INPATIENT REHABILITATION FACILITY (IRF) QUALITY REPORTING PROGRAM (QRP) PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM MAY AND AUGUST 2019 IRF QRP PROVIDER TRAININGS ON MAY 7 AND 8, 2019, AND AUGUST 13 AND 14, 2019

Current as of November 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Acronym List

Acronym	Definition
APU	Annual Payment Update
BMI	Body Mass Index
BP	Blood Pressure
CASPER	Certification And Survey Provider Enhanced Reports
CDC	Centers for Disease Control and Prevention
CEU	Continuing Education Unit
CMG	Case-Mix Group
CMS	Centers for Medicare & Medicaid Services
DRR	Drug Regimen Review
DTI	Deep Tissue Injury
FIM	Functional Independence Measures
FY	Fiscal Year
HCC	Hierarchical Condition Category
ICD	International Classification of Diseases
INR	International Normalized Ratio
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility Patient Assessment Instrument
IV	Intravenous
LTCH	Long-Term Care Hospital
NHSN	National Healthcare Safety Network
NQF	National Quality Forum
OT	Occupational Therapist
PAC	Post-Acute Care
PI	Pressure Injury
PPS	Prospective Payment System
PT	Physical Therapist
PU	Pressure Ulcer
QI	Quality Indicator
QIES	Quality Improvement Evaluation System
QM	Quality Measure
QRP	Quality Reporting Program
RN	Registered Nurse
SPADE	Standardized Patient Assessment Data Element

#	Category	Question	Answer
1	Welcome & Intro	There are updated versions and copyright dates on some of the Standardized Patient Assessment Data Elements (SPADEs). Because of this, we are unable to adopt the Centers for Medicare & Medicaid Services (CMS) version in our company's electronic medical record. Is CMS able to update their versions of SPADEs to match the most recent versions?	Copyrighted items finalized in the fiscal year (FY) 2020 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Final Rule for use as SPADEs were used in field testing and have been aligned across the various Post-Acute Care (PAC) settings. CMS requires that IRF providers use the version approved in the FY 2020 IRF PPS Final Rule.
2	Section GG	In a situation wherein a patient has an interrupted stay during the admission assessment period, can assessment documentation be used on the same day that a patient leaves the facility (e.g., admitted on Tuesday, assessed on Wednesday, goes acute on Wednesday, returns on Friday)?	For Section GG of the IRF-Patient Assessment Instrument (PAI), when an interrupted stay occurs during the 3-day assessment period, assessment data collected on the day of the transfer may be used. In the scenario described here, assessment data collected on Wednesday may be used.
3	Section GG	Please give details regarding supporting documentation necessary to support Care Tool Scoring.	Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the patient's medical record.
4	Section GG	How is Uniform Data System planning to measure quality outcomes for all patients to establish a realistic Program Evaluation and Monitoring score for facilities when CMS has facilities skipping Discharge items for GG0130A to GG0130H and GG0170A to GG0170SS3 for incomplete stays?	Please refer your question to your vendor.

#	Category	Question	Answer
5	Section GG	Without Functional Independence Measures (FIM), how is Section GG going to capture appropriate Case-Mix Group (CMG) and outcome measures accurately?	Our analysis shows that the Section GG items do a better job of capturing resource use in the IRF setting than the FIM.
6	Section GG	Determining percent of task is not well explained for each item; some appear to have the same rules as some of the FIM items, but it is not clearly stated. Please clarify how to determine percent for items assessed.	When coding Section GG0130 Self-care or GG0170 Mobility items, code based on the type and amount of assistance provided. A decision tree is available in the IRF-PAI Manual 3.0 (effective October 1, 2019) on page GG-9 (available as IRF-PAI Manual Version 3.0 April 2019 [ZIP, 7MB] on the Quality Reporting Program (QRP) training webpage at (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html) to help guide clinicians through the questions they should answer when determining how to code Section GG activities.
7	Section GG	Why is discharge data not collected for Section GG for incomplete stays?	Discharge functional status data should reflect that patient's status at the time of discharge. If the patient is urgently discharged—for example, due to a medical emergency—it may be challenging to collect discharge functional status data. During the development and testing of these data elements, we asked clinicians about this issue and determined that data collection approaches were not consistent across providers. We learned that some clinicians would report the patient's functional status based on the most recent observation of the patient, and others would report some activities based on the patient's status at the time of discharge (during the medical emergency). We have heard from some clinicians who appreciated not needing to collect these data if a patient leaves the IRF unexpectedly.

#	Category	Question	Answer
8	Section GG	We have patients that may have different functional abilities for GG0130E. Shower/bathe self at admission and discharge. Does it matter where bathing occurs to accommodate these functional abilities, allowing the patient to perform the activity as independently as possible while being safe? Has CMS considered using a qualifier for Shower/bathe self? Many patients may bathe in bed at admission but in the shower at discharge, and the score would not show progress or would show worsened function.	Coding for the item is based on the type and amount of assistance required to complete the activity, regardless of where the activity occurs.
9	Section GG	If someone is a wheelchair user for the last 5+ years and does not ambulate, would I select "N/A" or should I still attempt to assess it?	If a patient uses a wheelchair and was not walking prior to the current illness, injury, or exacerbation, code Section GG walking items as 09, Not applicable. Code 09, Not applicable, is used to indicate that the activity did not occur at the time of the assessment, and the activity did not occur prior to the current illness, injury, or exacerbation.
10	Section GG	If a patient cannot complete the task because they state they are simply tired, fatigued, or exhausted, should that be coded as a refusal or an 88 medical conditions or safety concerns? For example, for 12 stairs they complete 8 and then say they are done.	When coding section GG activities, if you or the patient believe there is a safety concern and the activity did not occur as a result of that concern, code 88, Not applicable due to medical or safety concerns. If your determination is that the patient is refusing to perform the activity and there is not a medical issue or safety concern associated with the refusal, code 07, Patient refused. Please use your clinical judgment based on the patient's circumstances. If the patient completes the activity once during the assessment period, code based on the amount of assistance provided.

#	Category	Question	Answer
11	Section GG	Why are Section B and Section H not being coded at discharge? Cognition affects a patient's ability to transition safely to home and manage medications. Polypharmacy complications and bowel and bladder function are key areas that have potential cause of readmissions resulting in 2-percent penalties.	Section B and Section H data elements included on the IRF-PAI are risk adjustors for the self-care and mobility Quality Measures (QM) and are thus only required on the admission assessment. We interpret your question to suggest you would like to collect these data at the time of discharge to monitor communication and bowel and bladder outcomes. Thank you for this feedback.
12	Section GG	If, during the assessment period, there are three documented levels of function by three different clinicians prior to any benefit from therapy (which is determined to be end of day 2), and they coded the patient a stage 2, 3, and 4, what is the most usual performance code to be documented on the IRF-PAI?	The intent of the admission assessment is to determine the patient's abilities close to the time of admission. Observe the patient's performance of the activities during the 3-day assessment period. Assess the patient with assistive devices needed for the patient to perform the activities as independently and safely as possible. Code performance using the 6-level rating scale based on the type and amount of assistance provided. Use the appropriate "activity not attempted" code if the activity did not occur during the 3-day assessment period. Provide physical assistance and/or directions as necessary in order for the patient to complete an activity as independently and safely as possible. Assess the patient using assistive devices during the initial assessment as necessary, including devices that have or have not been previously used the patient.
13	Section GG	Regarding Prior level of function with functional cognition: Should a patient who can no longer drive due to cognitive decline (but is still managing their own finances and meds) be coded as Assist?	When assessing GG0100D. Functional cognition (Prior functioning: Everyday activities), if a patient is no longer driving but is managing and planning regular tasks (such as shopping or remembering to take medication prior to current illness, exacerbation, or injury) independently, code GG0100D. Functional cognition as 3, Independent.
14	Section GG	Why is a cane not on the list for prior to admission equipment?	The devices listed in item GG0110. Prior device use, are included on the IRF-PAI because they are risk adjustors for the functional outcome measures. When we were developing the functional outcome measures, we did test whether prior use of a cane or crutches affected both self-care or mobility outcomes, and we found that these devices did not affect functional outcomes. For that reason, we did not need to include these items on the list of devices.

#	Category	Question	Answer
15	Section GG	Since it only lists walker, would this also include other devices, or only walkers?	We interpret your question to be about GG110. Prior device use. When coding GG110. Prior device use, consider all walkers. Page GG-5 of the IRF-PAI Manual 3.0 (available as IRF-PAI Manual Version 3.0 April 2019 [ZIP, 7MB] on the QRP training webpage at (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html) provides a list of types of walkers; however, this list is not all-inclusive.
16	Section GG	What is the name of the 6-point scale in self-care 1234 and mobility section of GG? The industry needs common nomenclature to communicate consistently across PAC settings.	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.
17	Section GG	Is use of a cane as an assistive device coded as None of the above?	We interpret your question to be about GG0110. Prior device use. If a patient was using a cane prior to the current illness, exacerbation, or injury and none of the listed devices, you would code GG0110. Prior device use as Z. None of the above.
18	Section GG	GG0130 and GG0170: The scale does not provide opportunities to capture the amount of resources needed nor show appropriate functional change at the lowest levels. Levels 1, 2, and 3 need to be redefined or further broken out to capture more refined levels of patient function for payment and quality	Thank you for your feedback. We will take this into consideration.
19	Section GG	In the first scenario video, should the correct answer be None of the above, since the patient used the walker outdoors?	In this video, the clinician was assessing GG110. Prior device use, which can include devices used for indoor and outdoor mobility. The response is correct that the patient used a walker. When assessing GG0100B. Prior functioning – Indoor mobility (Ambulation), only consider only indoor ambulation.

#	Category	Question	Answer
20	Section GG	How do you score someone who was admitted to rehab, sent back to acute 2 days later, and then returned back to rehab a few days later? They obviously needed assistance in acute care on second readmission, so do we score a 01 or 02 for this new admission?	Starting with IRF-PAI v2.0, effective October 1, 2018, there was a skip pattern for GG0130 and GG0170 discharge data if the patient has an incomplete stay. Due to this skip pattern, providers cannot enter data for these data elements for a patient with an incomplete stay. The software system would insert the caret (^) as part of the skip pattern specifications. 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 (LTCH). • Patients who die while in the IRF. • Patients who leave the IRF against medical advice. • Patients with a length of stay less than 3 days. A program interruption is defined as the situation where a Medicare (Part A or Medicare Advantage) inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. For program interruptions, the two segments of the stay are considered one stay.
21	Section GG	Can you please explain the rating scale?	When coding Section GG0130 Self-care or GG0170 Mobility items, code based on the type and amount of assistance provided. A decision tree is available in the IRF-PAI Manual 3.0 (effective October 1, 2019) on page GG-9 (available s IRF-PAI Manual Version 3.0 April 2019 [ZIP, 7MB] on the QRP training webpage at (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html) to help guide clinicians through the questions they should answer when determining how to code Section GG activities.
22	Section GG	Why isn't discharge GG self-care and mobility scoring only a 24-hour period in the last 3 days before discharge like FIM was?	The intent of collecting GG0130. Self-care and GG0170 Mobility discharge data is to document the patient's functional abilities at the time of discharge. Therefore, the assessment should occur as close to the time of discharge as possible, but must be within the discharge assessment period. The discharge assessment period is 3 calendar days and encompasses the day of discharge and the two calendar days prior to the day of discharge. If one or more activities is not assessed during the 24 hours before discharge, data based on an assessment that occurs during the discharge assessment period may be coded as the patient's discharge status.

#	Category	Question	Answer
23	Section GG	If a patient does not have clothing on the day of admission, do you code 10 Not applicable due to environmental limitations (i.e., lack of equipment) for Dressing?	The intent for this item is to assess the patient clothing that would be worn in the community. If clothing is available by day 3, code based on the assessment conducted on that day. If clothing is not available by day 3, paper scrubs could be used to assess the activities of upper and lower body dressing, if no other clothing is available. If a patient does not have upper body clothing other than a hospital gown during the entire 3-day assessment period, you would use code 10, Not attempted due to environmental limitations for GG0130F. Upper body dressing.
24	Section GG	Can Physical Therapy Assistants and Certified Occupational Assistants enter GG scores? In many States, these persons cannot “assess.” However, it is certainly within their scope to enter a score on how much assistance a person required during a treatment during the first few days.	For the purposes of completing Section GG, patient self-care and mobility performance is based on direct observation, incorporating patient self-reports and reports from qualified clinicians, care staff, or family documented in the patient’s medical record during the 3-day assessment period. While CMS does not designate who can or cannot complete Section GG, CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the patient during the 3-day assessment period. Qualified clinicians are healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations, and IRFs should refer to those Federal, State, and local regulations when determining the appropriate individuals to complete Section GG.
25	Section GG	If the patient has multiple rehab disciplines, but the Physical Therapist (PT) discharges the patient from physical therapy 7 days prior to the patient’s facility discharge, can we use the physical therapy discharge assessment (completed 7 days prior to facility discharge) for section GG? Or does another assessment need to be done at facility discharge for physical therapy-related items?	The intent of collecting GG0130. Self-care and GG0170. Mobility discharge data is to document the patient’s functional abilities at the time of discharge. Therefore, the assessment should occur as close to the time of discharge as possible, within the discharge assessment period. The assessment time frame for these data elements is 3 calendar days. The discharge assessment period encompasses the day of discharge and the two calendar days prior to the day of discharge. Assessment data from 7 days prior to discharge would not be used for the discharge assessment when coding Section GG data elements. In the example you reference, the activities need to be assessed during the discharge assessment period because the patient’s ability to complete activities may have changed. These activities can be assessed by any discipline (e.g., nursing, physical therapy, or occupational therapy), within the discharge assessment time frame.

#	Category	Question	Answer
26	Section GG	Can we see an example of what a dependent transfer would look like without a second helper present?	In order for a patient to be coded dependent, the helper must be completing the entire activity for the patient. A decision tree is available in the IRF-PAI Manual 3.0 (effective October 1, 2019) on page GG-9 (available as IRF-PAI Manual Version 3.0 April 2019 [ZIP, 7MB] on the QRP training webpage at (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html) to help guide clinicians through the questions they should answer when determining how to code Section GG activities.
27	Section GG	Just to be clear, if a patient is medically discharged to acute care unexpectedly, we do not have to do a full Self-care and Mobility discharge to code the items in IRF-PAI?	Starting with IRF-PAI v2.0, effective October 1, 2018, there was a skip pattern for GG0130 and GG0170 discharge data if the patient has an incomplete stay. Due to this skip pattern, providers cannot enter data for these data elements for a patient with an incomplete stay. The software system would insert the caret (^) as part of the skip pattern specifications. 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 LTCH. • Patients who die while in the IRF. • Patients who leave the IRF against medical advice. • Patients with a length of stay less than 3 days. Patients discharged to acute are identified based on coding of the Discharge Destination Item 44D on the IRF-PAI, and include the following codes: 02 = Short-term General Hospital, 63 = LTCH, 65 = Inpatient Psychiatric Facility, and 66 = Critical Access Hospital. There is no coding on the IRF-PAI to indicate that a discharge was planned or unplanned, so all patients discharged to these locations are considered incomplete stays.
28	Section GG	If a helper would have to redo for thoroughness, would you count that the patient completed the task at 01, Dependent, or 02, Substantial/Maximal assistance?	If the patient attempts to complete an activity, and the helper must re-do part of the activity, code based on the type and amount of assistance provided by the helper. For example, if the patient brushes his/her teeth and the helper brushes most of the patient's teeth for thoroughness, the clinician may consider that the assistance provided was more than half of the effort to complete the activity thoroughly and thus may be coded 02, Substantial/maximal assistance.
29	Section GG	Why is GG0130D skipped?	GG0130D. Wash upper body is included on the LTCH Continuity Assessment Record and Evaluation Data Set. It is not included on the IRF-PAI.

#	Category	Question	Answer
30	Section GG	Does Shower/bathe self include face and hands?	Shower/bathe self includes the ability to wash, rinse and dry the face, upper and lower body, perineal area and feet. Do not include washing, rinsing and drying the patient's back or hair.
31	Section GG	GG0130E: Can Shower/bathe self occur with a bed bath?	When coding GG0130E. Shower/bathe self, code based on the type and amount of assistance the patient requires to complete the activity (washing, rinsing, and drying the body) regardless of where bathing takes place (e.g., shower, bath, sink, bed bath). GG0130E. Shower/bathe self does not include transferring in/out of a tub/shower.

#	Category	Question	Answer
32	Section GG	Can you please provide examples of self-care that are partial/moderate assist and substantial/maximal assist, especially if we are not counting parts anymore?	A coding example for self-care that is 03, Partial/Moderate assistance is provided below: Ms. N declines to shower herself when the occupational therapist (OT) attempts to complete the assessment. The therapist asks Ms. N's Certified Nursing Assistant detailed questions about Ms. N's ability to shower/bathe herself and considers this input when coding the activity. The therapist learns that Ms. N takes a shower and initiates washing her face, arms, chest, part of her legs, and perineal area. She requires assistance to wash, rinse, and dry her lower extremities below the knees. Ms. N rinses and dries most of her body. GG0130E. Shower/bathe self would be coded 03, Partial/moderate assistance. The helper provides less than half the effort for Ms. N to complete the activity of shower/bathe self; during the 3-day assessment period, the therapist does not observe the patient and asks other clinicians and care staff about Ms. N's abilities to determine her abilities. A coding example for self-care that is 02, Substantial/Maximal assistance is provided below: Mr. T has reduced strength and range of motion in both upper extremities following spinal surgery, and he wears a cervical collar. The nurse puts on the cervical collar. Once Mr. T is sitting at the side of the bed, he threads his hand into the sleeve of his shirt, and due to his no-twisting precautions, the nurse pulls the shirt across his back and threads his other hand into the shirt sleeve. The nurse also pulls up the shirt over both shoulders; Mr. T buttons two of his shirt buttons and the nurse buttons the last three. GG0130F. Upper body dressing would be coded 02, Substantial/Maximal assistance. Mr. T threads one arm into his shirt sleeve and buttons up some of his buttons; the nurse assists Mr. T by applying the cervical collar and helping him to pull his shirt around his back, threading his other arm, pulling it over his shoulder, and buttoning some of the buttons. For dressing items, consider donning and/or doffing an orthosis/prosthesis or other device as a piece of clothing when dressing or undressing.
33	Section GG	Can a half-bath also be scored in Shower/bathe self? Sometimes, a patient prefers to bathe certain body parts only.	Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the patient's back or hair. The activity can occur any time during the entire 3-day assessment period.

#	Category	Question	Answer
34	Section GG	The CMS definition of 05, Set-up or clean up, states that the helper assists only prior to or following the activity. In the oral hygiene example, the caregiver provided set-up and cleanup assistance. Shouldn't that be coded as 04, Supervision?	Thank you for this feedback. If the helper provides both set-up and cleanup assistance, code 05. There were two oral hygiene examples. In the first example, the helper provided set-up assistance by putting toothpaste on the patient's toothbrush and cleanup assistance by putting away supplies after Mr. Smith completed the activity, therefore in this scenario GG0130B. Oral hygiene would be coded 05, Supervision. In the second example, the helper provides supervision and touching assistance in order for the patient to complete GG0130B. Oral hygiene, therefore in this example the activity would be coded 04, Supervision or touching assistance.
35	Section GG	Does the position in which a patient performs an activity in his/her prior level of function (i.e., use of a shower chair for safety during evaluation vs. standing prior to injury) have any bearing on GG scores?	When coding activities in Section GG, clinicians should code what occurs at the time of the assessment. It is possible that the patient may perform the activity in the IRF in a different manner compared to how the patient performed the activity prior to the current illness, exacerbation, or injury. In addition, how the patient performs the activity does not need to be the same on the admission assessment and the discharge assessment.
36	Section GG	How many body parts are included in bathing for Quality Indicators (QI) as compared with 10 body parts counted in FIM?	Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the patient's back or hair.
37	Section GG	Is it okay for a therapist to score an activity with only description from another staff member?	When assessing activities for GG0130. Self-care and GG0170. Mobility, assess the patient's performance based on direct observation as well as reports from the patient's self-report and reports from clinicians, care staff, or family reports documented in the patient's medical record during the 3-day assessment period.
38	Section GG	Is a dress or muumuu considered for upper body dressing?	These items would be included in coding GG0130F. Upper body dressing. Upper body dressing items used for coding include: bra, undershirt, T-shirt, button down shirt, pullover shirt, dresses, sweatshirt, sweater, and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.

#	Category	Question	Answer
39	Section GG	Can rationales to scoring responses be added as supplemental tool/resource?	The versions of the slide decks with the answers to the practice scenarios and knowledge checks and rationales for case studies will be posted after the training along with a link to the playlist of the video recordings of presentations and the Q&A document for the training. All materials will be posted on the IRF QRP Provider Training webpage. We will send everyone who registered for the training an email when the materials post.
40	Section GG	For Lower body dressing, can underwear or incontinence brief alone be coded?	The intent of GG0130G. Lower body dressing is to assess the patient's ability to dress in clothing that would be worn after discharge, for example, in the community. If clothing is available by day 3 of the admission assessment period, code based on the assessment conducted on that day. Pajama bottoms or paper/fabric scrubs may be used to assess the activities of lower body dressing if no other clothing is available.
41	Section GG	For discharge goals, with choices of 07, 09, 10, 88, why would the use of a dash still be an option?	A dash (–) indicates "No information", which has a different meaning than the "activity not attempted" codes. For more information about the "activity not attempted" codes please refer to the IRF-PAI Manual, which is available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-PAI-Manual.
42	Section GG	When a patient needed one helper to don a prosthesis/ orthosis in FIM, the patient was considered setup. How many steps are included in upper body dressing when donning a brace (e.g., thoracic-lumbar-sacrum-orthosis) in QIs in order to determine a percentage of completion as compared with FIM?	Based on guidance provided in the IRF-PAI Manual, the following items are considered a piece of clothing when coding the dressing items: Upper body dressing examples: thoracic-lumbar-sacrum-orthosis, abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic. Please refer to page GG-17 of the IRF-PAI Manual v.3.0, available for download at the following webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-PAI-Manual.
43	Section GG	Does application of a pedi-pad get counted for Lower body dressing?	We interpret your question to be about application of a sanitary pad in underwear and whether it can be considered when coding GG0130F. Lower body dressing. The application and management of a perineal (peri) pad would not be considered when coding lower body dressing; however, underwear would be considered.

#	Category	Question	Answer
44	Section GG	How would you code lower body dressing if a patient needs assistance putting on a bil stump?	A stump sock/shrinker and lower-limb prosthesis are considered clothing when coding lower body dressing. Code lower body dressing based on the type and amount of assistance with clothing, including the stump sock/shrinker and lower limb prosthesis.
45	Section GG	How does choosing 07, 09, 10, 88 as a goal support documentation that the admission is reasonable and necessary?	A goal for a single activity may be one of the "activity not attempted" codes, while goals for other activities may be one of the 6-level rating scale codes. If the patient does not attempt the activity and a helper does not complete the activity for the patient during the entire 3-day assessment period, code the reason the activity was not attempted. For example, code as 07 if the patient refused to attempt the activity during the entire 3-day assessment period; code as 09 if the activity is not applicable for the patient (the activity did not occur at the time of the assessment, and prior to the current illness, injury or exacerbation); code as 10 if the patient was not able to attempt the activity due to environmental limitations; or code as 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.
46	Section GG	How is the GG item goal data being utilized for data collection? Do you have any guidance for which goal items should be selected, as there is not currently a "standard or guideline" for the goals that various facilities will be providing?	The goal data are used to calculate the QM, an application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (National Quality Forum (NQF) #2631). For this measure, a minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the patient's discharge goal(s) using the 6-point scale. Beginning on October 1, 2018, use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect annual payment update (APU) determination.

#	Category	Question	Answer
47	Section GG	If a patient has a no bathing order due to a new cardiac monitor placement (loop monitor) but performs a partial sponge bath avoiding the area that cannot get wet, do you this situation 88 or score according to the amount of assistance needed for the partial sponge bath?	Assessment of Shower/bathe self can take place in a shower or bath or at a sink (i.e., full-body sponge bath). If the patient bathes with a sponge bath, code based on the level of assistance needed for the patient to wash, rinse, and dry the face, upper and lower body, perineal area, and feet.
48	Section GG	What if the patient was emergency transferred before being seen/assessed by any therapists? Do we still need a discharge goal in GG section?	For patients with incomplete stays, a minimum of one self-care or mobility goal must be coded per patient stay on the IRF-PAI. If the patient is discharged prior to being assessed by therapists, code at least one discharge goal to the best of your abilities based upon the predicted plan of care for the patient.
49	Section GG	What is coded as a goal if we do not expect the patient to perform an activity (for example, 12 steps)?	A minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the patient's discharge goal(s) using the 6-point scale. Use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.
50	Section GG	Lying to sitting: You say it is ok for the patient's lying position to be slightly elevated for medical reasons. It would be easier for that patient to go from lying to sitting than for a patient that is completely flat.	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.

#	Category	Question	Answer
51	Section GG	Section GG items are coded at admit and discharge, but is there a recommended frequency that they should be assessed/ documented during the patient's length of stay as well (i.e., weekly team conferences)?	For the purposes of the IRF QRP, the Section GG Self-care and Mobility data are only collected for admission and discharge. CMS does not provide guidance on documentation practice, including interim documentation.
52	Section GG	Please indicate whether a student under the direct supervision of a licensed PT/OT/Registered Nurse (RN) is able to complete the QI assessments.	Refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete an assessment. Patient assessments are to be done in compliance with facility, Federal, and State requirements.
53	Section GG	If there are six goals identified (by the PT/OT/patient/physician, etc.) in the patients care plan, is it expected that all six are scored on Section GG discharge goals?	A minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal.
54	Section GG	If a patient required 25 percent assistance for trunk and lower extremities during Supine to sit, Would you score based on level of assistance or amount of body parts assisted?	GG0170C. Lying to sitting on side of bed starts with the patient lying on the back and getting to a sitting position on the side of the bed with feet flat on the floor without back support. When assessing this activity, consider the type and amount of assistance a helper is providing. A decision tree is available in the IRF-PAI Manual 3.0 (effective October 1, 2019) on page GG-9 (available at: IRF-PAI Manual Version 3.0 April 2019 [ZIP, 7MB] on the QRP training webpage (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html) to help guide clinicians through the questions they should answer when determining how to code Section GG activities.
55	Section GG	Since FIM is no longer required, can the Section GG coding be used to replace FIM on daily documentation?	We interpret your question to be about documentation regarding Section GG. Please refer to facility, Federal, and State policies and procedures to determine documentation requirements. Documentation should be done in compliance with facility, Federal, and State requirements. Documentation in the medical record should support data reported on the IRF-PAI in Section GG.

#	Category	Question	Answer
56	Section GG	For Rolling left/right, how do you score if the person requires substantial assistance for one direction and 25-percent assistance for the other? Do you average assistance for the full task?	For GG0170A. Roll left and right, code based on the overall type and amount of assistance required.
57	Section GG	If a helper only assists with the bra clasp, would it be partial assistance for upper body dressing?	If the patient needs assistance with her bra clasp and the helper provides less than half of the effort, code 03, Partial/moderate assistance.
58	Section GG	Does the mechanical lift include devices like the Sara steady, which does not physically lift but provides blocking of knees and a bar for the patient to pull up on?	We interpret your questions to ask for guidance about coding item GG0170D. Sit to stand. If the assistance of one helper is required, and the patient contributes some effort (less than half), code 02, Substantial/maximal assistance. If the assistance of 2 people is required, code 01, Dependent. Using the equipment, the patient is providing some effort to complete the sit to stand activity. If you use a decision tree (available at the link below) to determine the code, you will notice that the questions ask about assistance from one helper through level 02. If two helpers are required, you would code 01, Dependent. When coding Section GG0130. Self-care or GG0170. Mobility items, code based on the type and amount of assistance provided. A decision tree is available in the IRF-PAI Manual 3.0 (effective October 1, 2019) on page GG-9 (available at: IRF-PAI Manual Version 3.0 April 2019 [ZIP, 7MB] on the QRP training webpage (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html) to help guide clinicians through the questions they should answer when determining how to code Section GG activities.
59	Section GG	How would I score Chair/Bed-to-chair transfer if the patient sleeps in a recliner?	If the patient uses a recliner, sofa, or mattress on the floor as the patient's "bed" (preferred or necessary sleeping surface), assess the patient's need for assistance using that sleeping surface when determining ability for bed mobility items (GG0170A. Roll left and right through GG0170E. Chair/Bed-to-chair transfer).

#	Category	Question	Answer
60	Section GG	Is Sit to stand included as part of GG0170E. Chair/Bed-to-chair transfer? (If the patient does a standing pivot transfer, with or without a device?)	Item GG0170E. Chair/Bed-to-chair transfer begins with the patient sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed.
61	Section GG	For stairs, if a patient did 1 step, continues to 4 steps and 12 steps without stopping, can all areas (1 step, 4 steps, 12 steps) be scored? Patients sometimes do not want to stop in between this type of activity.	If the patient is assessed going up and down 12 steps, the clinician may be able to determine the scores for 1 step and 4 steps during this assessment. Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type and amount of assistance needed for each individual activity.
62	Section GG	In the toilet transfer example, if the plan is for the patient to go home without the raised toilet seat, would you score it without the raised toilet seat on admission?	Toilet transfer includes the patient's ability to get on and off a toilet (with or without a raised toilet seat), or bedside commode. The patient can be assessed using an assistive device/equipment, such as a commode, at the time of admission. When coding Section GG activities, clinicians should code what occurs at the time of the assessment. It is possible that the patient may perform the activity in the IRF in a different manner compared to how the patient performed the activity prior to the current illness, exacerbation or injury. In addition, how the patient performs the activity does not need to be the same on the admission assessment and the discharge assessment. Please see page GG-35 of the IRF-PAI Manual for more information: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-PAI-Manual.
63	Section GG	What if a facility does not have a car simulator for transfers? Is it okay to always code 10?	For item GG0170G. Car transfer, use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin. In the situation where the patient is unable to perform a car transfer using a car or car simulator during the 3-day assessment period, code admission performance using the appropriate "activity not attempted" code (07, 09, 10, or 88).

#	Category	Question	Answer
64	Section GG	If patient propels wheelchair 40 feet and is pushed 10 feet, should wheelchair 50 feet be coded?	For the wheelchair items, a helper can assist the patient to complete the activity or make turns. Therefore, the activity can be completed and you can determine the type and amount of assistance required by the helper to complete the activity. In the example you described, if 2 turns were made while mobilizing the 50 feet, code item GG0170R. Wheel 50 feet based on the type and amount of assistance provided to complete the activity.
65	Section GG	Can a reacher be used for the item pick up GG0170P?	Yes, a reacher can be used when assessing GG0170P. Picking up object. GG0170P. Picking up object assesses the patient's ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. If a patient does not need any assistance to use a reacher to pick up an object from the floor and the patient was independent in retrieving the reacher, code GG0170P - Picking up object as 06, Independent. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
66	Section GG	During the assessment of the ambulation distances, does each assessment has to be performed separately? Meaning, if the patient ambulates 150 feet during one assessment, can you assess the 10 feet, 50 feet, and 150 feet, or do they need to be assessed separately?	GG0170J. Walk 50 feet with two turns and GG0170K. Walk 150 feet should be assessed separately, because the activity of walking 50 feet includes 2 turns and the walk 150 feet activity does not include any turns. If the patient is assessed going up and down 12 steps, the clinician may be able to determine the scores for 1 step and 4 steps during the assessment. Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type and amount of assistance needed for each individual activity.
67	Section GG	Does a single 180-degree turn count as two 90-degree turns? Or does there have to be two separate turns in the assessment?	The turns included in item GG0170J. Walk 50 feet with two turns are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right).

#	Category	Question	Answer
68	Section GG	If they do not walk the distance, Activity not attempted is not a code. Do we use 88, Medical?	A patient must walk the entire distance for each walking item to be coded using the 6-level rating scale. This is because a helper cannot "walk" the remaining distance for the patient, so you would not be able to determine the type and amount of assistance needed by a helper to complete the activity. If the patient was not able to walk the entire distance, the walking item would be coded with one of the "activity not attempted" codes, for example 88, Not attempted due to the medical condition or safety concerns.
69	Section GG	Does the activity taking more than reasonable time come into play in any of the QMs?	Code each activity based on the type and amount of assistance required by a helper to complete the activity. The amount of time required to complete the activity is not considered when coding.
70	Section GG	For one step/curb, you mentioned that this is appropriate for wheelchair only. Can you expand some more?	We would like to clarify that for the data element 1 step/curb, the patient may go up and down the curb or may go up and down 1 step in a wheelchair, if safe. Item GG0170M. 1 step (curb) can be assessed using a curb or a step with or without railing(s). If a person self-mobilizes in a wheelchair, going up and down a curb or one step in a wheelchair can be assessed and coded in item GG0170M, if safe.
71	Section GG	If a patient does not have their own clothing from home (for example, shirt), then would you code Unable to complete due to environmental limitation upon admission?	The intent of this activity is to assess the patient's ability to dress in clothing that would be worn in public. If clothing is available by day 3 of the admission assessment period, code based on the assessment conducted on that day. If the patient does not have clothing during the entire 3-day assessment period, paper or fabric scrubs could be used to assess the activities of lower body dressing. If a patient does not have any clothing other than a hospital gown during the entire 3-day assessment period, you would use code 10, Not attempted due to environmental limitations for GG0130F. Upper body dressing.
72	Section GG	For the purposes of coding one step (curb), does it have to be a curb step or can it be one step with handrails?	Item GG0170M. 1 step (curb) can be assessed using a curb or a step with or without railing(s).
73	Section GG	Does the height of the step matter (6-inch vs. 2-inch step)?	No. There are no specifications for the exact height of the step(s) for activities involving steps.

#	Category	Question	Answer
74	Section GG	Per the GG definition, the activities should reflect the patient's usual function prior to therapeutic intervention within the first 3 days. If therapy is initiated on the patient's second day, doesn't that limit us to only scoring on the patient's functional ability on day 1 and day 2 prior to therapy evaluations?	If the patient performed the activity during the 3-day assessment period, code the activity based on the type and amount of assistance needed by the patient during the assessment period. The intent of the admission assessment is to determine the patient's abilities close to the time of admission. Observe the patient's performance of the activities during the 3-day assessment period. Assess the patient with assistive devices needed for the patient to perform the activities as independently and safely as possible. Code performance using the 6-level rating scale based on the type and amount of assistance provided. Use the appropriate "activity not attempted" code if the activity did not occur during the 3-day assessment period.
75	Section GG	On stairs, if they didn't have 12 stairs to perform at home or elsewhere and didn't do it before, would it just be a N/A? Do they have to do it no matter if it is relevant to them or not?	Assess the patient going up and down 12 steps, if safe to do so. The patient may encounter stairs in the community after discharge.
76	Section GG	If a patient uses a reacher/grabber to pick up the object from the floor, does that make him independent?	If a patient does not need any assistance, including supervision and set-up assistance, to use a reacher to pick up an object from the floor, code GG0170P. Picking up object as 06, Independent.
77	Section GG	Picking up object: Can you score wheelchair level for those patients who do not walk? You allow us to score one curb wheelchair level, why not picking up object?	GG0170P. Picking up object assesses the patient's ability to bend/stoop from a standing position to pick up a small object such as a spoon from the floor. This activity cannot be assessed from a wheelchair because the activity begins with the patient in a standing position.
78	Section GG	Do the steps have to be assessed individually or can they assess all three step areas by doing 12 steps?	If the patient is assessed going up and down 12 steps, the clinician may be able to determine the scores for 1 step and 4 steps during this assessment. Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type and amount of assistance needed for each individual activity.

#	Category	Question	Answer
79	Section GG	If a patient uses a chair or the wall to steady themselves when picking up an object, is this independent?	When assessing GG0170P. Picking up object, code the activity based on a clinical assessment of the patient. If safe, code this activity with the patient starting in a standing position and allow the patient to perform the activity as independently as possible. Clinical judgment would be used to determine if the use of the wall or a chair would be a safe means of steadying to complete this activity. If a patient does not need any assistance, including supervision, to safely pick-up an object from the floor, code GG0170P. Picking up object as 06, Independent.
80	Section GG	Do you need to document where the two turns occurred while ambulating or during wheelchair mobility?	Each facility delivers patient care according to their unique characteristics and standards (e.g., patient population). CMS does not provide guidance on documentation practice. Thus, each facility self-determines their policies and procedures for patient documentation practices and completing the assessments in compliance with State and Federal regulations.
81	Section GG	If a patient has anti-embolic stockings during the 3-day admission assessment but will not have them at discharge, should the admission assessment be completed for H. Putting on/taking off footwear counting the anti-embolic stockings?	If donning and doffing an elastic bandage or compression stockings occurs while the patient is dressing/undressing, then count the elastic bandage/compression stocking as a piece of clothing when determining the amount of assistance, the patient needs when coding the dressing item. When coding Section GG activities, clinicians should code what occurs at the time of the assessment. How the patient performs the activity does not need to be the same on the admission assessment and the discharge assessment.
82	Section GG	Wheelchair items are required for IRF-PAI data collection but are not utilized for measuring quality. Will these items eventually be considered for use besides data collection purposes?	For the two mobility measures, IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) and IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) we have made several updates to the measure specifications with the most recent NQF annual update. The updated measures specifications include improvement in wheelchair mobility for patients who are unable to walk. More specifically, for patients who are not walking on both admission and discharge, the items GG0170R. Wheel 50 feet with two turns and GG0170S. Wheel 150 feet will be used instead of the walking items.

#	Category	Question	Answer
83	Section GG	Our facility uses Uniform Data System. Their interpretation of wheelchair when a patient is only able to propel a part of the distance is to consider the percentage of the distance that they complete (i.e., if the patient propelled 100 out of 150 feet, or 66 percent, score would be 03). Is this a correct interpretation?	When coding wheelchair items, please use clinical judgment to code based on the type and amount of assistance required to complete the activity. A decision tree is available in the IRF-PAI Manual 3.0 (effective October 1, 2019) on page GG-9 (available at: IRF-PAI Manual Version 3.0 April 2019 [ZIP, 7MB] on the QRP training webpage (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html) to help guide clinicians through the questions they should answer when determining how to code Section GG activities.
84	Section GG	If patient is medically discharged within their stay, please clarify whether we have to complete discharge scores on IRF-PAI.	Starting with IRF-PAI v2.0, effective October 1, 2018, there was a skip pattern for GG0130 and GG0170 discharge data if the patient has an incomplete stay. Due to this skip pattern, providers cannot enter data for these data elements for a patient with an incomplete stay. The software system would insert the caret (^) as part of the skip pattern specifications. 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 LTCH. • Patients who die while in the IRF. • Patients who leave the IRF against medical advice. • Patients with a length of stay less than 3 days. A program interruption is defined as the situation where a Medicare (Part A or Medicare Advantage) inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. For program interruptions, the two segments of the stay are considered one stay, and Section GG data are required at admission and discharge only.
85	Section GG	Can we score from car transfer simulation? We can't score if it's FIM.	For item GG0170G. Car transfer, use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer (i.e., a car seat within a car cabin).

#	Category	Question	Answer
86	Section GG	Can a patient use a reacher while retrieving item from floor?	Yes, a patient may use a reacher for item GG0170P. Picking up object. An example of this is included in the IRF-PAI Manual page GG-41: Picking up object: Ms. C has recently undergone a hip replacement. When she drops items, she uses a long-handled reacher that she had been using at home prior to admission. She is ready for discharge and can now ambulate with a walker without assistance. When she drops objects from her walker basket, she requires a nursing assistant to locate her long-handled reacher and bring it to her in order for her to use it. She does not need assistance to pick up the object after the helper brings her the reacher. Coding: GG0170P would be coded 05, Set-up or clean-up assistance. Rationale: The helper provides set-up assistance so that Ms. C can use her long-handled reacher.
87	Section GG	Are most facilities submitting more than one goal? If some submit 1 and others submit 20, won't that impact a comparison of "goals met" between facilities? Wouldn't it benefit us to submit more goals?	Information about goals included in Section GG of the IRF-PAI is used to calculate the QM Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). Documentation of a goal for a minimum of one of the function items (in GG0130 or GG0170) reflects that the patient's care plan addresses function. Please see Section 6.4 started on page 37 for details about calculating this measure. Please see the IRF Measure Calculation and Reporting User's Manual for more information about calculating this QM: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-Measure-Calculations-and-Reporting-Users-Manual-V30.pdf. IRFs may choose to code more than one goal in Section GG to reflect multiple self-care and mobility goals.

#	Category	Question	Answer
88	Section GG	If, through the course of rehab, the goals change, will there be an issue that admission and discharge goals are different?	We would like to clarify that discharge goal(s) is (are) coded with each admission assessment. Licensed qualified clinicians can establish a patient's discharge goal(s) at the time of admission based on the patient's prior medical condition, admission assessment self-care and mobility status, discussions with the patient and family, professional judgment, the professional's standard of practice, expected treatments, the patient's motivation to improve, anticipated length of stay, and the patient's discharge plan. Goals should be established as part of the patient's care plan. Code at least one goal to the best of your ability based on the predicted plan of care for the patient. The IRF-PAI Manual includes examples of coding discharge goals, including examples in which the discharge goal code is higher than admission performance code, and examples in which the discharge goal is the same as the admission performance goal.
89	Section GG	Why were options for "activity not attempted" included for goals? It doesn't make sense to set a goal for an activity to not occur.	The "activity not attempted" codes are now available to be coded based on requests from clinicians to be able to use these codes for goals.
90	Section GG	Is reassessing cognition at discharge being considered? How will we track progress for these items if not reassessed?	IRFs can assess patients' communication and cognitive function at discharge using the items included on the IRF-PAI admission assessment to determine progress. These data would not be required to be submitted on the IRF-PAI version 3.0.

#	Category	Question	Answer
91	Section GG	For application numerator, should we be submitting more than one goal and those goals that you have just listed (eating; oral; toileting; sit to lying; sit to stand; bed; wheelchair)? This would help the percentage, correct?	The QM, Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) reports the percent of IRF patients with an admission and a discharge functional assessment and a care plan that addresses function. The care plan provides evidence that a care plan with a goal has been established for the patient/resident. Therefore, for the function process QM (NQF #2631), a minimum of one GG0130. Self-care or GG0170. Mobility discharge goal must be coded. This documentation reflects that the patient's care plan addresses function. Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination. Please see the IRF Measure Calculation and Reporting User's Manual for more information about calculating this measure: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-Measure-Calculations-and-Reporting-Users-Manual-V30.pdf.
92	Section GG	Why does Section GG not have any speech therapy scoring options?	We interpret your question to be asking about assessment items related to speech language pathology services. Section B has communication items, Section C has cognitive items, and Section K has swallowing items.
93	Section GG	In regard to Section GG scoring, can you clarify if certain disciplines should be scoring certain items? Will nursing still only score bowel and bladder continence?	Each facility self-determines their policies and procedures for patient documentation practices and completing the assessments in compliance with State and Federal requirements. CMS does not provide guidance on which disciplines may complete patient assessments.
94	Section GG	If the patient could not stand to brush his teeth upon admission but is expected to be able to stand to do it upon discharge, is his oral care score altered because he could not stand initially?	When coding 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. When scoring oral hygiene, the assessment begins once the patient is in the location that the oral hygiene will be performed. Walking to or from the bathroom is not considered when coding this activity.

#	Category	Question	Answer
95	Section GG	Can we substitute the FIM score for the 6-point scale?	No. The 6-point scale is not equivalent to the FIM score.
96	Section GG	If a patient cannot understand the instructions to pick an object up from floor due to communication and cognition impairments, even after demonstration, would the patient be a 1 or 88?	Code GG0170P. Pick up object based on the type and amount of assistance required to complete this activity. If a patient is not able to participate because of communication and cognitive impairments, code using the appropriate "activity not attempted" code.
97	Section GG	What is considered an uneven surface? The type of surface used (gymnastics mat, grass, gravel, ramp) changes the assist level for most patients.	Item GG0170L. Walking 10 feet on uneven surfaces can be assessed inside a facility or outside the facility. Examples of an uneven surface include turf, gravel, or a sloping floor indoors or uneven outdoor pavement. The clinician should use clinical judgment in determining if a surface is uneven.
98	Section GG	Oral hygiene: If a patient does not have teeth or dentures, how do you code it? 9, N/A? Or does brushing gums count?	If a patient is edentulous (without teeth), code Oral hygiene based upon the amount of assistance the patient needs to complete the activity. In this scenario, you would code based on the amount of assistance needed to brush the patient's gums. Assess the patient for use of the appropriate oral hygiene tools for performing this activity and code according the assistance the patient requires.
99	Section GG	If a patient is able to walk with one helper but needs a second helper to push an IV poll or oxygen tank, is that scored as 01?	When coding GG0170I. Walk 10 feet, code based on the type and amount of assistance provided by the helper. In the scenario you provide, if the helper only manages the oxygen tank, code GG0170I. Walk 10 feet as 04, Supervision/ touching assistance, because the helper is required to be present during the activity in order for the patient to complete the activity safely.
100	Section GG	What if a patient has a c-collar but it is never taken off during their length of stay, does their ability to don/doff need to be considered in the score? Patient must wear at all times.	When assessing GG0130F. Upper body dressing, the c-collar would be considered a piece of clothing if it is related to tasks associated with dressing or undressing. Use clinical judgment to determine the type and amount of assistance the patient needs when assessing dressing and undressing.
101	Section GG	For curb/one step, how would you recommend coding on the IRF-PAI if the patient is unable to do a curb step but is able to do a step with a handrail?	If the patient is unable to step up a curb (with or without a device) but can go up and down one step with a railing (with or without a device), code the 1-step item based on the step with the railing.

#	Category	Question	Answer
102	Section GG	For the toilet transfer, if the patient did not use a raised seat prior to surgery but needs one for precautions, wouldn't it be an 88 if we are scoring on prior level of function?	For the admission assessment, the patient may be assessed based on the first use of an assistive device that the patient has not previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely and code based on the type and amount of assistance provided. Only code an "activity not attempted" code if the activity did not occur during the entire 3-day assessment period.
103	Section GG	If a patient "routinely" wore socks and shoes prior to admission and will need to at discharge, if only socks are available and tested on admission in the 3-day window due to lack of shoes, do you code 10 because both items are not available?	The activity of putting on/removing footwear refers to footwear that is appropriate for safe transfer and/or ambulation (mobility). If the patient wears footwear that is safe for mobility (e.g., grip socks), then the data elements may be coded. If the patient's sock is not considered safe for mobility, then code the appropriate "activity not attempted" code.
104	Section GG	Sit to stand: Some stroke patients are "pushers." During transfer activities, they are attempting to transfer but they are pushing against the therapist and actually hurting progress towards transfer. They are attempting but it is not meaningful to complete activity. Is this a total assist?	Use clinical judgment to determine the level of effort that the patient is contributing. In the scenario you describe, we interpret that the patient did not meaningfully contribute to the transfer and that the helper provided all of the effort, therefore you would code this item as 01, Dependent.
105	Section GG	Prior training has stated that "shower/bathe self" can occur at sink. Can a bed bath be coded for low-level patients, or should codes 09 or 88 be used, as appropriate?	When coding GG0130E. Shower/bathe self, code based on the type and amount of assistance the patient requires to complete the activity (washing, rinsing, and drying) regardless of where the bathing takes place. Per guidance in the IRF-PAI Manual, GG0130E. Shower/bathe self does not include transferring in/out of a tub/shower.

#	Category	Question	Answer
106	Section GG	For the GG sections, if the patient participates 10 percent in an activity, does that code to 1, Dependent, or 2, Max A?	When scoring Section GG data elements, score based on the type and amount of assistance provided. A decision tree is available on the CMS IRF QRP website to help guide clinicians through the questions they should answer when determining how to code Section GG activities: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/GG-Self-Care-and-Mobility-Activities-Decision-Tree.pdf. It is also available in the IRF-PAI Manual on page GG-9.
107	Section GG	For scoring eating, what if the patient is on a modified diet? Is this scored at 06 or 05, Set-up or clean-up assistance?	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 you describe, if the meal is placed before the patient with a modified consistency diet and the patient can bring the food to his/her mouth using suitable utensils and swallows the food and/or liquid safely, code GG0130A. Eating 06, Independent.
108	Section GG	Re: Upper body dressing: How do you score if the patient normally wears a bra but does not have one to assess this during the first 3 days if you are able to assess donning and doffing a shirt but not the bra?	When coding Section GG activities, code based on type and amount of assistance with the clothing used at the time of assessment. In the scenario you describe, assess GG0130F. Upper Body Dressing with a shirt.
109	Section GG	For bathing, can this be in bed? Only noted as shower, bath, or sink.	Code GG0130E based on the patient's ability to bathe themselves, regardless of where the bathing takes place. Consider the amount and type of assistance provided. Per guidance in the IRF-PAI Manual, GG0130E. Shower/bathe self does not include transferring in/out of a tub/shower.
110	Section GG	For upper dressing, is a hospital gown considered as a score 10?	The intent for this item is to assess the patient clothing that would be worn in the community. If clothing is available by day 3, code based on the assessment conducted on that day. If clothing is not available by day 3, paper scrubs could be used to assess the activities of upper and lower body dressing, if no other clothing is available. If a patient does not have upper body clothing other than a hospital gown during the entire 3-day assessment period, you would use code 10, Not attempted due to environmental limitations for GG0130F. Upper body dressing.

#	Category	Question	Answer
111	Section GG	Related to Section GG. Self-Care: I have seen elastic bandages indicated as lower body dressing and thromboembolism deterrent stockings (antiembolic stockings) counted as footwear. What if the elastic bandages cover the foot and are used for the same reason because thromborembolism-deterrents do not fit?	Clothing items that cover all or part of the foot (even if it extends up the leg, like a sock or ankle foot orthosis) would be considered when coding footwear. When assessing GG0130H. Putting on/taking off footwear, an elastic bandage or compression stocking is considered footwear, if it is related to tasks associated with putting on or taking off footwear. Please see page GG-17 of the IRF-PAI Training Manual for more information about some examples that are included in footwear: • Footwear examples, ankle foot orthosis, elastic bandages, foot orthotic, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
112	Section GG	If the patient walks 8 feet, how do you score walk 10 feet? How do you score walk 150 feet?	For a walking activity to be coded using the 6-point scale, the activity must be completed; that is, the patient must walk the entire distance. If, with or without assistance, a patient cannot walk the entire distance, a helper cannot complete the walking activity for the patient.
113	Section GG	If the patient is receiving the majority of nutrition via percutaneous endoscopic gastrostomy feedings but is able to drink by mouth clear liquids, can we score Eating when the patient is only getting fluids?	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 place before the patient. In the example you describe, the patient only takes clear liquids. Clinicians should use clinical judgment to determine whether observing the patient taking clear liquids allows the clinician to adequately assess the patient's ability to complete the activity of eating. If the clinician determines that the observation of taking clear liquids is adequate, code based on the type and amount of assistance required by the helper. If the clinician is unable to determine the patient's ability to eat, code one of the "activity not attempted" codes.
114	Section J	What is the new definition of major surgery?	Per the IRF-PAI Manual Version 3.0, page J-6:

#	Category	Question	Answer
115	Section J	Is there any effort to change the Number of falls since admission item from a general range code to an actual value? This would allow facilities to improve meaningful use of this element and improve national benchmarking comparison value.	We thank you for your suggestion regarding reporting the actual number of falls for each category in J1900. Number of falls since admission, instead of the current coding. We will take your suggestion into consideration.
116	Section J	Is there any correlation CMS has identified between quality data element prior level of function: History of falls and Number of falls since [IRF] admission? This could potentially help with fall prevention programs.	The IRF-PAI item J1750. History of falls is used as part of risk adjustment for the functional outcome QMs because a history of falls is associated with less improvement in mobility.
117	Section N	Can CMS provide/publish examples based on real-life submitted scenarios for Section N: Medications?	Thank you for your feedback. Several of the scenarios and Q&As included in the Section N presentation from the May 2019 IRF QRP Provider Training are based on questions submitted to CMS IRF helpdesks. CMS continues to monitor provider questions for further educational opportunities.
118	Section N	Please provide examples of ineffective drug therapy and non-adherence (purposeful or accidental).	These assessments should be completed by licensed clinicians within their scope of practice, and best clinical judgment should always be used. The intent of the Drug Regimen Review (DRR) is to identify, address, and prevent or mitigate harm to the patient.
119	Section N	Does the DRR include IV fluids such as normal saline?	Yes, according to page N-1 of the IRF-PAI Manual, a DRR includes all medications, prescribed and over-the-counter—including nutritional supplements, vitamins, and homeopathic and herbal products—administered by any route (e.g., oral, topical, inhalant, injection, sublingual, parenteral, by infusion). The DRR also includes total parenteral nutrition and oxygen.

#	Category	Question	Answer
120	Section N	Current IRF performance of the DRR measure is already well above 90 percent, with some IRFs coding incorrect values for the discharge item due to confusion with the verbiage used. While this is an important clinical topic, at what point will the measure be considered topped out or not a meaningful measure?	CMS is continually monitoring the performance of the measures in relation to the Meaningful Measures framework and will continue to do so.
121	Section N	What happens if, in your facility, the RN notifies the physician for any issue, even if it is not significant? Does PPS coordinator use their judgment to determine whether it is significant or not?	A clinician needs to make the decision as to whether the call to the physician relates to a clinically significant medication issue. Individual facilities may have their own policies regarding who can determine what is clinically significant. In that case, follow facility protocols.
122	Section N	Asking an RN to use clinical judgment as to ineffective drug therapy is out of scope for nursing practice. How do you determine this “at time of admission?” How do you know that it is ineffective on admission?	CMS does not provide guidance on who can or cannot code the DRR items. Please refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete a DRR. Data in the IRF-PAI should be consistent with information reported in the patient’s medical record. The necessary information needed and used to code the items should be recorded in the patient’s medical records. Each facility determines their policies and procedures for completing the assessments. Each facility provides patient care according to their unique characteristics and standards (e.g., patient population).
123	Section N	Please give more examples of “clinically significant” issues. Can you please provide the rationale for the timeframe of “midnight of the next calendar day?”	Best clinical practice would be to act upon any significant medication issue promptly. CMS had to put a time parameter on this item.

#	Category	Question	Answer
124	Section N	Do you need to consider internal insulin and/or fentanyl pumps when completing the DRR?	Yes, according to page N-1 of the IRF-PAI Manual, a DRR includes all medications, prescribed and over-the-counter—including nutritional supplements, vitamins, and homeopathic and herbal products—administered by any route (e.g., oral, topical, inhalant, injection, sublingual, parenteral, by infusion). The DRR also includes total parenteral nutrition and oxygen.
125	Section N	Our rehab physicians identify issues as the attending and adjust meds as needed. They have asked whether they should be self-reporting these as DRRs or if the target of this measure is the timeliness of their responses to DRRs escalated to them by the supporting treatment team?	In this scenario, the rehab physician identified and resolved a medication issue, therefore it did not require two-way communication with facility staff.

#	Category	Question	Answer
126	Section N	Would instances such as a patient whose pain was not sufficiently controlled during therapies, or someone who received sleep meds and was unable to sufficiently rouse the next morning, with communication of patient response to the provider, generally be considered as "clinically significant"?	The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record.

#	Category	Question	Answer
127	Section N	N2001 Admission: Is this the first 3 days or first 24 hours?	IRFs would follow best practices by conducting the DRR as soon after the patient's admission as possible. DRR items N2001 and N2003 would be completed upon admission or as close to the actual time of admission as possible. Any clinically significant medication issues identified during the DRR or at any other time throughout the patient's stay must be addressed by midnight of the next calendar day. Each facility delivers patient care according to its unique characteristics and standards (e.g., patient population). Thus, each facility determines its policies and procedures for documenting medication issues and the processes used to notify the physician. Examples of two-way communication with a physician or physician designee include in-person, telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the patient's status.
128	Section N	If a consulting physician identifies a medication issue and brings this to the attention of the attending via phone or verbally, is this a clinically significant medication issue for Section N?	If the provider identified a potential or actual clinically significant medication issue, contacted the attending physician, and recommended actions were completed by midnight of the next calendar day, then N2001 would be coded 1, Yes, and N2003 would be coded 1, Yes. Examples of two-way communication with a physician or physician designee include in-person, telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the patient's status.
129	Section N	I was under the understanding from the Impact Act that a pharmacist must conduct the admission DRR; your comment was that it could be any clinician; can you please clarify?	CMS does not provide guidance on who can or cannot code the DRR items. Please refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete a DRR. Data in the IRF-PAI should be consistent with information reported in the patient's medical record. The necessary information needed and used to code the items should be recorded in the patient's medical records. Each facility determines their policies and procedures for completing the assessments. Each facility provides patient care according to their unique characteristics and standards (e.g., patient population).
130	Section N	Regarding the DDR, what would be the appropriate response to N2003 if the physician does not carry out recommendations? For example, if the physician's judgment is to not make the recommended changes at that particular time/instance.	N2003. Medication follow-up and N2005. Medication intervention would both be coded as 1, Yes, in this scenario if the following occurred: • At admission and at any time throughout the patient stay, the clinician(s) contacted the physician/physician-designee regarding all identified potential or actual clinically significant medication issues. • The physician/physician-designee communicated to the clinician(s) that no actions were necessary regarding the reported issues. • All communications took place by midnight of the next calendar day.

#	Category	Question	Answer
131	Section N	Is there effort to close the interpretation gap with Section N as to what is considered clinically significant? I understand CMS states it is based on clinical judgment, but as a clinician, it is unclear what should be reported. Can CMS provide examples based on submitted scenario questions?	The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record. Thank you for your feedback, we will take this suggestion into consideration when producing education materials in the future.

#	Category	Question	Answer
132	Section N	In an example of a patient diagnosed as having hypertension with elevated blood pressure (BP) readings but noted to not be taking any medication for the condition, would this be an ineffective drug therapy? Who makes the call that this is an ineffective drug therapy: the doctor, pharmacist, or person completing the DRR?	The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record.

#	Category	Question	Answer
133	Section N	Is notifying a physician of abnormal lab values and receiving new orders for treatment included in DRR? For example, K+ of 2.5 requiring a new order for potassium.	The clinician uses their clinical judgment when activating facility protocols regarding abnormal laboratory values. Each facility delivers patient care according to their unique characteristics and standards (e.g., patient population). Thus, each facility self-determines its policies and procedures for completing the assessments in compliance with State and Federal requirements. The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record.

#	Category	Question	Answer
134	Section N	Is there a more detailed list of examples of what is considered a significant medication issue?	A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record. For additional examples of potential (or actual) clinically significant medication issues and how to complete N2001, N2003, and N2005, please refer to Section N of the IRF-PAI Training Manual, which can be found in the Downloads section of the following webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-PAI-Manual.

#	Category	Question	Answer
135	Section N	To be clear, if the pharmacist locates an error (e.g., duplicate therapy) and removes the medication per hospital policy, the code for N2001 is 0 because the pharmacist did not need to contact the physician?	In this scenario, the pharmacist identified and resolved a medication issue and therefore, did not require two-way communication with facility staff. The definition of a clinically significant medication issue requires the identification of a medication issue that warrants contacting a physician or physician-designee (i.e., two-way communication) in a timely manner and addressing all physician or physician-designee prescribed/recommended actions by midnight of the next calendar day at the latest. If no clinically significant medication issues were identified (because two-way communication was not warranted), then N2001 would be coded 0, No, and N2003 would be skipped.

#	Category	Question	Answer
136	Section N	Determination of what is to be considered a clinically significant issue, especially when considering changes in patient status, seems very arbitrary. Is there a plan in place to streamline this measure and make it more coding friendly?	The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record. CMS is continually monitoring the performance of the measures in relation to the Meaningful Measures framework and will continue to do so.

#	Category	Question	Answer
137	Section N	Can you explain ineffective drug therapy as it relates to DRR? If a patient requires an additional intervention, such as oxygen at 2L, and this prompted a call to the provider, would this be considered ineffective and warrant a DRR progress note?	The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record.

#	Category	Question	Answer
138	Section N	DRR question: If a patient is on oxygen on admittance and was found with the oxygen off and O2 was below 88 percent, is this an issue at discharge?	The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record.
139	Section N	If a patient was already on oxygen, and the RN contacted the physician to ask for an order for a higher flow rate due to desaturation, is this considered a clinically significant medication issue?	This is a clinical judgment based on the specific circumstances of the situation.

#	Category	Question	Answer
140	Section N	In slide 47 of the Section N presentation, a physician identifies an issue but resolved the issue without communicating with another physician. The answer is to code No for N2001. Can you please clarify your rationale?	If a facility-based physician-designee performed the DRR, identified a medication issue, and addressed it without needing to communicate with another physician/physician designee, then this means that this scenario did not require two-way communication with facility staff (because the physician-designee identified and resolved the medication issue). In this scenario, N2001 would be coded 0, No (no issues found during review), and N2003 would be skipped. This is because the definition of a clinically significant medication issue requires the identification of a medication issue that warrants contacting a physician or physician-designee (i.e., two-way communication) in a timely manner and addressing all physician or physician-designee prescribed/recommended actions by midnight of the next calendar day at the latest. Since no two-way communication was warranted, this is not considered a clinically significant medication issue for the purposes of completing N2001.
141	Section N	Since an RN is not able to diagnose renal insufficiency, does this mean that renal insufficiency might be out of scope for nurses?	CMS does not provide guidance on who can or cannot code DRR items. Please refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete a DRR. Data in the IRF-PAI should be consistent with information reported in the patient's medical record. The necessary information needed and used to code the items should be recorded in the patient's medical records. Each facility determines their policies and procedures for completing the assessments. Each facility provides patient care according to their unique characteristics and standards (e.g., patient population).
142	Section N	According to slide 43 and the example with Mr. B, the International Normalized Ratio (INR) was not going to occur until the next day. Could you please clarify the answer?	In Scenario 3, on the date of admission, the IRF pharmacist contacted the IRF physician caring for Mr. B and communicated a concern about a potential increase in the patient's INR with this combination of medications, which placed the patient at greater risk for bleeding. The IRF physician provided orders for laboratory testing so that the patient's INR levels would be monitored over the next 3 days, starting that day. However, the first INR laboratory test did not occur until after midnight of the next calendar day. In this scenario, the physician ordered INR monitoring starting the same day. However, INR monitoring did not begin until after midnight of the next calendar day. Therefore, N2003 should be coded as 0, No, because the IRF staff did not complete, to the extent possible, the necessary measures to comply with the recommended action (i.e., starting INR monitoring that day) until after midnight of the next calendar day.

#	Category	Question	Answer
143	Section N	The verbiage of the N2005 item and responses are causing issues with IRF performance on the DRR measure. Would CMS consider revising the verbiage so that the No response indicates that additional issues were found since admission and that the appropriate follow-up actions were not completed?	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.
144	Section N	Just a comment about N2005 on slide 65. Did CMS consider the amount of time it takes to review an entire medical record to determine compliance? We have thus far been compliant, and I expect most facilities have a high rate of compliance.	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.

#	Category	Question	Answer
145	Section N	A patient's BP remains elevated despite as needed BP medication dose. The physician contacted with hydrazine dosage, and BP parameters changed within the hour. Would this be reported as meeting the DRR reporting criteria?	The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record.

#	Category	Question	Answer
146	Section N	What happens if a DRR problem is identified on Day 9, the physician is notified and action happens appropriately within the required timeframe, but the problem should have been (but was not) identified on day 2? Do we dig that deep, or do we score based on the day the problem was identified?	The clinician should use clinical judgement to determine if the potential or actual issue would rise to the level of clinical significance that would require two-way communication with the physician and completion of prescribed/recommended actions by midnight of the next calendar day at the latest. Please refer to your facility and State policies and procedures for resolving potential or actual clinically significant medication issues when there is a discrepancy in documentation or there is disagreement among team members regarding whether or not a scenario is a potential or clinically significant medication issue. While the problem may have existed before Day 9; Day 9 is the day of identification. If the physician was notified and responded by midnight of the next day, then item N2005 should be answered to reflect that action.
147	Section N	To prevent incorrect coding of N2005, are there any plans to update the technical specifications to not allow the use of code 1 or code 9 in N2005 (only allowing code 0) if N2003 = 0, No?	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.
148	Section N	Most of my pharmacists focus on the words “since admission” on the discharge DRR question and argue that admission is not included. Can the question be reworded?	Item N2005 applies to the entire patient stay and includes clinically significant medication issues identified at admission or at any time throughout the patient stay (admission through discharge). Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.

#	Category	Question	Answer
149	Section N	If N2003 is coded 0, No, then N2005 must also be coded 0, No. Why are we documenting N2005? Please provide rationale.	The intent of the DRR data elements is to document whether IRF providers conducted a DRR upon the patient admission and whether clinically significant medication issues, which can occur throughout the stay, were addressed in a timely manner when identified throughout the patient stay. Coding N2005. Medication intervention at discharge captures all clinically significant medication issues that occurred throughout the stay that rose to the level of clinical significance requiring two-way communication with the physician and completion of prescribed/recommend actions by midnight of the next calendar day at the latest. All three DRR items are included in the calculation of this QM. Therefore, it is imperative that all three data elements be coded accurately to calculate your facility's DRR score. In the scenario you describe, the patient's stay would be included in the denominator but not in the numerator.
150	Section N	Regarding Scenario 6: Medication review issues were discovered at the time of discharge and proper action was taken. N2001 and N2003 are answered with respect to admission and would have been answered No. N2005 would be Yes. Please provide feedback on this confusing scenario.	In Scenario 6, during the admission assessment period, a clinically significant medication issue was identified and the physician was contacted on the same day. This issue was communicated and addressed by midnight of the next calendar day. Therefore, N2001 should be coded as 1, Yes (issues found during review), and N2003 should be coded as 1, Yes, because the two-way communication and completion of prescribed/recommended actions occurred by midnight of the next calendar day. Later during the stay, the patient's record included an order to hold the medication Ms. K was receiving for deep vein thrombosis prophylaxis for a scheduled procedure. The RN noted that this medication had not been restarted 48 hours post-procedure and determined that the physician needed urgent notification. The day after the notification occurred, the IRF physician provided an order to resume the medication, which was carried out by the nursing staff within the hour. This issue was communicated and addressed by midnight of the next calendar day. There were no additional clinically significant medication issues identified during the remainder of the IRF stay. Therefore, N2005 should be coded as 1, Yes, because both medication issues identified during Mrs. K's stay were communicated to the physician and resolved by midnight of the next calendar day after identification.

#	Category	Question	Answer
151	Section N	If N2003 was 0, then we identified medication issues later in the stay and addressed and resolved them in a timely manner, can N2005 be Yes?	In the scenario you describe, issues were found during the DRR conducted upon admission (N2001 = 1, Yes), and all of those identified potential or actual clinically significant medication issues were not addressed by midnight of the next calendar day (N2003 = 0, No). Later during the stay, an additional issue was found and addressed by midnight of the next calendar day. In this case, N2005 should be coded as 0, No, because the facility did not contact the physician (or physician-designee) and complete prescribed/recommended actions by midnight of the next calendar day each time clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge).
152	Section N	What is the definition of "DRR on admission?" Is this the day of admission up until midnight of the next calendar day?	IRFs would follow best practices by conducting the DRR as soon after the patient's admission as possible. DRR items N2001 and N2003 would be completed upon admission or as close to the actual time of admission as possible. Any clinically significant medication issues identified during the DRR or at any other time throughout the patient's stay must be addressed by midnight of the next calendar day. Each facility delivers patient care according to its unique characteristics and standards (e.g., patient population). Thus, each facility determines its policies and procedures for documenting medication issues and the processes used to notify the physician. Examples of two-way communication with a physician or physician designee include in-person, telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the patient's status.

#	Category	Question	Answer
153	Section N	Slide 93 says “patient stays in the denominator.” Is this correct?	The word denominator in the slide title is correct. The denominator is defined as number of patient stays during the reporting period, and the numerator is defined as number of patient stays in the denominator in which both of the following criteria are met: 1. The facility conducted a DRR on admission, which resulted in one of the following three scenarios being true: 1.1: No potential or actual clinically significant medication issues were found during the review (N2001 = [0]). 1.2: Potential or actual clinically significant medication issues were found during the review (N2001 = [1]) and a physician (or physician-designee) was contacted and prescribed/recommended actions were completed by midnight of the next calendar day (N2003 = [1]). 1.3: The patient was not taking any medications (N2001 = [9]). 2. Appropriate follow-up occurred each time a potential or actual clinically significant medication issue was identified during the stay (N2005 = [1]); or no potential or actual clinically significant medication issues were identified since admission, or patient was not taking any medications (N2005 = [9]).

#	Category	Question	Answer
154	Section N	What is considered the "patient stays during the reporting period" (on Slide 93)?	According to Section 1.2 of the IRF QRP Measure Calculations and Reporting User's Manual, when calculating a QM, the IRF Stay Definitions include: • Patient Stay-Level Record: A patient stay-level record is an IRF-PAI record that includes both admission and discharge data and reflects an IRF stay. • Stay: The period of time between a patient's admission date into an IRF and date of discharge from the IRF. The span of time that defines a measure reporting period varies by QM but is typically 12 months. Table 7-10 of the IRF QRP Measure Calculations and Reporting User's Manual provides more information about the DRR Conducted with Follow-Up for Identified Issues measure specifically. The denominator for DRR Conducted with Follow-Up for Identified Issues is defined as "Any patient stays (Medicare Part A or Medicare Advantage) during the reporting period." Since there are no exclusions for this QM, the measure includes all Medicare Part A or Medicare Advantage stays during a 12-month period. The discharge date for an IRF patient's stay is used to determine whether they are included in a specified reporting period. The IRF QRP Measure Calculations and Reporting User's Manual can be found in the downloads section of the IRF Quality Reporting Measures Information page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html.
155	Section N	If an issue was found on admission and the patient was discharged prior to the next midnight (unrelated), how would you score N2003?	In this scenario, if the patient was discharged prior to midnight of the next calendar day and the criteria for all potential and actual clinically significant medication issues identified during the admission DRR (i.e., two-way communication between the clinician and physician or physician-designee by midnight of the next calendar day and all physician or physician-designee prescribed/recommended actions completed by midnight of the next calendar day) were not met, then a dash would be a valid response for N2003; however, CMS expects dash use to be a rare occurrence.

#	Category	Question	Answer
156	Section N	If a patient was planning to leave today and a DRR was completed, but the discharge gets postponed to tomorrow, does the discharge DRR need to be done again the next day?	The intent of the DRR items is to document whether a DRR was conducted upon the patient's admission and throughout the patient's stay, and whether any clinically significant medication issues identified were addressed in a timely manner. The timing of formal (and informal) DRR activities would be completed based on patient need, complying with State and Federal regulations, as well as facility policies and procedures. N2005. Medication intervention, which is completed at discharge, identifies whether every clinically significant medication issue identified at the time of or at any time since the admission was communicated to the physician (or physician-designee) and whether, to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.
157	Section N	Is there a specific timeframe for N2001 and N2003?	IRFs would follow best practices by conducting the DRR as soon after the patient's admission as possible. DRR items N2001 and N2003 would be completed upon admission or as close to the actual time of admission as possible. Any clinically significant medication issues identified during the DRR or at any other time throughout the patient's stay must be addressed by midnight of the next calendar day. Each facility delivers patient care according to its unique characteristics and standards (e.g., patient population). Thus, each facility determines its policies and procedures for documenting medication issues and the processes used to notify the physician. Examples of two-way communication with a physician or physician designee include in-person, telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the patient's status.
158	Section N	Nurses have to acknowledge physician orders and changes—isn't that two-way communication?	Each facility delivers patient care according to its unique characteristics and standards (e.g., patient population). Thus, each facility determines its policies and procedures for documenting medication issues and the processes used to notify the physician. Examples of two-way communication with a physician or physician designee include in-person, telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the patient's status.

#	Category	Question	Answer
159	Section N	Who can conduct a DRR, and who should be involved in two-way communication?	CMS does not provide guidance on who can or cannot code the DRR items. Please refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete a DRR. Data in the IRF-PAI should be consistent with information reported in the patient's medical record. The necessary information needed and used to code the items should be recorded in the patient's medical records. Each facility determines their policies and procedures for completing the assessments. Each facility provides patient care according to their unique characteristics and standards (e.g., patient population). The definition of a clinically significant medication issue requires the identification of a medication issue that warrants contacting a physician or physician-designee (i.e., two-way communication between the clinician(s) and the physician or physician-designee) in a timely manner and addressing all physician or physician-designee prescribed/recommended actions by midnight of the next calendar day at the latest. According to Section N of the IRF-PAI Manual, contact with physician (or physician-designee) is defined as communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue AND a response from the physician (or physician-designee) to convey prescribed/recommended actions in response to the medication issue. Communication can be in person, by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. Communication can be directly to/from the physician (or physician-designee) or indirectly through the physician's office staff on behalf of the physician (or physician-designee), in accordance with the legal scope of practice. Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the DRR, and the patient and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.

#	Category	Question	Answer
160	Section N	If a physician contacts another physician for guidance on a medication concern or question, does it qualify for DRR?	The clinician should use clinical judgment to determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record.

#	Category	Question	Answer
161	Section N	What is the appropriate documentation for N2005 when the patient refuses a medication? The RN documents that the patient refused medication and notifies the physician. This is documented as Yes, a significant medication issue was found and the physician was notified—is this correct?	The clinician should use clinical judgment in conjunction with facility, State, and Federal guidelines to code these scenarios and determine whether an identified medication issue would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. Potential or actual clinically significant medication issues may include, but are not limited to, the following: • Adverse reactions to medications (such as a rash). • Ineffective drug therapy (such as analgesic that does not reduce pain). • Side effects (such as potential bleeding from an anticoagulant). • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic name and brand name-equivalent drugs are both prescribed). • Omissions (such as missing drugs from a prescribed regimen). • Dosage errors (either too high or too low). • Non-adherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record.

#	Category	Question	Answer
162	Section N	How is communication defined? Is data entered into electronic medical records "communication"?	The definition of a clinically significant medication issue requires the identification of a medication issue that warrants contacting a physician or physician-designee (i.e., two-way communication) in a timely manner and addressing all physician or physician-designee prescribed/recommended actions by midnight of the next calendar day at the latest. According to Section N of the IRF-PAI Manual, contact with physician (or physician-designee) is defined as communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue AND a response from the physician (or physician-designee) to convey prescribed/recommended actions in response to the medication issue. Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status. Communication can be directly to/from the physician (or physician-designee) or indirectly through the physician's office staff on behalf of the physician (or physician-designee), in accordance with the legal scope of practice.
163	Section N	Not a question, but a suggestion to supplement "clinical judgment" in how to define "clinically significant" DRR: If (1) it involves a change of prior medication, test, or treatment and (2) it leads to a new order from the provider.	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.
164	Section N	In regard to the DRR, if CMS states that we are to use clinical judgment for Section N, is there a point where we could be dinged or denied payment for answering "No" and during an audit CMS deems the answer "Yes?"	To accurately code the DRR data elements on the IRF-PAI, the data should be consistent with information reported in the patient's medical record. All IRF-PAI data elements should be accurately coded to reflect the patient's status and be submitted to CMS. It is the IRF's responsibility to ensure the completeness of the IRF-PAI data. By signing the IRF-PAI upon completion (Z0400A), IRF staff are certifying that the information entered is complete to the best of their knowledge and accurately reflects the patients' status.
165	Section N	There are several errors in the Training Manual (i.e., reference to Section 6). Will these be corrected in future manuals?	Thank you for your feedback. CMS will address in a future version of the IRF-PAI Manual.

#	Category	Question	Answer
166	Section N	Should admission assessment for DRR also be done within 3 days of admission.? Or on day 1?	IRFs would follow best practices by conducting the DRR as soon after the patient's admission as possible. DRR items N2001 and N2003 would be completed upon admission or as close to the actual time of admission as possible. Any clinically significant medication issues identified during the DRR or at any other time throughout the patient's stay must be addressed by midnight of the next calendar day. While item N2001 and N2003 apply only to the DRR conducted upon admission and to potential or actual clinically significant medication issues identified during the admission DRR, N2005. Medication Intervention, which is completed at discharge, identifies if every clinically significant medication issue identified throughout the patient stay (admission through discharge) was communicated to the physician (or physician-designee), and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission.

#	Category	Question	Answer
167	Section N	What is the process of submitting quality data for the QRP?	Data for the IRF QRP measures are collected and submitted through three methods: • IRF-PAI. • Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). • Medicare Fee-For-Service Claims (no additional submission needed). IRFs must submit data no later than 11:59 p.m. Pacific Standard Time the day of the submission deadline. The IRF-PAI must be transmitted to CMS through the Assessment Submission and Processing system to the Quality Improvement Evaluation System (QIES). Data for the NHSN measures must be submitted to CDC. No additional data submission is required for the claims-based measures. CMS strongly encourages submitting quality data prior to the deadline ensuring the data is complete and accurate and to address any data submission issues. For more information about IRF-PAI submission: https://qtso.cms.gov/providers/inpatient-rehabilitation-facility-irf-pai-providers/reference-manuals. For more information about how to verify your data submission, please see: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/PAC-IRF-QRG-FY2020-508.pdf. For questions about IRF quality data submitted to CMS via CDC's NHSN, or NHSN Registration, email NHSN@cdc.gov.
168	Section N	Does there need to be an ongoing list of identified medication issues and whether there was a response or just documentation somewhere in the record?	Each facility delivers patient care according to its unique characteristics and standards (e.g., patient population). Thus, each facility determines its policies and procedures for documenting medication issues and the processes used to notify the physician.

#	Category	Question	Answer
169	Section M	How many hours upon admission is allowed before the identification of the pressure ulcer (PU) is still considered "present upon admission?"	Clinical assessments of patients in the IRF should be completed according to accepted clinical practice and comply with facility policy and State and Federal regulations. The general standard of practice for newly admitted patients is that patient clinical Admission assessments are completed beginning as close to the actual time of admission as possible, and usually within 24 hours. For example, if a facility requires that a full patient assessment be completed within the first 24 hours, then the information required in the IRF-PAI Admission assessment would be coded based on that assessment.
170	Section M	While PU/Pressure Injury (PI) items are clinically useful, the Changes in Skin Integrity measure identifies less than 2 percent of Medicare cases. This provides little opportunity for improvement for IRFs, and with little/no changes over the last 3 years, brings into question if this meets meaningful measure criteria.	CMS is continually monitoring the performance of the measures in relation to the Meaningful Measures framework and will continue to do so.
171	Section M	Why don't you include urinary incontinence and high body mass index (BMI) in risk adjustment?	Data analysis has shown that high BMI and urinary incontinence do not have a high correlation for risk for PU/PI.
172	Section M	What percentage is considered a low BMI?	Section M does not require coding BMI. For purposes of risk adjustment for the PU QM, BMI is calculated using the items Height and Weight in the formula: BMI = (weight * 703 / height^2). Low BMI is defined as a BMI between 12 and 19. A value lower than 12 would reflect invalid height or weight.

#	Category	Question	Answer
173	Section M	When a patient arrives with a non-removable dressing or device with no documentation from the previous facility of PU/PI, the IRF has no way of assessing for PU/PI. If this device is removed during the IRF stay and the PU/PI is identified, this negatively impacts the IRF. How can we address this?	You must have documentation that there is a PU under the non-removable dressing to code it in Section M on admission.
174	Section M	That a stage 4 PU always stays a stage 4 throughout a stay is confusing. As it heals, doesn't it change in descriptor and staging?	Per the IRF-PAI manual and evidence-based practice, we do not reverse stage. Clinical standards do not support reverse staging or back staging as a way to document healing, as it does not accurately characterize what is physiologically occurring as the ulcer heals. Therefore, once a PU is coded as a stage 4, it will continue to be a stage 4 until it is healed or becomes unstageable.
175	Section M	If a patient goes to acute care facility and returns to the IRF (without being discharged) with a new PU, is that considered not present on admission (i.e., a new PU) at the IRF discharge?	If the patient has an interrupted stay and returns to the IRF with a new PU/PI, that PU/PI is not considered present on admission.
176	Section M	If a patient is admitted and we assess the PU as a stage 3, but it was a stage 4 at a previous setting, and the physician documents on History/Physical as a stage 3, what International Classification of Diseases (ICD)-10 code goes on the IRF PAI: the code for a stage 3 or for a stage 4?	The PU should be coded as a healing stage 4 for both Section M and item 24. Clinical standards do not support reverse staging or back staging as a way to document healing, as it does not accurately characterize what is physiologically occurring as the ulcer heals.

#	Category	Question	Answer
177	Section M	If a PU developed during the patient stay (after the 3-day admission assessment) but healed the day prior to discharge or the day of discharge (during the last 3 days), would this ulcer be coded/reported on the IRF-PAI?	If the initial skin assessment did not indicate a pressure ulcer/injury, then during the stay the patient developed a PU/PI, and at discharge you assess the patient and there are no PU/PI, you would not capture any PU/PI on the IRF-PAI.
178	Section M	Why does the Discharge section M0300 A only have one box for number of stage 1 pressure injuries? Why is there not a box for present on admission?	Stage 1 PUs that were present on admission are not included in the calculation of the numerator of the Changes in Skin Integrity PU measure; therefore, the data is not collected.
179	Section M	Regarding “not present on admission at that stage,” if a patient was admitted with a PI unstageable due to Deep Tissue Injury (DTI), but it opens during the stay and is unstageable due to slough, would this be considered worsened?	If the PU/PI was unstageable on admission but becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If an unstageable PU is able to be numerically staged and, subsequent to this numerical staging, the PU further deteriorates and is staged at a higher numerical stage and/or is unstageable due to slough or eschar at discharge, the PU would not be considered nor coded as present on admission on the discharge assessment (M0300F2 = 0).
180	Section M	If the PI was a stage 4 on admission but visually looks like a PI stage 1 upon discharge, should we still code it as a stage 4? And only describe it as healed if completely resolved?	Per the IRF-PAI Manual and evidence-based practice, we do not reverse stage. Clinical standards do not support reverse staging or back staging as a way to document healing, as it does not accurately characterize what is physiologically occurring as the ulcer heals. Therefore, once a PU is coded as a stage 4, it will continue to be a stage 4 until it is healed or becomes unstageable.

#	Category	Question	Answer
181	Section M	Prior to October 1, 2018, when a stage 3 or 4 PU became unstageable due to slough and/or eschar it was not considered worsened. After October 1, 2018, it is considered worsened. Can CMS clarify the clinical justification for this change?	A numerically staged pressure ulcer/injury that becomes covered with slough/eschar to the extent that the wound bed cannot be observed is considered to have worsened for the purposes of coding the assessment instrument.
182	Section M	In staging the admission PU, if the interrupted stay is within the Assessment Reference Date, why would we have to own that stage 3? Shouldn't it be a stage 3 on that admission?	The 3-day assessment period used in the IRF-PAI is not intended to replace the timeframe required for clinical Admission assessments as established by accepted standards of practice, facility policy, and State and Federal regulations. Therefore, the IRF-PAI Admission assessment's sections that include patient assessment should be consistent with the initial clinical assessment (e.g., the assessment of skin conditions that are present at the time of admission are based on the skin assessment that is in conjunction with the admission). If a patient that is clinically assessed upon admission has a PU/PI identified and staged, that initial clinical assessment is what should be used to assist in coding the IRF-PAI Admission assessment PU/PI items. If the PU/PI that is identified on admission increases in numerical staging (i.e., worsens) within the 3-day IRF assessment period, the initial stage of the PU/PI would be documented on the IRF-PAI Admission assessment. This PU/PI would be captured on the IRF-PAI Discharge assessment as worsened (unless it heals) and would not be coded as present on admission. If a patient is discharged to another facility/hospital for longer than 3 calendar days and subsequently returns to the IRF and a current PU increases in numerical stage, it is coded at the higher stage on the patient's new admission assessment for the second IRF stay. A new admission IRF-PAI is not completed for an interrupted stay.
183	Section M	If we are supposed to code PUs on admission to the IRF, why would we use a status from the acute care setting?	Review the history of each PU/PI in the medical record. If the PU/PI was previously classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. If the PU/PI was classified at a lower numerical stage than what is observed at admission to the IRF, the PU/PI is coded according to the initial skin assessment completed upon admission to the IRF.

#	Category	Question	Answer
184	Section M	For PU/PI risk adjustment, what code(s) for GG0170C and H0400 affect risk?	Risk adjustors for the Skin Integrity measure for items GG0170C and H0400 are calculated in the following manner: 1. Functional Mobility Admission Performance: Coding of dependent or substantial/maximal assistance for the functional mobility item Lying to Sitting on Side of Bed at admission: a. Covariate = [1] (Yes) if GG0170C = [01, 02, 07, 09, 10, 88] ([01] = Dependent, [02] = Substantial/maximal assistance, [07] = Patient refused, [09] = Not applicable, [10] = Not attempted due to environmental limitations, [88] = Not attempted due to medical condition or safety concerns). b. Covariate = [0] (No) if GG0170C = [03, 04, 05, 06, –] ([03] = Partial/moderate assistance, [04] = Supervision or touching assistance, [05] = Set-up or clean-up assistance, [06] = Independent, [-] = No response available). 2. Bowel Incontinence: Bowel Continence (H0400) at admission a. Covariate = [1] (yes) if H0400 = [1, 2, 3] ([1] = Occasionally incontinent, [2] = Frequently incontinent, [3] = Always incontinent). b. Covariate = [0] (no) if H0400 = [0, 9, –] ([0] = Always continent, [9] = Not rated, [–] = Not assessed/no information).
185	Section M	Is the program interruption the important factor in the first scenario?	In example 1, the education point was that if the patient had a stage 2 and was out of the facility for 2 days and returned to the IRF with a stage 3, the PU would not be considered as present upon admission.
186	Section M	For Scenario 1: Will that be counted against the IRF as acquired even though it was acquired when the patient is out during the program interruption?	In example 1, the education point was that if the patient had a stage 2 and was out of the facility for 2 days and returned to the IRF with a stage 3, the PU would not be considered as present upon admission.
187	Section M	For the PU scenario (stage 2 becomes stage 3 after interruption of stay), which PU codes would be listed under comorbid conditions and/or complications on the IRF-PAI?	A new admission assessment is not completed for an interrupted stay.

#	Category	Question	Answer
188	Section M	If a patient developed a blister along their Achilles tendon due to ill-fitting shoes and this blister opened, would this be considered a PU?	If an ulcer/injury arises from a combination of factors, and pressure is considered the primary cause, then the ulcer/injury would be coded in Section M as a PU/PI. Per the requirements of section M of the IRF-PAI, pressure should be the primary cause of the wound.
189	Section M	Does a picture taken upon admission count as evidence like a written description does to correct an error of staging upon admission?	Documentation should be based on accepted standards of practice and comply with facility policy and State and Federal regulations.
190	Section M	Regarding scenario 2, would the pressure ulcer/injury be coded a stage 4 at discharge if it was coded a stage 4 on admission and there is only a little slough at discharge that does not prevent you from seeing the wound bed?	If a PU/PI is covered with some slough but you are able to see underlying structures like bone or tendon, you can stage the wound as a stage 4.
191	Section M	Updated medical records transferred over with the patient stated that he had a stage 2 PU, but when the admission assessment was completed no PUs were noted—how would you code that?	If the patient does not have a PU/PI at the time of admission to the IRF, then M0210. Unhealed PU/PIs are coded 0, No, and the M0300 items are skipped.
192	Section M	I thought you said that if we know the stage of the wound under the dressing, we are supposed to stage the wound. For example, in scenario 4, we know it is a stage 4 before it was dressed.	A known PU/PI that is covered by a non-removable dressing or device is coded as unstageable due to non-removable dressing/device in M0300E.

#	Category	Question	Answer
193	Section M	How should a wound under a non-removable device at admission be coded at discharge if it is not a DTI? Would it be considered worsened?	If the PU/PI was unstageable on admission but becomes numerically stageable later, it should be considered as "present on admission" at the stage at which it first becomes numerically stageable when completing this patient's discharge assessment. If it subsequently increases in numerical stage, that higher stage should not be considered "present on admission" when coding this patient's discharge assessment.
194	Section M	If there is discrepancy/conflict between assessments—say, an RN admits a patient and documents a stage 2 ulcer, but the physician assessed and determined that the wound is moisture-associated instead of pressure—how should you rate the admission levels?	If there is disagreement among team members, refer to your facility policy for resolving these issues. If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the ulcer/injury should be included in this section as a PU/PI. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.
195	Section M	Does an ulcer under a Trach collar work like mucosal ulcers, or would you stage like actual PU?	The location and tissue type involved would identify whether it is a mucosal ulcer or a PU/PI.
196	Section M	If a wound goes from stage 4 on admission to unstageable due to slough, does that go in the numerator of the quality metric as a PU that worsened? What if it is a stage 4 on admission and is now covered with non-removable dressing, how does that factor into the quality metric numerator?	If a stage 4 PU on admission is covered with a non-removable dressing at the time of discharge, the unstageable PU/PI due to non-removable dressing is considered present on admission if the stage 4 was not unstageable due to slough/eschar when covered by the non-removable dressing.
197	Section M	Would you code a wound on a prolapsed uterus as a PI/PU?	This would not be coded as a PU, as the tissue is mucosal in nature.
198	Section M	What if the PU is from the securement device from the catheter tubing, not the insertion site?	Any injury with a primary cause of pressure in tissue that is non-mucosal would be coded as PI at the stage it is identified.

#	Category	Question	Answer
199	Section M	Would oxygen tubing putting pressure on the outside of the ears be considered a PU?	Yes, if pressure is the primary cause of the injury and it is not mucosal tissue, it would be considered a PI.
200	Section M	I want to fully understand the skin assessment. The skin assessment will only be valid within 24 hours of admission. If a wound care nurse evaluates the patient post-24 hours per protocol or availability and notes a PI or ulcer, then it should not be documented as present on admission?	The skin assessment should be completed as close to admission as possible, and the first time this is completed, it is considered the admission skin assessment and should be used for coding. The IRF-PAI Admission assessment's sections that include patient assessment should be consistent with the initial clinical assessment (e.g., the assessment of skin conditions that are present at the time of admission are based on the skin assessment that is in conjunction with the admission). Any pressure related injuries after this initial skin assessment would not be coded as present upon admission.
201	Section M	Our nurses were consistently documenting wounds incorrectly, so they are unable to stage wounds at this time. We have a wound-certified nurse and team that rounds every week. How can we make sure we are using appropriate documentation if the wound team rounds on day 2?	Documentation should be based on accepted standards of practice and comply with facility policy and State and Federal regulations.
202	Section M	If our wound nursing team does not assess patients on the weekends and our admission nurse assess skin integrity at a stage 2 but it was actually a stage 3 and documented by our wound team on Monday, do we code this a stage 2 on admission?	The skin assessment should be completed as close to admission as possible, and the first time this is completed, it is considered the admission skin assessment and should be used for coding. Any pressure-related injuries after this initial skin assessment would not be coded as present upon admission.

#	Category	Question	Answer
203	Section M	BMI is used as a risk adjustment measure. I do not feel that this is being calculated correctly for amputees. The BMI calculator for height and weight alone is not effective for amputees.	CMS appreciates this feedback and will take it into consideration in future risk adjustment adaptations.
204	Section M	For Slide 49, Section M: What if you have a non-removable dressing on admit but the nurse in the acute floor knows the stage of the PU?	If, on the initial skin assessment, you have a known PU under a non-removable dressing, you would code M0300E1 as 1, as you cannot observe the injury to stage it. Known PU/PI covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. “Known” refers to when documentation is available that says a PU/PI exists under the non-removable dressing/device.
205	Section M	Since you do not use stage 1 pressure information in quality reporting measures, why do you have us collect it?	Stage 1 PU information is used in testing and validation studies for PU QMs.
206	Section M	Why do you have us report PI information on the IRF-PAI and NHSN?	Collection of PU/PI data is required as a part of the IRF QRP. Failure to submit required QI data may result in a 2-percentage-point reduction in the IRF’s Annual Payment APU.
207	Section M	The IRF-PAI Manual defines present “on admission” for PU “as close to the actual time of admission as possible” Can you be more specific by referring to up to what time from admission? Will this be within 3 days from admission?	Clinical assessments performed on patients in the IRF should be completed according to accepted clinical practice and comply with facility policy and State and Federal regulations. The general standard of practice for newly admitted patients is that patient clinical Admission assessments are completed beginning as close to the actual time of admission as possible, and usually within 24 hours. For example, if a facility requires that a full patient assessment be completed within the first 24 hours, then the information required in the IRF-PAI Admission assessment would be coded based on that assessment and coincide with the findings that were completed within that same timeframe. The 3-day assessment period used in the IRF-PAI is not intended to replace the timeframe required for clinical Admission assessments as established by accepted standards of practice, facility policy, and State and Federal regulations.

#	Category	Question	Answer
208	Section M	On admission, if you have a small amount of slough but the clinician says they can see the depth of the wound and they can see bone, so they say stage 4, but at discharge there is a small amount of slough and the clinician believes they can see the wound bed, is it appropriate to call it stage 4?	If the wound bed is only partially covered by eschar or slough and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer/injury and do not code this as unstageable.
209	Section M	Is it acceptable for the assessment to be conducted on Day 2 if that is when the wound nurse evaluates the patient?	The skin assessment should be completed as close to admission as possible and the first time this is completed it is considered the admission skin assessment and should be used for coding. The IRF-PAI Admission assessment's sections that include patient assessment should be consistent with the initial clinical assessment (e.g., the assessment of skin conditions that are present at the time of admission are based on the skin assessment that is in conjunction with the admission).
210	Section M	Regarding the PUs being a stage 4 in the acute facility and now the IRF admits with a stage 3, continuing to code on the IRF-PAI as a stage 4 is not going to accurately match documentation, which is going to be used to assign ICD-10 codes.	If a patient is admitted with an ulcer that is documented as a stage 4, and when admitted to the IRF the same ulcer appears to be a stage 3, you would still code this ulcer as a stage 4 because you do not reverse stage. Your ICD-10 code would also be coded as a stage 4 until the wound is healed.
211	Section M	If a patient is admitted from the acute hospital and their PU is staged "correctly," but then the admitting nurse at the IRF stages the ulcer "incorrectly," are we then permitted to use the acute care notes to appropriately stage the wound on the IRF-PAI?	In this example, if you have documentation that a PU/PI is staged from the acute care hospital and the nurse in the IRF has staged the wound at a lesser stage due to the PU healing, you would code as the documented stage from the acute care hospital. If, in this example, the nurse coded the PU at an increased stage, then correct the code to the observed stage.

#	Category	Question	Answer
212	Section M	What timeframe would be appropriate to say the wound was likely present in admission?	The skin assessment should be completed as close to admission as possible, and PU/PI that are assessed to be present at that time should be coded in Section M.
213	Section M	Regarding scenario 5, the ulcer will be coded with ICD-10 codes. Will it be a red flag when the claim form does not match the assessment?	In scenario 5, the patient was admitted with intact skin; on day 7 of the IRF stay, a stage 2 PU is identified on the coccyx; and at discharge, the PU is healed. In this scenario, this stage 2 PU would not be captured on the IRF-PAI. There may be diagnosis that are captured in ICD-10 codes that may not be identified on the IRF-PAI, as this is looking at two different time points of admission and discharge.
214	Section M	Referring to mucosal ulcers, is a PU in the area of a G-Tube (percutaneous endoscopic gastrostomy) considered a mucosal ulcer?	The stoma area of the G-tube is considered mucosal, but the skin portion would not be considered mucosal.
215	Function Measures	NQF# 2631 specifically identifies LTCH. Why is this being collected and reported for IRF level of care?	The title of the QM, Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), includes LTCH because the QM was endorsed as a QM for the LTCH setting by the NQF in 2015. In the FY2016 IRF PPS final rule, CMS modified the measure for cross-setting use and thus it is called “Application of Percent of LTCH Patients….” This measure was adopted into the IRF QRP and data collection began with patients discharged on or after Oct 1, 2016.
216	Function Measures	One of the exclusion criteria for these QMs is discharge to a short-term general hospital. If we are discharging a patient to an acute care cancer center (which is not coded as 02 on the UB-04, but is coded as cancer center), do we code 44D on the IRF-PAI as 02 or 99, Not listed (since both must match)?	If a patient is discharged to a cancer center, code item 44D on the IRF-PAI as 99 – Not listed. For the functional outcome measures, a patient’s IRF-PAI record that has item 44D coded as 99 will be included in the QM calculation. Complete the discharge Section GG data elements, because the patient’s stay will not be considered an incomplete stay.

#	Category	Question	Answer
217	Function Measures	Can CMS provide a user-friendly table that lists and identifies which functional items impact payment, which impact/included in QMs, and which are both? This would be helpful for clinical training.	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.
218	Function Measures	How is the length of stay being calculated?	For the four IRF Functional Outcome Measures, length of stay calculated for the purpose of excluding very short stays (i.e., stays less than 3 days in the IRF). For this purpose, length of stay is calculated as Discharge Date (Item 40) – Admission Date (Item 12) using the IRF-PAI data.
219	Function Measures	Why were patients with quadriplegia not excluded from the self-care measures? Their self-care gain is extremely limited.	Patients with tetraplegia are excluded from the self-care and mobility QMs. For more information, please see the IRF Measure Calculation and Reporting User's Manual for more information about calculating this measure: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-Measure-Calculations-and-Reporting-Users-Manual-V30.pdf.

#	Category	Question	Answer
220	Function Measures	While there are a number of risk adjustment factors, patient length of stay is not a factor. Since the risk factors differ from CMGs, CMS CMG length of stay values may influence outcomes and the ability for patients to meet or exceed expected values. Is CMS evaluating length of stay as a risk factor?	The goal of risk adjustment is to control for differences across facilities in patient characteristics at admission that might be related to the outcome of interest. Risk factors are typically patient demographic or clinical characteristics that are observed at the time of admission (start of care). The clinical factors used to assign patients into a CMG (impairment group code, motor function, age, cognitive function) and other factors are included in the risk-adjustment model as unique covariates. For QMs, we generally do not adjust for factors that occur after admission. Any clinical issue that occurs after the start of care—in other words, anything on the "causal pathway" to the outcome—is typically not included in a regression model, so that care provided after admission does not confound the outcome. If an IRF implements treatment practices that are associated with better functional outcomes, the IRF's QM scores should result in better QM scores. If an IRF tends to have longer IRF stays than the average IRF, and their patients achieve better patient functional outcomes due to the longer stay, the IRF's QM scores would reflect more functional improvement. If the functional outcome measures were adjusted for length of stay, the effect of the longer lengths of stay on functional outcomes would be removed. As noted below, treatment practices that are associated with better functional outcomes should result in better QM scores.
221	Function Measures	Can you repeat what the national average change in self-care and change in mobility scores were?	The national average score for the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) for calendar year 2017 was 11.5 units of change in self-care. The national average score for the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) for calendar year 2017 was 28.3 units of change in mobility. The data and analyses are available in the updated materials recently submitted for NQF endorsement maintenance. You can search for a measure by its NQF number on the Quality Positioning System to access these public materials: http://www.qualityforum.org/QPS/QPSTool.aspx.

#	Category	Question	Answer
222	Function Measures	Will you post on the comparison website how many spinal cord injury patients, coma patients, and anoxic brain injury patients an IRF treats so that percentages make sense to the public? The percentages may look low if one is a spinal cord injury or traumatic brain injury model center.	For the IRF Functional Outcome Measures, only the IRF's QM score will be displayed to the public on the IRF Compare website. The IRF's numerator and denominator will be included in the downloadable data file also available on the website. The number of patient stays excluded will not be reported to the public. The IRF Compare website includes reports of the number of Medicare patients by certain medical condition (including spinal cord and brain injury) treated by each IRF during a recent 12-month period. This information is available when viewing a single facility, comparing multiple facilities, and in the downloadable data file. No exclusion criteria are applied to these data prior to determining the counts.
223	Function Measures	Why does the admission self-care score count twice in the risk adjustment?	Thank you for your inquiry. We believe you are referring to the continuous form and squared form of the admission self-care score used in risk adjustment of the self-care functional outcomes measures. The initial selection of risk adjustors was based on a review of the literature, input from technical experts and public comments, followed by data analysis. Since improvement in self-care during the IRF stay may vary based on admission self-care ability, we risk adjusted for admission self-care scores in our regression model. Scatter plots of admission self-care scores and change in self-care scores showed a non-linear relationship between the two variables. Therefore, we included admission self-care scores in two forms in the model: a continuous form, and a squared form to account for the curvilinear relationship. The continuous form (coefficient = 0.0793, $p < 0.001$) and the squared form (coefficient = -0.0163, $p < 0.001$) of admission self-care scores had significant effects. Thus, we included both forms of admission self-care in the final model. This data is from calendar year 2017, and these analyses are available in the updated materials recently submitted for NQF endorsement maintenance. You can search for a measure by its NQF number on the Quality Positioning System to access these public materials: http://www.qualityforum.org/QPS/QPSTool.aspx.
224	Function Measures	On slide 25, 1 and 2 should state "self-care" score, not "mobility" score.	Thank you. We will correct that slide.

#	Category	Question	Answer
225	Function Measures	Are Medicare Replacement plans included in the inclusion criteria as well as Medicare-only plans?	Yes, patients with Medicare Part A and Medicare Advantage (Part C) are included in the calculation of the Functional Outcome Measures.
226	Function Measures	Is there a way to know what our facility's mean scores are for change in self-care and mobility?	IRFs may review their facility-specific data in Certification And Survey Provider Enhanced Reports (CASPER). The Facility-Level QM Reports include the Average Observed Admission Score and the Average Observed Discharge Score.
227	Function Measures	Under QM exclusions, six options were noted, three of which included (1) 21 years old or younger, (2) discharge to hospice or institutional facility, (3) not Medicare patients. Does this mean these patients do not require QI completion for discharge, admission, or both? Is a skilled nursing facility an "institutional facility"?	Section GG data are required for all Medicare (Part A and Medicare Advantage) patients. For patients with an incomplete stay, discharge Section GG data are not required, and the IRF-PAI includes a skip pattern so that these data are not submitted. For the QM calculation, there are exclusion criteria, including patients discharged to hospice. The exclusion is based on coding of IRF-PAI item 44D. Patient's discharge destination/living setting. Patients discharge to hospice (IRF-PAI item 44D) are coded as 50, Hospice (home), or 51, Hospice (institutional facility).
228	Function Measures	Is an unplanned discharge to any location considered an incomplete stay (i.e., skilled nursing facility, acute care, home against medical advice)?	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 LTCH. • Patients who die while in the IRF. • Patients who leave the IRF against medical advice. • Patients with a length of stay less than 3 days. For the purposes of measure calculation, patients discharged to acute care are identified based on coding of the Discharge Destination Item 44D on the IRF-PAI, and include the following codes: 02 = Short-term General Hospital, 63 = LTCH, 65 = Inpatient Psychiatric Facility, and 66 = Critical Access Hospital. There is no coding on the IRF-PAI to indicate that a discharge was planned or unplanned, so all patients discharged to these locations are considered incomplete stays. Additionally, using the coding of Patient Discharged Against Medicare Advice Item 41 on the IRF-PAI, patients who were discharged against medical advice (Item 41 = 1) are also considered an incomplete stay for measure calculation.

#	Category	Question	Answer
229	Function Measures	Why do you not risk-adjust on discharge? Would that skew the results in change?	The goal of risk adjustment is to control for differences across facilities in patient characteristics at admission that might be related to the outcome of interest. Risk factors are typically patient demographic or clinical characteristics that are observed at the time of admission (start of care). For QMs, we generally do not adjust for factors that occur after admission. Any clinical issue that occurs after the start of care, in other words, anything on the "causal pathway" to the outcome, is typically not included in a regression model, so that care provided after admission does not confound the outcome.
230	Function Measures	Why do you not consider wheelchair mobility in the change in mobility measure? Does their improvement not count?	Thank you for your question. For the two mobility measures, IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) and IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) we have made several updates to the measure specifications with the most recent NQF annual update. The updated measures specifications include improvement in wheelchair mobility for patients who are unable to walk. More specifically, for patients who are not walking on both admission and discharge, the items GG0170R. Wheel 50 feet with two turns and GG0170S. Wheel 150 feet will be used instead of the walking items.

#	Category	Question	Answer
231	Function Measures	With these QMs, are the PPS coordinators expected to do all of the calculations? I am completely lost as to what we do with this information even if I could figure out how to calculate the measures. Or is this just information on how CMS measures outcomes?	CMS, or contractors hired by CMS, are responsible for calculating the QM scores using the IRF-PAI data submitted by IRFs. You can review your IRF's QM scores in the CASPER Reporting system. Review and Correct Reports are on-demand, user-requested reports that are updated weekly and allow providers to access QM results prior to the quarterly data submission deadline to ensure accuracy of their data. These user on-demand reports only contain assessment-based measures and are not risk-adjusted. The QM reports are on-demand, user-requested reports that are updated monthly and help facilities to identify possible areas for further emphasis in their quality improvement activities. These user on-demand reports contain data at both the facility and patient level, which are both observed and risk-adjusted. The QM reports contain assessment-based, CDC NHSN, and claims-based measures. Lastly, the Provider Preview reports provide a preview of the data which will be publicly reported on the IRF Compare website. These reports will appear automatically in your CASPER folder about 5 months after the end of each data collection quarter. Providers then have 30 days to review the numbers.

232	Function Measures	Can we have an example that shows the calculation of the risk adjustment for self-care and mobility?	The IRF Measure Calculations and Reporting User's Manual V3.0 (IRF QM User's Manual) and accompanying Risk Adjustment Appendix file on CMS's Measures Information webpage can be used to calculate the expected scores (i.e., risk adjusted scores). This manual can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html. We provide additional information below: The intercept and coefficient values for each of the covariates listed by QM in Section A-1 (page 94 of the IRF QM User's Manual) are available in the Risk-Adjustment Appendix file. This Risk-Adjustment Appendix file contains current and historical intercept and coefficient values and the risk-adjustment schedule including applicable discharge dates for each update to the intercept and coefficient values. As an example, to apply intercept and coefficient values to calculate the IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) you would do the following: • Check the discharge date. Example: An IRF-PAI record had a discharge date of 01/15/2019. • In the Schedule tab of the Risk-Adjustment Appendix file, refer to the Discharge Mobility measure. The discharge date of 01/15/2019 is within the discharge date range for Risk-Adjustment Update ID 2 (10/01/2018–09/30/2019). Therefore, the user should use the information provided in the Risk-Adjustment ID 2 column. • Select the Discharge Mobility tab and apply the intercept and coefficient values in the Risk-Adjustment ID 2 column for each covariate. • For details on how to determine the calculations for each covariate using the IRF-PAI data elements, please refer to Table A-5 of the QM User's Manual. To clarify, a covariate and its associated coefficient value is only used to calculate a patient's expected score if the characteristic or condition applies to that patient during the stay. For example, if a patient is 77 years old, he/she would be assigned to the 75–84 Age Group covariate and you would use that coefficient value for "Age". As another example, if the patient did not have a prior surgery (J2000 = 0) then this covariate does not apply and the coefficient for this risk adjustor is a zero value. For the comorbidity Hierarchical Condition Category (HCC) groups, the ICD-10 codes for HCC groups can be found on this website:

#	Category	Question	Answer
			https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/risk-adjustors.
233	Function Measures	Why are we submitting goals if you are basing change on your expected level versus what clinically we see in the patient?	The requirement to submit a minimum of one self-care or mobility goal is tied to the QM, Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), which was adopted by the IRF QRP.
234	Function Measures	How is it possible for a person who is dependent on use of a wheelchair prior to admission and at discharge to meet or exceed CMS expectations for Mobility if 8 out of the 15 items are not applicable to them? Should these patients be excluded for this measure?	Thank you for your question. For the two mobility measures, IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) and IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) we have made several updates to the measure specifications with the most recent NQF annual update. The updated measures specifications include improvement in wheelchair mobility for patients who are unable to walk. More specifically, for patients who are not walking on both admission and discharge, the items GG0170R. Wheel 50 feet with two turns and GG0170S. Wheel 150 feet will be used instead of the walking items.
235	Function Measures	Subscribers of the Uniform Data System for Medical Rehabilitation have expected values calculated for them in the software to manage performance on these measures, and some using this information are questioning why the Prior Surgery factor increases expected values and why some risk factors, especially the HCCs, have coefficients of zero value.	Based on our analyses, patients who had recent major surgery tend to have slightly more self-care and mobility improvement than patients who did not have major surgery after adjusting for other factors such as age, primary medical condition, and comorbidities. Therefore, the regression coefficient for the covariate “major surgery” is a positive value. For several comorbidity groups, analysis of more recent data showed these comorbidities are no longer significantly associated with the functional outcomes. We will continue to monitor the risk factors associated with the functional outcomes.
236	Function Measures	When these goals are not revised, does this affect the scores as well?	The goals reported in Section GG are not used to calculate the expected scores for the functional outcome measures and thus do not affect the function QM scores.

#	Category	Question	Answer
237	Function Measures	Do all of the QMs in mobility and self-care items make up the publicly reported data? Are any items excluded?	This function measure currently available on the Compare website is the Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). This measure reports the percent of patients with both an admission and a discharge functional assessment and a treatment goal that addresses function. Only selected self-care and mobility items are included in this QM. The QMs available to the public can be viewed on IRF Compare: https://www.medicare.gov/inpatientrehabilitationfacilitycompare/. The specifications for calculating this assessment-based QM can be found on pages 37-42 of the IRF QRP Measure Calculations and Reporting User's Manual V3.0. More information about what qualifies as an "incomplete stay" for the purposes of measure calculation is found on page 37: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-Measure-Calculations-and-Reporting-Users-Manual-V30.pdf.
238	Function Measures	It would be more helpful to see a live demonstration of one of the QM calculations vs. listing the variables involved in the calculation.	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.

#	Category	Question	Answer
239	Function Measures	I think there is some confusion with regards to goals set by clinicians versus the expected discharge performance with regards to this QM. Could you please clarify?	We believe your question is referring to the two discharge measures: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) and Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). Please see the IRF Measure Calculation and Reporting User's Manual for more information about calculating these QMs, including the expected discharge scores: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-Measure-Calculations-and-Reporting-Users-Manual-V30.pdf. These measures are reported at the facility-level, and report the percent of patients in your facility who met or exceed the expected discharge self-care [or mobility] score. An observed discharge score and an expected discharge score are calculated for each patient. Step 3 on pages 55–56 outlines the steps for calculating the expected discharge Self-Care score and Step 3 on page 60 outlines the steps for calculating the expected discharge Mobility score. The "expected discharge score" is calculated for each patient stay and uses risk-adjustment data/values. Risk adjustors for these measures include age, primary diagnosis, prior functioning, PUs, bowel and bladder incontinence, and comorbidities for example. Intercept and regression coefficient values for the risk adjustors can be reviewed on the following website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-. Once the observed and expected discharge scores are obtained for each patient stay, the percent of patients in your facility with an observed discharge score that is equal to or higher than the expected discharge score is calculated. This percentage is your final measure score. Information about goals included in Section GG of the IRF-PAI is used to calculate the QM Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). Documentation of a goal for a minimum of one of the function items (in GG0130 or GG0170) reflects that the patient's care plan addresses function. Please see Section 6.4 started on page 37 for details about calculating this measure.

#	Category	Question	Answer
240	Function Measures	There have been patients who have qualified for IPR inpatient rehabilitation needing physical therapy and speech therapy or occupational therapy and speech therapy. How will this affect a facility's quality scoring if a patient does not have much change, if any, in self-care if their program is focused on physical therapy/mobility and speech therapy/cognition?	The functional outcome measures are risk-adjusted to address different expected need and functional outcomes for IRF patients.
241	Function Measures	Can you please provide the Discharge national averages for the QMs?	The national average score for the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) in calendar year 2017 was 11.5 units of change in self-care. The national average score for the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) in calendar year 2017 was 28.3 units of change in mobility. For the additional function measures, the national average score for the IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) in calendar year 2017 was 55.8%. The national average score for the IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) in calendar year 2017 was 50.7%. These performance measures estimate the percent of patients who met or exceeded a risk adjusted expected discharge score. These results are available in the updated materials recently submitted for NQF endorsement maintenance. You can search for a measure by its NQF number on the Quality Positioning System to access these public materials: http://www.qualityforum.org/QPS/QPSTool.aspx.

#	Category	Question	Answer
242	Function Measures	Facilities code diagnoses differently (non-traumatic spinal cord injury vs. spinal cord disorder may be grouped together; hemorrhagic stroke with craniectomy could be placed under stroke or brain injury). Will there be an effort to streamline diagnoses into certain categories to show equal comparison of numbers served?	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.
243	Function Measures	Has the nomenclature been set as to what these codes will be called? I've heard various terms (Quality Indicators, Functional Outcome Measures, QMs, Section GG) and believe the industry would benefit from a set name for these codes.	Thank you for your feedback. CMS is always open to stakeholder feedback. We take all feedback under consideration.
244	IRF Functional Measures	Is a discharge code 09 recorded as a 01 for the outcomes? An IRF should be expected to demonstrate improvement with activities that the patient did not complete at baseline.	Yes, if an activity is coded 09 at discharge, it will be recoded to 01 for the functional outcome measures. If the patient needed assistance to perform an activity prior to the current illness, injury, or exacerbation, the prior functioning items would be coded to indicate that the patient needed assistance and any prior devices used would be indicated, and these data would be used for risk adjustment.
245	IRF Functional Measures	Is the expected score determined by each element, or just as an overall score?	The expected score is calculated at the level of the self-care score and mobility score, not at the item level.
246	IRF Functional Measures	What is the difference between the continuous and squared scores?	If the self-care score was 10, then the squared value would be 10 times 10, which is 100.
247	IRF Functional Measures	What is the height of curb step and one step in scoring?	There are no specifications for the exact height of the step(s) for activities involving steps.

#	Category	Question	Answer
248	IRF Functional Measures	If you score a 07 on a discharge performance, does it get a value of 01 for calculation of the QI?	Yes, a code of 07 at discharge is recoded to a code of 01 for the QM calculation.
249	IRF QRP Reports	The Provider Threshold Report is producing results that are inconsistent with the IRF-PAI Assessments with Error XXXX report and is incorrectly suggesting that some providers are at risk for a 2-percent payment penalty. Has CMS identified the issue with this report and, if so, when will it be corrected?	There were changes to the IRF QRP measures for Q4 of 2018. These changes have not yet been updated in the Provider Threshold Report. If your report is showing 0 or an * for those measures for Q4 of 2018, that is most likely why. Additionally, the Provider Threshold Report is only updated monthly, on the first business day after the 15th. Therefore, any update made after April 16 will not be reflected in the report. The best method to verify your current IRF-PAI data submission is by running Final Validation and Assessments with Error Number XXXX reports. Error messages 5004 and/or 5061 relate to items that may result in not meeting the required APU minimum submission threshold. Detailed guidance on how to run and interpret IRF-PAI reports can be found in the CASPER IRF-PAI Reporting User's Manual. Select "Section 3 – IRF-PAI Provider Reports" to open the PDF. Section 5 of the IRF-PAI Submission User's Guide contains information on error messages. The best method to verify your current NHSN data submission is by running the CMS reports found in the Analysis Reports section of NHSN. Detailed guidance on how to run and interpret CMS reports and all other NHSN reports, as well as a checklist used to ensure complete reporting into NHSN, can be found at NHSN. If you have questions regarding these reports within NHSN, please contact the NHSN Helpdesk: NHSN@cdc.gov. For more information refer to the Measure Calculations and Reporting User's Manual located in the Downloads box on the IRF Quality Reporting Measures Information website. Please note: corrections to the IRF-PAI records must be submitted prior to the final submission deadline as outlined on the IRF Quality Reporting Data Submission Deadlines website.

#	Category	Question	Answer
250	IRF QRP Reports	Can CMS provide patient-level data for claims-based measures? Receiving this data as a single, aggregate number is not actionable for providers.	For the IRF QRP, patient-level reports for claims-based measures, including the IRF readmissions measures, are not currently available. The procedures for following Health Insurance Portability and Accountability Act (HIPAA) regulations differ for PAC measures given that the data comes from multiple covered entities. Although we are unable to provide the information requested at this time for the IRF QRP, we are actively investigating avenues by which greater detail may be made available. We hope to have additional information for the IRF QRP soon and appreciate your patience.
251	IRF QRP Reports	If the PAC comparison grouping national average is so incredibly low for the IRF setting, when will CMS consider no longer requiring reporting of such measures, as is evident within the number of falls with major injury, new or worsening pressures ulcer, and presumably the medication QI?	CMS is continually monitoring the performance of the measures in relation to the Meaningful Measures framework and will continue to do so.
252	IRF QRP Reports	Can you explain why NQF #0678, PUs, is now reported a quarter behind the other IRF-PAI measures on the provider preview reports and IRF Compare?	As finalized in the FY2018 IRF PPS Final Rule which was published in the Federal Register on 08/03/2017 (82 FR 36277), this measure was replaced by a modified version of the measure entitled “Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury” beginning with the FY2020 IRF QRP.

#	Category	Question	Answer
253	IRF QRP Reports	Why is the preventable readmission rate currently suppressed from public reporting? When can we expect the data to be made public?	Beginning in fall 2019, CMS will publicly display on IRF Compare website two new measures: the Potentially Preventable 30-Day Post-Discharge Readmissions and Potentially Preventable Within-Stay Readmissions measures adopted for the IRF QRP. We postponed publishing these measures in late 2018 to allow more testing to ensure they provide a reliable, accurate picture of provider performance on quality, in line with CMS's Meaningful Measures Initiative to address high-priority areas for quality measurement with measures that will help improve patient outcomes while minimizing provider burden. We have since completed this additional testing and have refined the method for assigning providers to performance categories, in which their performance level is compared to the national rate. For more information, please visit the IRF Quality Public Reporting webpage.
254	IRF QRP Reports	For programs reporting 0 infections, why does the outcome state "data not available?" This is misleading and not reflective of true performance.	Data may be unavailable on IRF Compare for several different reasons, including: • The provider was open for less than 6 months. • The number of cases/patient stays was too small for public reporting. • No data were submitted for the reporting period. • The data were suppressed by CMS for one or more quarters. For a detailed explanation of the footnotes that accompany a "not available" result see the footnote details at the bottom of the "About the Data" page on IRF Compare (https://www.medicare.gov/inpatientrehabilitationfacilitycompare/#about/theData). If you have a specific facility you would like to inquire about, please contact our help desk and we can provide more detail.
255	IRF QRP Reports	What does triggered vs. not triggered mean?	"Triggered" indicates that the patient met the criteria to be included in the numerator of a measure. "Not Triggered" indicates that the patient did not meet the numerator criteria and is, therefore, not included in the QM. For detailed information on measure inclusion and exclusion criteria, refer to the IRF QRP Measure Calculations and Reporting User's Manual Version 3.0, which can be accessed at the following url: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html.

#	Category	Question	Answer
256	IRF QRP Reports	If the data correction period is still open, does it allow re-submission of the PAI in QIES to correct the facility data?	Yes. IRFs may submit corrections to IRF-PAI records via the CMS QIES Assessment Submission and Processing system while the data correction period is open for a particular quarter.
257	IRF QRP Reports	Is the data on IRF Compare risk-adjusted?	Measure results displayed on IRF Compare are risk-adjusted as applicable.
258	IRF QRP Reports	Please note slide 24: Does the first gray box have a typo? Says "LTCH" but the measure is for IRF industry. The following three box headings all say "IRF" as expected.	This is not a typo. This cross-setting process measure is an application of the QM "Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)." The measure contains the word "LTCH" because it was originally developed for the LTCH setting but was later modified for use in other PAC settings, including IRFs.
259	IRF QRP Reports	Will we be receiving a list of the factors that will trigger or not trigger or exclude a patient from a specific measure?	Detailed information for each QM, including QM definitions, inclusion and exclusion criteria and measure calculation specifications are available in the IRF QRP Measure Calculations and Reporting User's Manual Version 3.0, which can be accessed at the following url: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html.
260	IRF QRP Reports	When will you begin reporting the Functional Outcomes measures Discharge Self-Care and Mobility and Change in Self Care and Mobility on IRF Compare?	Public reporting of the IRF functional outcome measures is expected to begin in the fall of 2020.
261	IRF QRP Reports	For "change in function scores," is this just a change in self-care and mobility data because data was entered on admission or discharge or is it what the expected change should be?	The "Change in Self-Care" and "Change in Mobility" outcome measures estimate the risk-adjusted change in self-care and mobility scores between admission and discharge among IRF patients age 21 and older. The change in self-care/mobility score is calculated as the difference between the discharge self-care/mobility score and the admission self-care/mobility score.

#	Category	Question	Answer
262	IRF QRP Reports	How do you access the QM Reports? Where can I find instructions and screenshots I can use for reference?	The IRF QRP reports can be accessed by logging in to the Internet QIES system (iQIES) at https://iqies.cms.gov/. Select 'Report' from the welcome page main menu. On the following screen, select 'Quality Reporting Program' from the Report Category dropdown menu. A list of available quality reporting program reports will display along with a brief description of the report. The login used to access iQIES to submit assessments is the same login used to access the QRP and provider reports. There are several training videos available at https://go.cms.gov/iQIES_Training. Topics include How to Run Reports, as well as other videos related to patient accounts and how to submit an assessment. Additional help resources are also available within iQIES once you login.
263	IRF QRP Reports	How many users per facility can have access to CASPER? We have only been given two.	Currently, there is a two-person limit to access CASPER. If you have any technical issues requesting or accessing the reports, please contact the QIES Technical Support Office Help Desk by email at Help@qtso.com or by phone at (800) 339-9313.
264	IRF QRP Reports	How many users are allowed in the iQIES system to transmit accounts per facility?	The iQIES system will allow access by multiple users and will not be limited to two user accounts.
265	IRF QRP Reports	The IRF Compare website uses different formats for posting data that could cause confusion to the consumer. Instead of having percentages for some measures and the explanation of worse than national average without percentages for some measures, could CMS consider making the format the same?	Thank you for your suggestion regarding the format of IRF Compare. CMS will take your input into consideration.

#	Category	Question	Answer
266	IRF QRP Reports	When will the timeframes for measures on IRF Compare be aligned? Currently, performance is measured on multiple different periods of time where facility case mix may differ, significantly impacting results. Would the timeframes be something CMS would consider for standardization?	Thank you for your comment regarding the alignment of timeframes for IRF Compare measures. CMS will take your input into consideration.
267	IRF QRP Reports	What if my IRF does not show up on IRF Compare? Other IRFs that are on there have been closed. How often is it updated?	Data may be unavailable on IRF Compare for several different reasons, including: • The provider was open for less than 6 months. • The number of cases/patient stays was too small for public reporting. • No data were submitted for the reporting period. • The data were suppressed by CMS for one or more quarters. For a detailed explanation of the footnotes that accompany a "not available" result see the footnote details at the bottom of the "About the Data" page on IRF Compare (https://www.medicare.gov/inpatientrehabilitationfacilitycompare/#about/theData). If you have a specific facility you would like to inquire about, please contact our help desk and we can provide more detail.
268	IRF QRP Reports	What is the best report to use to determine that your facility is above the 95-percent threshold? Some of the CASPER reports are showing erroneous data for Q4 2018.	The IRF Provider Threshold Report details the status of the measures required for the APU by fiscal year of the APU. For more information about this report, consult Section 3 of the CASPER IRF-PAI Reporting User's Manual, which can be accessed at the following URL: https://qtso.cms.gov/system/files/qtso/cspr_sec3_irf_prvdr.pdf.

#	Category	Question	Answer
269	IRF QRP Resources	CDC/NHSN will only answer clinical, infection-related questions. They defer to CMS for any IRF QRP-related questions. When this occurs, which group should IRFs contact at CMS to avoid being redirected back to CDC?	For IRF QRP-related questions, including questions on the IRF-PAI Quality Indicator items, IRF providers should contact the IRF QRP Helpdesk at IRF.Questions@cms.hhs.gov. If you are unsure which helpdesk to contact, email your question to this helpdesk for triage.
271	IRF QRP Resources	For the GG section, we use metrics. Is 150 feet 45.7 meters or is it rounded up to 50 meters like FIM?	In the scenario you describe, if you are using the metric system to measure the distance for this activity, you would assess the patient's ability to walk at least 45.7 meters in a corridor or a similar space.
272	Case Study	In the case study, it is stated that the nurse determines no clinically significant issues. Is CMS suggesting that it is the responsibility of the RN to determine clinically significant issues, or could this be done by another discipline, such as a pharmacist?	CMS does not provide guidance on who can or cannot code the DRR items. Please refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete a DRR. Data in the IRF-PAI should be consistent with information reported in the patient's medical record. The necessary information needed and used to code the items should be recorded in the patient's medical records. Each facility determines their policies and procedures for completing the assessments. Each facility provides patient care according to their unique characteristics and standards (e.g., patient population).
273	Case Study	In the wheel 50 feet, you state that the score should be 2. He never made it 50 feet or 150 feet—shouldn't it be an 88? Walking is scored this way.	The walking items differ from the wheelchair items because a helper cannot complete the activity of walking for the patient. A helper can, however, assist with wheeling a patient. In this scenario, wheeling 150 feet was attempted but the patient was only able to wheel 20 feet before requiring a helper to complete the remaining 130 feet distance. The helper provides more than half of the effort to complete the activity, therefore GG0170S. Wheel 150 feet would be coded as 02, Substantial/maximal assistance.
274	Case Study	Why isn't wheel 150 feet 01, Dependent? The patient only went 20 feet out of 150. That is only 13 percent of the task.	The correct code for GG0170S. Wheel 150 feet is 02, Substantial/maximal assistance, for Mr. K. Although the helper contributed more than half of the effort to complete the activity, the patient contributed some effort (wheeling 20 feet). If the helper did all of the effort to complete the activity or if two or more helpers were needed to complete the activity for the patient, code 01, Dependent, should be used.

#	Category	Question	Answer
275	Case Study	Why would one set a goal of 150 feet when he never did this before when using a wheelchair prior to admission?	Mr. K was able to go 150 feet or greater prior to his current illness with the assistance of his daughter. After wheeling 70 feet, Mr. K relied on his daughter to propel him greater distances due to fatigue. It is anticipated that Mr. K will be able to return to this prior level of function at discharge. Therefore, a discharge goal was established at admission for this item.
276	Case Study	Why wouldn't wheel 150 feet be coded 9, N/A, as the patient only wheeled 70 feet at home?	Mr. K was able to wheel 150 feet or greater prior to his current illness with the assistance of his daughter. After wheeling 70 feet, Mr. K relied on his daughter to propel him the remaining distance due to fatigue.
277	Case Study	The nurse noted that the patient is on 2L of O2. Why is there not an order for O2? O2 is considered a medication—is that not an error that there is no O2 order?	Thank you for your comment. Oxygen was inadvertently omitted from the medication list.
278	Case Study	Case study discharge assessment for skin: Why is the admission stage 4 PU not captured for number of stage 4 on admission?	The healing stage 4 PU observed at admission on the coccyx has closed at discharge. It is now considered to be a healed stage 4 and would not be coded in M0300 on the Discharge Assessment. Mr. K had an unstageable PU due to slough and/or eschar on his right lateral malleolus at discharge. This PU was identified as a DTI at admission. During the patient's IRF stay, it was reclassified as a stage 4. However, at discharge, slough completely covered this PU, preventing visualization of the wound bed. Therefore, it is considered not present on admission. A numerically staged PU/PI that becomes unstageable due to slough or eschar at discharge would not be coded as present on admission in M0300F2.
279	Case Study	If the patient had a code 88 on the walk 50 feet item, wouldn't the walk 150 feet item have the skip pattern (you would not be able to code a 09) for the admission assessment?	GG0170J. Walk 50 feet with two turns does not have a skip pattern. The walking items are only skipped if GG0170I. Walk 10 feet is coded 07, 09, 10, or 88. If GG0170I. Walk 10 feet is coded using the 6-point scale, proceed to coding items GG0170J. Walk 50 feet with two turns and GG0170K. Walk 150 feet.
280	General	The webcast is cutting in and out already and a blank black screen from time to time. We may need the initial instructions repeated to assist with our participation.	If you are having trouble with the screen flickering or going blank from time to time or if you have a latency issue, we recommend that you refresh your browsers periodically.

#	Category	Question	Answer
281	General	The slides are different from the presentation.	Since the pre-training version of the presentation does not include the answers to knowledge checks and practice scenarios, there will be missing slides. Rather than have a different numbering scheme, slides without answers were simply removed from the presentations so that the slide numbers on the remaining slides match the slide numbers of the full versions of the presentations that are being projected on the screen during the presentations. The post-training versions of the presentations with answers will be posted to the IRF QRP Training webpage shortly after the training will include all of the slides, including those with answers. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
282	General	All the questions previously asked just disappeared.	Each session has its own “room” without Slido. You will only be able to upvote questions asked during a single presentation.
283	General	Are you going to provide the answer rationales in written form for participants to have from the practice coding scenarios?	The versions of the slide decks with the answers to the practice scenarios and knowledge checks and rationales for case studies will be posted after the training along with a link to the playlist of the video recordings of presentations and the Q&A document for the training. All materials will be posted on the IRF QRP Provider Training webpage. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
284	General	You mentioned the new updated IRF PAI manual and it appeared that even though items 18 and 19 were deleted under ID information on the IRF Organizational Assessment Instrument form, the manual was not adjusted for those deleted numbers. Is that being corrected?	This section of the IRF-PAI Manual has been corrected. Please download the IRF-PAI Manual again to see the corrected section.
285	General	While completing polls remotely, the presenter does not get to the slide, yet the question times out. Thank you.	There is a slight latency issue for those viewing online. We have timed it at approximately 5–10 seconds. We do our best to open the polls as quickly as possible and leave them open as long as possible, so those online have the opportunity to respond. Until we have to open up the next polling slide, the previous poll remains open and participants may submit responses.

#	Category	Question	Answer
286	General	Wanted to take this opportunity to mention that when I downloaded all the handout materials, there are multiple pages missing. It seems to be that after the practice scenarios, at least 3 to 4 pages are missing.	Since the pre-training version of the presentation does not include the answers to knowledge checks and practice scenarios, there will be missing slides. Rather than have a different numbering scheme, slides without answers were simply removed from the presentations so that the slide numbers on the remaining slides match the slide numbers of the full versions of the presentations that are being projected on the screen during the presentations. The post-training versions of the presentations with answers will be posted to the IRF QRP Training webpage shortly after the training will include all of the slides, including those with answers. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
287	General	Will the webcast be available after Friday? If so, how could I access it?	A playlist with video recordings of the presentation will be available on the CMS YouTube site. Those who registered for the May 2019 IRF QRP Provider Training will receive an email with information about accessing the video recordings when they are available.
288	General	Will the answers to the questions be posted online?	A Q&A document that includes responses to questions submitted by participants during the May 2019 IRF QRP Provider Training will be posted to the IRF QRP Training webpage. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
289	General	Not enough time allowed to answer questions.	Thank you for your feedback. We will look at opportunities to extend the amount of time allowed for questions and answers at future trainings.
290	General	For the CMS website help email addresses, it would be helpful to have some sort of way to track the current state of a question that was submitted. I submitted a question 2 weeks ago and am still waiting on a response. I have no way of knowing when my question will get answered.	Thank you for your suggestion. We will take it under consideration.

#	Category	Question	Answer
291	General	Could you send the link out for the slideshows? I did not get the email and would like to have access to the slideshows to present to my staff.	All of the presentations for the May 2019 IRF QRP Provider Training are posted to the IRF QRP Training webpage. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
292	General	Where can webcast participants get the decision tree for GG0130 and GG 0170?	The GG Self-Care and Mobility Activities Decision Tree is located in the Downloads section of the IRF QRP Training webpage. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
293	General	Will the decision tree video be available in the downloads section for us at a later date?	The post-training version of the Section GG presentation will include live links to the videos. Additionally, a link to the standalone videos for Prior Functioning, the Section GG Decision Tree, Oral Hygiene, and Lying to Sitting are available on the CMS YouTube site. Links can be accessed on the IRF QRP Training webpage. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
294	General	Can we use these CMS training PowerPoint slide decks, including videos, to train our staff?	Yes. These materials are available for your use. The post-training version of the Section GG presentation will include live links to the videos. Additionally, a link to the standalone videos for Prior Functioning, the Section GG Decision Tree, Oral Hygiene, and Lying to Sitting are available on the CMS YouTube site. Links can be accessed on the IRF QRP Training webpage. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
295	General	These videos are very helpful. Will they be available to us to educate staff?	The post-training version of the Section GG presentation will include live links to the videos. Additionally, a link to the standalone videos for Prior Functioning, the Section GG Decision Tree, Oral Hygiene, and Lying to Sitting are available on the CMS YouTube site. Links can be accessed on the IRF QRP Training webpage. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.

#	Category	Question	Answer
296	General	What were the answers for Admission PUs? The livestream was down when the answers were given.	A post-training version of the presentation with answers to polling scenarios and knowledge checks and the rationale for the case study will be posted to the IRF QRP Training webpage following the training. Materials will be available in the Downloads section of the webpage. The URL for the IRF QRP Training webpage is: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html.
297	General	Note that there have been some connectivity issues, therefore we might miss a few too many questions. Can we still get credit for the workshop?	During the May 2019 IRF QRP Provider Training, we experienced a downtime with the livestream of just under 3 minutes. Polling questions asked during that period were removed from the calculation of the 80-percent threshold for responses to polling scenarios required for online participants to receive a Certificate of Completion for participating in the training.
298	General	How do webcast participants get attendance certificate?	Certificates of Completion will be emailed to online participants who created a profile in Slido, responded to 80 percent of the polling scenarios (minus those asked during the 3-minute downtime), and requested a Certificate of Completion by indicating so at the end of training evaluation.
299	General	Will the survey be emailed to us or posted here? And how long do we have to complete it to receive Continuing Education Units (CEUs)?	The training evaluation was available via Slido from the end of the training through midnight of that day. While CMS did not offer CEUs for the May 2019 IRF QRP Provider Training, participants may want to petition their professional associations for CEUs by submitting a Certificate of Completion and agenda and following any additional guidelines stipulated by their professional association.
300	General	One of the confusing aspects of the IRF QRP website is that the IRF QRP User's Manual that was preciously referenced is located under the measures information tab, while there is also an IRF-PAI and IRF QRP Manual tab.	Thank you for your feedback regarding the placement of these two manuals on the IRF QRP website. CMS will take this feedback into consideration for future IRF QRP website updates. The two manuals referenced serve different purposes: • The "IRF Measure Calculations and Reporting User's Manual," located in Downloads of the Measures Information web page, presents the methods used to calculate QMs that are included in the IRF QRP. This manual provides detailed information for each QM, including QM definitions, inclusion and exclusion criteria and measure calculation specifications. • The IRF-PAI Manual Version 3.0, located in the Downloads of the IRF-PAI and IRF-PAI Manual web page, contains information regarding data collection on the IRF-PAI version 3.0, effective October 1, 2019.

#	Category	Question	Answer
301	General	It would be nice if downloads had dates affiliated with them, as they are not in chronological order.	Thank you for your feedback. We will consider your suggestion when posting materials for future trainings.
302	General	How can I confirm that I am on the CMS email list for updates and other new information that is made available?	If you have registered for this training, you will be included on an email list for notifications of future trainings. If you have any question about your status, please email the PAC Training mailbox at PACTraining@EconometricaInc.com, and we can ensure that you are added to our email distribution list.
303	General	With the termination of the call-in helpdesk for non-QRP items, the timeframe for responses is so delayed that it may result in errors in transmitted assessments. Is there any plan to speed up the responses for both QRP and non-QRP items to assist providers with questions?	Thank you for your feedback. We will take this under consideration.
304	General	How do I access materials and the EventHub?	The materials for today's presentation can be located in the Downloads section of the IRF QRP Training web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html. Prior to and during the training, the materials are also available via the IRF QRP Event Hub at the following URL: https://pac.training/irf/august2019/.