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

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON AUGUST 9–10, 2016

Current as of October 2016

Question #	Question	Section	Item #	Answer
1.	When determining which code to assign, does coding 3 or 4 mean comprehension of complex messages and coding 1 or 2 mean comprehension of basic messages? How is this broken down for expression and comprehension?	B	BB0700; BB0800	The intent of these items is to document the patient's ability to understand and communicate with others. In general, patients who understand complex conversations and express complex ideas would have higher scores. For the item Understanding Verbal Content, code 4 if the patient has clear comprehension of complex messages without cues or repetition. Complex messages include discussion about medication administration, discharge planning, and caregiver issues. The difference between coding a 2, Sometimes understands and a 3, Usually understands is based on the frequency of the difficulty the patient has understanding complex conversations. For example, code 3 if the patient occasionally has difficulty understanding complex information, and code 2 if the patient understands only simple, direct phrases.

Question #	Question	Section	Item #	Answer
2.	If the patient is aphasic and primarily communicates with yes/no gestures, is it acceptable to administer the BIMS with this communication style?	C	C0100–C0500	A patient does not need to express messages verbally in order for the clinician to complete the BIMS. The Quality Indicator Section (Section 4) of the IRF-PAI Training Manual version 1.4 provides steps for completing the BIMS, which includes the following guidance: “If the patient seems unable to communicate, offer alternatives such as an electronic device (smart phone, tablet, laptop, etc.), writing, pointing, nodding, or using cue cards.” Please see the August release of the IRF-PAI Training Section 4 Manual pages C19–C20: Guidance for Completing the BIMS Using Alternative Methods. Section 4 of the IRF-PAI Training Manual can be found at the following Web pages: • https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html • https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-PAI-Manual-Section-4-Quality-Indicators-V14-Revised-August-2016.zip If the interview should not be attempted because the patient is rarely/never understood, cannot respond verbally or in writing or an interpreter is needed but not available, then item C0100, Should BIMS be conducted? should be coded as 0, No, and skip to C0900, Memory/Recall Ability.

Question #	Question	Section	Item #	Answer
3.	Will an IRF meet the CMS Quality Regulation if it implements the process to have one discipline (OT/PT/SCP/RN) to rate a quality indicator item ONE time during the admission and discharge collection period?	GG		We anticipate that a multidisciplinary team of clinicians is involved in assessing the patient. Clinicians from one discipline may be assigned to gather assessment data by observing the patient's performance, as well as gathering other information such as the patient's self-report and reports from the clinician, care staff, or family as documented in the medical record during the 3-day assessment period. CMS does not provide guidance on who can or cannot complete assessment items. Refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete an assessment. Each facility delivers patient care according to their unique characteristics and standards (e.g., patient population). Thus, each facility self-determines their policies and procedures for completing the assessments in compliance with State and Federal requirements. That said, the goal for the assessment is to accurately reflect the patient's status; therefore, staff completing the IRF-PAI should have knowledge of the patient's status. For most items, the assessment should not be based upon a single assessment by the therapist, but rather upon collaboration with other clinicians, the patient, and family during the 3-day assessment period.
4.	Is it possible to declare one goal for a facility? Does each patient need to have different goals set? The goal would be either a self-care or mobility goal.	GG		For each IRF-PAI, completion of at least one discharge goal is required for one of the self-care or mobility items to fulfill the requirements of the IRF QRP. In other words, one self-care or one mobility item must have a discharge goal per patient stay. Even though only one discharge goal is required, the facility may choose to code more than one discharge goal for a patient. If at least one self-care or mobility goal is entered on the IRF-PAI, use of a dash for the remaining discharge goal items will not affect the Annual Payment Update (APU) determination.

Question #	Question	Section	Item #	Answer
5.	Usual performance.... Just to clarify, could we assess the patient in all areas on Day 1 prior to therapy intervention and no longer have to score the patient for the rest of the 3-day assessment period? Because realistically, all patients are getting therapy by Day 2, if not Day 1, to be able to hold up to all other regulations on minutes....	GG		For the admission assessment, the intent is to report the patient's baseline admission status. The clinician may begin to assess the patient on the day of admission. However, in many cases, not all self-care and mobility activities will be assessed during the first day. For example, activities such as eating and oral hygiene may be assessed on the day of admission, but walking 150 feet may not occur on the first day of admission. The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 p.m. Clinicians should code the patient's admission functional status, based on a functional assessment that occurs soon after the patient's admission. The admission function scores should reflect the patient's admission baseline status and be based on a functional assessment. The score should reflect the patient's status prior to any benefit from therapy. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.
6.	If there is variability in the type of environment for assessment from bed type, chairs, railings, etc., between SNF, IRF, LTCH, and yet a score of 4 is a 4 across settings, what will protect these sites from being compared as equal by Recovery Audit Contractor (RAC) reviewers?	GG		The intent of the self-care and mobility items is to assess the patient's functional status and the amount of assistance needed when performing the activities. The items do not take bed type, seating chair type, and railing type into account. These items are also not meant to be compared across PAC settings.

Question #	Question	Section	Item #	Answer
7.	What (if any) is the downside from CMS perspective, if our facility chooses to only submit one goal and use dashes for the rest? I understand we can use a dash for goals, but will this negatively affect our outcomes (that CMS will report on eventually)?	GG	A–H Goal Section	Completion of at least one discharge goal is required for at least one of the self-care or mobility Items in Section GG to fulfill the requirements of the IRF QRP. Even though only one discharge goal is required, the facility may choose to code more than one discharge goal for a patient. When coding the patient's discharge goal(s), use the 6-point scale. Do not use the "activity was not attempted" codes (07, 09, or 88) to code discharge goal(s). Use a dash (-) to indicate that a specific activity is not a goal. If at least one self-care or mobility goal is entered on the IRF-PAI, the use of a dash in this allowed instance does not affect the Annual Payment Update (APU) determination.
8.	Prior Functioning: For a score of 3 (independent), it says the patient may use device but not use a helper. If a patient has a service animal, is that a device or a helper?	GG	GG0100	GG0100. Prior Functioning: Everyday Activities: The intent of coding the level of assistance required by the patient prior to the current illness, exacerbation, or illness is to determine if assistance was needed to complete the activity. For the prior level of functioning items, the use of an assistive device without additional assistance from a helper results in the activity coded as 3 - Independent. A service animal is to be considered an assistive device for the purposes of coding the IRF-PAI Prior Functioning items, and as long as the service animal is trained and present, then the patient can be considered independent.
9.	Does toileting hygiene include incontinent episodes?	GG	GG0130C	Yes, if a patient is incontinent, you can code item GG0130C. Toileting Hygiene. Code this item based on the amount of assistance the patient requires to remove clothing, provide perineal care, and adjust clothes after the episode of incontinence.
10.	The clarification response for what body parts are included in bathing indicates the focus is on the patient's ability to wash, rinse, and dry the upper and lower body (face, chest, and limbs). Is cleaning of the perineal area included in this activity?	GG	GG0130E	For the item GG0130E. Shower/Bathe Self, the assessment focuses on washing, rinsing, and drying the entire body. The assessment can be based on a sponge bath or bathing at the sink. The focus of the assessment is the patient's ability to bathe his/her upper and lower body, including the face, chest, upper and lower limbs, and perineal area. Do not include assistance with washing, rinsing or drying the patient's back or hair as part of this activity.

Question #	Question	Section	Item #	Answer
11.	Can bathing be assessed at the bedside or sink level vs. a tub/shower? (Especially if they sponge bathed prior to admission.)	GG	GG0130E	For the item GG0130E. Shower/Bathe Self, the assessment can be based on a sponge bath or bathing at the sink. The focus of the assessment is the patient's ability to bathe his/her upper and lower body, including washing, rinsing, and drying the face, chest, upper and lower limbs, and perineal area. Do not include assistance with washing, rinsing or drying the patient's back or hair as part of this activity.
12.	Since Upper/Lower Body Dressing includes item retrieval, should the mobility to retrieve the items be included in the assessment of the scoring (i.e., Patient needs moderate assistance to ambulate to the closet and back to the bed, but once patient sits on bed, can don pants without touching/steadying, what would the score be?)	GG	GG0130F; GG0130G	The focus of Items GG0130F. Upper body dressing, GG0130G. Lower body dressing and GG0130H. Putting on and taking off footwear is assessment of the patient's ability to complete the dressing activity. If the only assistance required is for retrieving the clothing/footwear items, then code the items 05, Set-up or clean-up assistance. Assistance while walking to retrieve clothing is not considered when coding the dressing/footwear items.
13.	Can you give an example of clean-up for roll left and right?	GG	GG0170A	GG0170A. Roll left and right would be coded 05, Setup or clean-up if the patient needed, for example the bed railing to be set up into the upright position before the activity and or removed (cleaned up) after the activity was performed. For bed mobility code, 05 is typically used for Setup; whereas, other activities may require clean-up after an activity was completed (for example, oral hygiene, bathing, and dressing). Whether setup or clean-up is required the item is coded 05, Setup or clean-up.
14.	For Roll left and right, if the patient is medically contraindicated to roll one way, is the entire activity coded 88?	GG	GG0170A	If the patient has a physician order that prevents the patient from rolling onto the right or left side and returning onto the back, then code GG0170A. Roll left and right as 88, Not attempted due to medical condition or safety concerns.

Question #	Question	Section	Item #	Answer
15.	What if the patient is non-weight bearing on the left shoulder due to a humerus fracture? The patient is independent to roll right but not medically advised to roll left. The weight bearing status is not going to change by discharge. The patient is also does not want to roll to the left due to pain, and the patient's home setting is not such that they will need to roll to left. How do you code left and right when they can only go one way?	GG	GG0170A	If the patient has a non-weight bearing status order from a physician or physician designee that prevents rolling onto the affected shoulder, then code GG0170A. Roll left and right as 88, Not attempted due to medical condition or safety concerns.
16.	If the level is different for sit to stand from chair and sit to stand from bed, which code would you use?	GG	GG0170D	The intent of item GG0170D. Sit to stand is to assess the patient's ability to safely come to a standing position from sitting in a chair or on the side of the bed. If the assistance level varies, code based on what the patient does most of the time to reflect the patient's usual performance.
17.	Chair/bed-to-chair: Is chair/bed-to-chair transfer assessed starting from a sitting position? Is it assessed separately from sit to stand, if the transfer includes sitting? Or can both chair/bed-to-chair and sit to stand be assessed during one transfer?	GG	GG0170D; GG0170E	For the item GG0170E. Chair/bed-to-chair transfer, a transfer from a bed to a chair would begin with the patient sitting on the side of the bed and ends with the person sitting in a chair or wheelchair. For a transfer from a chair or wheelchair back into bed, the transfer would end with the person sitting on the side of the bed. Sit to stand is coded separately from chair/bed-to chair transfer. Item GG0170D. Sit to stand assesses the patient's ability to safely come to a standing position from sitting in a chair or on the side of the bed. Not all patient transfers from chair/bed-to-chair include the patient coming to a complete standing position (for example, a transfer board transfer).

Question #	Question	Section	Item #	Answer
18.	How do you perform a car transfer if you don't have access to a car or a simulated car? What if the patient uses public transportation as their primary mode of transportation?	GG	GG0170G	For item GG0170G. Car Transfer, if it is not safe for a patient to transfer into or out of a car, code 88, Not attempted due to medical condition or safety concerns. We understand that many IRF patients may not perform car transfers on admission due to their medical condition or safety concerns. Use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a standard car seat within a car cabin. If the facility does not have an indoor car or access to an outdoor car during the 3-day assessment period, then the item would be coded 09. Not applicable. Further, not all patients will use cars for transportation. As in your example, the patient may only use public transportation and therefore the activity would be coded 09. Not applicable.
19.	If our facility does not have a car or a portion of a car, how would we score the new car transfer item? Currently, we simulate the car transfer on a mat or on a recumbent stepper. Can we score item GG0170G based on this simulated car transfer? If we cannot, do we use a dash?	GG	GG0170G	Use of an indoor car or partial car can be used to simulate car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a standard car seat within a car cabin. If the facility does not have an indoor car or access to an outdoor car during the 3-day assessment period, then the item GG0170G. Car Transfer would be coded 09, Not applicable. The use of a mat or recumbent stepper is not an acceptable substitute when assessing the patient car transfer, because the transfer is not similar to a car transfer. For item GG0170G. Car Transfer, if it is not safe for a patient to transfer into or out of a car, code 88, Not attempted due to medical condition or safety concerns. We understand that many IRF patients may not be able to attempt car transfers on admission due to a medical condition or safety concerns.

Question #	Question	Section	Item #	Answer
20.	What if weather precludes car transfers? Is it acceptable to code 88? (Safety concerns due to snow, ice, rain.)	GG	GG0170G	For item GG0170G. Car Transfer, if it is not safe for a patient to transfer into or out of a car, code 88, Not attempted due to medical condition or safety concerns. We understand that many IRF patients may not be able to perform car transfers on admission due to safety concerns. Use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a standard car seat within a car cabin. If the facility cannot assess this activity due to weather, or the facility does not have an indoor car or access to an outdoor car during the 3-day assessment period then the item would be coded 09, Not applicable
21.	For walking and wheelchair, is there a standard flooring? It can be very different on a linoleum surface compared to a carpeted surface.	GG	GG0170	For the walking and wheelchair items, the assessment would be completed on the standard flooring in your facility.
22.	Is it reasonable to have a patient walk in the parallel bars for item I. Walk 10 feet since devices have no impact, and the parallel bars are essentially a device?	GG	GG0170H1	The use of parallel bars is not acceptable when assessing the patient's ability to walk for the Section GG walking items. If it is safe to do so, observe the patient's performance using assistive devices and code the item according to the amount of assistance the patient requires. If the patient is unable to walk without the parallel bars due to medical condition or safety concerns, use code 88, Not attempted due to medical condition or safety concerns.

Question #	Question	Section	Item #	Answer
23.	The IRF-PAI item GG0170H1 states if you code this item 1, No, and walking goal is clinically indicated, to code a discharge goal, then skip to item GG0170Q1. Does the patient use a wheelchair/scooter? If a patient is not able to ambulate at admission, but you anticipate an ability to ambulate at Discharge, would you not also code these three admission items (GG0170I, J, K) 88, not attempted due to medical condition or safety concerns?	GG	GG0170H1	If the patient is not walking on admission, item GG0170H1 is coded 0, No, and walking goal is not clinically indicated or 1, No, and walking goal is clinically indicated. Based on this response, we know the patient is not currently walking. Therefore, you do not need to code Admission Performance for the walking items GG0170I, J, or K. If you indicate in GG0170H1 that goals are clinically indicated, you will be able to enter goals for the walking items.
24.	If walking is attempted with a helper, but the patient can't walk 10 feet, what would the code be?	GG	GG0170I	If a patient begins an activity but cannot complete the activity, and a helper does not complete the activity for the patient, code 88, Not attempted due to medical condition or safety concerns. If the patient walks 8 feet but cannot walk 10 feet, code 88, Not attempted due to medical condition or safety concerns.

Question #	Question	Section	Item #	Answer
25.	Please review the Not attempted codes and when we would use them vs not using them. Would we use 9 if the patient can't do it now but could do it before the illness?	GG	GG0170	Here are examples of the activity not attempted codes: • Code 88, Not attempted due to medical condition or safety concerns, if a patient begins but cannot complete an activity and a helper does not complete the activity for the patient. Use this code if the patient is too ill or unsafe to perform the activity. For example, if a patient walks 8 feet with assistance but is unable to walk 10 feet, code 88, Not attempted due to medical condition or safety concerns. • Code 88, Not attempted due to medical condition or safety concerns, if the clinician determines the patient should not attempt the activity due to medical condition or safety concerns. The therapist is to use clinical judgment to decide whether the patient should perform an activity. For example, if a patient does not eat by mouth due to a swallowing problem, code the eating item 88, Not attempted due to medical condition of safety concerns. • Code 09, Not applicable, if the clinician determines the assessment activity is not applicable to the patient. An activity is not applicable if the patient did not perform an activity prior to the current illness, exacerbation, or injury. For example, if a patient only used public transportation prior to the current illness, injury, or exacerbation, and did not transfer into or out of a car, code the GG0170 item 09, Not applicable. We refer you to the IRF-PAI manual for further explanation of the codes. • Code 07, Patient refused, if the patient refuses to perform an activity.

Question #	Question	Section	Item #	Answer
26.	Second helper: If the second helper is there to push the wheelchair just in case or a standard procedure of the facility, do we still code a 1? What if a second helper is only pushing an IV pole?	GG		If a patient requires the assistance of two helpers to ambulate safely, including the example of one helper providing trunk support and one helper following closely with a wheelchair, code the walking item 01, Dependent. The same guidance would apply if the patient has an IV pole. However, depending on the situation, an IV may be allowed to be disconnected for short periods of time. If this is the case, then the patient can be assessed without the need for an additional person pushing the IV pole; alternatively, if the IV will be discontinued before the patient is discharged, assess the patient walking after the IV is discontinued.
27.	If you have a wheelchair follow along with a therapist providing assistance, would this be coded as dependent?	GG	GG0170J; GG0170K	If a patient requires the assistance of two helpers to ambulate, including the example of one helper providing trunk support and one helper following closely with a wheelchair, code the walking item 01, Dependent.
28.	If a patient is unable to walk 150 feet due to fatigue, decreased endurance, weakness, etc., but is able to complete more than 50 feet, should the query for 150 feet be scored as 01, dependent or 88, Not attempted?	GG	GG0170K	If a patient begins an activity but cannot complete the activity, and a helper cannot complete the activity for the patient, code 88, Not attempted due to medical condition or safety concerns. In the example you provided, GG0170K. Walk 150 feet should be coded as 88, Not attempted due to medical condition or safety concerns. The clinician is to assess and document each walking item individually. Item GG0170J assesses the ability to walk 50 feet and make two turns. Assess by observing the amount of assistance required from the helper. Code this item according to the amount of assistance that was needed in order for the patient to complete this activity.
29.	UDS does not consider the curb of a sidewalk to be a step for the FIM score under Stairs (coded “0” on the FIM for Stairs). Please confirm/clarify that the CARE Tool item GG0170M does consider a step as either the curb of a sidewalk or a single platform step.	GG	GG0170M	We would like to clarify that Section GG: Functional Abilities and Goals is the section used to collect these function items, located on the IRF-PAI. The CARE Tool is not used to collect these items. In Section GG, item GG0170M. 1 step (curb), can be assessed using 1 step or a sidewalk curb.

Question #	Question	Section	Item #	Answer
30.	Do steps have to be assessed individually for each item (1 step, 4 steps, and then 12 steps)? This was answered for walking in Q&A document, but not for steps. This could be exhausting for patient and impact overall performance.	GG	GG0170M; GG0170N; GG0170O	The clinician is to assess each walking and stair item individually during the 3-day assessment period. Use clinical judgment to determine how much rest a patient needs between the assessment of each activity or if the assessment should be completed at another time during that day or within the 3-day assessment period. If a patient does not complete an activity due to medical condition or safety concerns, code the item 88, Not attempted due to medical condition or safety concerns.
31.	I would never instruct my patient to bend or stoop because it is not proper body mechanics. I would tell them to support.	GG	GG0170P	If there is a medical concern that prevents completion of activity GG0170P. Picking up object, use code 88, Not attempted due to medical condition or safety concerns. If the patient simply needs support in performing this activity, the therapist should provide the necessary support or ensure that the patient is instructed in how to support this movement safely and with good body mechanics. During the patient's stay, therapy may include patient education in use of an assistive device, such as a long-handled reacher. If this occurs, for the discharge assessment, the activity would be coded based on the amount of help required as the patient performed the activity with use of the assistive device. For discharge, if a device is not used and the patient's medical status still precludes picking up an object from the floor, then the activity would be coded as 88, Not attempted due to medical condition or safety concerns.
32.	If a patient is going to primarily ambulate on discharge, but they use a wheelchair to get to/from therapy while they recover, should we code both walking and wheelchair mobility?	GG	GG0170Q1	Only code wheelchair mobility based on an assessment of the patient's ability to mobilize in the wheelchair. Do not code wheelchair mobility if the patient only uses a wheelchair when transported between locations within the hospital. Code walking and wheelchair items, if the patient walks and uses a wheelchair.

Question #	Question	Section	Item #	Answer
33.	In many areas of the training, the presenters state the rationale is “a risk adjuster.” What exactly does this mean? Is it meant to capture information for us as a facility or a risk adjuster for data CMS is gathering? Thank you.	H	H0350	Risk adjustment is a statistical method that is used in quality measurement to “level the playing field” by compensating for differences in patients or populations and their health outcomes. Risk adjustors are essentially covariates, or variables, used to adjust out for patient or population differences. CMS adopted several functional outcomes measures into the IRF QRP. When calculating the functional outcomes, CMS risk adjusts for a patient’s admission clinical and demographic characteristics so that differences in functional outcomes reflect differences in the effectiveness of IRF services rather than differences in the types of patients treated within each IRF. The data submitted for the “risk adjustor” items will be used to risk adjust the functional outcome quality measures.
34.	Does a spinal cord injury patient have to perform their bowel program over a toilet? If they have their bowel program in bed as a scheduled event, should the nurse score them as “continent” or “incontinent”?	H	H0400	If the bowel program is performed successfully as a scheduled event, then item H0400. Bowel Continence would be coded 0, Always continent. A bowel program does not have to occur using a toilet or bedpan.
35.	When will the update to the IRF-PAI training manual be available? Will Section 4 be available as a stand-alone document sooner than the entire update?	J		The August 2016 release of Section 4 is now posted on the IRF Quality Measures Web page. The Q&A from May is now on the IRF QRP Web site at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html
36.	If the preadmission nurse gathers information on falls in the last 100 days, can this information live in the preadmission screen? Or does the information need to be pulled from the admission profile? Does it matter where the information is found and when it was documented?	J	J1750	Information about the patient’s history of falls that is collected during the preadmission process may be used to complete IRF-PAI item J1750. History of Falls. Please note the item refers to two or more falls or any fall with injury in the past year.

Question #	Question	Section	Item #	Answer
37.	In Section J, do they mean all falls, either minor or major injury?	J	J1750	Item J1750. History of Falls, asks if the patient had two or more falls in the past year or any fall with injury in the past year. A major injury would include a bone fracture, joint dislocation, closed head injury with altered consciousness, or subdural hematoma. An injury (except major) would include skin tears, abrasions, lacerations, superficial bruises, and sprains; or any fall-related injury that causes the person to complain of pain. Please refer to the definition of a fall, on page J-1 and the definitions of “injury related to a fall” “injury (except major)” and “major injury” on the subsequent pages in Section 4 Quality Indicator Section of the IRF-PAI Training Manual Version 1.4 available in the downloads section of the following CMS link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html

Question #	Question	Section	Item #	Answer
38.	Question: Intercepted Falls: Would this include during therapy times when the therapist is working with and pushing the patient?	J	J1800	The definition of a fall, which includes an intercepted fall, can be found on page J-1 in Section 4 Quality Indicator Section of the IRF-PAI Training Manual Version 1.4, available in the downloads section of the following CMS link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html The definition of a fall provided in the manual is: an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). An intercepted fall is considered a fall. 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. The definition of a fall and the examples provided in the IRF-PAI Training Manual are to assist a clinician in using professional judgment to distinguish whether a fall (or intercepted fall) occurred. We understand that there are situations in which clinicians will be challenging a patient's balance and training them to recover from a loss of balance. We do not consider these anticipated losses of balance as intercepted falls. It is not our intention to limit patients' rehabilitation progression in any way. Our intention is to maximize patient safety and capture events that represent threats to patient safety. Only those falls with "major injury" (item J1900C.) are used in the calculation of the Quality Measure: Percent of Residents Experiencing One of More Falls with Major Injury.

Question #	Question	Section	Item #	Answer
39.	Follow-up to the example given for Falls: If the patient is pushed to the floor by a door opening into their path, and the patient sustains a hip fracture from landing on the floor, is this event captured as a fall under this section?	J	J1800; J1900	The definition of a fall can be found on page J-1 in Section 4 Quality Indicator Section of the IRF-PAI Training Manual Version 1.4 available in the downloads section of the following CMS link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html The definition of a fall provided in the manual is: “Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (e.g., a patient pushes another patient).” What you describe, the door opening, appears to be the result of “an overwhelming external force” and therefore would not be captured as a fall and recorded in Section J of the IRF-PAI. However, since this incident resulted in harm to the patient, it should be recorded per your organization’s protocol for tracking and analyzing adverse events.

Question #	Question	Section	Item #	Answer
40.	You gave an example of a patient that was feeling weak and lowered to the ground for safety. The patient did not stumble or trip, but is this considered an intercepted fall? You lowered them to prevent them from falling, but don't patients use walkers to prevent themselves from falling? If the patient says they feel weak and they are lowered into a chair, is that also an intercepted fall?	J	J1900	The definition of a fall, which includes an intercepted fall, can be found on page J-1 in Section 4 Quality Indicator Section of the IRF-PAI Training Manual Version 1.4, available in the downloads section of the following CMS link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html The definition of a fall provided in the manual is: an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). An intercepted fall is considered a fall. 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. The definition of a fall and the examples provided in the IRF-PAI Training Manual are to assist a clinician in using professional judgment to distinguish whether a fall (or intercepted fall) occurred. There may be instances when a patient uses a walker to catch him/herself from falling. This may be witnessed, or a patient may report this information. In this case this would be considered an intercepted fall. If a patient becomes weak and is lowered into a chair to prevent a fall, then this is considered an intercepted fall. The intention of items J1800 and J1900 is to maximize patient safety and capture events that represent threats to patient safety. Only those falls with "major injury" (item J1900C.) are used in the calculation of the Quality Measure: Percent of Residents Experiencing One of More Falls with Major Injury.

Question #	Question	Section	Item #	Answer
41.	Is a patient considered as having an overnight stay for major surgery if after an outpatient cardiac procedure/stent, they are kept in observation bed in acute care overnight, but not admitted to acute care inpatient hospital?	J	J2000	A patient would be required to stay at least one night in an acute care hospital for the surgery to be considered major surgery. An outpatient cardiac procedure would not be considered major surgery.
42.	Inconsistency between sections M & J make it confusing to keep straight. You want us to document "the worst injury" on a fall, but initial assessment of pressure ulcer even if it gets worse in 3 days? You should make it consistently worse injury or initial assessment.	J & M		These items are two very different items clinically. They require different types of assessments and are collected at different points in time. The falls item mentioned (J1900) is collected on discharge and asking whether a fall has occurred since admission and whether or not that fall caused a major injury. Regarding pressure ulcers, the admission clinical skin assessment is what is used to complete the IRF-PAI. Any subsequent change in the pressure ulcer, even if the change occurs on day 3 of the admission, is identified on the discharge IRF-PAI. This is because the assessment item indicates what the skin status is "on admission," which is defined as close to the date of admission as possible. Therefore, if a patient is admitted with a Stage 2 pressure ulcer and the initial clinical skin assessment identifies on day 1 that the pressure ulcer is a Stage 2 on admission that is the stage that is entered into the admission IRF-PAI. If on day 3, that pressure ulcer is further assessed (which would indicate a second skin assessment occurred within the 3-day assessment window), and the ulcer has a deeper level of tissue damage necessitating a change in numerical stage, that stage would be captured on the discharge IRF-PAI as long as the pressure ulcer has not deteriorated further or has healed prior to discharge. The pressure ulcer would also be captured in M0800 Worsening in Pressure Ulcer Status Since Admission, if the pressure ulcer has not healed, since the stage assessed as close to the admission as possible was a stage 2. For further information, please refer to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html

Question #	Question	Section	Item #	Answer
43.	On admission/initial skin assessment, if an area is identified with a consult to wound care team or nurse who will stage within 12–24 hours or within 36 hours, would this staging be appropriate to record on IRF-PAI?	M		The admission skin assessment should be completed as close to the time of admission as possible. If a wound care specialist is consulted to assist with the assessment, the consultation may occur during the 3-day assessment period; however, the original assessment that was completed as close to the time of admission as possible should be used to complete the assessment. Clinical assessments performed on patients in the IRF should be completed according to accepted clinical practice and comply with facility policy and State and Federal regulations. The general standard of practice for newly admitted patients is that a patient's skin assessment is completed as close to the time of admission as possible and usually within 24 hours. For example, if a facility requires that a full patient assessment be completed within the first 24 hours, then the information required in the IRF-PAI admission assessment would be coded based on that assessment and coincide with the findings that were completed within that same timeframe.
44.	Does the discharge timeframe for GG items include the 3 days prior to discharge or something more specific? For example, would it need to be from one 24-hour period within the 3 days?	General		The discharge assessment period encompasses the day of discharge and the 2 calendar days prior to the day of discharge. The observation period for the discharge items is 3 calendar days. While CMS allows a 3-day observation period, the discharge assessments should be completed as close to the time of discharge as possible, to most accurately represent the patient's discharge status.