INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM WEBINAR TRAINING ON AUGUST 15, 2017

Current as of October 2017

#	Question Category	Question	Response
1	General	Will there be a recording of this webinar? We have personnel who were not available for today's presentation.	A video recording of this event will be posted to the Centers for Medicare & Medicaid Services (CMS) YouTube website. Spotlight and Training Announcements will be posted to the inpatient rehabilitation facility (IRF) Quality Reporting Program (QRP) website when the video is available.
2	General	Is there a website where we can access this PowerPoint? This has been very helpful, and I would like to distribute it to those who were not able to attend.	A PDF of the presentation (with and without answers) is posted on the IRF Quality Reporting Training website, in the Downloads section.

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3	Section C	If a patient returns to acute care prior to completing the Brief Interview for Mental Status (BIMS) Assessment, how should the coding of Section C be handled?	If a patient is in the IRF for fewer than 3 days (incomplete stay), code Section C items to the best of your abilities. If, during the patient's stay, the patient was rarely or never understood because of a medical condition: 1. Code C0100 – Should Brief Interview for Mental Status (C0200–C0500) Be Conducted? as 0, No. 2. Skip to C0900 – Staff Assessment for Mental Status – Memory/Recall Ability. 3. Complete item C0900 by checking all that the patient was normally able to recall. If the BIMS should have been attempted but was not, code Section C as follows: 1. Indicate that the BIMS should have been conducted by coding C0100 as 1, Yes. 2. Enter dashes for each of the BIMS items (C0200, C0300ABC, C0400ABC). 3. Enter a dash for item C0500 – BIMS Summary Score. 4. Code C0600 as 1, Yes. 5. Complete C0900 Staff Assessment for Mental Status. CMS recently posted a document that provides information regarding those items necessary to calculate the IRF QRP assessment-based measures (used for compliance determination) and those items used only for risk adjustment (not used for compliance determination). This document can be found at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-QRP-Technical-Specifications-for-Reporting-Assessment-Based-Measures.pdf.

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4	Section C	If a facility's practice is to assess the BIMs during the Occupational Therapist (OT) evaluation, and the patient returns to acute care prior to the assessment, how do you score Section C (BIMs or Staff Assessment)?	If, during the patient's stay, the patient was rarely or never understood because of a medical condition during the 3-day assessment period: 1. Code C0100 – Should Brief Interview for Mental Status (C0200–C0500) Be Conducted? as 0, No. 2. Skip to C0900 – Staff Assessment for Mental Status – Memory/Recall Ability. 3. Complete item C0900 by checking all that the patient was normally able to recall. If the BIMS should have been attempted but was not, code Section C as follows: 1. Indicate that the BIMS should have been conducted by coding C0100 as 1, Yes. 2. Enter dashes for each of the BIMS items (C0200, C0300ABC, C0400ABC). 3. Enter a dash for item C0500 – BIMS Summary Score. 4. Code C0600 as 1, Yes. 5. Complete C0900 – Staff Assessment for Mental Status. CMS recently posted a document that provides information regarding those items necessary to calculate the IRF QRP assessment-based measures (used for compliance determination) and those items used only for risk adjustment (not used for compliance determination). This document can be found at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-QRP-Technical-Specifications-for-Reporting-Assessment-Based-Measures.pdf.

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5	Section GG	If a patient has a new diagnosis of bilateral below-the-knee amputations, how do we code putting on/taking off footwear?	If the patient has a new medical diagnosis of bilateral below-the-knee amputations and does not use prosthetic devices during the assessment period, then code GG0130H - Putting On/Taking Off Footwear as 88, Not Attempted Due to Medical Condition or Safety Concerns. Code 09 is used to indicate that the patient does not perform the activity at the time of the assessment, and the patient did not perform the activity before the current illness, injury, or exacerbation. If the patient's condition is new, code this item as 88, Not Completed Due to Medical Condition or Safety Concerns. For item GG0130G – Lower Body Dressing, coding would include the amount of assistance the patient needs to put on or take off stump socks/pressure garments that are to be applied by the patient and worn on his/her lower extremities.
6	Section GG	When you mentioned that a code 09 could be used for car transfers and for uneven surfaces if equipment is not available, are you referring to admission, discharge, or both?	For item GG0170G – Car Transfer, use of an outdoor car, indoor car, or simulator can be used to simulate outdoor car transfers. These half or full cars would need to have physical features similar to those of a real car (i.e., a car seat within a car cabin) to simulate a car transfer. If the facility does not have an indoor car, simulator, or access to an outdoor car during the 3-day assessment period, then the item would be coded 09, Not Applicable. This applies to both the admission and discharge assessment periods. Item GG0170L – Walking 10 Feet on Uneven Surfaces, can be assessed inside or outside the facility and can include an indoor simulation. During inclement weather, the clinician can use indoor uneven surfaces to assess the patient. The clinician should use clinical judgement in determining whether a surface is uneven. If the facility cannot assess this activity outside and cannot simulate this activity inside the facility during the 3-day assessment period, then the item would be coded 09, Not Applicable. This applies to both the admission and discharge assessment periods.

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7	Section GG	In your example, "The patient uses bilateral prosthetics with attached socks and shoes. The patient used both prosthetics prior to his acute care and IRF admission." I thought prosthetics were considered footwear. Why would the patient be coded 09, Not Applicable?	If the prosthetic/orthotic is associated with the upper or lower leg, it would be considered when coding lower extremity dressing. If the prosthetic/orthotic is associated with the patient's foot or shoe, it is considered when coding putting on/removing footwear. In the example, the patient does not perform the activity of putting on/taking off footwear, because socks and shoes are attached to the prosthetics. If a patient used bilateral prosthetics with attached socks and shoes before his or her current episode of care (acute care and IRF stay), then code GG0130H – Putting On/Taking Off Footwear as 09, Not Applicable. Code 09 is used to indicate that the patient does not perform the activity, and the patient did not perform the activity before the current illness, injury, or exacerbation. If the patient's condition is new, code this item as 88, Not Completed Due to Medical Condition or Safety Concerns.
8	Section GG	The second question at the Q&A discussion today did not seem to be answered directly, and I wondered if you could clarify. The question was, "If a GG item was not assessed within the last 3 days due to an unexpected discharge, do you use 88 or enter the last assessed level of function?" So, if the item or items were assessed 5 days prior to the unexpected discharge but not during the last 3 days, would it be better to use the "min assist" that was assessed or an 88?	For patients who experience an incomplete stay, such as a patient with an unplanned discharge, code the discharge self-care and mobility performance items as 88, Not Attempted Due to Medical Condition or Safety Concerns. Patients with incomplete stays include patients who are discharged to an acute care setting (short-stay acute care hospital, critical access hospital, inpatient psychiatric facility, or long-term care hospital) because of a medical emergency; patients discharged to a hospice; patients who die or leave the IRF against medical advice; and patients with a length of stay of fewer than 3 days.

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9	Section GG	Would it be appropriate to enter code 88 on admission items for the higher functional Mobility Performance tasks?	The admission assessment period for mobility items is 3 calendar days. Certain mobility activities, such as GG0170K – Walk 150 Feet, may only occur once during the 3-day assessment period. If this is the case, code the IRF-Patient Assessment Instrument (PAI) admission assessment Section GG items based on the single occurrence of the activity. We recognize that some activities may not be assessed on admission because of a patient's medical condition or safety concern. For admission activities that do not occur during the 3-day assessment period (e.g., GG0170G – Car Transfer, or GG0170P – Picking Up Object), code 88, Not Attempted Due to Medical Condition or Safety Concerns. The clinician would use clinical judgement to determine whether a patient should attempt an activity. Allowing a patient to rest between activities, or completing activities at different times during the day or on different days, may facilitate completion of the activities.
10	Section GG	To clarify, if a therapist is unable to score a task during the initial evaluation because of refusal, but the patient is agreeable to perform it the next day, should we use the next day's score?	The admission assessment period for the self-care and mobility items is 3 calendar days. Clinicians should code the patient's admission functional status based on a functional assessment that occurs soon after the patient's admission. If the patient refuses to complete an activity on the first day of the 3-day assessment period, the assessment can be completed on day 2 or 3. We anticipate that a multidisciplinary team of clinicians will be involved in assessing a patient's admission and discharge status. If the patient does not perform the activity in therapy, direct care staff should be consulted about the patient's status on the nursing unit.
11	Section GG	Does walking 10 feet on uneven surface have to be done outside? Can a ramp be considered an uneven surface indoors?	Item GG0170L – Walking 10 Feet on Uneven Surfaces, can be assessed inside or outside the facility. Examples of an uneven surface include a sloping indoor floor or uneven outdoor pavement. During inclement weather, the clinician can use indoor uneven surfaces to assess the patient. The clinician should use clinical judgement in determining whether a surface is uneven.

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12	Section GG	If, on admission, the patient does not complete the activity of going up and down stairs secondary to medical condition 88 and no progress from the previous level of function (independent) is anticipated, is a goal of a 01 appropriate?	If a patient is not expected to go up and down stairs by discharge, code 01 as the goal. A minimum of one self-care or mobility goal must be coded per patient stay on the IRF-PAI. A dash may be used for GG0130 or GG0170 discharge goal items, provided that at least one self-care or one mobility item has a discharge goal. Using the dash in this allowed instance does not affect APU determination.
13	Section GG	For patients with incomplete stays, if the patient had some of quality items completed within the last 3 days, should we record those assessments? Or should we use code 88 for all items, as it was an incomplete stay? According to the webinar, we “can” use code 88, but “should” we be using 88 for all items because they did not have a complete stay?	For patients with an incomplete stay, code all discharge self-care and mobility items as 88, Not Attempted Due to Medical Condition or Safety Concerns.
14	Section GG	If a patient is using tube feeding for medications but not for nutrition, what would be the score for eating? If the patient is using a tube to supplement feeding and eating meals, what would be the score?	If the patient eats and drinks by mouth, in addition to using a feeding tube, the presence of a feeding tube does not affect the eating score. Code the eating item based on the amount of assistance the patient required to complete the activity of eating. If eating and drinking by mouth do not occur because of a recent-onset medical condition, then the activity is coded as 88, Not Attempted Due to Medical Condition or Safety Concerns. Assistance with tube feedings is not considered when coding this item.
15	Section H	Would urge incontinence or dribbling be considered stress incontinence?	Stress incontinence is defined as a small amount of urine leakage only associated with physical movement or activity, such as coughing, sneezing, laughing, lifting heavy objects, or exercise.

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16	Section J	What is an example of an "overwhelming external force" that would not be coded as a fall?	Falls that are a result of an overwhelming external force resulting in a patient losing his/her balance and/or having an unintentional change in position are not coded as a fall on the IRF-PAI for J1750 – History of Falls, or J1800 – Any Falls Since Admission. Some examples of an overwhelming external force that would not be coded as a fall are: (1) a patient is pushed by another patient in the hospital, (2) a patient falls at home because of a stair breaking, and (3) a patient falls off a horse.
17	Section J	A patient is in the hallway with a therapist, practicing ambulating. He loses balance just a bit and puts a hand on the wall or handrail to regain balance. Is that a fall?	An anticipated loss of balance is not considered a fall. Therefore, if the physical therapist anticipated that the patient might have a loss of balance while practicing ambulating because of a challenge to his/her balance, this would not be considered a fall (J1800 – Any Falls Since Admission would be coded 0, No). If the patient's loss of balance was not anticipated, this scenario would be considered an intercepted fall (J1800 – Any Falls Since Admission would be coded 1, Yes). An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person.
18	Section J	Our nurses and CNAs are expected to make their interactions with patients therapeutic moments, not simply perform tasks for the patients. Your examples highlight the patient being in therapy, but often, our patients perform transfers and self-care tasks with nurses and Certified Nursing Assistants (CNAs). Would a loss of balance requiring intervention from the CNA or nurse be considered a fall if the patient did not change to a lower surface such as a bed, chair, or the floor?	An anticipated loss of balance that requires intervention from any direct care provider (e.g., physical therapist, CNA, nurse) during self-care and mobility activities that may challenge a patient's balance is not considered a fall. In the scenario you describe, J1800 – Any Falls Since Admission would be coded 0, No, if the patient's loss of balance was anticipated by the CNA or nurse.

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19	Section M	What do you do when there is conflicting documentation between different nurses and/or physicians regarding the staging of pressure ulcers?	If clinician skin assessment findings differ, follow facility policy about resolving these differences for coding the IRF-PAI. IRFs are responsible for submitting accurate IRF-PAI data to CMS. Procedures for the data collection of the Quality Indicator pressure ulcers items are to be completed in compliance with facility, State, and Federal requirements. Please note that the information in the IRF-PAI must correspond with the information provided in the patient's IRF medical record.
20	Section M	Is an ulcer from friction or shearing always considered a pressure ulcer?	A pressure ulcer is a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. If an ulcer arises from a combination of factors that are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer. Pressure ulcers occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force and friction are important contributors to pressure ulcer development.
21	Section M	If a patient had a stage 4 pressure ulcer in critical care, but by the time they came to IRF it was a stage 2, how would you code that on the IRF-PAI?	If a patient is admitted to the IRF with pressure ulcers/injuries, review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed at the time of admission, it should continue to be classified at the higher numerical stage. In the scenario described, the pressure ulcer would be considered a healing stage 4 upon admission to the IRF and therefore would be documented as a stage 4 in Section M items of the IRF-PAI admission assessment.
22	Section M	If a patient developed a pressure ulcer on day 4 of admission to the IRF but it gets resolved prior to discharge, does this need to be recorded in the IRF-PAI?	A pressure ulcer that was identified after the initial skin assessment and then healed before the 3-day discharge assessment period would not be reported in Section M of the IRF-PAI. This pressure ulcer would not be coded in the Section M admission or discharge assessment items.

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23	Section O	If a community begins flu vaccination season early or ends later than October 1 to March 31, do we use the early/late dates to determine whether a patient is in the facility during the vaccination season, or do we still use the October 1 to March 31 dates?	If the patient did not receive the influenza vaccine for the current influenza season, and the reason is that the patient was not in the IRF between October 1 and March 31, code O0250C as 1 – Patient Not in This Facility During This Year's Influenza Vaccination Season. If the patient received the influenza vaccine for the current influenza season, code that the patient received the vaccine in the IRF (O0250A = 1) or outside the facility (O0250C = 2). Code the influenza vaccination items on the IRF-PAI for all patients, regardless of the time of year. Follow your facility policies for influenza vaccinations when your community makes recommendations regarding patient vaccinations. For the quality measure, calculations are based on the pre-established national dates of October 1 to March 31. If a patient is in your IRF one or more days between October 1 and March 31, the patient's record is included in the quality measure's target population.
24	Coding Tips	Can code 88 be used when there is a planned discharge to a Short Term General Hospital?	If a patient is discharged to an acute care hospital/unit, the patient's stay would be considered an incomplete stay. For patients with an incomplete stay, code all discharge self-care and mobility items as 88, Not Attempted Due to Medical Condition or Safety Concerns.

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25	IRF QRP	If a facility only has an inpatient rehabilitation unit, does the CMS IRF QRP apply to them as well?	To determine whether a rehabilitation unit/hospital is included in the IRF QRP, the provider must determine whether it is being paid under Medicare's IRF Prospective Payment System (PPS). If any of the following are true for a freestanding IRF or IRF unit, the IRF is paid under the IRF PPS and is subject to the requirements of the IRF QRP: • The Medicare provider number ends in 3025-3099, or • The Medicare provider number has a "T" in the third position, or • The Medicare provider number has an "R" in the third position. If any of the above criteria are true for the IRF, the IRF must comply with IRF QRP. Failure to submit the required quality data will result in a 2-percentage-point reduction in the IRF's annual payment update. For more information about the IRF QRP, please visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html.
26	Findings from Data Analysis or Section O	Slide 159: If the patient was in the facility earlier that same year (e.g., February 1–15, 2017), can we still code the response as code 01 upon discharge from the June stay?	If the patient was in the facility in February 2017 and received the influenza vaccination during that IRF stay, then code the following for the June IRF stay: O0250A – Did the Patient Receive the Influenza Vaccine in This Facility for This Year's Influenza Vaccination Season? would be coded 1, Yes. O0250B – Date Influenza Vaccine Received, would be coded with the date from the February IRF stay that the patient received the influenza vaccine. It should correspond with the IRF-PAI discharge assessment from the February stay. O0250C – If Influenza Vaccine Not Received, State Reason, would be skipped.