

CHAPTER 2: OVERVIEW TO THE ITEM-BY-ITEM GUIDE TO THE INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT

This chapter provides item-by-item coding instructions for IRF staff members to complete each section of the IRF-PAI Version 4.0. The goal of this chapter is to provide IRF staff with the rationale and guidance necessary to accurately complete each item of the IRF-PAI.

2.1 Using This Chapter

Throughout this chapter, sections of the IRF-PAI Version 4.0 are presented using a standard format for ease of review by IRF staff.

Where appropriate, the order of information for each section of the IRF-PAI is presented as follows:

- **Intent.** States the reason(s) for including this set of assessment items in the IRF-PAI.
- **Item Display.** Each assessment section provides the item from the IRF-PAI Version 4.0.
- **Item Rationale.** Explains the purpose of documenting particular facility characteristics, patient demographics, and/or clinical or functional status.
- **Steps for Assessment.** Provides resources and methods for determining the correct response when coding each IRF-PAI Version 4.0 data element.
- **Coding Instructions.** Outlines the proper method of recording each response, with explanations of individual response categories.
- **Coding Tips and Special Populations.** States clarifications, issues of note, and conditions to be considered when coding each IRF-PAI Version 4.0 data element.
- **Examples.** Illustrates examples of appropriate coding for several of the IRF-PAI Version 4.0 data elements.

NOTE: The coding scenarios found throughout this chapter are intended to provide examples of how guidance instructions are applied in order to select an accurate code to one or more IRF-PAI items. The scenarios are not intended to imply that the patients portrayed in these examples would necessarily meet coverage or program eligibility requirements for this setting. Likewise, the scenarios are not intended to suggest or prescribe clinical practice, nor do the scenarios provide the comprehensive clinical presentation that would be required for planning, delivering, and documenting medically necessary patient care.

Table 2-1 provides the title and intent for each section of the IRF-PAI Version 4.0.

Table 2-1
IRF-PAI Version 4.0 Sections

Section	Title	Intent
A	Administrative Information	This section includes Payer Information, Medical Information, Discharge Information, and Therapy Information. Additionally, it includes Ethnicity, Race, Language, and Transportation.
B	Hearing, Speech, and Vision	This section includes Hearing, Vision, Health Literacy, Expression of Ideas and Wants, and Understanding Verbal and Non-Verbal Content.
C	Cognitive Patterns	This section includes the Brief Interview for Mental Status (BIMS), Staff Assessment for Mental Status, and Signs and Symptoms of Delirium (from CAM©).
D	Mood	This section includes the Patient Mood Interview (PHQ-2 to 9) and Social Isolation.
GG	Functional Abilities and Goals	This section includes Prior Functioning: Everyday Activities, Prior Device Use, Self-Care, and Mobility. This section assesses the patient's need for assistance with functional activities.
H	Bladder and Bowel	This section includes Bladder Continence and Bowel Continence.
I	Active Diagnoses	The items in this section are intended to indicate the presence of active diagnoses that influence a patient's functional outcomes or increase a patient's risk for the development or worsening of pressure ulcer(s).
J	Health Conditions	This section includes Pain Effect on Sleep, Pain Interference with Therapy Activities, Pain Interference with Day-to-Day Activities, History of Falls, Prior Surgery, Any Falls Since Admission, and Number of Falls Since Admission.
K	Swallowing/ Nutritional Status	This section includes Nutritional Approaches.
M	Skin Conditions	The items in this section document the presence, appearance, and change of pressure ulcers.
N	Medications	This section includes High-Risk Drug Classes: Uses and Indication, Drug Regimen Review, Medication Follow-up, and Medication Intervention.
O	Special Treatments, Procedures, and Programs	This section includes Special Treatments, Procedures, and Programs. The intent of the item in this section is to identify any special treatments, procedures, and programs that the patient received during the stay.
Z	Assessment Administration	The items in this section provide signatures of individuals completing the IRF-PAI.

2.2 IRF-PAI Item Completion

Admission and discharge IRF-PAI items must be completed before data records are transmitted to the Centers for Medicare & Medicaid Services (CMS). As required by Section 3004(b) of the Affordable Care Act, failure to complete Quality Reporting Program (QRP) items may result in payment reductions of 2 percentage points starting in FY 2014.

The federal regulations require that data must be collected and entered into the data collection software (i.e., encoded) by specified time periods. An IRF may change the IRF-PAI data at any time before transmitting the data, but only if the data were entered incorrectly.

Item Completion When a Patient Has a Stay That Is Less Than 3 Calendar Days

If the patient's stay is less than 3 calendar days in length, the staff of the rehabilitation facility must complete the IRF-PAI admission items, but do not have to complete all of the discharge IRF-PAI items. The IRF is required to collect information and record it on the IRF-PAI as completely as possible. The correct date for Item 13. Admission Assessment Reference Date, is typically the 3rd calendar day of the stay. If the stay is less than 3 calendar days, the admission assessment reference date is the last day of the stay (either day 1 or day 2).

EXAMPLES ILLUSTRATING THE ASSESSMENT AND DISCHARGE ASSESSMENT SCHEDULES

The following examples apply to patients whose stay is at least 3 calendar days.*

Charts 1 and 2 below illustrate the assessment, coding, and data transmission dates for the IRF-PAI admission assessment. Charts 1 and 2 are similar to, but are updated versions of the charts that appear on pages 41330 and 41331 of the Final Rule entitled "Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities; Final Rule". That Final Rule was published in the Federal Register, Volume 66, Number 152, on Tuesday, August 7, 2001.

Chart 1 – Patient Assessment Instrument Admission Assessment Schedule of Dates

Assessment Type	Hospitalization Time Period and Observation Time Period	Assessment Reference Date	Patient Assessment Instrument Must Be Completed By	Patient Time Covered By This Assessment	Patient Assessment Data Must Be Encoded By	Patient Assessment Instrument Must Be Transmitted By
Admission Assessment	First 3 Calendar Days	Day 3*	Day 4	Entire Medicare Stay Time Period	Day 10	See ** Below For How To Calculate This Date

* In accordance with Section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule exception as specified in §412.610(c)(1)(ii), CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.

** Because all the assessment data for admission and discharge assessments must be transmitted together after the patient is discharged, the admission assessment data must be transmitted at the same time the discharge data are transmitted. That transmission date is by the 7th calendar day in the period beginning with the last permitted discharge patient assessment instrument "encoded by" date.

Chart 2 – Example Applying the Patient Assessment Instrument Admission Assessment Schedule of Dates

Assessment Type	Hospitalization Time Period and Observation Time Period	Assessment Reference Date	Patient Assessment Instrument Must Be Completed By	Patient Time Covered By This Assessment	Patient Assessment Data Must Be Encoded By	Patient Assessment Instrument Data Must Be Transmitted By
Admission Assessment	10/4/11 to 10/6/11	10/6/11*	10/7/11	Entire Medicare stay time period	10/13/11	See ** Below For How To Calculate This Date

* In accordance with Section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule exception as specified in §412.610(c)(1)(ii), CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.

** Because all the assessment data for admission and discharge assessments must be transmitted together after the patient is discharged, the admission assessment data must be transmitted at the same time the discharge data are transmitted. That transmission date is by the 7th calendar day in the period beginning with the last permitted discharge patient assessment instrument “encoded by” date.

Below, chart 3 illustrates how to determine the assessment, coding, and data transmission dates for the IRF-PAI discharge assessment. Chart 3 is an updated version of a chart that appears on page 41332 of the August 7, 2001 Final Rule and on page 45683 of the August 1, 2003, Final Rule entitled “Medicare Program; Changes to the Inpatient Rehabilitation Facility Prospective Payment System and Fiscal Year 2004 Rates; Final Rule”. The August 1, 2003, Final Rule was published in the Federal Register, Volume 68, Number 148. Chart 3 illustrates that CMS will determine that the IRF-PAI data are not transmitted late if they are transmitted no later than 27 calendar days from the day the patient is discharged. NOTE: The discharge day is counted as one of the 27 calendar days, and the 27-calendar-day time span also includes the 10 calendar days specified in the FY 2004 Final Rule (68 FR 45683). Also, the meaning of the term “discharge day”, which is one of the days counted in the 27-calendar-day time span, is the day defined according to the revised definition of “discharge” specified in §412.602 as stipulated in the August 1, 2003 Final Rule. In some cases, that may be different from the discharge assessment reference day specified in §412.610(c)(2)(ii).

Chart 3 – Example Applying the Patient Assessment Instrument Discharge Assessment Schedule of Dates

Assessment Type	Discharge Date*	Assessment Reference Date	Patient Assessment Instrument Must Be Completed On**	Patient Assessment Instrument Data Must Be Encoded By	IRF-PAI Data Transmitted By	Date When Patient Assessment Instrument Data Transmission Is Late
Discharge Assessment	10/16/21	10/16/21*	10/20/21	10/26/21	11/1/21	11/12/21***

* In accordance with Section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule exception as specified in §412.610(c)(1)(ii), CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.

** This is the last day by when the discharge patient assessment must be completed. However, this does not prohibit discharge patient assessment data from being recorded on the patient assessment instrument prior to this date.

*** Or any day after 11/12/21.

NOTE: For more information regarding the admission and discharge assessments, please refer to the IRF PPS Final Rules and other CMS publications for authoritative guidance. The CMS publications related to the IRF PPS can be found at the CMS IRF PPS website:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html>

2.3 IRF QRP Data Collection

Under the IRF QRP, IRFs are required to submit quality measure and standardized patient assessment data elements to CMS. For all measures and standardized patient assessment data element requirements adopted into the IRF QRP, IRFs must meet or exceed two separate data completeness thresholds:

- One threshold set at 95 percent for completion of required quality measures data and standardized patient assessment data collected using the IRF-PAI submitted through the Internet Quality Improvement and Evaluation System (iQIES).
- A second threshold set at 100 percent for measures data collected and submitted using the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). For more information about the NHSN, please see Appendix D.

An IRF must meet or exceed both thresholds to avoid receiving a 2-percentage-point reduction to its Annual Increase Factor (AIF) for a given fiscal year.

Effective October 1, 2022, the data collection instrument for these measures is the IRF-PAI Version 4.0 (see Appendix B). The IRF-PAI Submission Specifications for submitting these data using the IRF-PAI are available on the IRF Quality Reporting Technical Information webpage: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Technical-Information.html>

For general questions about data collection required for the IRF QRP, please see: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-FAQs.html>

A. Data Submission Deadlines for the IRF QRP

For more information about data submission deadlines for the IRF QRP Measures and standardized patient assessment data elements Reporting, please see: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.html>

B. IRF QRP Measure Information

For the measures collected via the IRF-PAI, please refer to the *IRF Measure Calculations and Reporting User's Manual* and additional information found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html>

For specific direction regarding the submission of these quality measures to CMS via the CDC's NHSN, please refer to the CDC's NHSN website for IRF reporting at <https://www.cdc.gov/nhsn/inpatient-rehab/>. Additional information can also be found in Appendix D, or at: <https://www.cdc.gov/nhsn/inpatient-rehab/>