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

## Archived Quarterly Q&As

## Consolidated June 2022 to December 2023

# Introduction

The Centers for Medicare & Medicaid Services (CMS) has archived questions from Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Quarterly Q&As, in light of the release of the CMS IRF-PAI 4.0 and 4.2 Manuals, effective October 1, 2022 and October 1, 2024 respectively. These Q&As have been archived due to inclusion of guidance in the manual, retiring of guidance, and where items are no longer included in the IRF-PAI.

The latest version of the IRF-PAI Quarterly Q&As can be found on the IRF-PAI and IRF-PAI Manual webpage:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-PAI-Manual

## Consolidated Table of Contents

## Quality Indicators (QI): General Questions

**Question 1: If a patient is admitted to an IRF on Monday but has to be transferred back to the acute care hospital the next day (Tuesday) and then returns to the IRF on Thursday, we know that this is considered a program interruption and the ARD date would be updated to reflect the days the patient was not in the IRF. Can we use assessment information from Tuesday morning's functional assessments (the day the patient returned to the acute care hospital) to code the admission QI items?**

**Answer 1:** If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days used to calculate the ARD, however the assessment data gathered on the discharge date (the day the patient is admitted to Acute Care from the IRF) may be used to code the admission QI items.

*At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance.*

Added: June 2020

**Archived: June 2022**

**Question 2: In the latest Q&A release, there was a question that spoke to a decline with a patient within the assessment window with instructions to not update the assessment with such. The example given was related to dysphagia following an ER stay. I am questioning now if we can identify other "updates" within the 3-day admission assessment time period.**

**Answer 2:** Each IRF-PAI item should be considered individually, and coded based on the guidance provided for that item.

Unless otherwise specified in item guidance, information collected by the assessing clinician during the time period for the specified assessment type may be used to inform IRF-PAI coding.

Note that item guidance does specify special rules for coding pressure ulcer/injury and GG items at admission. To support consistency of data collection related to pressure ulcers and GG function data across all post-acute care (PAC) providers, cross-setting guidance directs coding for pressure ulcers/injuries to be based on the "first skin assessment" and GG self-care and mobility items should be based on a functional assessment that occurs at or soon after the patient's admission, and reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

Added: June 2021

**Archived: June 2022**

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

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

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

If the patient meets the criteria for an unplanned discharge, complete the discharge IRF-PAI Quality Indicator items using the following discharge assessment guidance:

If assessment of an item was not completed prior to the unplanned discharge, code the item using available documentation/information. When the patient is unable to respond and it is allowable, code 8 - Patient unable to respond or code X - Patient unable to respond. If assessment of an item was not completed prior to the unplanned discharge and no information is available, a dash is a valid response. Review guidance manual and Q&As for item-specific guidance.

Please note that while the coding of a dash is an optional response value for some data elements, its use does not count toward meeting the AIF minimum submission threshold. Failure to meet the minimum threshold may result in a two (2) percentage point reduction in the IRF's AIF.

CMS is aware of concerns brought forth by IRF providers as they relate to coding certain assessment items during an unplanned discharge. While we believe this to be an infrequent scenario, CMS will be very closely monitoring new assessment data submissions in this area, beginning October 1, 2022.

As always, we will continue to partner with IRF providers to address compliance matters on a case-by-case basis.

Added: September 2022

**Archived: March 2024**

**Question 8: When a patient has an unplanned discharge and the facility did not have time to complete the patient interview items before the patient left, how should we complete the patient interview items on the IRF-PAI 4.0 discharge assessment in order to avoid the 2 percent penalty?**

**Answer 8:** Some of the new IRF-PAI 4.0 interview items allow a "dash" as a response option, and some interview items do not. In the case of an unplanned discharge, the patient interview items on the discharge assessment that **do not allow** a dash as a response option must be completed using the appropriate coding guidance. These items are A1250 - Transportation, B1300 - Health Literacy, D0700 - Social Isolation, J0510 - Pain Effect on Sleep, J0520 - Pain Interference with Therapy Activities, and J0530 - Pain Interference with Day-to-Day Activities. When the patient

experiences an unplanned discharge, an IRF would need to determine which of the response options are applicable to the specific patient scenario.

Under normal circumstances, C0200-0500, Brief Interview for Mental Status (BIMS) or D0150, Patient Mood Interview (PHQ-2 to 9) require a patient interview to complete these items. However, these items **allow** dash as a response option in cases where the patient assessment could not be completed prior to the unplanned discharge. CMS is closely monitoring these data. IRFs that have an increased number of incomplete assessments due to coding a "dash" for these items as a result of following CMS guidance will not be penalized.

Added: September 2023

**Archived: March 2024**

# Section A: Administrative Information

## 25A, 26A

**Question 1: When entering a patient's height and weight on admission for items 25A and 26A do the height and weight need to be measured while a patient is in the Inpatient Rehabiliation Facility? Can they be estimated per facility policies and procedures or can they be reported based on a height and weight obtained from documentation from another facility?**

**Answer 1:** The intent of item 25A - Height on admission is to record the patient's most recent height. The intent of item 26A - Weight on admission is to record the initial weight measuresment for the patient. Only enter a height and weight that have been directly measured by your facility staff. Do not enter a height or weight that is self-reported or derived from documentation from another provider setting.

Added: March 2021

**Archived: June 2022**

## 25A

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

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

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

Added: December 2020

**Archived: June 2022**

## 44D

**Question 1: We had a patient who transferred from our IRF to the COVID Field Hospital in our area. Would the discharge disposition be Acute Care Hospital?**

**Answer 1:** We interpret your question to be about Item 44D – Discharge disposition in the IRF-PAI. The two discharge dispositions that potentially apply are:

- **Short-term General Hospital** – refers to a short-term acute care hospital

- **Critical Access Hospital (CAH)** – used to identify an admission/transfer to a critical access hospital for inpatient care

If a field hospital is operating as an extension of a Medicare participating hospital (operating as a mobile unit), as long as the mobile unit complies with all the hospital conditions of participation (including the Life Safety Code), and the provider-based rules (including remaining within 35 miles of the main provider), and meets the provider-based regulations in 42 C.F.R. § 413.65, the mobile unit uses the associated main hospital's provider number. Item 44D is coded based on the classification of the main hospital and the definitions above.

If the mobile unit does not meet these criteria, it is treated as a freestanding clinic and item 44D is scored as 99 – Not listed.

Added: September 2020

**Archived: June 2022**

## A1005, A1010, A1110, A1250

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

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

Added: December 2022

**Archived: March 2024**

## A2122, A2124

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

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

Added: March 2023

**Archived: March 2024**

# Section C: Cognitive Patterns

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

**Question 1: Is it allowable to use the BIMS information that was completed on days 4, 5, 7 or 8 on patients to complete the IRF-PAI or would we dash the BIMS items since it was not completed during the 3-day admission assessment period?**

**Answer 1:** The Brief Interview for Mental Status (BIMS) should be attempted with all patients during the 3-day admission assessment period.

If the patient should have been interviewed but the facility did not complete the interview during the 3-day assessment period, respond 1-Yes to C0100 – Should Brief Interview for Mental Status (C0200-C0500) Be Conducted?, and enter dashes for C0200 through C0500. Then complete the staff observation items (C0600 and C0900) using information in the medical record or interviews with IRF staff reflecting the patient status during the first 3 days of the stay.

Only answer 0-No to C0100 if the interview should not have been attempted because the patient was rarely/never understood, could not respond verbally or in writing, or an interpreter was needed but not available.

Added: June 2020

**Archived: June 2022**

**Question 2: When conducting the BIMS assessment with a patient if, for C0300C - Temporal Orientation; Day of the week, the patient's answer is the current date but not the day of the week would this be considered a correct answer?**

**Answer 2:** C0300C - Temporal Orientation; Day of the week asks the patient "What day of the week is today?" In order to code 1 - Correct, the patient must be able to report the correct day of the week. Reporting the date is not considered a day of the week.

Added: December 2021

**Archived: June 2022**

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

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

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

Added: December 2022

**Archived: March 2024**

## C0600

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

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

Added: June 2022

**Archived: March 2024**

## C1310

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

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

As stated in the Coding Instructions for C1310A - Acute Onset Mental Status Change, code 1 - Yes, if patient has an alteration in mental status observed in the assessment period or in the cognitive assessment (e.g., BIMS) that represents an acute change from baseline.

Examples of acute mental status changes:

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

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

Added: December 2022

**Archived: March 2024**

# Section D: Mood

## D0150

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

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

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

Added: June 2023

**Archived: March 2024**

# Section GG: Functional Abilities and Goals

## GG0100C

**Question 1: How should GG0100C - Prior functioning: Everyday Activities Stairs be coded if a patient uses a ramp to enter their home and does not use any other stairs?**

**Answer 1:** GG0100C - Prior functioning: Everyday Activities Stairs, identifies the patient's need for assistance with internal or external stairs (with or without a device such as a cane, crutch, walker, railing, or stair lift) prior to the current illness, exacerbation, or injury.

The activity being assessed in GG0100C is going "up and down the stairs." A ramp is not considered stairs for coding GG0100C.

If the patient was able to go up and down stairs prior to the current illness, exacerbation, or injury, code based on the amount of assistance the patient required to complete the activity.

If, even with assistance and/or devices, the patient was not able to go up and down stairs prior to the current illness, exacerbation, or injury, code 9 - Not Applicable.

Added: June 2021

**Archived: June 2022**

## GG0100C, GG0170M, GG0170N, GG0170O

**Question 1: We have a patient who used a stair lift to get from one level to another in her home prior to admission to our IRF.**

**How would this be coded for both prior function and for admission performance? Would Code 09 - Not applicable be appropriate; or would another code best fit this scenario?**

**Answer 1:** GG0100C - Prior Functioning: Everyday Activities Stairs identifies the patient's need for assistance with internal or external stairs prior to the current illness, exacerbation, or injury.

Completing the stair activity for GG0100C indicates that a patient went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment including a stair lift, and/or with or without some level of assistance.

For GG0170M - 1 Step (Curb), GG0170N - 4 Steps, and GG0170O - 12 Steps, completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (including cane, walker, railing, or stair lift) and with or without some level of assistance. Going up and down stairs by any safe means includes the patient walking up and down stairs on their feet or bumping/scooting up and down stairs on their buttocks.

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

Added: June 2021

**Archived: June 2022**

## GG0110

**Question 1: Should a transport chair be considered a "wheelchair" for GG0110 - Prior Device Use?**

**Answer 1:** The intent of GG0110 - Prior Device Use is to indicate which devices and aids were used by the patient prior to the current illness, exacerbation, or injury. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how prior device use applies for each individual patient.

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

Added: December 2020

**Archived: June 2022**

## GG0130, GG0170

**Question 1: For section GG what is the definition of "therapeutic intervention"?**

**Answer 1:** At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff. "*Prior to the benefit of services*" means prior to provision of any care by your facility staff that would result in more independent coding.

Please note that the term "*prior to the benefit of services*" replaces the term "therapeutic intervention" for the GG activities.

*At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance.*

Added: June 2020

**Archived: June 2022**

**Question 2: Establishing a goal is required for at least one self-care or mobility activity in section GG. Can the GG goals be changed once established during the first 3 days if the patient's status changes?**

**Answer 2:** The GG Self-care and Mobility Discharge Goals are used in the calculation of the Process Measure - Percentage of Patients with an Admission and Discharge Function Assessment and a Care Plan that Addresses Function. The measure reports, in part, that discharge goals were established, and does not take into consideration whether or not the goals were met. Once a goal

is established, there is no need to update it if circumstances change or additional information becomes available either within or after the 3-day assessment time period.

Added: June 2020

**Archived: June 2022**

**Question 4: The IRF-PAI manual for section GG clarifies that a Code 03 - Partial/moderate assistance indicates the helper is required to provide less than half the effort and a Code 02- Substantial/maximal assistance indicates the helper is required to provide more than half the effort. If a helper is required to provide exactly half the effort, how would the item be coded?**

**Answer 4:** In the situation described, the helper and patient each are providing exactly half of the effort to complete a GG activity. If the patient performs half of the effort, code the item 03- Partial/moderate assistance.

Added: June 2020

**Archived: June 2022**

**Question 5: On day 2, during an evaluation, the physical therapist feels the patient is unable to complete an activity such as sit to stand without providing therapy services; for example: skilled instruction on safe body mechanics for transfers or proper technique to maintain weight bearing restrictions. Is it appropriate to code 88 as the admission QI assessment of baseline functional status prior to benefiting from therapy services? PT initiates treatment by providing a walker, instructing in its use, and offering cues for proper technique. The patient performed sit to stand transfers with moderate assistance the rest of the day 2 and day 3.**

**Answer 5:** At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

For the admission assessment, the patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, prior to the benefit of services provided by your facility/staff.

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

Introducing a new device should not automatically be considered as "providing a service". Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility/staff.

Communicating the activity request (i.e., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely

complete the activity ("Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.

In your scenario, if even with assistance the patient was unable to perform the sit to stand activity prior to the benefit of services and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities use the appropriate "activity not attempted" code.

Added: June 2020

**Archived: June 2022**

## GG0130A

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

**Answer 1:** The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

At admission, the performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

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

Only use an "activity not attempted" code if the patient was not able to complete the activity prior to the benefit of services and the performance code cannot be determined based on patient/ caregiver report, collaboration with other facility staff, or assessment of similar activities.

Added: December 2020

**Archived: June 2022**

**Question 3: How would you code GG0130A - Eating for a patient who has been on tube feeding for years but is able to drink water independently?**

**Answer 3:** The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient. For a patient taking only fluids by mouth, the item may be coded based on ability to bring liquid to mouth, once the drink is placed in front of the patient.

When coding activities in Section GG, clinicians should code based on the patient's baseline ability during the 3-day assessment period. Allow the patient to perform the activity as independently as possible, as long as the patient is safe, regardless of the food consistency and regardless of how the patient performed the activity prior to the current illness, exacerbation, or injury.

In the scenario, if the patient is independently taking liquids by mouth, code 06 - Independent.

Added: March 2021

**Archived: June 2022**

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

**Answer 4:** The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient. The adequacy of the patient's nutrition or hydration is not considered for GG0130A - Eating.

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

Added: June 2022

**Archived: March 2024**

## GG0130B

**Question 1: A helper gathers and sets out the patient's oral hygiene items. The patient is able to brush their teeth with steadying assist from a helper while standing at the sink. What is the code for oral hygiene?**

**Answer 1:** The intent of GG0130B - Oral hygiene is to determine the patient's ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

When coding activities in Section GG, clinicians should code based on the type and amount of assistance required to complete the activity, allowing the patient to perform the activity as independently as possible, as long as they are safe.

In your scenario, if the patient standing at the sink requiring steadying assistance to brush their teeth represents the patient performing the activity as independently as possible, then code 04-Supervision or touching assistance for GG0130B - Oral hygiene.

Added: June 2020

**Archived: June 2022**

## GG0130C

**Question 1: A patient used a bedpan for both bowel and bladder and was able to lift and lower her hospital gown (no brief or underwear were stated to be present), and the patient was not able to perform any of her own perineal hygiene for bowel or bladder. How is Toileting hygiene coded?**

**Answer 1:** The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes before and after voiding or having a bowel movement.

In your scenario, code GG0130C - Toileting hygiene based on the type and amount of assistance required to complete the ENTIRE activity, including toileting hygiene and adjusting any clothing relevant to the individual patient (in this case lifting and lowering the hospital gown). If, in the assessing clinician's clinical judgment, the patient required a helper to provide less than half the effort then code 03 - Partial/moderate assistance; or if the patient required the helper to provide more than half the effort code 02 - Substantial/maximal assistance.

Added: June 2020

**Archived: June 2022**

**Question 2: If a patient is admitted to an IRF with a Foley catheter and does not have a bowel movement during the 3-day assessment period how should GG0130C - Toileting hygiene be coded? Would it be Code 88 - Not attempted due to medical conditions or safety concerns or can the nurse code the activity based on how much assistance the patient requires to manage the Foley bag?**

**Answer 2:** The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

The toileting hygiene activity can be assessed and coded regardless of the patient's need to void or have a bowel movement.

If a patient has a Foley catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site. It does not include management of the equipment.

If the patient has an indwelling urinary catheter and has bowel movements, code the toileting hygiene item based on the type and amount of assistance needed by the patient before and after moving his or her bowels. This may necessarily include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.

If a patient manages an ostomy, include wiping the opening of the ostomy or colostomy bag but not managing equipment for GG0130C - Toileting hygiene.

Added: June 2021

**Archived: June 2022**

**Question 3: How should GG0130C - Toileting hygiene be coded if a patient requires different types and amount of assistance after voiding versus after having a bowel movement?**

**Answer 3:** The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

When the patient requires different levels of assistance to perform toileting hygiene after voiding vs. after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity. This is true even in scenarios where GG0130C - Toileting hygiene is not completed entirely during one clinical observation.

Added: June 2021

**Archived: June 2022**

**Question 5: Should the assessment for GG0130C - Toileting hygiene include the patient's ability to maintain perineal hygiene and adjust clothing during episodes of both continence and incontinence?**

**Answer 5:** The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

For some patients, this may include assessing the type and amount of assistance needed to complete clothing management and hygiene tasks after episodes of incontinence as well.

Added: September 2023

**Archived: March 2024**

## GG0130E

**Question 1: If a patient is accustomed to washing their face when they perform grooming tasks and they do not wash their face again while bathing the rest of their body at another time during the day, is it acceptable to combine information to score bathing for item GG0130E?**

**Answer 1:** The intent of GG0130E - Shower/bathe self, is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). The activity does not include transferring in/out of tub/shower.

When a GG self-care activity is not completed entirely during one clinical observation (i.e., a patient washes their body in the shower and washes their face at the sink), then code based on the type and amount of assistance required to complete the ENTIRE bathing activity.

Added: June 2020

**Archived: June 2022**

**Question 2: We have a patient who agreed to shower with OT on day 2 of admission but would not let the OT help her at all after the tub transfer. The only thing the patient did was wet her body and wash her abdomen. She would not let the therapist complete tasks for thoroughness and cleaning. Could she still be coded as 03 - Partial/moderate assistance because she completed less than half the tasks? OT does not want to put her at supervision level because she did not perform well.**

**Answer 2:** The intent of GG0130E - Shower/bathe self, is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). The activity does not include transferring in/out of tub/shower.

If the patient only wets her body and washes her abdomen and does not have a complete bath during the entire 3-day assessment period, use clinical judgment to determine if the assessment based on the partial bath can represent the patient's bathing ability. If so, code the bathing activity based on the type and amount of assistance the patient required to complete the partial bath.

If, using clinical judgment, it is determined that the partial bath does not represent the patient's ability to shower/bathe and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities, use the appropriate "activity not attempted" code.

Added: June 2020

**Archived: June 2022**

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

**Answer 3:** The intent of GG0130E - Shower/bathe self, is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). The activity does not include transferring in/out of tub/shower.

When coding any of the self-care or mobility activities in Section GG, clinicians should code what occurs at the time of the assessment and allow the patient to perform the activity as independently as possible, as long as the patient is safe, regardless of how the patient performed the activity prior to the current illness, exacerbation, or injury.

Added: June 2020

**Archived: March 2024**

**Question 4: For GG0130E - Shower/bathe self, does the shower/bathing have to be an actual wet shower or bath, or can a simulated performance be scored?**

**Answer 4:** The intent of GG0130E - Shower/bathe self is to assess the patient's ability to wash, rinse, and dry self (excluding washing of back and hair), regardless of where the bathing takes place. It does not include transferring in/out of a tub/shower, or onto or off a tub bench.

Coding of an activity may be based on observation, patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.

Use clinical judgment to determine if simulating the shower/bath allows the clinician to adequately assess the patient's ability to complete the activity of shower/bathe self (GG0130E). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the shower/bathing activity.

Added: September 2020

**Archived: June 2022**

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

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

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

Added: December 2020

**Archived: June 2022**

## GG0130F, GG0130G, GG0130H

**Question 1: A patient can dress her upper body, except for requiring assistance with her bra clasp. Should the code be 04-Supervision or touching assistance, or 03-Partial/moderate assistance?**

**Answer 1:** If a patient requires assistance with dressing including assistance with any type of fasteners (e.g. with buttons, zippers and/or fastening a bra) code based on the type and amount of assistance required to complete the entire upper body dressing activity. If a patient requires assistance with fasteners and a helper provides less than half the effort code 03 - Partial/moderate assistance. Note that this is a change from previous guidance that considered buttons and/or fasteners as incidental help, which was previously coded as 04 - Supervision or touching assistance.

Added: June 2020

**Archived: June 2022**

## GG0130G, GG0130H

**Question 1: It is my understanding that donning/doffing an ankle foot orthosis (AFO) is included with GG0130H - Putting on/taking off footwear. For a patient using a knee ankle foot orthosis (KAFO), is this also included with GG0130H - Putting on/taking off footwear, or would this be considered part of GG0130G - Lower body dressing since it includes both the foot, knee, and the upper leg?**

**Answer 1:** For GG0130H - Putting on/taking off footwear, consider any item/device that covers all or part of the foot as footwear, even if it extends up the leg. Do not also consider any required assistance with the item/device when coding GG0130G - Lower body dressing.

Added: June 2021

**Archived: June 2022**

## GG0130G

**Question 1: If a patient is wearing a hospital gown and underwear the first time a functional assessment is conducted, is this scenario acceptable to rate lower body dressing? Or if on the following day during the assessment period, if the patient is wearing more items including underwear and shorts/pants, should we use this scenario instead as a true baseline of their lower body dressing ability?**

**Answer 1:** The intent of GG0130G - Lower body dressing is to assess the patient's ability to dress and undress below the waist, including fasteners, if applicable.

At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

Use clinical judgment to determine if observing the patient dress and undress in the lower body clothing item (i.e. underwear) worn during the first assessment allows the clinician to adequately assess the patient's ability to complete the activity of lower body dressing (GG0130G). If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient required to complete the activity.

Added: June 2020

**Archived: June 2022**

## GG0130H

**Question 1: As the definition of "Footwear" states that it "includes the ability to put on and take off socks and shoes", how should coding occur when only one of these items (socks or shoes) is worn by the patient?**

**Answer 1:** The intent of GG0130H - Putting on/taking off footwear is to determine a patient's ability to put on and take off socks and shoes or other footwear.

GG0130H - Putting on/taking off footwear is assessed with 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 GG0130H - Putting on /taking off footwear, may be coded. If the patient's socks are not considered safe for mobility, and the patient does not have shoes available, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities, then code the appropriate "activity not attempted" code.

If the patient wears shoes that are safe for mobility, but does not wear socks, then GG0170H - Putting on/taking off footwear, may be coded.

Added: June 2020

**Archived: June 2022**

## GG0170J

**Question 1: When assessing GG0170J - Walk 50 feet with two turns, can the two turns be combined, or should they be completed at different times during the 50 feet?**

**Answer 1:** The intent of GG0170J - Walk 50 feet with two turns is to assess the patient's ability to ambulate 50 feet with two turns once in a standing position.

The turns included in GG0170J are 90-degree turns. The turns may occur at any time during the 50-foot distance.

Added: September 2023

**Archived: March 2024**

## GG0170

**Question 1: Please provide guidance for discharge IRF-PAI coding in this scenario: A patient is scheduled to be discharged on a Tuesday. On the preceding Friday, the patient participates in strengthening exercises. On Saturday, the patient is in dialysis. On Sunday, the patient's family visits and decides to take the patient home right away, and the patient is discharged before a discharge assessment is completed. All discharge self-care items can be coded because the patient performed them with nursing staff. However, the patient was last assessed performing the walking and stair activities on Thursday – 4 days prior to discharge – and walked 50 feet with 2 turns and negotiated 4 steps independently. Can the assessment for those items be used to code the IRF-PAI, based on the above-described circumstances? It seems that coding a dash or a Not Attempted code would not accurately represent the patient's true baseline status.**

**Answer 1:** In the scenario you describe, it appears that you know the patient's performance level for ambulation and on stairs from 4 days prior to discharge but the patient has not completed the walking or the stair activities since that time.

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

If based on the guidance stated above you are able to determine the patient's discharge ability in conjunction with all current discharge assessment findings, then code the walking and stair activities with the performance code that best represents the type and amount of assistance needed at discharge to safely complete the activity.

Added: September 2020

**Archived: June 2022**

## GG0170C

**Question 1: How do we code lying to sitting on side of bed for a bilateral amputee not wearing their prosthetics, since the definition states "with feet on floor"?**

**Answer 1:** If the patient with a unilateral (or bilateral) lower extremity amputation does not have or is not wearing a prosthesis (or prostheses), use clinical judgment to determine if the patient completes the activity (Lying to sitting on side of bed without back support). Code the activity based upon the type and amount of assistance the patient requires to safely complete the activity.

Added: June 2020

**Archived: June 2022**

## GG0170F

**Question 1: If a patient gets up off the side of the bed, walks to the bathroom, and then sits down on the toilet, is the effort necessary to lift up off the bed considered for coding GG0170F - Toilet transfer?**

**Answer 1:** The intent of GG0170F - Toilet transfer is to assess the patient's ability to get on and off a toilet (with or without a raised toilet seat) or commode once the patient is at the toilet or commode.

In the scenario described, the effort necessary to lift up off the bed does not count toward the toilet transfer in GG0170F - Toilet transfer.

Added: September 2020

**Archived: June 2022**

**Question 2: A patient completes a toilet transfer requiring only supervision. As he was ambulating with contact guard assistance back to his bed he lost his balance and required assistance to steady himself. Would the contact guard assist and assistance to steady himself be considered in determining the performance code for GG0170F - Toilet transfer?**

**Answer 2:** The intent of GG0170F - Toilet transfer is to assess the patient's ability to get on and off a toilet (with or without a raised toilet seat) or commode once the patient is at the toilet or commode.

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

Added: December 2020

**Archived: June 2022**

## GG0170G

**Question 2: If at discharge we assess the patient getting into their car to leave our facility, can we code this OR do we have to see transfers both in and out of car in order to code?**

**Answer 2:** The intent of GG0170G - Car transfer is to assess the patient's ability to transfer in and out of a car seat or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

Code the patient's functional status based on a functional assessment that occurs at discharge. The function scores are to reflect the patient's discharge status, and are to be based on observation of activities, to the extent possible.

The assessing clinician may combine general observation, assessment of similar activities, patient/caregiver(s) report, collaboration with other facility staff, and other relevant strategies to complete any and all GG items, as needed.

If, using clinical judgment, it is determined that the patient status for transferring into the car at discharge adequately represents the patient's discharge ability to transfer in and out of a car, this could be used for the coding of GG0170G - Car Transfer.

Added: June 2020

**Archived: June 2022**

**Question 3: What constitutes set-up/clean-up assistance for GG0170G - Car transfer? The guidance says it does not include the ability to open/close a door or fasten a seat belt. What, then, is set-up or clean-up assistance for a car transfer?**

**Answer 3:** The intent of GG0170G - Car transfer is to assess the patient's ability to transfer in and out of a car or van on the passenger side. As you mention, the item does not include the ability to open/close a door or fasten a seat belt.

Code 05 - Set-up or clean-up assistance is selected when a patient requires a helper to set up or clean up; patient completes the activity and the helper is required to assist only prior to or following the activity.

An example of set-up or clean-up assistance with a car transfer is a caregiver who folds a walker and places it in the back seat after the patient transfers into the car, then retrieves the walker and sets it up for the patient prior to the patient transferring out of the car. If the patient requires the set-up (or clean-up) of this walker in order to complete the car transfer, but no assistance is needed during the completion of the activity, Code 05 - Set-up/clean-up assistance would be appropriate.

Use clinical judgment to determine if the assistance the patient requires from a helper before or after the car transfer meets the definition of set-up or clean-up as above. If it does, and the patient requires no further assistance to complete the car transfer activity, code GG0170G as 05 - Set-up/Clean-up.

Added: September 2020

**Archived: June 2022**

**Question 4: Has CMS offered any new guidance on functional activities that cannot be assessed due to a patient having COVID-19? Specifically interested in car transfers. We have our COVID-positive patients on isolation in their rooms and are unable to assess them using the car simulator. Are we able to simulate a car transfer using a mat to assess this item?**

**Answer 4:** The intent of GG0170G - Car transfer is to assess the patient's ability to transfer in and out of a car or van seat on the passenger side.

The performance code is to reflect the patient's baseline ability to complete the activity, and is based on observation of activities, to the extent possible. The assessing clinician may, as needed, combine general observation, assessment of similar activities, patient/caregiver report, collaboration with other facility staff, and other relevant strategies to complete all GG items.

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

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

Added: December 2020

**Archived: June 2022**

**Question 5: Can you code GG0170G - Car transfer with a performance code if the patient transfers into the back seat or into a long sitting position because of medical restrictions?**

**Answer 5:** The intent of GG0170G - Car transfer is to assess the patient's ability to transfer in and out of a car or van on the passenger side.

Clinical judgment may be used to determine if a transfer in and out of the back seat is an acceptable alternative to meet the intention of this activity. The car transfer could still be completed while accommodating medical restrictions such as long sitting.

Added: March 2021

**Archived: June 2022**

**Question 7: If a wheelchair-bound patient independently uses a wheelchair ramp/lift to transfer into a van, how should GG0170G - Car transfer be coded?**

**Answer 7:** The intent of item GG0170G - Car transfer focuses on transferring into and out of a car or van seat. If the patient remains in the wheelchair, and did not transfer into or out of a car or van seat, then the activity is not completed.

In your scenario select the appropriate "activity not attempted" code depending on if the patient was able to complete the car transfer prior to the current illness, exacerbation, or injury.

Added: June 2021

**Archived: June 2022**

**Question 8: Question 9 of the September Quarterly Q&As (GG0170G Q3 of the IRF Q&As March 2021) provided examples of setup/clean-up for GG0170G - Car transfer. One example given was a helper folding a walker and putting it in the back seat of the car after the transfer. The question we have now is what if the walker was not needed for the car transfer itself. Is putting the walker in the back seat still counted if the patient did not use it for the car transfer?**

**Answer 8:** The intent of GG0170G - Car transfer is to assess the patient's ability to transfer in and out of a car or van on the passenger side. The item does not include the ability to open/close a door or fasten a seat belt.

The setup and/or clean-up of an assistive device that is used for walking to and from the car, but not used for the transfer in and out of the car seat, would not be considered when coding the car transfer activity.

The required setup and/or clean-up of an assistive device that is used for the transfer in and out of the car seat would be considered when coding the car transfer activity.

Code GG0170G based on the type and amount of assistance that the patient requires to transfer in and out of the car seat.

Added: June 2021

**Archived: June 2022**

## GG0170I, GG0170J, GG0170K, GG0170L

**Question 4: At discharge, if it is not recommended that a patient ambulate when they return home because it is not functional for them, or if a discharge goal was not selected for an activity, should the GG walking activities still be assessed and coded with a performance code or should an "activity not attempted" code be used?**

**Answer 4:** Assessment of the GG self-care and mobility items is based on the patient's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking may be assessed for a patient who did/does/will use a wheelchair as their primary mode of mobility).

At discharge, code based on the patient's ability to complete each activity regardless of whether a goal was established for that activity at admission.

If the patient is able to complete a walking activity with the assistance of one or two people, code based on the type and amount of assistance required even if walking is not being recommended or used as a functional mode of mobility.

If based on the guidance stated above, you are unable to determine the patient's discharge ability in conjunction with all current discharge assessment findings or the patient is not able to complete a walking activity safely even with the assistance of two people, code using the appropriate "activity not attempted" code.

Added: June 2021

**Archived: June 2022**

## GG0170I

**Question 1: How would you code a situation where the patient walks part of the distance, say 4 feet, and then the helper carries them the remaining distance to get to the 10 feet needed for GG0170I - Walk 10 feet? Would this be a Code 02 - Substantial/maximal assistance because the helper is carrying the patient the majority of the distance? We understand that with the wheelchair activities a helper can complete the distance needed by pushing the patient in the wheelchair. Is this also true for the walking items?**

**Answer 1:** The intent of the walking item GG0170I - Walk 10 feet is to assess the type and amount of assistance a patient requires to ambulate 10 feet once in a standing position.

Since a helper cannot complete a walking activity for a patient, the walking activities cannot be considered completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance.

In your scenario, where the patient participates in walking 4 feet and then requires the helper to carry them for further distances, the activity walking 10 feet (GG0170I) is not considered completed. If the stated distance of 10 feet was not walked by the patient, with or without some

level of assistance, GG0170I would be coded with one of the "activity not attempted" codes, for example 88-Not attempted due to the medical condition or safety concerns.

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

Added: June 2020

**Archived: June 2022**

## GG0170M, GG0170N, GG0170O

**Question 2: I have a question about how to code a specific scenario. A patient did NOT perform stairs prior to this illness, exacerbation, or injury due to frequent falls and fear of falling; however, during the evaluation, the patient told the therapist she has a goal to do stairs because her daughter recently moved into a house with 2 stairs to enter. The therapist felt it was unsafe to perform stairs within the first 3 days of the IRF stay but thought it would be a reasonable goal for the patient to perform 1-2 steps, with assistance, at discharge. Should we code the admission performance with a Code 09 - Not applicable or Code 88 - Not attempted due to medical condition or safety concerns, and if we use an activity not attempted for the performance code, how do we code the discharge goal?**

**Answer 2:** The intent of the GG step activities is to assess the patient's ability to go up and down 1 step/curb, 4 steps, and 12 steps with or without a railing.

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

The definitions of Code 88 and Code 09 are as follows:

Code 88 - Not attempted due to medical condition or safety concerns if at the time of assessment, the patient is unable to complete the stair activities due to medical conditions/safety concerns but could perform the activities prior to the current illness, exacerbation, or injury.

Code 09 - Not applicable if at the time of assessment if the patient is unable to complete the stair activities due to medication conditions/safety concerns and could not perform the activities prior to the current illness, exacerbation, or injury.

If the admission performance of an activity was coded using one of the "activity not attempted" codes, a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.

Added: September 2020

**Archived: June 2022**

## GG0170M

**Question 1: A question has come up regarding when it is appropriate to use Code 09 - Not applicable for functional tasks such as a curb/step and stairs. If a patient has a ramp at home used to enter the home due to past medical issues would we use Code 09 - Not applicable? Or do we use Code 88 – Not attempted due to medical conditions or safety concerns?**

**Answer 1:** The intent of GG0170M - 1 step (curb) is to assess the patient's ability to go up and down a curb and/or up and down one step. If, at the time of the assessment, the patient is unable to complete the activity and the performance cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities use the appropriate "activity not attempted" code.

Code 88 - Not attempted due to medical conditions or safety concerns indicates the patient performed the activity prior to the current illness, exacerbation, or injury, but does not perform the activity at the time of assessment due to a medical issue or safety concern.

Code 09 - Not applicable indicates that the patient did not perform the activity prior to the current illness, exacerbation, or injury and the patient does not perform the activity at the time of assessment.

Added: September 2020

**Archived: June 2022**

## GG0170N, GG0170O

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

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

Added: June 2020

**Archived: March 2024**

**Question 2: For the GG stair activities is a patient permitted to take a seated rest at the top of a staircase, prior to descending, and still have the stair activity be considered as completed?**

**Answer 2:** For GG0170N - 4 steps and GG0170O - 12 steps, code based on the type and amount of assistance required for the patient to go up and down 4 steps and 12 steps by any safe means, with or without any assistive devices (for example, railing or stair lift).

Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up and down stairs occurs sequentially, the patient may take a rest break between ascending and descending the 4 steps or 12 steps.

Added: June 2021

**Archived: June 2022**

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

**Answer 3:** Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up and down stairs, by any safe means, occurs sequentially, the patient may take a rest break between ascending and descending the 4 steps or 12 steps.

While a patient may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means without taking more than a brief rest break in order to consider the stair activity completed.

Added: March 2022

**Archived: March 2024**

## GG0170Q

**Question 1: We have a question regarding the appropriate scoring for an IRF patient who does not use a wheelchair during the admission assessment, but then begins to use a wheelchair later during the IRF stay. Our system software will not allow us to upload goals after the 3-day admission assessment has ended. When a patient does begin using a wheelchair later in the stay, would it be appropriate to go back to the initial wheelchair assessment on the IRF-PAI and change GG0170Q to "YES" and add the corresponding goals even though they were established after the admission assessment has ended?**

**Answer 1:** The intent of GG0170Q - Does the patient use a wheelchair and/or scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. Only code 0-No if, at the time of the assessment, the patient does not use a wheelchair or scooter under any condition.

If, at the time of admission, GG0170Q is answered "No" correctly, and following the admission assessment period the patient begins to utilize a wheelchair, there is no need to update the admission performance and/or discharge goals for GG0170 activities on the admission IRF-PAI. The gateway wheelchair item (GG0170Q1 and GG0170Q3) might not be coded the same on the admission and discharge assessments.

If, at the time of admission, GG0170Q was answered incorrectly then corrections to the admission IRF-PAI should be made following Federal, State, and facility policy guidelines.

Added: June 2020

**Archived: June 2022**

**Question 2: If a patient utilizes a wheelchair for mobility and is able to wheel 50 feet with 2 turns but is unable to wheel 150 feet (code 07, 09, 10, 88) , how should we code items GG0170S/SS1? There is not a skip pattern if one of the "activity not attempted" codes are used for GG0170S, and the guidance on the IRF-PAI states for GG0170SS1 to "Indicate the type of wheelchair or scooter used." Selecting one or the other does not feel logical but using a dash [-] impacts compliance with the IRF QRP.**

**Answer 2:** You are correct that there is no skip pattern for GG0170S/SS1 unless GG0170Q1 is answered "no." However, for the wheelchair items, a helper can assist the patient to complete the activity or make turns if required. Therefore, if the patient is unable to wheel the entire distance with or without assistance the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required to complete the entire activity.

If, in your scenario, the patient was unable to complete the 150 feet themselves, GG0170S - Wheel 150 feet could still be coded with a performance code based on the type and amount of assistance required to complete the entire activity. Then GG0170SS1 could indicate the type of wheelchair used.

Added: June 2021

**Archived: June 2022**

## GG0170R

**Question 1: When assessing GG0170R - Wheel 50 feet with two turns, can the two turns be combined, or should they be completed at different times during the 50 feet?**

**Answer 1:** The intent of GG0170R - Wheel 50 feet with two turns is to assess the patient's ability, once seated in wheelchair/scooter, to wheel at least 50 feet and make two turns.

The turns included in GG0170R are 90-degree turns. The turns may occur at any time during the 50-foot distance.

Added: September 2023

**Archived: March 2024**

## GG0170R, GG0170S

**Question 1: Regarding Section GG Wheelchair Items, does the activity of wheeling 50 feet with 2 turns need to be done independent of the activity of wheeling 150 feet?**

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

**Answer 1:** The intent of GG0170R - Wheel 50 feet with two turns is to assess the patient's ability, once seated in wheelchair/scooter, to wheel at least 50 feet and make two turns.

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

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

At Admission, the performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

The patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely. The item would then be coded based on the type and amount of assistance required, prior to the benefit of services provided by your facility staff.

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

Introducing a new device should not automatically be considered as "providing a service". Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility.

Added: December 2020

**Archived: June 2022**

## GG0170S

**Question 1: A patient was able to propel his wheelchair for 100 feet with moderate assistance. He was unable to go farther and the therapist pushed the wheelchair the rest of the way to the gym, which was a total of 150 feet. What score would you give this patient for GG0170S - Wheel 150 feet?**

**Answer 1:** The intent of GG0170S - Wheel 150 feet is to assess the patient's ability, once seated in wheelchair/scooter, to wheel at least 150 feet. If the patient is unable to complete the entire distance required for this activity the assessing clinician can assist the patient to complete the activity, and code this item based on the type and amount of assistance required to complete the entire activity.

In your example, the patient completed wheeling 100 feet of the 150 feet with moderate assistance; and required the helper to complete the remaining distance. Use clinical judgment to determine if the patient required the helper to provide less than half the effort (then Code 03-Partial/moderate assistance); or if the patient required the helper to provide more than half the effort (then Code 02-Substantial/maximal assistance).

Added: June 2020

**Archived: June 2022**

# Section H: Bladder and Bowel

## H0350

**Question 1: Please clarify the use of the code 4 - Always incontinent for H0350 - Bladder Continence. The coding instructions state that this code is used if during the 3-day assessment period the patient had no continent voids. What if during the 3-day assessment period the patient has no continent episodes because the patient was catheterized during some portion of the 3-day assessment period?**

**Answer 1:** The intent of H0350 - Bladder Continence is to gather information on bladder continence. Code 4 - Always Incontinent is applicable when the patient had no continent voids and did not require the use of any type of catheter at any time during the 3-day assessment period.

Added: December 2020

**Archived: June 2022**

**Question 2: How would the following scenarios for H0350 - Bladder Continence be coded?**

**Scenario 1**

**Day 1: One intermittent catheterization, no other bladder episodes**

**Day 2: Foley was placed, no other bladder episodes**

**Day 3: Foley remained in place the entire day**

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

**Scenario 2**

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

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

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

**Answer 2:** The intent of H0350 - Bladder Continence is to gather information on bladder continence. Incontinence refers to the involuntary loss of urine, when there is a loss of control of the evacuation of urine from the bladder, regardless of whether clothing or linens are soiled.

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

Added: December 2020

**Archived: June 2022**

## H0400

**Question 1: If a patient only has one bowel movement during the admission assessment period, and that bowel movement is incontinent, how would H0400 be coded? With the current verbiage in the IRF-PAI manual, it meets the definition of two scores; Code 3 (because all bowel episodes were incontinent) and Code 1 (because the patient only had one bowel movement). There was a reference from a training in 2016 that states the scenario would be coded as Code 1-Occasionally incontinent. Is this still true?**

**Answer 1:** The intent of H0400 - Bowel Continence is to gather information on the frequency of bowel continence during the 3-day assessment period. Code 1-Occasionally incontinent should only be selected if during the 3-day assessment period the patient was incontinent for bowel movement once. This includes incontinence of any amount of stool at any time. Code 3-Always incontinent is selected if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).

If a patient has only one bowel movement that was incontinent during the 3-day assessment period, and there were no episodes of continent bowel movements, then Code 3-Always incontinent.

*At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance.*

Added: June 2020

**Archived: June 2022**

# Section J: Health Conditions

## J0520

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

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

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

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

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

Added: September 2022

**Archived: March 2024**

## J1800, J1900

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

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

Added: September 2022

**Archived: March 2024**

## J1900

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

**the time the patient left the IRF or coded using additional information from the acute-care hospital?**

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

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

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

Added: June 2023

**Archived: March 2024**

# Section K: Swallowing/Nutritional Status

## K0520

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

### Admission

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

### Discharge

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

**Answer 1:** The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

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

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

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

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

Added: December 2022, Edited: June 2023

**Archived: March 2024**

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

**Answer 2:** The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

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

Added: December 2022

**Archived: March 2024**

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

**Admission**

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

**Discharge**

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

**Answer 6:** The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

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

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

At discharge for column 4 - Last 7 days, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the last 7 days, even if not used in the last 7 days. At discharge for column 5 - At Discharge, check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, even if not used during the 3-day discharge assessment time period.

Added: June 2023

**Archived: March 2024**

## K0110

**Question 1: How should K0110 - Swallowing/Nutritional Status be coded if a patient is on a liquid diet or a mechanical soft consistency diet due to reasons other than difficulty with eating and/or swallowing? Some examples might include a patient who is on a liquid or modified consistency diet following bariatric surgery, or a patient on a liquid or modified consistency diet who is recovering from an acute case of diverticulitis. Would the correct code be A. Regular food or B. Modified food consistency/supervision?**

**Answer 1:** For item K0110 - Swallowing/Nutritional Status, coding should reflect the patient's status due to swallowing ability only. Therefore do not check B. Modified food consistency/

supervision if a patient requires a modified consistency diet or liquid diet due to a medical reason not related to swallowing.

Added: March 2021

**Archived: June 2022**

# Section M: Skin Conditions

## M0210, M0300

**Question 1: How would the following scenario be coded: A patient is admitted to a facility with one deep tissue injury (DTI) on the sacrum. A second DTI develops during the stay. A week after admission the patient is discharged emergently and does not return to the facility. Upon completion of the discharge assessment it is determined that there was no skin assessment completed during the 3-day discharge window but one was completed 3 days prior to discharge. How would M0210 - Unhealed Pressure Ulcers/Injuries and M0300 – Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage be coded?**

**Answer 1:** In the scenario described it appears that the stages of the two pressure ulcers/injuries are known from 3 days prior to discharge but a full skin assessment has not been completed within the 3-day assessment period. If using this information in conjunction with all current discharge assessment findings you are able to determine the appropriate stage of the pressure ulcers/injuries, then code Section M based on this information. If there is no information available enter a dash (-) for M0210 - Unhealed Pressure Ulcers/Injuries and M0300 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.

Added: March 2021

**Archived: June 2022**

## M0300

**Question 1: I am seeking guidance on how to complete the IRF-PAI accurately in this scenario. Patient is admitted with an Unstageable - Deep Tissue Injury on his right heel. On discharge, the nurse's assessment of the patient right heel was that DTI had become Unstageable - due to the presence of eschar. How do we code M0300 at Discharge?**

**Answer 1**: For each pressure ulcer/injury observed at discharge, consider current and historical levels of tissue involvement. Discharge coding for the scenario described is dependent upon the clinical progression of the wound during the IRF stay.

If the DTI noted at admission, does not evolve to be numerically stageable and becomes unstageable due to eschar or slough at the time of discharge, code at Discharge as follows:

M0300F1. Unstageable - Slough and/or eschar = 1

M0300F2. Unstageable - Slough and/or eschar = 1

M0300G1. Unstageable - Deep tissue injury = 0

M0300G2. Unstageable - Deep tissue injury = skip

However, any pressure ulcer/injury that is observed to be unstageable due to slough and/or eschar at the time of discharge, but was previously numerically stageable, is considered new, and not coded as present at admission on the discharge assessment.

Added: June 2020

**Archived: June 2022**

**Question 2: Is a pressure ulcer that was present when the first skin assessment was completed then healed during the stay and reopened at the same stage or less during the same stay, considered "present on admission" when completing the discharge assessment?**

**Answer 2**: If a patient has a pressure ulcer that was documented on admission, and at discharge is documented at the same stage, it would be considered as "present on admission". This guidance is true even if during the stay the original pressure ulcer healed and reopened.

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

Added: December 2020

**Archived: June 2022**

**Question 3: A patient is admitted Monday evening by the admissions nurse and no pressure ulcers/injuries are documented at that time. The next day the wound nurse assesses the patient's spinal incision and notices a stage 2 pressure ulcer on coccyx. Is this pressure ulcer considered "present on admission" or facility acquired?**

**Answer 3:** The intent of the items in Section M - Skin Conditions is to document the presence, appearance, and change of pressure ulcers/injuries.

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

The pressure ulcer items should be coded based on findings from the first skin assessment that is conducted on or after, and as close to the admission as possible.

Added: December 2020

**Archived: June 2022**

**Question 4: I am looking for clarification in regard to coding of a wound. A patient is admitted with a Deep Tissue Injury (DTI). During the stay the DTI opens, and at discharge presents as two distinct openings, each appearing as a stage 3 pressure ulcer. For the discharge IRF-PAI should the wound be coded as one DTI - "present on admission" or as two stage 3 pressure ulcers - also "present on admission"?**

**Answer 4:** If at discharge the patient has two stage 3 pressure ulcers, code M0300C1 - Number of Stage 3 pressure ulcers as 2. Assuming no other pressure ulcers/injuries are present at discharge, M0300G1 - Unstageable Pressure Injuries Presenting as Deep Tissue Injury = 0.

If both stage 3 pressure ulcers present at discharge evolved from the DTI that was present at admission they would be considered "present on admission" and M0300C2 - Number of these Stage 3 pressure ulcers that were present upon admission = 2. This is because they were both numerically staged as a stage 3 when first numerically stageable.

Added: September 2021

**Archived: June 2022**

**Question 5: I have a question about the current guidance that states: If a pressure ulcer/injury is surgically closed with a flap or graft, it should be considered a surgical wound and not a pressure ulcer/injury. If the flap or graft fails, it should still be considered a surgical wound until healed.**

**Is this in reference to ANY point in time that the flap/graft fails? For example, if the area of flap/graft has been 100% re-epithelized greater than 30 days and patient subsequently develops a wound due to pressure at the site of the original flap/graft, would it be still considered failed surgical site or would it be considered a pressure ulcer/injury?**

**Answer 5:** If a pressure ulcer was closed with a skin graft, the surgical wound healed, and another wound forms in the same anatomical location due to pressure, then this would be considered a pressure ulcer/injury. Note it should be staged at the highest stage the pressure ulcer/injury was prior to closure, unless currently presenting at a higher stage or unstageable.

Added: December 2021

**Archived: June 2022**

# Section N: Medications

## N0415

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

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

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

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

When coding N0415, determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). If Column 1 is checked (patient is taking a medication in drug classification), review patient documentation to determine if there is a documented **patient-specific** indication for all medications in the drug class (Column 2).

When coding N0415, consider a medication that is included in the patient's prescribed drug regimen even if it is not taken during the 3-day assessment period.

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

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

Added: September 2022

**Archived: March 2024**

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

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

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

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

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

Added: December 2022

**Archived: March 2024**

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

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

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

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

Added: March 2023

**Archived: March 2024**

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

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

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

Added: March 2023

**Archived: March 2024**

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

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

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

Added: March 2023

**Archived: March 2024**

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

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

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

Added: June 2023

**Archived: March 2024**

# Section O: Special Treatments, Procedures, and Programs

## O0110

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

**Answer 1:** The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

Check all treatments, programs, and procedures that are part of the patient's current care/treatment plan during the 3-day admission (or 3-day discharge) assessment time period. Include treatments, programs, and procedures performed by others and those the patient performed themself independently or after setup by facility staff or family/caregivers. Check treatments, procedures, and programs that are performed in the care setting, or in other settings (e.g., dialysis performed in a dialysis center).

At discharge O0110 considers special treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, and not what is expected to occur after discharge.

Added: September 2022

**Archived: March 2024**

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

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

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

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

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

Added: December 2022

**Archived: March 2024**

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

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

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

Added: March 2023

**Archived: March 2024**

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

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

Added: March 2023

**Archived: March 2024**

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

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

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

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

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

Please note the following exclusions:

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

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

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

Added: March 2023

**Archived: March 2024**