170 - Mobility, it is our facility's policy that a patient always have a staff member present during walking or toileting activities. Is it possible for the GG activity to be assessed and coded 06 - Independent, for situations where a staff member is required to be present per facility policy, but is not required to assist or supervise the patient in any way?

Answer 9: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe.

If a helper is present (only due to facility policy) code the activity based on the type and amount of assistance the patient requires to complete the activity as independently as possible, as long as they are safe. If no assistance/supervision/set-up is required, then code 06 - Independent.

Added: September 2021

Question 10: When determining the appropriate performance code at admission for the GG self-care and mobility activities there are times when the score on day 1 differs from the scores on days 2 and 3. For example:

- **On Day 1 when attempting to perform a sit to stand transfer, even with assist from the therapist the patient is unable to complete the transfer due to pain. The therapist scores GG0170D - Sit to stand as a Code 88 - Not attempted due to medical condition or safety concerns in day 1 notes. On day 2, per therapy notes the patient was able to complete the sit to stand transfer with assistance of two people. Which code would I use? Code 88 - Not attempted due to medical condition or safety concerns or Code 01 - Dependent?**
- **On Day 1 there is no mention of sit to stand noted in documentation. On day 2 documentation reports that the patient requires partial/moderate assistance of 1 (Code 03) and later that day the therapy note shows that the patient required the assistance of two people to stand. How would this scenario be coded? Does any source take priority? Do I look at all three days and select usual performance from all sources?**

Answer 10: 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.

When the baseline function code differs from the usual performance during the assessment period, report the baseline function code.

If in your first scenario, the patient being unable to complete the sit to stand activity due to medical conditions or safety concerns represents their baseline ability, then code 88 - Not attempted due to medical condition or safety concerns.

In your second scenario, as in all admission scenarios, select the code that represents the patient's baseline ability to complete the activity as independently as possible as long as they are safe, prior to the benefit of services provided by your facility staff.

Added: December 2021

Question 11: The guidance for GG0130 and GG0170 states "the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely, not based on the availability of such assistance." Can you provide an example of "not based on the availability of such assistance"?

Answer 11: When assessing and coding GG activities, allow the patient to perform the activity as independently as possible, as long as they are safe. Select the code based on the type and amount of assistance required to complete the activity, not based on the availability of assistance.

For example, a patient requires a physical therapist to provide assistance to ambulate 10 feet safely. However, when the therapist is not available, the patient is unable to ambulate 10 feet safely. The walking activity would be coded based on the type and amount of assistance required (assistance to walking 10 feet), even though a physical therapist may not always be available to provide the needed assistance.

Added: September 2022

GG0130A

Question 1: Archived June 2022

Question 2: A patient is admitted to an Inpatient Rehabilitation Facility (IRF) with quadriparesis 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?

Answer 2: 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.

Added: December 2020

Question 3: Archived June 2022

Question 4: A patient is independent with self-feeding, but requires encouragement for adequate intake. Would the encouragement to increase food and/or fluid intake be considered when scoring GG0130A - Eating?

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. The adequacy of the patient's nutrition or hydration is not considered for GG0130A - Eating.

When coding activities in Section GG, clinicians should code based on the type and amount of assistance required allowing the patient to perform the activity as independently as possible, as long as they are safe. If the patient is able to meet the intent of the activity with no assistance (physical, verbal/nonverbal cueing, setup/clean-up) then code 06 - Independent.

Added: June 2022

GG0130B

Question 1: Archived June 2022

GG0130C

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Archived June 2022

Question 4: I understand that if a helper provides setup before toileting hygiene or clean-up after, and the patient completes the activity of toileting hygiene without additional assistance, the correct code is 05 - Setup or clean-up assistance.

What would the correct code be if a helper provided assistance (contact guard or touching assistance) to the patient as the patient gathered their incontinence products but then the patient completed the toileting hygiene activity without further assistance?

Answer 4: 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.

It is not the type of assistance that is provided that determines the 05 - Setup or clean-up assistance code but rather when (related to the completion of the activity) the needed assistance is provided.

If the assistance provided is necessary only before or after the activity is completed, and no assistance is needed during the completion of the activity, select Code 05 - Setup or clean-up assistance.

Added: December 2021

GG0130E

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: For a patient who stood while showering prior to this illness, should we now be assessing and scoring showering/bathing based on the patient's status standing?

Answer 3: 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). The activity does not include transferring in/out of tub/shower.

When coding any of the self-care or mobility 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.

Added: June 2020

Question 4: Archived June 2022

Question 5: Archived June 2022

GG0130F, GG0130G, GG0130H

Question 1: Archived June 2022

GG0130G, GG0130H

Question 1: Archived June 2022

GG0130G

Question 1: Archived June 2022

GG0130H

Question 1: Archived June 2022

Question 2: We have a question regarding the following scenario. On day 2 of the patient's stay, the occupational therapist (OT) evaluates and assesses all the GG self-care activities. During that evaluation, for footwear, the patient only dons hospital socks (regular shoes and socks are not available) and requires only cueing. Toward the end of the session (after the assessment), the OT initiates the intervention of ADL re-training. On day 3, after the initiation of ADL re-training, the patient's spouse brings in socks and tennis shoes with laces, which are the patient's preferred footwear. The patient now requires greater than 50% assistance of one helper for donning footwear. Even though it is post intervention, can the "greater than 50% assistance" score be reported since it is still within the assessment timeframe?

Answer 2: The intent of GG0130H - Footwear is to assess the patient's ability to put on and take off socks and shoes or other footwear that is appropriate for safe transfer and/or ambulation (mobility), including fasteners (if applicable).

When assessing self-care and mobility activities, 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 reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

Clinicians should use clinical judgment to determine if observing the patient putting on and taking off the footwear (i.e., hospital socks) worn during the first assessment allows the clinician to adequately assess the patient's baseline ability to complete the activity of putting on/taking off footwear (GG0130H). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the activity.

Added: September 2020

GG0170

Question 1: Archived June 2022

Question 2: 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 2: 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. A walking activity 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.

Added: December 2020

GG0170C

Question 1: Archived June 2022

GG0170E

Question 1: 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 1: 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 they are 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.

Added: December 2020

GG0170F

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: 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 3: 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 simulating the toilet transfer adequately respresents the patient's ability to complete the GG0170F activity, 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.

Added: December 2020

GG0170G

Question 1: In the assessment of a patient's ability to perform a car transfer, does adjusting the car seat constitute 05-Setup or clean-up assistance? For example, after the helper reclined the seat to accommodate the patient's total hip precautions, the patient did not need any additional help to get into or out of the car.

Answer 1: The intent of GG0170G - Car transfer is to assess the patient's ability to transfer in and out of a car or van on the passenger side. This does not include the ability to open/close door or fasten seat belt.

Code 05 - Setup or clean-up assistance is selected when a patient requires a helper to set up or clean up; patient completes the activity and the helper is required to assist only prior to or following the activity. In the scenario described, assuming the seat adjustment was required for safe completion of the activity, and no assistance was required during the safe transfer in and out of the car, then the seat adjustment would be coded as 05 - Setup or clean-up assistance.

Added: June 2020

Question 2: Archived June 2022

Question 3: Archived June 2022

Question 4: Archived June 2022

Question 5: Archived June 2022

Question 6: When coding GG0170G - Car transfer based on a simulation, what equipment or environmental setup would we need to have in order to make the activity similar enough to the car transfer?

Answer 6: 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.

In situations where specific equipment may not be available (e.g., 12 steps, a vehicle), the assessing clinician may determine that assessment of a similar activity adequately represents the patient's ability to complete the 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 proxy 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, using clinical judgment, simulating the car transfer 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.

Use of an "activity not attempted" code should occur only after determining that the activity is not completed, and that the performance code cannot be determined based on patient/caregiver report, collaboration with other staff, or assessment of similar activities, in conjunction with all current assessment findings.

Note that this is a refinement to instructions that was in the V3.0 guidance manual that stated if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period, then report Code 10 - Not attempted due to environmental limitations.

Added: March 2021

Question 7: Archived June 2022

Question 8: Archived June 2022

GG0170I, GG0170J, GG0170K, GG0170L

Question 1: Many of our patients with a stroke ambulate with PT along a railing mounted in the hall. We understand that walking/transferring in the parallel bars would not be used to code the GG activities. Could coding be based on the patient walking in the hallway if using a railing as a support?

Answer 1: 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.

As noted in your question, you would not code self-care and 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). Note that while a patient may use a hallway railing during therapy sessions, its use would not be restricted to therapy sessions only and therefore does not meet the definition described above.

CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Other than the exceptions listed above, clinical assessments may include any device or equipment (including a hallway railing) that the patient can use to allow them to safely complete the activity as independently as possible.

Added: June 2020

Question 2: Can you give some clarification regarding scoring a performance with the help of a second person (if this second person is helping push an oxygen tank, IV pole, or wheelchair following the patient) because the first helper is physically assisting the patient during the walking activity? Both helpers are needed to complete the activity safely. The IRF-PAI manual says "Code 01, Dependent - if the assistance of two or more helpers is required for the patient to complete the activity."

Answer 2: The intent of the GG0170 walking items is to assess the patient's ability once standing to safely walk the stated distances and circumstances in each item.

You are correct that if a patient requires the assistance of two helpers to complete an activity (one to provide support to the patient and a second to manage the necessary equipment to allow the safe walk), Code 01 - Dependent is the appropriate code.

If a single helper only manages the oxygen tank or the IV pole and otherwise the patient needs no assistance to safely complete the walking activity, code the walking activity as 04 - Supervision or touching assistance. This is because the helper is required to be present during the activity for the patient to complete the activity safely.

Added: September 2020

Question 3: If a patient requires a therapist to provide steadying assistance/contact guard assist and manage an oxygen tank while the patient is ambulating how would the walking activities be coded?

Answer 3: The intent of the GG0170 walking items is to assess the patient's ability once standing to safely walk the stated distances and circumstances in each item.

If the helper is required to manage the oxygen tank and/or oxygen tubing and/or provide steadying assistance/contact guard, to allow the patient to complete an activity safely, then code 04 - Supervision or touching assistance.

Added: March 2021

Question 4: Archived June 2022

GG0170I

Question 1: Archived June 2022

GG0170M, GG0170N, GG0170O

Question 1: When we initiate the assessment of GG0170M - 1 step (curb), we determine that the patient is not able to go up/down the curb due to medical/safety reasons. Are we then required to assess using a single step (i.e. the bottom step of a set of practice steps)?

Answer 1: 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 assist and/or a railing.

Added: June 2020

Question 2: Archived June 2022

Question 3: What is specifically assessed when a patient uses a stair lift to ascend/descend stairs? Should the GG activities be coded based on the type and amount of assistance required to get on and off the stair lift? Or is it the type and amount of assistance required to use the stair lift itself?

Answer 3: The intent of Section GG stair activities is to assess the patient's ability to go up and down 1 step/curb, 4 steps, and 12 steps. Clinicians should code based on the type and amount of assistance required for the patient to complete the stair activities as independently and safely as possible.

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. 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.

When using a stair lift to ascend/descend stairs code based on the type and amount of assistance the patient requires to ascend/descend stairs once seated.

Added: June 2022

GG0170M

Question 1: Archived June 2022

GG0170N, GG0170O

Question 1: When assessing the GG activities for 4 and 12 steps, the patient is able to navigate 4 and 12 steps by bumping up and down them with supervision. However, he needs assist getting seated on the step, and again to come to standing once completed with the steps. Is the assist required to sit on the step or to come to standing considered when coding these two stair items?

Answer 1: The intent of Section GG stair activities is to assess the patient's ability to go up and down 1 step/curb, 4 steps, and 12 steps. Clinicians should code based on the type and amount of assistance required for the patient to complete the stair activities as independently and safely as possible. Do not consider the stand-to-sit or sit-to-stand transfer when coding any of the step activities.

Added: June 2020

Question 2: Archived June 2022

Question 3: The Guidance Manual discusses how a patient is permitted to take a seated rest break between ascending and descending 4 or 12 steps. Can a patient take a seated rest break at any time while completing the activity? For example, they start ascending 12 steps but after 5 steps need to stop and rest before completing the remaining 7 steps?

Answer 3: 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.

Added: March 2022

GG0170P

Question 1: We understand that verbal cueing during a task should fall under the score of 04 - Supervision or touching assistance. Our question is can a verbal cue provided prior to the task be considered set up as long as no further cues were provided during the actual task?

A specific example we just encountered was during the "Picking up an item from the floor" activity. The therapist cued the patient prior to the activity where to place their hand for stability (in a novel environment), and then the patient completed all of the activity safely and without further cues or assistance. Is this Code 05-Setup or clean-up assistance or Code 04 - Supervision or touching assistance?

Answer 1: When assessing self-care and mobility activities, 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 reflect the patient's baseline ability to complete the activity prior to benefit of services provided by your facility staff. This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code, and coding based on the type and amount of assistance required.

Communicating the activity request (i.e., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity ("Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.

In the scenarios described, assuming the verbal cues were only provided prior to the benefit of services and were required, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues would be considered 05 - Setup or clean-up assistance.

Added: June 2020

GG0170Q

Question 1: Archived June 2022

Question 2: Archived June 2022

GG0170R, GG0170S

Question 1: Archived June 2022

GG0170S

Question 1: Archived June 2022

Section H: Bladder and Bowel

H0350

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Please provide clarification on how the following scenario would be coded for H0350 – Bladder Continence on Admission?

Day One: Admitted with Indwelling catheter

Day Two: Indwelling removed, 1 incontinent episode, 2 Continent

Day Three: 1 incontinent episode, 2 Continent

Answer 3: 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 in use during part of the 3-day assessment period, but not used for the entire 3-day assessment period), code continence level based on when catheter is not in use during the 3-day assessment period.

If the incontinent episodes during the 3 days occur only with stress, then code 1 - Stress Incontinence Only. If a patient is incontinent 1 or 2 times or incontinent any number of times on one or two days, but at least one full day with no incontinent episodes, then code 2 - Incontinent Less than Daily.

Added: June 2022

H0400

Question 1: Archived June 2022

Section J: Health Conditions

J0520

Question 1: The rehab therapy definition in J0520 - Pain Interference with Therapy Activities in the guidance manual states:

Rehab Therapy - special healthcare service or programs that help a person regain physical, mental, and or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, PT, OT, SLP, and cardiac and pulmonary therapies

Based on the term "regain," would maintenance therapy not be considered a rehab therapy for the item J0520 - Pain Interference with Therapy Activities?

Answer 1: Rehabilitation Therapy includes, but is not limited to, special healthcare service or programs that help a person regain physical, mental, and or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, any services provided by PT, OT, SLP, and cardiac and pulmonary therapies

Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present, regardless of the rehab focus or goal(s).

Added: September 2022

J1800, J1900

Question 1: Is a fall that occurred at an acute care hospital during a program interruption considered when coding J1800 - Any Falls Since Admission and J1900 - Number of Falls Since Admission on the discharge IRF-PAI?

Answer 1: J1800 and J1900 include all falls that occurred since the time of admission. This would include any falls that occurred outside of the IRF facility during a program interruption.

Added: September 2022

J1900

[NEW] Question 1: If a patient falls while a patient of an IRF but the level of injury related to the fall is not known until after the patient has been sent to the acute-care hospital for treatment, should J1900 - Number of Falls Since Admission be coded based on information known at the time the patient left the IRF or coded using additional information from the acute-care hospital?

Answer 1: The intent of J1900 - Number of Falls Since Admission is to determine the number of falls that occurred since admission and code the level of fall-related injury for each. For item J1900, include all falls that occurred since the time of admission. This would include any falls that occurred during a program interruption.

An injury related to a fall is defined as any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall. A major injury is defined as bone fractures, joint dislocation, closed head injuries with altered consciousness, and subdural hematoma. If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

Facilities are encouraged to utilize accurate and/or new information regarding fall-related injuries as information becomes known. Errors should be corrected following the facility's correction policy. For example, injuries can present themselves later than the time of the fall. The facility may not learn of the level of injury until after the IRF-PAI assessment is completed or the patient has left the facility (e.g., because the patient was transported to ER and admitted to an inpatient facility post-fall).

Added: June 2023

Section K: Nutritional Approaches

K0520

Question 1: When coding K0520 - Nutritional Approaches should we only consider those nutritional approaches that the patient actually receives at admission and discharge or just those that are included on the plan of care? When coding K0520 at discharge should we only indicate those nutritional approaches that the patient will continue to receive after the patient is discharged?

Admission

K0520. Nutritional Approaches Check all of the following nutritional approaches that apply on admission.	
	1. On Admission **Check all that apply** ↓
A. Parenteral/IV feeding	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐
Z. None of the above	☐

Discharge

K0520. Nutritional Approaches		
4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days **5. At Discharge** Check all of the nutritional approaches that were being received at discharge	**4. Last 7 Days** **Check all that apply** ↓	**5. At Discharge** ↓
A. Parenteral/IV feeding	☐	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. None of the above	☐	☐

Answer 1: 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 discharge.

At admission check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day admission assessment time period, even if not used during the 3-day admission assessment time period.

At discharge for column 4 - Last 7 days, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the last 7 days, even if not used in the last 7 days. At

discharge for column 5 - At Discharge, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, even if not used during the 3-day discharge assessment time period.

At discharge, K0520 does not report on nutritional approaches that are expected to occur after discharge.

Added: December 2022, Edited: June 2023

Question 2: For K0520A - Nutritional Approaches; Parenteral/IV feeding, is Parenteral/IV feeding coded when there is just a documented need for hydration or does the documented need have to be for both hydration and nutrition?

Answer 2: 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 discharge.

IV fluids can be coded in K0520A if the additional fluid intake reflects a specifically documented need for nutrition and/or hydration.

Added: December 2022

Question 3: If a patient is placed on a full liquid diet for a bowel cleanse should this be considered a mechanically altered diet when coding K0520 - Nutritional Approaches?

Answer 3: 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 discharge.

K0520C - Nutritional Approaches; Mechanically altered diet reports if the patient requires a mechanically altered diet.

Mechanically altered diet is defined as a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids for patients having trouble chewing and/or swallowing foods or thin liquids.

If, in your scenario, the diet texture is altered for a reason other than to facilitate oral intake, it would not be considered a mechanically altered diet when coding K0520C.

Added: December 2022

Question 4: Please provide guidance as to the accurate response for K0520Z - Nutritional Approaches; None of the Above in the following scenario:

K0520A - Parenteral/IV Feeding = checked

K0520B - Feeding Tube = not checked

K0520C - Mechanically altered diet = Dash to indicate there was no available information

K0520D - Therapeutic diet = not checked

Should K0520Z be unchecked because K0520A is checked, or dashed because K0520C is dashed?

Answer 4: When one or more items for K0520A - K0520D is checked, to indicate that the specified nutritional approach applies to the patient, then K0520Z should be left unchecked. This is true even if one of the other items K0520A - K0520D is dashed.

This same concept applies to N0415 - High Risk Drug Classes: Use and Indication and O0110 - Special Treatments, Procedures, and Programs.

Added: March 2023

Question 5: We are having difficulty determining when we should consider food modifications as a mechanically altered diet for K0520C - Nutritional Approaches; Mechanically altered diet. Is there a specific reference CMS suggests utilizing to determine this?

Answer 5: 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 discharge.

K0520C - Nutritional Approaches; Mechanically altered diet reports if the patient requires a mechanically altered diet.

Mechanically altered diet is defined as a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake.

A specific cross-walk does not exist between any diet classification system and the coding of K0520. Utilizing a diet classification system to code may lead to inaccuracies in K0520.

If the diet texture is altered for a reason other than to facilitate oral intake, it would not be considered a mechanically altered diet when coding K0520C.

Added: March 2023

[NEW] Question 6: Should K0520B - Nutritional Approaches; Feeding Tube be checked if there is a feeding tube present, but it is not being utilized for nutritional/hydration purposes? Can K0520B be checked if the feeding tube is just used to deliver medications?

Admission

K0520. Nutritional Approaches Check all of the following nutritional approaches that apply on admission.	
	1. On Admission **Check all that apply** ↓
A. Parenteral/IV feeding	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐
Z. None of the above	☐

Discharge

K0520. Nutritional Approaches		
4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days **5. At Discharge** Check all of the nutritional approaches that were being received at discharge	**4. Last 7 Days** **Check all that apply** ↓	**5. At Discharge** ↓
A. Parenteral/IV feeding	☐	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. None of the above	☐	☐

Answer 6: 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 discharge.

If a feeding tube is in place but there are no scheduled or PRN orders to provide nutrition or hydration via the feeding tube on the current care/treatment plan, do not code K0520B - Feeding Tube.

At admission check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day admission assessment time period, even if not used during the 3-day admission assessment time period.

At discharge for column 4 - Last 7 days, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the last 7 days, even if not used in the last 7 days. At discharge for column 5 - At Discharge, check all of the nutritional approaches that are part of the

patient's current care/treatment plan during the 3-day discharge assessment time period, even if not used during the 3-day discharge assessment time period.

Added: June 2023

Section M: Skin Conditions

M0210, M0300

Question 1: Archived June 2022

M0300

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Archived June 2022

Question 4: Archived June 2022

Question 5: Archived June 2022

Section N: Medications

N0415

Question 1: If a medication is ordered at admission but not taken within the first 3 days of the IRF stay (e.g., PRN orders), does this medication get considered for N0415 - High-Risk Drug Classes: Use and Indication?

Additionally, is there guidance on how specific the indication documented needs to be? Can the generic use of the medication included on a pharmacy pamphlet suffice?

If a medication is ordered for the patient to take once they return home, should that medication be considered when coding N0415 at discharge?

Answer 1: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

When coding N0415, 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 assessment period.

Review patient documentation to determine if there is a patient-specific indication noted for all medications in the drug class.

At Discharge, N0415 considers medications included in the patient's prescribed drug regimen at discharge, and not what is expected to occur after discharge.

Added: September 2022

Question 2: When determining if a medication should be included in one of the 6 high-risk drug classes collected in the new item N0415 - High-Risk Drug Classes: Use and Indication, which drug classification system should be used?

Is there a specific drug classification system that should be used, or can facilities use any authoritative source even if a system describes the drug classes using terminology that differs from the exact drug classes reported in the item?

Answer 2: N0415 - High-Risk Drug Classes: Use and Indication identifies if the patient is taking any prescribed medication in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Code medications according to the medication's therapeutic category and/or pharmacological classification.

CMS does not specify a source for identifying the therapeutic category and/or pharmacological classification.

Added: December 2022

Question 3: Please provide guidance as to the accurate response for N0415Z - High-Risk Drug Classes; None of the Above in the following scenario:

> **N0415A - Antipsychotic; Column 1 (Is Taking) = checked**
>
> **N0415E - Anticoagulant; Column 1 (Is Taking) = not checked**
>
> **N0415F - Antibiotic; Column 1 (Is Taking) = Dash to indicate there was no available information**
>
> **N0415H - N0415J; Column 1 (Is taking) = not checked**

Should N0415Z be unchecked because N0415A is checked, or dashed because N0415F is dashed?

Answer 3: When one or more items for N0415 is checked, to indicate that the patient is taking a medication in one or more of the high-risk drug classes, then N0415Z should be left unchecked. This is true even if one of the other N0415 items is dashed.

This same concept applies to K0520 - Nutritional Approaches and O0110 - Special Treatments, Procedures, and Programs.

Added: March 2023

Question 4: Our facility has a standard order set for all patients that includes PRN antiemetics including prochlorperazine, which is classified in the classification reference we use as an antipsychotic. The majority of our patients do not end up needing/receiving this PRN medication.

Guidance from the September IRF-PAI Quarterly Q&As states to "consider a medication that is included in the patient's prescribed drug regimen even if it is not taken during the 3-day assessment period."

Does this mean our facility should be checking N0415A – High-Risk Drug Classes; Antipsychotics for every patient with this standing order?

Answer 4: Some facilities utilize standing orders or a standing order set, providing a specific PRN order for all patients. If a medication is included on the patient's prescribed drug regimen due to facility policy (and not due to patient-specific need), it would only be considered for N0415 - High-Risk Drug Classes: Use and Indication if the patient received it during the 3-day assessment time period.

Added: March 2023

Question 5: Are the following scenarios acceptable approaches when determining if a patient-specific indication is documented for N0415 - High-Risk Drug Classes: Use and Indication:

- **A clinician finds the patient-specific indication noted on the discharge paperwork from the referring facility/provider (e.g., coumadin for afib)**
- **There is no patient-specific indication noted for a medication, so the clinician contacts the physician to verify why the patient is taking the med and adds the physician response to the IRF medical record**
- **The patient or family member verbally tells the clinician why the medication is being used (e.g., "for my back pain," "for my infection") and the clinician documents this reason(s) in the IRF medical record**
- **A clinician sees a diagnosis documented in discharge or referral paperwork (e.g., diabetes, schizophrenia) and the patient is taking related medications (e.g., hypoglycemic, antipsychotic) so considers the documented diagnosis as the patient-specific indication**

Answer 5: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

When coding N0415, 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).

Sources include medical records received from providers or facilities where the patient received health care, the patient's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

Discussions (including with the acute care hospital, other staff and clinicians, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.

CMS does not provide an exhaustive list of examples for determining the source for the documented patient-specific indication. Use available resources along with clinical judgment to determine if the scenarios you suggest meet the criteria for a patient-specific indication for the purposes of N0415.

Added: March 2023

Question 6: If an anticoagulant is used to flush a PICC line that has become blocked with clotted blood, should that anticoagulant be considered when coding N0415 - High-Risk Drug Classes: Use and Indication?

Answer 6: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Do not include flushes to keep an IV access port patent.

Added: March 2023

Question 7: For N0415 - High-Risk Drug Classes: Use and Indication can you provide an example of a combination drug that would be in more than one of the listed high-risk drug classes?

Answer 7: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Combination medications should be coded in all categories/pharmacologic classes that constitute the combination, regardless of why the medication is being used. For example, Percodan is a combination medication (oxycodone and aspirin) classified as both an opioid and an antiplatelet. Therefore, for both N0415H - Opioid and N0415I – Antiplatelet, *Column 1 – Is Taking* would be coded, regardless of why the medication is being used.

Added: March 2023

[NEW] Question 8: Please provide guidance on the following scenario. A patient is admitted to an IRF and then, during the 3-day assessment time period, goes to the Emergency Department (ED) and recieves a one-time dose of a medication that is classified as a high-risk medication for N0415 - High-Risk Drug Classes: Use and Indication. If the admission assessment was not completed until after the patient returned from the ED should the medication that was received in the ED be considered when coding N0415?

Answer 8: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Code any medication that is used by any route in any setting (e.g., at an IRF, in a hospital emergency room, at physician office or clinic) while a patient of the IRF that is also part of a patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment period.

Added: June 2023

N0415 & O0110

Question 1: We have a question regarding how to code N0415 - High-Risk Drug Classes and O0110 - Special Treatments, Procedures, and Programs for a patient who has an interrupted stay within the admission assessment period.

Our patient was admitted on 11/4, went out to an acute facility on 11/5, and returned on 11/7. Therefore, the admission assessment days will be 11/4, 11/7, and 11/8.

Guidance for N0415 states to consider medications that are included in the patient's prescribed drug regimen as well as to include any of these medications used by any route (e.g., PO, IM, transdermal, or IV) in any setting (e.g., at IRF, in a hospital emergency room, at physician office or clinic) while a patient of the setting.

Guidance for O0110 states, "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 themselves 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)."

Using this guidance, does this mean that we will need to consider what occurs during the interrupted stay in order to accurately code these items?

Answer 1: Each IRF-PAI item should be considered individually and coded based on the guidance provided for that item at each assessment time period.

N0415 - High-Risk Drug Classes and O0110 - Special Treatments, Procedures, and Programs should be completed based on an assessment that occurs within the 3-day admission assessment time period or the 3-day discharge assessment time period.

As stated, the coding for N0415 and O0110 includes medications, special treatments, procedures, and programs that are included in the patient's drug regimen/current care/treatment plan during the 3-day assessment time period, even if the medication or treatment is received outside of the assessment time period and/or while at another setting.

When coding N0415 and O0110 during the 3-day admission assessment time period, there may be situations in which a medication or treatment provided in another setting (e.g., acute care hospitalization during an interrupted stay within the admission assessment time period) would be reported. Review of documentation from other provider settings may be helpful in order to code N0415 and O0110 accurately.

Added: March 2023

N2005

Question 1: Can the response for N2005 - Medication Intervention be determined at any time during the discharge window (day of discharge and 2 calendar days preceding the day of discharge) or does this item need to be completed on the day of discharge?

Answer 1: The intent of N2005 - Medication Intervention is to indicate if the facility contacted and completed physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission.

In order to report on all potential clinically significant medication issues, N2005 should be completed at the time of discharge.

Added: September 2021

Section O: Special Treatments, Procedures, and Programs

O0110

Question 1: We have a question regarding O0110 - Special Treatments, Procedures, and Programs. Are treatments, procedures, and/or programs that the patient was receiving only on the day of admission and only on discharge considered? For the discharge assessment, must we also consider what the patient has ordered to receive after discharge (e.g., Chemotherapy or radiation scheduled to begin after discharge)?

Answer 1: 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 treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, and not what is expected to occur after discharge.

Added: September 2022

Question 2: 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 assesment 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?

Answer 2: 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 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).

Added: September 2022

Question 3: 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.

Answer 3: If the BiPAP or CPAP is part of the patient's current care/treatment plan, then mark O0110G1 - Non-Invasive Mechanical Ventilator and O0110G2 or O0110G3 - CPAP.

Added: September 2022

Question 4: Regarding coding O0110, the IRF-PAI V4.0 Manual states in the Coding Tips for O0110 - Non-Invasive Mechanical Ventilator "*If a ventilator is being used as a substitute for BiPAP/CPAP, code here (and do not check O0110G2 or O0110G3).*" However, if O0110G1 - Non-Invasive Mechanical Ventilator is marked then per the technical data specifications O0110G2 - BiPAP and/or O0110G3 - CPAP must also be marked. Please advise.

Answer 4: The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

If a patient's current care includes non-invasive mechanical ventilation, code O0110G1 – Non-Invasive Mechanical Ventilator. Code O0110G2 - BiPAP if the non-invasive mechanical ventilator support was BiPAP. Code O0110G3 - CPAP if the non-invasive mechanical ventilator support was CPAP.

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle.

Please disregard the portion of the statement in the manual that reads "*(and do not check O0110G2 or O0110G3).*"

Added: December 2022

Question 5: Please provide guidance as to the accurate response for O0110Z - Special Treatments, Procedures, and Programs; None of the Above for the following scenario. At least one of the listed treatments, procedures, and programs is checked to indicate it applies to the patient but another of the listed treatments, procedures, and programs must be dashed because there is no information available.

Should O0110Z be unchecked because at least one of the other O0110 items is checked, or dashed because one of the O0110 items is dashed?

Answer 5: When one or more items for O0110 - Special Treatments, Procedures, and Programs is checked, to indicate that the treatment, procedure, or program applies to the patient, then O0110Z should be left unchecked. This is true even if one of the other O0110 items is dashed.

This same concept applies to K0520 - Nutritional Approaches and N0415 - High-Risk Drug Classes: Use and Indication.

Added: March 2023

Question 6: Would an AV fistula be reported in O0110O1 - IV Access?

Answer 6: An AV fistula does not meet the definition of IV Access for O0110O1.

If there is not a current IV access in place at the time of assessment, and no other treatments, procedures, or programs listed in O0110 apply to the patient then code O0110Z - None of the above.

Added: March 2023

Question 7: A patient's intake orders include an order for PRN IV Lasix. At the time of the assessment and during the assessment time period the patient did not meet the parameters to administer the Lasix. We understand that we would report this on O0110H1 - IV Medications, since the PRN IV Lasix is part of the patient's drug regimen, even though it is not being received during the assessment time period. Would we also report O0110O1 - IV Access, even though the IV Access is not in place or needed during the assessment time period?

Answer 7: The intent of O0110 - Special Treatment, Procedures, and Programs is to identify any listed special treatments, procedures, or programs that apply to the patient.

Check all treatments, procedures, and programs that are part of the current care/treatment plan during the 3-day admission assessment period or the 3-day discharge assessment period, even if it is not received during the 3-day assessment period. However, if there is not a current IV access in place at the time of assessment do not code IV access for O0110O1, even if a treatment which would require an IV access is part of the patient's current care/treatment plan.

Added: March 2023

Question 8: Our facility utilizes a standing order set for all patients that allows the use of supplemental oxygen if certain conditions are met. Does this mean that we should be selecting Oxygen Therapy for all patients when coding O0110 - Special Treatments, Procedures, and Programs?

Answer 8: Some facilities utilize standing orders or a standing order set, providing a specific PRN order for their patients. If a standing order for treatment is included on the patient's current care/treatment plan due to facility policy (and not due to patient-specific need), it would only be considered for O0110 - Special Treatments, Procedures, and Programs, if the patient received it during the 3-day assessment time period.

Added: March 2023

Question 9: A patient is currently using a Trilogy 202 ventilator, which can provide either invasive ventilation support or non-invasive ventilation support. Should O0110 - Special Treatments, Procedures, and Programs be coded based on the type of device (invasive ventilator vs. non-invasive ventilator) that is used or the type of support (invasive ventilation vs. non-invasive ventilation) that is being provided?

Answer 9: The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

Code O0110F1 - Invasive Mechanical Ventilator (ventilator or respirator), if any type of electrically or pneumatically powered closed-system mechanical ventilator support device is used that ensures adequate ventilation in the patient who is or who may become (such as during weaning attempts) unable to support their own respiration.

Code O0110G1 - Non-Invasive Mechanical Ventilator, if any type of respiratory support device is used that prevents airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle.

Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day admission assessment or the discharge assessment, even if not received during the 3-day assessment time period.

If your scenario meets the criteria for invasive mechanical ventilation, code O0110F1. If your scenario meets the criteria for non-invasive mechanical ventilation, code O0110G1.

Added: March 2023

Question 10: The guidance for O0110H1 - IV Medications includes an exclusion for Dextrose 50% and Lactated Ringers, stating that these are not considered medications. There are also references to the National Drug Code Directory and Orange Book with guidance to use those references to determine what is considered a medication.

When reviewing those references, both Dextrose 50% and Lactated Ringers are listed as medications. Should these be excluded from consideration when coding O0110H1? Should any solution that includes dextrose be excluded from consideration? Are these references the only resources we should use to determine what is and what isn't a medication?

Answer 10: At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases use the most recent guidance. This Q&A represents the most recent guidance.

Please disregard the statement from the Guidance Manual that states: "Dextrose 50% and/or Lactated Ringers given IV are not considered medications and should not be included here."

As stated in the Coding Instructions for O0110H1 - IV Medications, "Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item."

Please note the following exclusions:

"Do not include flushes to keep an IV access port patent, or IV fluids without medication here. Subcutaneous pumps are not included in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy."

Specifically, for O0110H1 do include IV fluids with medications added, unless otherwise excluded in guidance.

The National Drug Code Directory and Orange Book are examples of resources that could be used. CMS does not specify a source that must be used for determining what is and what is not considered a medication for O0110.

Added: March 2023

[NEW] Question 11: If during the 3-day admission (or discharge) assessment time period, a patient who utilizes oxygen wears it one day for greater than 14 hours continuously but other days uses it less than 14 hours continuously, can both O0110C3 - Oxygen Therapy; Intermittent and O0110C4 - Oxygen Therapy; Continuous be checked?

Answer 11: The intent of O0110 - Special Treatments, Procedures, and Programs identifies if any of the listed special treatments, procedures, and programs apply to the patient.

Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day admission (or discharge) assessment time period.

That may include marking both intermittent and continuous oxygen for a patient where both apply during the assessment time period.

Regardless of how the oxygen is ordered (i.e., continuously or intermittently), for O0110 apply the specific definitions in determining whether oxygen is coded as continuous (delivered for ≥ 14 hours per day) or intermittent (oxygen was not delivered continuously for at least 14 hours per day).

Added: June 2023

[NEW] Question 12: We know that we code O0110 - Special Treatments, Procedures, and Programs based on what is part of the current care/treatment plan during the 3-day assessment time period. Can CMS provide further clarification on how to code O0110O1 - IV Access and O0110O4 - IV Access; Central if a PICC line is being pulled during the discharge assessment?

Answer 12: 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, procedures, and programs that are part of the patient's current care/treatment plan at the time of assessment, even if not used during the 3-day assessment time period.

This includes a PICC line that is being discontinued at the time of the assessment.

Added: June 2023