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

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON MAY 18–19, 2016

Current as of August 2016

Question #	Question	Section	Item #	Answer
1.	How much time is required to train providers/clinicians on new and revised data standards?	General		CMS does not require that providers be trained for a specific amount of time. The training sessions from the in-person training on May 18–19 were video-recorded and will be made available on the CMS YouTube Channel: https://www.youtube.com/user/CMSHHSgov. The power point presentations are posted in the Download section of the IRF QRP training page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Training.html.
2.	CMS states the time to complete the IRF-PAI QI should be generally 54.5 minutes per patient. This time does not count the clinical time required to complete the assessments with the patient. It can take 54 minutes just to do one or two functional items; therefore, it does not represent a true time to complete the tool. Can the estimated time be updated to accurately reflect the true cost?	General		For the current IRF-PAI (version 1.3, effective October 1, 2015), the time required to complete each IRF-PAI is estimated to average 54.5 minutes, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. As finalized in the IRF PPS FY 2016 Final Rule (80 FR 47086 through 47120), the IRF-PAI V1.4 (effective October 1, 2016) contains additional elements that we estimate will take a total of 41.5 minutes. (Source: 2016 Final Rule.) Thus, for the IRF-PAI V1.4, the total time required to complete the IRF-PAI is expected to average 96 minutes (54.5+41.5=96).
3.	Do staff need certification like FIM certification every 2 years? I think it should be mandatory. This will give us info if training needs to be for only certain discipline or does all staff need training for all codes.	General		There is currently no plan to require mandatory certification for completion of the IRF-PAI. Procedures for the data collection of the Quality Indicator items on the IRF-PAI are to follow facility policies. IRFs are responsible for submitting accurate data for all IRF-PAI items. Patient assessments are to be done in compliance with facility, State, and Federal requirements. CMS does not dictate who may complete patient assessments.
4.	How are the quality measures attained by CMS?	General		CMS proposes and adopts quality measures for the IRF Quality Reporting Program through rulemaking in the Federal Register. A list of proposed and final rules is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/List-of-IRF-Federal-Regulations.html.

Question #	Question	Section	Item #	Answer
5.	If a patient is discharged acutely and returns within 3 days, do we use the information obtained from the first admission (like we do for IRF now)?	General		If an IRF patient has an interrupted stay (the patient is transferred to an acute care facility and returns to the IRF within 3 calendar days) and the admission assessment that was conducted when the patient was first admitted to the IRF (prior to the program interruption) would be the patient's admission assessment. No additional IRF-PAI assessment data are completed for patients who have one or more program interruptions. This approach is consistent with current IRF-PAI submission requirements.
6.	Do we still choose one 24-hour period for discharge, scoring like we do with IRF-PAI?	General		No, the 24-hour period for discharge is not used for the quality indicator items. For the Section GG function items, the discharge assessment period encompasses the day of discharge and the 2 calendar days prior to the day of discharge. Clinicians should code the patient's discharge functional status, based on a functional assessment that occurs during the discharge assessment period. The code should reflect the patient's functional abilities at the time of discharge. During the assessment, patients should be allowed to perform activities as independently as possible, as long as they are safe. The assessment should occur near the end of therapeutic intervention in order to capture the patient's true progress. This is because interventions can affect the patent's functional status; the discharge score should reflect the patient's status after any benefit from therapy
7.	Is the 3-day admission timeframe in hours (starting the hour they are admitted), or is it by the number of nights they are there?	General		The 3-day assessment period for the admission assessment includes the first day of admission and the following 2 days, ending at 11:59 p.m. If a patient is admitted in the afternoon, the assessment period will be just less than 2.5 days. The discharge assessment period encompasses the day of discharge and the 2 calendar days prior to the day of discharge.
8.	Is the IRF-PAI in its final form, or do you expect additional revisions?	General		The IRF-PAI version 1.4, effective October 1, 2016, has been finalized.

Question #	Question	Section	Item #	Answer
9.	Why does CMS require FIM discharge scores? I understand admission scores support Case Mix Group assignments, but why not "retire" the discharge FIM section?	General		CMS requires collection of the FIM® items as part of the Inpatient Rehabilitation Facility (IRF) Prospective Payment System.
10.	It appears we are assessing similar, if not the same, items, as the FIM, and double documenting on two different rating scales. How will this save time and money? The IRF-PAI rating system also seems very general, having a wide variance of ability in one score section (e.g., 51 percent to 99 percent helper for a code of 2).	General		CMS requires collection of the FIM® items as part of the Inpatient Rehabilitation Facility (IRF) Prospective Payment System. CMS requires collection of items included in the Quality Indicator section of the IRF-PAI in order to calculate quality measures adopted in the IRF Quality Reporting Program. The intent of coding the IRF-PAI items is for standardized assessment of a patient's status across post-acute settings. The daily activities are items that clinicians typically assess at admission and/or discharge to help determine patient needs, evaluation of patient progress and to prepare patients and families for the transition to home or another setting. The key differences between the FIM® items and the Section GG function items include (1) the data collection and associated data collection instructions; (2) the rating scales used to score a patient's level of independence; and (3) the item definitions. While many of the items to be included have labels that are similar to FIM® items, there are several key differences between the assessment item sets that may result in variation in the patient assessment results. For example, the standardized Section GG items are scored using a 6-level rating scale, while the existing FIM® items are scored using a 7-level rating scale. The Section GG items include four items focused on the activity or walking and two items focused on wheelchair mobility. The walking items are Walking 10 feet (even surfaces), walking 50 feet with two turns, Walking 150 feet and Walking 10 feet on uneven surfaces, and the wheelchair mobility items are Wheel 50 feet with two turns and Wheel 150 feet. The FIM® instrument includes one item that is scored based on walking, wheelchair mobility, or both.

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11.	Do the coding items for quality indicators need to be documented on patient medical records? Can this be coded directly on IRF-PAI form and not on patient records?	General		Clinical documentation in the medical record is used to support clinical assessment coding. IRF-PAI data should be consistent with data reported in the patient's medical record. Data in the medical record can be documented by appropriate health care personnel, consistent with the facility and State standards.
12.	Because of the requirement to code items on admission prior to the start of therapy intervention, we generally collect all admission data on Days 1 or 2. If therapy interventions start prior to that time, should all scoring be done by the therapist?	General		Items should be assessed prior to the initiation of therapy. Clinicians are required to complete the patient's assessment within 3 days. The assessment should be conducted as close to the time of the patient's admission as possible, and all 3 days may not be needed to complete the assessment of all activities. For example, the skin conditions items (Section M), should be assessed as close to the admission as possible. Some of the activities in Functional Abilities and Goals (Section GG) will occur more frequently than others and the patient's baseline status may be sufficiently assessed on the first or second day while other activities may not be fully assessed until the third day.
13.	Will patients who had a prior level of function that was reduced or used a device be targeted for audits?	General		The items GG0100 Prior Functioning: Everyday Activities and GG0110 Prior Device Use are included on the IRF-PAI because these data are needed to risk adjust the functional outcome measures.
14.	How do you recommend controlling for errors when IRF staff are scoring FIM and coding for IRF-PAI? Scoring a 4 on FIM for upper body dressing (Min assist) may score a 3 on GG0130F.	General		Knowledge about the type and amount of helper assistance is needed in order to code the Section GG items accurately. Observing the patient or reviewing clinical notes to determine the correct code would focus on whether supervision or steadying assistance was provided (code 4, Supervision/touching assistance) or assistance with putting on/removing the clothing (code 3 or below).
15.	Please provide ideas on where documentation for this should be to fill out IRF-PAI. Aside from reading nursing/therapy notes, should there be a separate documentation tools to gather these data?	General		The IRF Training Manual contains suggestions for sources of information by quality indicator section. Potential sources of information include the medical record (e.g., nursing, physician, therapy, dietician, and speech language pathologist notes), incident reports, fall logs interviews with the patient, and interviews with family members or significant others.

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16.	Can CMS clarify when information can be collected. It appears some components are "before therapeutic treatment begins"; historically, regulations have not allowed IRFs to collect information used for the IRF-PAI before consent is signed. Will this stipulation be modified or removed for IRFs?	General		Once the patient is in the IRF, the IRF is responsible for the patient.
17.	Why are HH, SNF, and LTCH not collecting the very same information as being asked of IRFs as outlined in the Affordable Care Act?	General		The IRF QRP was established in accordance with section 1886(j) of the Social Security Act as amended by section 3004(b) of the Affordable Care Act (ACA). Therefore, the ACA established the IRF QRP. Beginning in FY 2014, IRFs that fail to submit data will be subject to a 2.0-percentage-point reduction of the applicable IRF Prospective Payment System (PPS) payment update. The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services to require IRFs to report standardized patient assessment data, data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care providers. Therefore, the IMPACT Act mandates the collection of standardized data, or the same information, across post-acute care settings under various specified clinical domains/categories.

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18.	If patient is emergently discharged within first 3 days of admission, should items not assessed be coded as “88” or “—”? **Note about survey device: It would be much more helpful to use the numbers on the device that match the score (e.g., A=1). If it is a medical discharge, do we code everything 88? Should Section GG account for a patient going out on Leave of Absence in the first 3 days? The answer given was it was the “first 3 days,” but does that mean the 3 days they are in the IRF?	GG	GG0130; GG0170	If an IRF patient has an interrupted stay (the patient is transferred from the IRF and returns to the IRF within 3 calendar days) and the admission assessment was conducted prior to the program interruption, the IRF-PAI should be coded to reflect information from the initial admission assessment. If the program interruption occurred during or prior to the admission assessment period, the IRF-PAI admission assessment should be completed as soon as possible to reflect the patient’s status at the time of admission. For patients with incomplete stays, you may code the discharge self-care and mobility items as “88, Not attempted due to medical condition or safety concerns.” Patients with incomplete stays include patients who are unexpectedly discharged to an acute care setting, such as Short-stay Acute Hospital, Critical Access Hospital, Inpatient Psychiatric Facility, or Long-term Care Hospital, because of a medical emergency; patients discharged to a hospice; patients discharged to another IRF; patients who die or leave an IRF against medical advice; and patients with a length of stay less than 3 days.
19.	Please include verbiage in the IRF-PAI QRP manual that states IRFs will not get a 2-percent penalty for the use of dashes in Section C Item C0400 when applicable. Thank you.	General		Thank you for your feedback. The IRF-PAI Data Specifications have been revised with the issuance of an errata to address this issue. If the BIMS cannot be completed, dashes for C0400A-C will not trigger an APU warning.
20.	Please clarify (in IRF-PAI manual) which items should be assessed multiple times (all shifts) over the 3-day assessment and which items just need one assessment during the 3-day assessment (e.g., BIMS).	General		CMS plans to update Section 4 of the IRF-PAI Manual and will include additional guidance.

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21.	With regard to the link listed below for the IRF-PAI training manual, the most current 2016 manual has sections listed by letter not number. Which section letter corresponds to Section 4?	General		Section 4 refers to the section of the IRF-PAI Training Manual that contains the instructions for coding the IRF QRP quality indicator items (pp. 4–17 of the IRF-PAI v1.4). The document labels refer to the item coding labels of the IRF-PAI Quality Indicator Items. For example, the document labelled "C" includes instructions for coding items C0100 through C0900.
22.	Regarding understanding verbal content, the terms "usually" and "sometimes" are subjective. How will staff interpret where one ends and the other begins? How will you know staff are using the tool correctly or consistently? Is it greater 50 percent and less than 50%? Is it assessed over the course of 3 days or at the end of the assessment; is it a snapshot in time?	B	BB0800	Clinicians should code the patient's admission communication abilities based on an assessment that occurs soon after the patient's admission. The code should reflect the patient's baseline (admission) abilities. The assessment should occur prior to the start of therapy focused on speech or language in order to capture the patient's true baseline status. If the patient's status varies, record the patient's usual ability. Observing the patient's interactions with others in different locations and circumstances is important for a comprehensive understanding of the patient's usual ability to express wants and ideas and his/her understanding of verbal content. It is important to consider use of a hearing aid, if needed, or other device, and exclude language barriers. The difference between coding a 2, Sometimes understands and a 3, Usually understands is based on the frequency of the difficulty the patient has understanding complex conversations. For example, code 3 if the patient occasionally has difficulty understanding complex information and code 2 if the patient only understands only simple, direct phrases.
23.	What do you code for patient who has a Passy-Muir Valve but is difficult to understand due to breathy voice? What about the use of an electrolarynx?	B	BB0700	In the situation that patient has difficulty expressing themselves due to a Passy-Muir Valve or tracheostomy, Section B can be assessed using alternative electronic devices (e.g., smart phone, tablet, laptop), writing, pointing, nodding, or using cue cards.

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24.	If primary mode of comprehension is auditory, would we not assess understanding verbal content (verbally) auditory (e.g., patient without hearing aid present during assessment period codes 2, but if introduced with written content scores 4), can you clarify how to score?	B	BB0800	Clinicians should code the patient's communication abilities based on an assessment that evaluates the patient's preferred method of communication, whether spoken, written, or in sign language, or Braille. In the example you described, if the patient prefers to verbally express his or her ideas and wants and prefers to understand verbal content, an assessment based on verbal communication should be completed.
25.	Please define "usually" vs. "sometimes" in manual.	B	BB0800	The difference between coding a 2, Sometimes Understands, and a 3, UsuallyUnderstands, is based on the frequency of the difficulty the patient has understanding complex conversations. For example, code 3 if the patient occasionally has difficulty understanding complex information and code 2 if the patient only understands only simple, direct phrases. CMS plans to update Section 4 of the IRF-PAI Manual and will include additional guidance.
26.	For a patient who is deaf (congenital) and relies mostly on sign language to communicate, can you use sign language, or must use written communication?	B	BB0800	When coding items BB0700 and BB0800, sign language may be used in the event that a patient is deaf.
27.	Please provide definitions and differences among some, frequently, usually, most; one person's usually is another person's some.	B	BB0700 and BB0800	CMS plans to update Section 4 of the IRF-PAI Manual, and will include additional guidance.
28.	How do you differentiate coding 3 (usually) or 2 (sometimes)? Do you count the number of times patient has difficulty? Do you estimate a percentage of times? If so, what numbers or percentages correlate to code 3 or code 2? Or is this purely subjective by interviewer?	B	BB0700	The difference between coding a 2 or 3 is not based on just the number of words or gestures if the patient is nonverbal. It also considers the frequency of the difficulty the patient has expressing their wants and ideas; e.g., if the patient occasionally has difficulty versus it being the usual pattern for the patient. It would be helpful to observe the patient's interactions with others in different locations and circumstances and obtain input from a variety of clinicians, including a speech pathologist if possible, across different shifts. Soliciting input from family members may also be helpful. The assessment should be completed prior to the initiation of any therapy focused on speech and language.

Question #	Question	Section	Item #	Answer
29.	If interviewing patient, does documentation need to be in medical record or interview to prove patient statement of questions with interview?	C	C0200-C0500	The interview is a primary source document and would not need backup documentation in the medical record.
30.	This section is used to risk-adjust the functional items How will familiarity with these questions, due to multiple stays in different PAC settings, affect the risk adjustment (e.g., patient says “yeah, yeah—sock, blue, bed” before even prompted or family knows to prompt/practice prior to assessment)?	C	C0200	Severe and moderate cognitive impairment are risk factors for the functional outcome measures. Specifically, patients with cognitive impairment had less functional improvement than patients without cognitive impairment. If the patient recalls the words from a previous interview, then the patient likely does not have severe or moderate cognitive impairment, and risk adjustment for cognitive impairment would not be needed for this patient at the time of admission.

Question #	Question	Section	Item #	Answer
31.	If cognitive pattern assessment occurs prior to therapy, how would you differentiate aphasia or speech deficits? Do you not complete the test? If someone has expressive aphasia, can they point to “a color” or words?	C	C0200	Complete the assessment to the best of the patient's ability The Brief Interview for Mental Status (BIMS) should be attempted with all patients. If the patient’s primary method of communication is in written format, the BIMS can be administered in writing. The administration of the BIMS in writing should be limited to this circumstance. Instructions for BIMS When Administered in Writing 1. Interview any patient not screened out by Should Brief Interview for Mental Status Be Conducted (item C0100)? 2. Conduct the interview in a private setting. 3. Patients with visual impairment should be tested using their usual visual aids. 4. Minimize glare by directing light sources away from the patient’s face and from written materials. 5. Provide a written introduction before starting the interview. 6. Suggested language: “I would like to ask you some questions, which I will show you in a moment. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult. We ask these questions of everyone so we can make sure that our care will meet your needs.”

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32.	If cognitive pattern assessment occurs prior to therapy, how would you differentiate aphasia or speech deficits? Do you not complete the test? If someone has expressive aphasia, can they point to "a color" or words?	C	C0200	7. Directly provide the written questions for each item in C0200 through C0400 at one sitting and in the order provided. ○ For each BIMS question, show the patient a sheet of paper or card with the instruction for that question from the form clearly written in a large enough font to be easily seen. ○ The patient may respond to any of the BIMS questions in writing. ○ Show separate sheets or cards for each question or statement. ○ For C0200 items, instructions should be written as: ▪ I have written 3 words for you to remember. Please read them. Then I will remove the card and ask you repeat or write down the words as you remember them. ▪ Category cues should be provided to the patient in writing after the patient's first attempt to answer. Written category cues should state: "sock, something to wear; blue, a color; bed, a piece of furniture." ○ For C0300 items, instructions should be written as: ▪ C0300A: "Please tell me what year it is right now." ▪ C0300B: "What month are we in right now?" ▪ C0300C: "What day of the week is today?" ○ For C0400 items, instructions should be written as: ▪ Let's go back to an earlier question. What were those three words that I asked you to repeat?" ▪ If the patient is unable to remember a word, provide Category cues again, but without using the actual word. Therefore, Category cues for: i. C0400A should be written as "something to wear." ii. C0400B should be written as "a color." iii. C0400C should be written as "a piece of furniture."

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33.	If cognitive pattern assessment occurs prior to therapy, how would you differentiate aphasia or speech deficits? Do you not complete the test? If someone has expressive aphasia, can they point to "a color" or words?	C	C0200	8. If the patient chooses not to answer a particular item, accept his or her refusal and move on to the next questions. For C0200 through C0400, code refusals as incorrect. 9. Rules for stopping the interview are the same as if for administering the BIMS verbally. 10. The facility may develop its own signs for this process. If the facility develops its own, it must use the exact language used in the item set.
34.	Why is BIMS only measured on admission?	C	C0200-C0500	Section C Cognitive Patterns is required on the admission assessment because the items are used for risk adjustment for the IRF self-care and mobility quality measures. Data for items used for risk adjustment of a quality measure should reflect the patient's baseline (admission) status, and thus only admission data are needed to calculate the quality measure. A table describing how data coded for each item are used to calculate quality measures is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html.
35.	How would you rate a patient who used the three words in a sentence and another word (e.g., patient says, "I put the blue socks in the dresser because they were on the bed.")?	C	C0200, C0400	You would score this as a 3 if it was the first attempt to recall the words without any cues. The words in item C0200 may be recalled in any order and in any context. For example, if the words are repeated back in a sentence, they would be counted as repeating the words.
36.	A month can be 28, 29, 30, or 31 days. How do we assess what constitutes a month?	C	C0300B	You would score based on the current month. For example, if today was March 2 and the patient answered February, it is within 5 days.
37.	Can families/family member be used to interpret if needed?	C	C0100	If the patient requests or needs an interpreter, every effort should be made to have an interpreter present for the BIMS or any part of the IRF-PAI assessment. Refer to facility policies to determine if a family member qualifies as an interpreter for your facility.

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38.	How do you code these items after a patient with severe global expressive aphasia who only has the understanding, memory, and comprehension to respond but cannot?	C	C0300, C0400	If the patient is rarely/never understood or cannot respond verbally or in writing, the staff assessment should be completed instead of the BIMS. If the Patient can respond in writing, the BIMS may be completed in writing.
39.	How are you envisioning the care team use the BIMS score? Could you provide scenarios about how certain scores would guide intervention?	C	C0500	The BIMS can give you a guideline for the care plan and care delivery for the patient based on short-term memory and ability to need cues to recall.
40.	What is required to be in patient chart? Does a copy of BIMS need to be in chart?	C	C0200-C0500	A copy of the IRF-PAI is to be included in the patient's medical record, and the BIMS is included on the IRF-PAI.
41.	What if patient states he is in a hospital but has the wrong name of hospital? He said he is at St. Mary's Hospital, but he really is at Dexter General Hospital. Is this considered correct because he knows the hospital he is in?	C	C0900	Yes. Check C0900E if the patient is able to determine that he or she is currently in a hospital/hospital unit. To check this item, it is not necessary that the patient be able to state the name of the hospital; however, he or she should be able to refer to the hospital by a term such as a "hospital," "rehabilitation center," or "where I am getting therapy."
42.	Memory/Recall Ability items tend to be more difficult than the BIMS questions (e.g., location of room and staff names). C0900 does not seem to be a fitting alternative to the BIMS. What value is this portion?	C	C0900	Most patients are able to attempt the BIMS. If the BIMS is not conducted or the patient is unable to complete the BIMS, C0900 Staff Assessment for Mental Status is an alternative assessment that provides information from observation of cognitive performance.
43.	Can software (EMR) calculate and fill in C0500 and C0600?	C	C0500, C0600	The interview should be completed and the answers encoded. CMS provides technical submission specifications for these items for software vendors. These vendors incorporate specifications within their own products, however, may add more features that are not part of CMS' specifications. Automatic calculation of BIMS scores are not a part of the CMS submission specifications.
44.	This question is not appropriate for all patients. It is lengthy and several bits of information (TOO MANY WORDS leading up to the three words). For cognitive testing, clinically you would do differently baseline tests for an ortho patient compared to the TBI or stroke patient.	C	C0200	The BIMS should be attempted with all patients according to the instructions in the IRF manual. Should the patient fail the BIMS, C0900 Staff Assessment for Mental Status is completed.

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45.	What do you do for cognitive assessment on a severe traumatic brain injury patient (minimally conscious, not yes/no reliable)? Cannot do a BIMS, and C0900 (recall/memory) does not really apply?	C	C0100, C0900	If the BIMS is not conducted or the patient is unable to complete the BIMS, C0900 Staff Assessment for Mental Status is completed. If the patient is minimally conscious, check Z, None of the above for C0900 Memory/Recall Ability.
46.	Can LCSWs (licensed clinical social workers) complete the BIMS? Or an MSW? Social worker?	C	C0200-C0500	Patient assessments are to be done in compliance with facility, State, and Federal requirements. CMS does not dictate who may complete patient assessments.
47.	How does BIMS scoring compare to the MoCA? Can they be used interchangeably?	C	C0500	The BIMS and the Montreal Cognitive Assessment are different assessments. The IRF QRP requires that the BIMS be attempted with all patients.
48.	When assessing car transfer, can a car simulator be used for car transfer? Can a training car in the gym by a simulated car? Can you set up a simulated car transfer using a mat table, other equipment, etc.?	GG	GG0170G	The 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 (e.g., car seat within a car cabin).
49.	Regarding uneven surfaces, does it have to be gravel? Can a mat, tile, carpet, ramp indoors be utilized to simulate uneven surfaces or a ramp? There are times that weather will not permit outdoor activity.	GG	GG0170L	For item GG0170L Walking 10 feet on uneven surfaces: The assessment may be completed outside or indoors using equipment to simulate walking on an uneven surface. The clinician should use clinical judgment in determining if a surface is uneven outside or inside a facility. Examples of an uneven surface include a sloping floor indoors or uneven outdoor pavement.
50.	Please explain when it is appropriate to use the “activity not attempted” codes of 07, 09, 88?	GG	GG0130, GG0170	If the patient does not attempt the activity and a helper does not complete the activity for the patient, code the reason the activity was not attempted. For example, code 07 if the patient refused to attempt the activity or code 88 if the patient was not able to attempt the activity due to medical condition or safety concerns. If the patient did not perform the activity prior to the current illness, injury, or exacerbation, code 09, Not applicable.

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51.	What are CMS' expectations related to capturing "usual" status? How will CMS view discrepancies between QRP score (usual) and FIM score (most dependent)?	General		Usual status for Section GG is defined as how the patient typically performs the activity at the time of admission or discharge. If the patient's functional activity performance varies during the assessment period, report the patient's usual status, not the patient's most independent performance or most dependent episode; e.g., the admission score that reflects the patient's baseline status and should be based on an assessment of the patient's abilities during which the patient is allowed to be as independent as possible as long as he/she is safe. We are aware that guidance for the collection of FIM® data and the collection for Section GG data vary because they are collected for different purposes.
52.	Are you saying there will be no risk of penalty for any dashes used for goals as long as one goal is entered?	GG	GG0130, GG0170	Yes, that is correct. Completion of at least one discharge goal will be required for one of the Self-Care or Mobility Items to fulfill the requirements of the IRF QRP. In other words, one Self-Care or one Mobility item must have a discharge goal. CMS applauds the reporting of more than one goal in order to best address the needs of the patient.
53.	What if the patient performs exactly 50 percent (half of effort)? Do you code "03" or "02" (e.g., patient does 50 percent and helper does 50 percent)?	GG	GG0130. GG0170	If the patient performs half of the effort, code the item 03, Partial/moderate assistance.
54.	Are you able to utilize information from only one discipline to complete the coding? For example, wheelchair transfers—occupational therapy, physical therapy and nursing all perform these functions.	GG	GG0110; GG0130	Procedures for the data collection of the Quality Indicator items on the IRF-PAI are to follow facility policies. Patient assessments are to be done in compliance with facility, State, and Federal requirements. CMS does not provide guidance on which disciplines may complete patient assessments.

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55.	Do you choose the closest score (code) to the admission date? What if the code closest to the admission date is higher than the next day's code?	GG	All	Clinicians should code the patient's functional status, based on a functional assessment that occurs soon after the patient's admission. The code should reflect the patient's baseline (admission) functional abilities. The assessment should occur prior to the start of therapy interventions in order to capture the patient's true baseline status. If the patient's status varies, record the patient's usual ability to perform each activity. Do not record the patient's best performance or worst performance, but rather record the patient's usual performance.
56.	If item is scored and there are an equal number of two or three scores, how do you determine most usual score?	GG	GG0130, GG0170	Direct observation of the patient's performance, review of medical records, and discussion with clinical staff are methods of gathering information to determine the patient's usual performance. Each facility typically designates a responsible discipline for coding the patient's performance of each activity. The clinician coding Section GG items needs to have thorough knowledge of each activity definition. Understanding the tasks that are included within each activity will facilitate accurate coding.
57.	If you record 07 or 88, you are saying that the patient refused or had a medical/safety concern for the entire 3-day assessment period, correct? If the patient refuses on Day 1 or 2 but completes the task on Day 3, would 07 or 88 be coded (because it is most usual) or the scored value?	GG	GG0130, GG0170	That is correct: If the patient completes the activity during the admission assessment period, the activity should be scored using codes 01-06.

Question #	Question	Section	Item #	Answer
58.	When coding usual performance, the instructions indicate not to code worst or best performance and also to code before any intervention occurs. Generally we evaluate once, so how many times do we need to assess the patient to determine "usual" performance?	GG	GG0130, GG0170	Clinicians are required to complete the patient's assessment within 3 days. The items are not required to be assessed and coded every time the patient completes the activity; only one code is reported on the IRF-PAI. The assessment should be conducted as close to the time of the patient's admission or discharge as possible, and all 3 days may not be needed to complete all the items. For example, the skin conditions items (Section M), should be assessed as close to the admission or discharge as possible. Some of the activities assessed in Functional Abilities and Goals (Section GG) will occur more frequently than others, and the patient's baseline may be sufficiently assessed on the first or second day, while other activities may not be fully assessed until the third day.
59.	Is the intent of the admission assessment to get multiple responses, or is one person's assessment sufficient?	GG	GG0130, GG0170	The intent of the admission assessment is to report an assessment of the patient's baseline functional abilities. The assessment should occur prior to the start of therapeutic intervention in order to capture the patient's true baseline status. Procedures for the data collection of the Quality Indicator items on the IRF-PAI are to follow facility policies. Patient assessments are to be done in compliance with facility, State, and Federal requirements. CMS does not provide guidance on which disciplines may complete patient assessments.
60.	If there are only I-Z scores for an item in the 3-day assessment, what is the usual score, the lowest or the highest? Can each item be assessed one time and still be considered "usual"? (Can we use the same 24-hour period we use to do our FIM scoring to come with up with our "usual" score)?	GG	GG0130-GG0170	A patient may perform an activity only once during the assessment period. If this occurs, code the activity based on the single performance of the activity by the patient. For example, if the patient only transfers into and out of a car once during the last 3 days of the IRF stay, code based on the assistance associate with the single assessment.

Question #	Question	Section	Item #	Answer
61.	For the items A, B, C, D, would you give an example of when the use of 9 (not applicable) would be used?	GG	GG0100 Score of 9	Code 09, Not applicable if the patient did not perform the activity prior to the current illness, injury, or exacerbation. Here is an example: Putting On/Taking Off Footwear Mrs. J is admitted following a stroke. Prior to her stroke, she underwent a bilateral below-the-knee amputation (BKA) and does not use lower extremity prosthetics. The amputation resulted in each lower extremity ending approximately 8–10 inches below each of her knee joints. Coding: GG0130H Putting on/taking off footwear would be coded 09, Not Applicable. Rationale: Prior to the current illness, Mrs. J had bilateral BKA amputations and the absence in use of lower extremity prosthetics; therefore, the activity of putting on/taking off footwear is not applicable.
62.	In discussing an “incomplete stay,” when is it appropriate to use code “88, Not attempted due to medical condition or safety concerns”?	GG	GG0130, GG0170	For patients with incomplete stays, you may code the Self-Care and Mobility items as 88, Not attempted due to medical condition or safety concerns. Patients with incomplete stays include patients who are unexpectedly discharged to an acute care setting, such as Short-stay Acute Hospital, Critical Access Hospital, Inpatient Psychiatric Facility, or Long-term Care Hospital, because of a medical emergency; patients discharged to a hospice; patients discharged to another IRF; patients who die or leave an IRF against medical advice; and patients with a length of stay less than 3 days.
63.	Does eating include tube feeding? If tube fed, would it be 09 or 88? Or is it similar to FIM scoring? How do you code tube feed at discharge? What if patient has PO food and tube feeding?	GG	GG0130	If the patient eats by mouth, code the item GG130A Eating, based on the type and amount of assistance required from a helper. The patient may be eating by mouth even though he/she has a G-tube. If the patient does not eat by mouth due to a medical condition, and relies solely on nutrition through a G-Tube or total parenteral nutrition, code Eating item GG130A as 88, Not attempted due to medical condition or safety concerns.

Question #	Question	Section	Item #	Answer
64.	If you score 88, what should you do about setting a discharge goal (e.g., car, stairs, walking, transfer)? Can you change your goals once you submit if status changes? Can goal be changed after 3-day assessment period? If yes, how often?	GG	GG0130	Self-care and mobility discharge goals are established at admission as part of the patient's care plan and documented on the IRF-PAI. Licensed clinicians establish a patient's discharge goal(s) at the time of admission based on the admission assessment, discussions with the patient and family, professional judgment, and the professional's standard of practice. For the IRF QRP, at least one self-care or mobility discharge goal is reported for each patient at admission. The goals entered on the admission assessment are not changed after admission. For example, the patient may not meet the discharge goal (established at admission) because the patient may have experienced a decline in status resulting in performing the activity at a more dependent level than originally anticipated.
65.	Does Item GG0130H include anti-embolic stockings?	GG	GG0130H	Anti-embolic stockings are considered footwear, and putting on and removing these items should be assessed when coding GG0130H, Putting on/taking off footwear. If a helper assists with putting on or removing anti-embolic stockings, the code for GG0130H Putting on/taking off footwear would be 3, Partial/moderate assistance or lower.
66.	It was stated that a prosthetic/orthosis should be considered as a piece of clothing. Is a prosthetic leg assessed under lower body dress or footwear? How and where is a TLSO application assessed and coded?	GG	GG0130F, G, H	If the prosthetic/orthotic is associated with the upper or lower leg, it would be considered as part of the patient's lower extremity. If the prosthetic/orthotic is associated with the patient's foot or shoe, it is considered footwear
67.	For rolling left and right, if the physician orders patient not to roll to one side but they can roll to the other side, would the code be 88 or coded 1-6? Do we score on one side?	GG	GG0170	If the patient can roll to one side but needs assistance from a helper to turn to the other side, the patient will be coded 3, Partial/moderate assistance or lower.
68.	Is sponge bathing considered bathing?	GG	GG0130 E &G	Item GG0130E Shower/Bathe Self, assesses the patients' ability to bathe the upper and lower body, including washing, rinsing, and drying. If a medical condition or expected home environmental constraints prevent safe utilization of a tub or shower, then the patient may be assessed based on a sponge bath at the patient's bedside or the sink.

Question #	Question	Section	Item #	Answer
69.	What body parts are included in bathing (e.g., back, face)? Is hair care/washing part of activity of bathing?	GG	GG0130E	For the item GG0130 E Shower/Bathe Self, the assessment focuses on washing, rinsing, and drying the upper and lower body. The assessment can be based on a sponge bath or bathing at the sink. The focus of the assessment is the patient's ability to bathe his/herself, both the upper and lower body, including washing, rinsing, and drying the face, chest, and limbs. Do not include the patient's back or hair in this activity.
70.	If sit to lying and sit to stand are assessed as separate items, what is assessed as "transfer"? Once standing, is it pivot only, unable to stand from sitting, or no sitting balance from lying? How is sitting balance addressed in lying to sitting on side of bed? The patient can do the activity but cannot sustain sit; is there a timeframe (e.g., 1 second, 2 seconds)?	GG	GG0170	GG0170C Lying to sitting on the side of the bed uses the term "back support." The activity ends when the patient is sitting on the side of the bed without back support.
71.	Regarding sitting on edge of bed with feet flat on the floor back unsupported, some patients are very short and feet do not reach the floor. Is it okay to code as long as patient is sitting and not supported?	GG	GG0170 C	GG0170C Lying to sitting on the side of bed: If the patient's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment or a footstool is required to accommodate foot placement on the floor/footstool.
72.	Is there a minimum height requirement for a step/curb?	GG	GG0170M	The height of the step for items GG0170M 1 step (curb), GG0170N 4 steps, and GG0170O 12 steps is not defined by height.
73.	What is considered a "turn"? 45 degrees? 90 degrees? 180 degrees? 360 degrees? Does it have to be both directions?	GG	GG0170J	The turns included in the items GG0170J and GG0170R (walking or wheeling 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). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (e.g., cane, wheelchair).

Question #	Question	Section	Item #	Answer
74.	Please provide a definition of upper body dressing and items that should be included?	GG	GG0130F	Upper body dressing can include the following clothing items: bra, undershirt, T-shirt, button-down shirt, pullover shirt, sweatshirt, sweater, and pajama top. Upper body dressing cannot be assessed based solely using a hospital gown. Upper body dressing also includes any orthotic or prosthetic that the patient is required to wear, such as Thoracic-Lumbar-Sacrum-Orthotic (TLSO), back brace or any upper body support, neck support, upper body prosthetics (e.g., arm or hand prosthesis).
75.	Does application of a TLSO go under upper extremity dressing?	GG	GG0130	Upper body dressing includes any medical equipment that the patient is required to wear, such as Thoracic, Lumbar, Sacrum, Orthotic (TLSO), back brace or any upper body support, neck support, upper body prosthetics. If the patient needs assistance from a helper to apply and remove the TLSO, the code for Upper body dressing would be 03, Partial/moderate assistance or lower.
76.	Does definition of walker include standard walker, rolling walker, and rollators/walkers with seats?	GG	GG0110-D	For GG0110 Prior Device Use, check D. Walker for all walker types, including a pick-up walker, hemi-walker, rolling walker, platform walker, four-wheel walker, rollator walker, knee walker, walkers for mobilizing while seated in walker.
77.	Do these have to be individual assessments, or can the patient go 150 feet (or go up/down 12 steps) and score all three areas? If the patient is not walking on admission but can walk by discharge, can you score at discharge? Does “walking 10 feet” include parallel bars? What if the patient did the distance but not two turns? If person clinically cannot walk 150 feet and therapist knows it, why is it not dependent (1) vs. 88?	GG	GG0130, GG0170	The clinician is to assess each walking item individually. Each item has specific activity components or tasks that assess the level of function. Item GG0170I assesses the ability to walk at least 10 feet. Item GG0170J assesses the ability to walk 50 feet and make two turns. Item GG0170K assesses the ability to walk 150 feet. The clinician should assess the patient’s performance specific to each item. For example, the patient may walk 10 feet without assistance but may need some assistance to walk further or make turns. Each activity should be assessed by observing the amount of assistance required from the helper.

Question #	Question	Section	Item #	Answer
78.	What if patient only uses wheelchair in the community? Do you still check it even though it's outside of house? Does wheelchair mobility need to be coded if wheelchair only used for in facility transport?	GG	GG0110; GG0130	Only code wheelchair mobility based on an assessment of the patient's ability to mobilize in the wheelchair. Do not code wheelchair mobility if the patient only uses a wheelchair when transported between locations within the hospital. If a patient walks and uses a wheelchair, both the walking and wheelchair items on the IRF-PAI version 1.4 are to be coded.
79.	We do not have 12 steps in a row; can the patient go up and down 3 stairs 4 times to score this?	GG	GG0170	GG0170O 12 steps: the ability to go up and down 12 steps with or without a rail. If the patient practices in the therapy gym with equipment that only has 4 steps, the patient can go up and down the 4 steps multiple times in order to code the patient's ability to walk up and down 12 steps.
80.	If an activity is assessed more than once is the first 3 days, which score should you use on the IRF-PAI?	GG	GG0130	If the patient's function activity performance varies during the assessment period, report the patient's usual status, not the patient's most independent performance or most dependent episode; e.g., the admission score that reflects the patient's baseline status and should be based on an assessment of the patient's abilities during which the patient is allowed to be as independent as possible as long as he/she is safe.
81.	Do the quality indicators assess a patient's ability to complete intermittent catheterization independently?	H	H0350	H0350 assesses bladder incontinence, not the ability to self-catheterize.
82.	If patient has an indwelling cath or ostomy that leaks, do you consider this incontinence? Would you not use code 9?	H	H0350;H0400	Code 9, Not applicable, if during the 3-day assessment period, the patient had an indwelling bladder catheter, condom catheter, or ostomy for the entire 3 days.
83.	Patient uses urinal successfully but tends to spill urine when removing it and linens get wet. Is this considered an incontinence episode?	H	H0350	If the urine spills from a urinal after the patient uses it, this is not considered an incontinent episode. For the bladder continence item, incontinence refers to the involuntary loss of urine, where there is a loss of control of the evacuation of urine from the bladder, regardless of whether clothing or linens are soiled.

Question #	Question	Section	Item #	Answer
84.	How do we code if the patient has stress incontinence usually and during the assessment period patient had bladder incontinence daily?	H	H0350	If the patient is incontinent daily during the admission assessment period, item H0350 Bladder Continence is to be coded 03. Incontinent daily. Stress incontinence is coded if the patient has only stress incontinence. Stress incontinence refers to episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
85.	What if a patient is incontinent four times, but only on Day 1? The rest of Days 2 and 3 the patient is continent (e.g., on Code 2). Are you asking about number of days or number of incontinent episodes?	H	H0350	The codes reflect the frequency of incontinent episodes during the 3-day assessment period. If the patient is incontinent 4 times on Day 1 and remains continent for Days 2 and 3, the correct code would be 2.
86.	If patient is continent but purposefully urinates on the floor due to behavior, is that coded as 4 because it is not in a toilet, bedpan, urinal, or commode?	H	H0350	If the patient is continent but, due to behavior, purposely voids on the floor, it is not an incontinent episode.
87.	Can you please review your point about someone who has a history of stress incontinence and why it might be different? If condom catheter falls off and patient is incontinent, how is it coded?	H	H0350	Stress incontinence refers to episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise. A code 9 should be used for indwelling bladder catheter, condom catheter, or ostomy that is in place for the entire 3 days. If the condom catheter falls off and the patient is incontinent, the episode of incontinence should be coded.
88.	For bladder incontinence, does there need to be a physician documentation of stress incontinence during the 3-day assessment period to justify the coding of 1? Does there need to be documentation of the staff saying that it is stress incontinence in order to code 1?	H	H0350	There does not need to be a physician diagnosis of stress incontinence to code 1 for H0350 Bladder Continence. Based on the clinician's assessment, patient or family reporting, or physician documentation, a patient can be coded a 1, Stress incontinence only.

Question #	Question	Section	Item #	Answer
89.	Regarding diaper brief incontinence, is there a difference in coding between the use of traditional diapers or underwear-style briefs? Diapers are more challenging for patients to apply.	H	H0350	H0350 assesses the patients' continence only, regardless of or what type of incontinence garment they use.
90.	How do you score bowel incontinence if patient is unable to use bedpan due to skin issues and uses absorbent pad? It is contraindicated to use a bedpan. Is this considered incontinence?	H	H0400	If the patient is unable to use a bedside commode, toilet, or bedpan and has a bowel program that has been developed to induce stool, then it would not be considered an incontinent episode. A scheduled bowel movement would be considered incontinent if it occurred at a later time.
91.	If a patient is on a bowel program using a suppository and he/she does this in bed and release into a disposable pad, is this considered continent?	H	H0400	If the patient is unable to use a bedside commode, toilet, or bedpan for skin or safety reasons, and the bowel program defines the use of a suppository and a disposable pad, this would not be considered an incontinent episode following the suppository. Any other unplanned stool would be considered an incontinent episode.
92.	What if patient only has intermittent cath within 3-day assessment, with no voids between episodes?	H	H0350	If the patient has maintained continence due to the use of intermittent straight catheterizations, then the patient is continent and item H0350 would be coded 0, Always continent.
93.	Related to use of ostomy, does patient spillage during ostomy management count as incontinence when equipment failure does not?	H	H0400	If a patient has an ostomy for bowel elimination, code 9, Not rated to indicate this item cannot be rated.
94.	If the idea is to get a baseline assessment and you want to let the patient be as independent as possible, should we refrain from putting a patient on a scheduled bowel and bladder program during the 3-day assessment period?	H	H0350	No, data collection for this item should not change your current clinical practice.
95.	How effective would patient be on bowel/bladder incontinence, especially if the patient feels unsecure/bad about the incontinence? In other words, patient could be hiding the instance.	H	H0350, H0400	Assessments should include a review of the medical record for bladder incontinence records, flow sheets, nursing assessments and progress notes, physician history and physical exam, interview patient and family, and consultation with direct care staff who routinely work with the patient about incontinence episodes.
96.	How are urinal and/or bedpan spills coded?	H	H0350	Urinal spills are not considered incontinent episodes.

Question #	Question	Section	Item #	Answer
97.	What if the patient urinates on the floor (intentional or not intentional)?	H	H0350	If the patient intentionally urinates on the floor, it is not considered incontinent because he/she is able to control the release of urine. If the patient unintentionally urinates on the floor because he/she cannot control the urine, then he/she would be considered incontinent.
98.	Please clarify on the example of the patient who has foley Day 1 and it is removed Day 2; can patient be coded a 3 since there was no incontinence Day 1?	H	H0350	We interpret this question to mean that the patient was continent on Day 1 and incontinent on Days 2 and 3. Therefore, you would code the assessment a 2, Incontinent less than daily, since the patient cannot be considered incontinent on Day 1 due to the use of a foley catheter.
99.	If a patient has one bowel movement in the first 3 days of admission and is incontinent, should the patient be coded a 1, Occasionally incontinent (one episode of bowel incontinence) or a 3, Always incontinent (no episodes of continent bowel movements)?	H	H0400	If the patient has one bowel movement that is an incontinent episode, code 1, Occasionally Incontinent. The patient had one episode of bowel incontinence during the 3-day assessment period.
100.	Why would a condom catheter not be counted as incontinence?	H	H0350	If it is noted that the patient uses a device, such as an indwelling catheter or a condom catheter, we are aware the patient may not be continent without the device.
101.	What if incontinence was due to the nurse or Certified Nursing Assistant not getting to the patient quick enough?	H	H0350, H0400	Regardless of the reason, if the patient is incontinent, he/she should be coded as incontinent.
102.	When would diagnoses reported in Section I not be also reported in items 22 and No. 24?	I	I0900 I2900 I7900	Section I and Item 24 would be different if a patient was found to have an active diagnosis after the 3-day assessment period but not on the day of discharge or the day before the day of discharge. In this scenario, Item 24 would have an ICD-10 code listed, but in Section I, I7900 None of the above would be checked. The items in No. 24 may not be the same as the diagnoses in Section I. There are only two diagnoses identified in Section I-PVD/PAD and Diabetes. Otherwise, I7900 None of the Above would be checked.

Question #	Question	Section	Item #	Answer
103.	Section I can be document from any staff to code diagnosis, but in comorbid section must be documented by physician to do ICD-10—is that correct? Is that your meaning by different rules?	I	0900 I2900 I7900	Yes. These items are collected for different purposes. There must be specific documentation in the medical record by a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized staff if allowable under State licensure laws) of the disease or condition being an active diagnosis.
104.	If a patient undergoes amputation due to PVD/PAD and the PVD/PAD condition is resolved with the amputation, do we still code it?	I	I0900	If the physician does not document that the diagnosis is active, then it cannot be coded.
105.	Physicians can correct the History and Physical Examination (H&P) during a patient's entire stay. Can Section I be corrected after the first 3 days if the H&P has been corrected?	I	0900 I2900 I7900	If the original H&P was incorrect and the physician corrected it after the 3-day assessment period, you may correct Section I data up until the data submission deadline for the applicable quarter.
106.	Speaker stated Section I is for risk adjustment. Is this only risk adjustment for pressure ulcer risk?	I	0900 I2900 I7900	Data from items in Section I are used as risk adjusters for the pressure ulcer quality measure.
107.	If a patient loses his/her balance and grabs a wall to stop from falling, is this considered a fall? Thank you.	J	1800	Yes, this is considered a fall.
108.	Is a bruise an injury?	J	J1750	Please refer to the IRF-PAI Training Manual (p. J-4) for the definition of injury (except major) and major injury.
109.	Please provide more clarification or examples of "overwhelming external force" in the definition of a fall. In addition to being pushed by another person, what else could this be?	J	J1750	An example of an "overwhelming external force" would be a push or shove from another person, or being hit with a piece of equipment. There needs to be an external force applied.
110.	Patient fell, lacerated her head, and was sent to ED. A head CT revealed a subdural hematoma. The patient was admitted to acute care unit and did not return to the IRF. How would I score J1900 A, B, and C?	J	J1900B	Based on the scenario outlined in the question, and assuming this was the only fall, then J1900A=0, J1900B=0, J1900C=1.

Question #	Question	Section	Item #	Answer
111.	For J1750, are falls assisted and unassisted falls?	J	J1750	Falls include falls and intercepted falls.
112.	If a patient fell in room or bathroom with hitting head on nightstand or skin with minor abrasions and concussion (no loss of consciousness, just headaches, CT is negative for subdural hemorrhage/hematoma), is it a minor or major injury?	J	J1900B and C	If the fall did not cause a major injury, such as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma, for example, it would be considered an injury (except major).
113.	Prior to admission when asking about falls, do you ask patients and families about how many intercepted falls they had?	J	J1800	When asking about falls prior to admission, we are focusing on falls, not intercepted falls.
114.	Scenario 2 - patient with cut above the left eye, I would have coded it as 1 1 0 but not 0 1 0. Can you please explain why it is 0 1 0, as the R.N. would clearly see patient would have a cut over the left eye when PTO completing physical assessment? I believe A and B of J1900 is confusing (no injury and injury)? PLEASE CLARIFY. Thank you! :)	J	J1900	No injury is assessed by the staff. Minor injury would be a finding that did not meet the major injury definition.
115.	Does major surgery include total hip or total knee replacement that is completed under general anesthesia if patient does not have a 1-day stay in acute care hospital (less than 24-hour stay)?	J	J2000	An overnight stay in an acute care hospital is required for a procedure to be classified as major surgery.
116.	Add more clarification to training manual. Regarding health conditions, what is the definition of major surgery? The training manual only spells out that a simple skin tag is not major surgery. Does an outpatient procedure requiring sedation (e.g., dental surgery) count as a major surgery, or does it require a hospital stay? Does outpatient surgery requiring general anesthesia but in which patient does not stay overnight acute (e.g., cholecystectomy (emergency gall bladder removal) or oral surgery (because it affects eating) count as major surgery?	J	J2000	Generally, major surgery refers to a procedure requiring general anesthesia. In addition, major surgery usually carries some degree of risk to the patient's life, or the potential for severe disability if something goes wrong during the surgery. An overnight stay in an acute care hospital is required for a procedure to be classified as major surgery.

Question #	Question	Section	Item #	Answer
117.	What if diet starts at modified then is upgraded to regular within 3 days? Check A & B?	K	K0110	If a diet starts as modified and is changed to regular within the first 3 days, it is appropriate to check both A and B.
118.	Why are you using 2007 NPUAP standards when new, updated standards available? Friction has been removed from current standards (2016– NPUAP) Slide 8? Slide 12 "Do not use the NPUAP definitions to code the IRF-PAI"? Terms such as "deepest anatomical stage," "boggy" are no longer considered current practice available. What about deep tissue pressure injury (DTPI), especially DTPIs that resolve? Concerned about use of outdated data/information. Thank you.	M		The current definitions used across all the settings for the assessments are from 2007 NPUAP. These are the definitions that are needed to complete this assessment.
119.	If a patient came in with a suspected deep tissue injury, gets debrided, and is a Stage 4, I thought we could go back to the admission and change I to a Stage 4. This was from a CMS conference around 5 years ago (Baltimore).	M	M0300	Changing the admission pressure ulcer data was permitted with the 2012 release of the IRF-PAI, because unstageable pressure ulcers could not be documented on the IRF-PAI (2012 release). Starting with the 2014 IRF-PAI (version 1.3), unstageable pressure ulcers can be reported on the IRF-PAI, so you would code the status of the pressure ulcer at the appropriate stage or as unstageable at admission. You would not need to change the admission data. For the example you describe, you would code the pressure ulcer on admission as you assessed it (unstageable) and on discharge as a Stage 4.
120.	In coding scenario number 2 in the handout presented by Ann Spenard, the coding was such that it would have been the same coding if the patient's Admission Stage 2 wound had healed and an additional wound developed in a separate location and was staged a 3 on discharge as in the example when a Stage 2 on admission progressed to a Stage 3 during the stay.	M	M0300	You are correct that the admission assessment would show a Stage 2 pressure ulcer and the discharge assessment would show a Stage 3 pressure ulcer. You would capture the difference in M0800 Worsening of Pressure Ulcer Status Since Discharge. In this case you would have a new Stage 3, and 0 at Stage 2.

Question #	Question	Section	Item #	Answer
121.	If a patient is admitted with a non-removable cast and during the stay has the cast removed, at which point a full thickness wound is discovered underneath the cast, though there is no indication this wound was present on admission, how would you code this?	M	M0800	You would code the pressure ulcer in item M0800 Worsening in Pressure Ulcer Status Since Admission. You would also report the pressure ulcer in an M0300 item (e.g., M0300D) if the pressure ulcer was a Stage 4 pressure ulcer.
122.	Regarding Scenario 2, for admission assessment, it is a 3-day lookback, so if Stage 2 on admission becomes Stage 3 on Day 2, why would you also not code Stage 3 on admission assessment? Admission assessment is only a snapshot of Day 1 for skin.	M	M0300	Complete the admission assessment of skin as soon as possible after admission. If you assessed a pressure ulcer on Day 1 as Stage 2, you would code the pressure ulcer as Stage 2.
123.	If there is a Stage 3 with little slough and then it completely gets covered with slough, then on discharge, would we mark "1" for E because this is worse?	M	M0800	No, if the pressure ulcer is a Stage 3 at the time of admission and then becomes unstageable, it does not mean it got worse. You would code it as unstageable due to slough at the time of discharge.
124.	At d/c, it states to indicate the number of current PUs that were not present or were at a lesser stage on admission. For items D, E, F, how would we determine that it is worse or was at a lesser stage?	M	M0800	For each pressure ulcer that is present at discharge, you would determine if it has worsened since the admission assessment.
125.	Regarding special treatments, what is the timeframe (pre-admit, on admit, 3-day assessment)?	O	Admit page 11	For Special Treatments, the timeframe is at the time of admission to the IRF. If TPN is ordered on the day of admission or during the 3-day assessment timeframe.
126.	If patient received the influenza vaccine in an acute care hospital, was then discharged and admitted to the IRF in the same hospital, do you code A as "01, Yes"?	O	O0250	If the patient received the vaccine during the acute care stay, prior to the IRF stay, you would code 0, the patient did not receive the vaccine in the IRF, and in Section O0250C you would code 2, received outside this facility. The facility refers to the IRF, not the acute care hospital.
127.	There are a number of fields in which we are instructed to use a dash if applicable. Will the *IRF-PAI Assessment with Error Number XXXX* report be updated to eliminate those cases from being included?	Data Submission	Error Message 5004	The use of a dash for the function goals and BIMS has been addressed in an erratum, which may be found here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/Errata_V2004_for_IRFPAI_Data_Specs-_V2000_DRAFT_06062016.pdf.