SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

ITEM COMPLETION

Admission and discharge IRF-PAI items must be completed before data records are transmitted to the Centers for Medicare & Medicaid Services (CMS). For a complete list of voluntary and mandatory IRF-PAI items, refer to the tables in Section 9: Voluntary/Mandatory IRF-PAI Items of this manual. The CMS data system will accept a record if the voluntary items are not completed. However, as required by Section 3004(b) of the Affordable Care Act, failure to complete Quality Reporting Program items may result in payment reductions of two percentage points starting in FY 2014. For the remaining IRF-PAI items that are identified as mandatory, any missing or invalid data entered into the data collection software may cause a record to be rejected by CMS.

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

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

If the patient's stay is less than 3 calendar days in length, the staff of the rehabilitation facility must complete the IRF-PAI admission items, but do not have to complete all of the discharge IRF-PAI items. However, for the discharge assessment an IRF must complete all of the functional modifiers and FIM instrument items. The IRF is required to collect information and record it on the IRF-PAI as completely as possible. Although data collection for a patient whose stay is less than 3 calendar days in length may be more difficult, particularly the discharge assessment, codes of "0" may be used if necessary for certain function modifiers (See Overview For Use of Code "0" in Section 3: The FIM™ Instrument of this manual). When coding the discharge assessment for a patient whose stay is less than 3 calendars days, it is possible that the discharge FIM scores may be the same as the admission FIM scores. However, if a code of "0" was used on admission, then the corresponding FIM item should be scored with a "1" at discharge. The correct date for Item 13, Admission Assessment Reference Date, is typically the 3rd calendar day of the stay. If the stay is less than 3 calendar days, the admission assessment reference date is the last day of the stay (either day 1 or day 2).

EXAMPLES ILLUSTRATING THE ASSESSMENT AND DISCHARGE ASSESSMENT SCHEDULES

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

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

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

Chart 1. - Patient Assessment Instrument Admission Assessment Schedule of Dates

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

*In accordance with section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule excetion as specified in §412.610(c)(1)(ii) CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.
**Because all the assessment data for admission and discharge assessments must be transmitted together after the patient is discharged, the admission assessment data must be transmitted at the same time the discharge data are transmitted. That transmission date is by the 7th calendar day in the period beginning with the last permitted discharge patient assessment instrument "encoded by" date.

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

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

*In accordance with section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule excetion as specified in §412.610(c)(1)(ii) CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.
**Because all the assessment data for admission and discharge assessments must be transmitted together after the patient is discharged, the admission assessment data must be transmitted at the same time the discharge data are transmitted. That transmission date is by the 7th calendar day in the period beginning with the last permitted discharge patient assessment instrument "encoded by" date.

Below, chart 3 illustrates how to determine the assessment, coding, and data transmission dates for the IRF-PAI discharge assessment. Chart 3 is similar to, but is an updated version of a chart that appears on page 41332 of the August 7, 2001 Final Rule and on page 45683 of the August 1, 2003, Final Rule entitled “Medicare Program; Changes to the Inpatient Rehabilitation Facility Prospective Payment System and Fiscal Year 2004 Rates; Final Rule.” The August 1, 2003, Final Rule was published in the Federal Register, Volume 68, Number 148. Chart 3 illustrates that CMS will determine that the IRF-PAI data was not transmitted late if it is transmitted no later than 27 calendar days from the day the patient is discharged. **NOTE:** The discharge day is

counted as one of the 27 calendar days, and the 27 calendar day time span also includes the 10 calendar days specified in §412.614(d)(2). Also, the meaning of the term "discharge day," which is one of the days counted in the 27 calendar day time span, is the day defined according to the revised definition of "discharge" specified in §412.602 as stipulated in the August 1, 2003 Final Rule. In some cases, that may be different from the dicharge assessment reference day specificed in §412.610(c)(2)(ii).

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

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

* In accordance with section IV.A.3. of the August 7, 2001 Final Rule preamble, and the admission assessment general rule excetion as specified in §412.610(c)(1)(ii) CMS may stipulate instructions in this manual that may result in some items having a different admission assessment reference date.
**This is the last day by when the discharge patient assessment must be completed. However, this does not prohibit discharge patient assessment data from being recorded on the patient assessment instrument prior to this date.
***Or any day after 11/12/11.

NOTE: For more information regarding the admission and discharge assessments, please refer to the IRF PPS Final Rules and other CMS publications for authoritative guidance. The CMS publications related to the IRF PPS can be found at the CMS IRF PPS website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html.

IDENTIFICATION INFORMATION

1. **Facility Information:**
   A. **Facility Name:** Enter the full name of the facility.
   B. **Facility Medicare Provider Number:** Enter the facility medicare provider number. Verify the number through the business office.

2. **Patient Medicare Number:** Enter the patient's Medicare Number (Part A). Verify the number through the business office.

   NOTE: For those patients with a Medicare Advantage (Medicare Part C) Plan, a Medicare number is still needed to complete this section of the IRF-PAI. For additional information regarding how to obtain this number, reference the IRF PPS FY 2010 final rule (74 FR 39799).

3. Patient Medicaid Number: Enter the patient's Medicaid Number. Verify the number through the business office.

NOTE: This item is mandatory if the patient is a Medicaid recipient.

4. Patient First Name: Enter the patient's first name. Verify this information through the business office.

5A. Patient Last Name: Enter the patient's last name. Verify this information through the business office.

5B. Patient Identification Number: Enter the patient's medical record number or other unique identifier.

6. Birth Date: Enter the patient's birthdate. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., 1938).

7. Social Security Number: Enter the patient's Social Security Number. Verify the number with the patient and/or business office.

NOTE: If the patient is unwilling to disclose their social security number or if the facility is unable to obtain this information, a blank value can be submitted without causing the IRF-PAI to be rejected.

8. Gender: Enter the patient's gender as:
(1- Male; 2- Female)

9. Race/Ethnicity: Check all that apply.
(A. American Indian or Alaska Native, B. Asian, C. Black or African American, D. Hispanic or Latino, E. Native Hawaiian or Other Pacific Islander, F. White)

NOTE: If the patient is unwilling to disclose their race information or if the facility is unable to obtain this information, a blank value can be submitted without causing the IRF-PAI to be rejected.

10. Marital Status: Enter the patient's marital status at the time of admission.
(1- Never Married; 2- Married; 3- Widowed; 4- Separated; 5- Divorced)

NOTE: If the patient is unwilling to disclose their marital status or if the facility is unable to obtain this information, a blank value can be submitted without causing the IRF-PAI to be rejected.

11. Zip Code of Patient's Pre-Hospital Residence: Enter the zip code of the patient's pre-hospital residence.

ADMISSION INFORMATION

12. Admission Date: Enter the date that the patient was admitted to the IRF. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31*), and *YYYY* is the full year (e.g., *2014*).

13. Assessment Reference Date: This is the 3rd calendar day of the rehabilitation stay, which represents the last day of the 3-day admission assessment time period. These 3 calendar days are the days during which the patient's clinical condition should be assessed. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., *2014*). **Example:** If Admission Date is 07/04/14, then the Assessment Reference Date is 07/06/14.

NOTE: If the stay is less than 3 calendar days, the admission assessment reference date is the last day of the stay (either day 1 or day 2).

NOTE: If the patient has an program interruption, the discharge date is not included as one of the 3 calendar days. Example: Patient was admitted to IRF on 7/4/14. Patient was discharged to Acute Care on 7/6/14. Patient returned to IRF on 7/7/14. The assessment reference date would be 7/7/14. Day 1 would be 7/4/14, Day 2 would be 7/5/14 and Day 3 would be 7/7/14. Example: Patient was admitted to IRF 7/4/14. Patient was discharged to Acute Care on 7/5/14. Patient returned to IRF on 7/6/14. The assessment reference date would be 7/7/14. Day 1 would be 7/4/14, Day 2 would be 7/6/14 and Day 3 would be 7/7/14.

14. Admission Class: Enter the admission classification of the patient, as defined below:

1- Initial Rehab: This is the patient's first admission to any inpatient rehabilitation facility for this impairment.
2- THIS CODE IS NO LONGER VALID
3- Readmission: This is a stay in which the patient was previously admitted to an inpatient rehabilitation facility for this impairment, but is **NOT** admitted to the current rehabilitation program DIRECTLY from another rehabilitation program.
4- Unplanned Discharge: This is a stay that lasts less than 3 calendar days because of an unplanned discharge (e.g., due to a medical complication). If the patient stays less than 3 calendar days, see the first page of Section II for item completion instructions.
5- Continuing Rehabilitation: This is part of a rehabilitation stay that began in another rehabilitation program. The patient was admitted directly from another inpatient rehabilitation facility.

15. Admit From: Enter the setting from which the patient was admitted to rehabilitation.

01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate Care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (institutional facility)
61- Swing Bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

NOTE: Definitons of Patient Status Codes for Item 15, 16, and 44D can be found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf

16. Pre-Hospital Living Setting: Enter the setting where the patient was living prior to being hospitalized.

01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate Care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (institutional facility)
61- Swing Bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

17. Pre-Hospital Living With: Enter the relationship of any individuals who resided with the patient prior to the patient's hospitalization. If more than one person qualifies, enter the first appropriate category on the list.

** Complete this item *only* if you selected code 01 (Home) in Item 16 (Prehospital Living Setting).

(01- Alone; 02- Family/Relative; 03- Friends; 04- Attendant; 05- Other)

18. DELETED

19. DELETED

PAYER INFORMATION

20. Payment Source: Enter the source of payment for inpatient rehabilitation services. Enter the appropriate category for both primary and secondary source of payment.

(02- Medicare Fee For Service; 51- Medicare-Medicare Advantage; 99- Not Listed)

A. **Primary Source**
B. **Secondary Source**

MEDICAL INFORMATION

21. Impairment Group: For the admission assessment, enter the code that best describes the primary reason for admission to the rehabilitation program (Codes for this item are listed in the table listed Impairment Group Codes).

22. Etiologic Diagnosis: Enter the ICD code(s) to indicate the etiologic problem that led to the impairment for which the patient is receiving rehabilitation (Item 21 - Impairment Group). Refer to Section 6 of this manual for ICD codes associated with specific Impairment Groups. Commonly used ICD codes are listed, but the list is not exhaustive. Consult with health information management staff and current ICD coding books for exact codes.

23. Date of Onset of Impairment: Enter the onset date of the impairment that was coded in Item 21 (Impairment Group). The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., *2014*).

NOTE: If a condition has an insidious onset, or if the exact onset date is unknown for any reason, follow these general guidelines:

- If the year and month are known, but the exact day is not, use the first day of the month (e.g., MM/01/YYYY).
- If the year is known, but the exact month is not, use the first of January of that year (e.g., *01/01/YYYY*).
- If the year is an approximation, use the first of January of the approximate year (e.g., *01/01/YYYY*).

The following represents more specific instructions for determining date of onset for major impairment groups:

Stroke**
Date of admission to acute hospital. If this is not the patient's first stroke, enter the date of the most recent stroke.

Brain Dysfunction
-Traumatic
Date of Injury.
-Non-traumatic
More recent date of: date of surgery (e.g., removal of brain tumor) or date of diagnosis.

Neurological Conditions
-Multiple Sclerosis
Date of exacerbation
-All Remaining Neurological Conditions
Date of diagnosis

Spinal Cord Dysfunction
-Traumatic
Date of injury
-Non-traumatic
More recent date of: date of surgery (e.g., tumor) or date of diagnosis.

Amputation
Date of most recent surgery

Arthritis
Date of diagnosis (if arthroplasty, see impairment group "Orthopaedic Conditions")
Pain Syndromes
Date of onset related to cause (e.g., fall, injury)

Orthopaedic Conditions
-Fractures
Date of fracture
- Replacement
Date of surgery

Cardiac Disorders
More recent date of: Date of diagnosis (event) or date of surgery (e.g., bypass, transplant)

Pulmonary Disorders

-COPD
Date of initial diagnosis (not exacerbation)
-Pulmonary Transplant
Date of surgery
Burns
Date of burn(s)

Congenital Deformities
Date of birth

Other Disabling Impairment
Date of diagnosis

Major Multiple Trauma
Date of trauma

Developmental Disabilities
Date of birth

Debility**
Date of acute hospital admission

Medically Complex Conditions**
-Infections
Date of admission to acute hospital
-Neoplasms
Date of admission to acute hospital
-Nutrition
Date of admission to acute hospital
-Circulatory
Date of admission to acute hospital
-Respiratory
Date of admission to acute hospital
-Terminal Care
Date of admission to acute hospital
-Skin Disorders
Date of admission to acute hospital
-Medical/Surgical
Date of admission to acute hospital

-Other Medically Complex Conditions
Date of admission to acute hospital

NOTE: If there was no admission to an acute hospital prior to the admission to the inpatient rehabilitation facility, record as the date of onset the date of diagnosis of the impairment which led to the admission to the rehabilitation facility.

24. Comorbid Conditions: Enter up to twenty-five (25) ICD codes for comorbid conditions. A patient comorbidity is defined as a secondary condition a patient may have in addition to the primary diagnosis for which the patient was admitted to the IRF. Enter ICD codes which identify comorbid conditions that are not already included in the Impairment Group Code (IGC). The patient comorbidity/ies listed in Item 24 of the IRF-PAI should have significant impact on the patients' course of treatment for their primary diagnosis. Comorbidities that are identified on the day prior to the day of the rehabilitation discharge or the day of discharge should not be listed on the discharge assessment, since these comorbidities have less effect on the resources consumed during the entire stay.

NOTE: Providers should complete the number of spaces that coincides with the number of comorbid conditions the patient has. Providers do not need to complete all 25 spaces of this item, unless of course, the patient has 25 comorbid conditions.

Example: The patient has 15 comorbid conditions. The provider should complete 15 spaces for this item.

24A. **Arthritis Conditions:** Enter one of the following codes to indicate whether one or more of the arthritis conditions recorded in items #21(Impairment Group), #22(Etiologic Diagnosis), or #24(Comorbid Conditions) meet all of the applicable regulatory requirements for IRF classification (in 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii)).

(*0- No; 1- Yes)*

If the code *0- No* is entered into this item, then that means that either the patient does not have any arthritis conditions recorded in items #21, #22, or #24 of the IRF-PAI or that the arthritis conditions recorded in #21, #22, or #24 of the IRF-PAI fail to meet the applicable regulatory requirements for IRF classification (in 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii)).

If the code *1- Yes* is entered into this item, then this claim may be selected by the MAC for review of the documentation in the IRF medical record to assure that the patient has met all of the applicable regulatory requirements, including that the patient has completed an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the IRF admission. CMS expects that the IRF will obtain copies of the therapy notes from the outpatient therapy or from the therapy services provided in other less intensive settings and include these in the patient's medical record at the IRF (in a section for prior records). These

prior records will be available to the MAC staff who reviews the medical records for compliance with the applicable regulatory requirements.

NOTE: Below references 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii)) for additional information about the regulatory requirements.

(x) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(xi) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(xii) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

NOTE: As discussed in Chapter 3, Section 140.1.1 of the Medicare Claims Processing Manual (Pub. 100-04), which can be downloaded from the CMS Website at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html, "an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation services" in these regulations means the following:

[A]n appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of

rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the MAC's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI/MAC has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the MAC considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the MAC with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. The outpatient therapy services (or services in other less intensive settings) must immediately precede the IRF admission or result from a systemic disease activation immediately before admission.

25A. Height on admission (in inches): Record 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.)
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.

26A. Weight on admission (in pounds): Record the initial weight measurement for the patient.

- Measure the patient's weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.).
- If the patient has been weighed multiple times during the assessment period, use the first weight.
- Use mathematical rounding (e.g., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.

- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code ("-") and document the rationale on the patient's medical record.

27. DELETED

28. DELETED

FUNCTION MODIFIERS

Function Modifiers (Items 29 – 38) should be completed prior to scoring the FIM™ instrument items (Items 39A – 39R). Function modifiers are to be coded both at the time of the admission and discharge.

General Information on Use of Function Modifiers to Determine FIM Scores
Function modifiers serve several purposes. One purpose is to assist in the scoring of related FIM instrument items. A second purpose is to provide explicit information as to how a particular FIM item score has been determined. This information is especially useful for those FIM items that contain multiple components. Note, however, that the way in which the function modifiers relate to the FIM item scores varies by item. These variations are listed in detail in the table that follows on the next page.

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

Scoring Function Modifiers and Related FIM™ Items

Function Modifier	Function Modifier Scoring Rules	Relationship of Function Modifier to FIM Item Scores
29. Bladder Level of Assistance	Use FIM levels 1 - 7 to score this item, based upon the 3 calendar day assessment period. Do not use code 0.	Record in Item 39G. (Bladder) the lower score of Items 29 and 30.
30. Bladder Frequency of Accidents	Use scale listed on IRF-PAI to score frequency of accidents, based upon the 7 calendar day assessment period. Do not use code 0.	
31. Bowel Level of Assistance	Use FIM levels 1 - 7 to score this item, based upon the 3 calendar day assessment period. Do not use code 0.	Record in Item 39H. (Bowel) the lower score of Items 31 and 32.
32. Bowel Frequency of Accidents	Use scale listed on IRF-PAI to score frequency of accidents, based upon the 7 calendar day assessment period. Do not use code 0.	
33. Tub Transfer	Score either Item 33 or 34 but not both; leave the unscored item blank. Use FIM levels 1 - 7. If the patient does not transfer in/out of a tub or shower during the assessment time period, code Item 33 as 0 - Activity does not occur, and leave Item 34 blank. If both types of transfer occur during the assessment period, record the more frequent type of transfer.	Record in Item 39K (Transfers: Tub, Shower) whichever of the two Function Modifer Items (33 or 34) was scored.
34. Shower Transfer		
35. Distance Walked	Code these two items using the 3-level scale listed on the IRF-PAI to record the distance traveled, in feet.	The distance information is needed to determine the scores for Items 37 and 38.
36. Distance Traveled in Wheelchair		
37. Walk	Use FIM levels 1 - 7 to score these items; use 0 if Activity does not occur. Use information from Items 35 and 36 above to help determine scores.	Score Item 39L at Admission based upon the expected mode of locomotion at discharge. For example, if the patient walks at admission, and is expected to walk at discharge, enter in Item 39L the score from Item 37. If the patient uses a wheelchair at admission, and is expected to use a wheelchair at discharge, enter in Item 39L the score from Item 38.[1]
38. Wheelchair		

[1] This method of scoring the Walk/Wheelchair item is in accordance with § 412.610 "Assessment schedule" of the Final Rule (pages 41389-41930) that allows exceptions to the general rules for the admission and discharge assessments to be specified in this manual.

Specifics for Scoring Function Modifiers and Relationship to FIM Item Scores

29. Bladder Level of Assistance: Score this item using FIM levels 1-7 (Do not use code "0"). See Section 3: The FIM™ Instrument: *Bladder Management – Level of Assistance* `in this manual for scoring definitions for this item. The admission assessment time frame for this item is the first 3 calendar days of the patient's inpatient rehabilitation admission. The discharge assessment time frame for this item is the last 3 calendar days of the patient's inpatient rehabilitation stay.

30. Bladder Frequency of Accidents: The assessment time frame for this item is 7 calendar days on admission and discharge. For admission assessments, this will include the four days prior to the rehabilitation admission, as well as the first 3 days in the inpatient rehabilitation facility. If information about bladder accidents prior to the rehabilitation admission is not available, record the scored based upon the number of accidents since the rehabilitation admission. For discharge assessments it includes the last 7 days of the inpatient rehabilitation stay with the day of discharge being the 7th day. Use the following scores for this item:

7- No accidents
6- No accidents; uses device such as a catheter
5- One accident in the past 7 days
4- Two accidents in the past 7 days
3- Three accidents in the past 7 days
2- Four accidents in the past 7 days
1- Five or more accidents in the past 7 days

The definition of bladder accidents is the act of wetting linen or clothing with urine, and includes bedpan and urinal spills by the patient. If the helper spills the container, it is not counted as a patient accident. For more information, see Section 3: The FIM™ Instrument*: Bladder Management – Frequency of Accidents* in this manual.

31. Bowel Level of Assistance: Score this item using FIM levels 1-7 (Do not use code "0"). For more information, see Section 3: The FIM™ Instrument*: Bowel Management – Level of Assistance* in this manual. The admission assessment time frame for this item is the first 3 calendar days of the patient's inpatient rehabilitation admission. The discharge assessment time frame for this item is the last 3 calendar days of the patient's inpatient rehabilitation stay.

32. Bowel Frequency of Accidents: The assessment time frame for this item is 7 calendar days on admission and discharge. For admission assessments, this will include the four days prior to the rehabilitation admission, as well as the first 3 days in the inpatient rehabilitation facility. If information about bowel accidents prior to the rehabilitation admission is not available, record the scored based upon the number of

accidents since the rehabilitation admission. For discharge assessments it includes the last 7 days of the inpatient rehabilitation stay with the day of discharge being the 7th day. Use the following scores for this item:

7- No accidents
6- No accidents; uses device such as an ostomy
5- One accident in the past 7 days
4- Two accidents in the past 7 days
3- Three accidents in the past 7 days
2- Four accidents in the past 7 days
1- Five or more accidents in the past 7 days

The definition of bowel accidents is the act of soiling linen or clothing with stool, and includes bedpan spills by the patient. If the helper spills the container, it is not counted as a patient accident. For more information, see Section 3: The FIM™ Instrument*: Bowel Management – Frequency of Accidents* in this manual.

33. Tub Transfer: Score this item using FIM levels 1 - 7 (A code of "0" if activity does not occur may be used for the admission assessment). For more information, see Section 3: The FIM™ Instrument*: Transfer: Tub* in this manual.

If the patient uses a tub for bathing during the assessment time period, record the associated FIM level (1 - 7) for Item 33. If a score is recorded in Item 33, do not score Item 34. That is, for each of the assessments (admission and discharge), a score should be recorded for Item 33 or 34 but not both items. If the patient does not transfer in/out of a tub or shower during the assessment time period, code Item 33 as "0" (Activity does not occur) and leave Item 34 blank. If the patient transfers into both the tub and shower during the assessment period, score the more frequent transfer activity.

If Item 33 is scored (i.e., tub is the mode of bathing), record the score for Item 33 in Item 39K (Transfers: Tub, Shower). Scores for Item 39K may range from 0 - 7 on Admission, and 1 - 7 on Discharge.

NOTE: For Tub/Shower Transfer, the mode on admission does NOT have to match the mode on discharge.

34. Shower Transfer: Score this item using FIM levels 1 - 7. For more information, see Section 3: The FIM™ Instrument*: Transfer: Shower* in this manual.

If the patient uses a shower for bathing during the assessment time period, record the associated FIM level (1 - 7) for Item 34. If a score is recorded in Item 34, do not score Item 33. That is, for each of the assessments (admission and discharge), a score should be recorded for Item 33 or 34 but not both items. If the patient does not transfer in/out of a tub or shower during the assessment time period, code Item 33 as "0" (Activity does not

occur) and leave Item 34 blank. If the patient transfers into both the tub and shower during the assessment period, score the more frequent transfer activity.

If Item 34 is scored (i.e., shower is the mode of bathing), record the score for Item 34 in Item 39K (Transfers: Tub, Shower). Scores for Item 39K may range from 0 - 7 on Admission, and 1 - 7 on Discharge.

NOTE: For Tub/Shower Transfer, the mode on admission does NOT have to match the mode on discharge.

35. Distance Walked: Code this item using:

3- 150 feet or greater
2- 50 to 149 feet
1- Less than 50 feet
0- Activity does not occur (e.g., patient uses only a wheelchair, patient on bed rest)

Scoring for Item 35 should be based upon the same episode of walking as that for Item 37 – Walk.

36. Distance Traveled in Wheelchair: Code this item using:

3- 150 feet or greater
2- 50 to 149 feet
1- Less than 50 feet
0- Activity does not occur (e.g., patient does not use wheelchair)

Scoring for Item 36 should be based upon the same episode of wheelchair use as that for Item 38 – Wheelchair.

37. Walk: Score this item using FIM levels 1 - 7 (code "0" if activity does not occur). Scoring this item requires consideration of both the level of assistance and the distance walked. For more information, see Section 3: The FIM™ Instrument*: Locomotion: Walk* in this manual.

Admission: Score Item 39L based upon the expected mode of locomotion at discharge. For example, if the patient uses a wheelchair at admission, and is expected to walk at discharge, enter in Item 39L the FIM score from Item 37 (Walk). If the patient uses a wheelchair at admission, and is expected to use a wheelchair at discharge, enter in Item 39L the FIM score from Item 38 (Wheelchair). If the patient walks at admission, and is expected to walk at discharge, enter in Item 39L the FIM score from Item 37 (Walk).

Discharge: Score Item 39L based upon the more frequent mode of locomotion at discharge. If the patient walks, enter in Item 39L the FIM score from Item 37 (Walk). If the patient uses a wheelchair, enter in 39L the FIM score from Item 38 (Wheelchair).

NOTE: In Item 39L, the mode of locomotion at admission must be the same as the mode of locomotion at discharge.

38. Wheelchair: Score this item using FIM levels 1 - 7 (code "0" if activity does not occur). Scoring this item requires consideration of both the level of assistance and the distance walked. For more information, see Section 3: The FIM™ Instrument*: Locomotion: Wheelchair* of this manual.

Admission: Score item 39L based upon the expected mode of locomotion at discharge. For example, if the patient uses a wheelchair at admission, and is expected to walk at discharge, enter in Item 39L the FIM score from Item 37 (Walk). If the patient uses a wheelchair at admission, and is expected to use a wheelchair at discharge, enter in Item 39L the FIM score from Item 38 (Wheelchair). If the patient walks at admission, and is expected to walk at discharge, enter in Item 39L the FIM score from Item 37 (Walk).

Discharge: Score Item 39L based upon the more frequent mode of locomotion at discharge. If the patient walks, enter in Item 39L the FIM score from Item 37 (Walk). If the patient uses a wheelchair, enter in 39L the FIM score from Item 38 (Wheelchair).

NOTE: In Item 39L, the mode of locomotion at admission must be the same as the mode of locomotion at discharge.

39. FIM™ INSTRUMENT

FIM™ Instrument: Score Items 39A through 39R at both admission and discharge using FIM levels 1 – 7. The following FIM items may be coded as "0" (Activity does not occur) on admission: Item 39A – Eating; 39B – Grooming; 39C – Bathing; 39D – Dressing-Upper; 39E – Dressing-Lower; 39F – Toileting; 39I – Transfers: Bed, Chair, Wheelchair; 39J – Transfers: Toilet; 39K – Transfers: Tub, Shower; 39L – Walk / Wheelchair; 39M – Stairs. If a patient expires while in the rehabilitation facility, record a score of Level 1 for all discharge FIM items. See Section 3: The FIM™ Instrument of this manual for further information.

Scoring FIM Goals at Admission: At the time of the admission assessment, enter the patient's FIM goal (i.e., expected functional status at discharge) for each of the FIM items (39A – 39R).

NOTE: The completion of the Goal section of the FIM Instrument is not required.

DISCHARGE INFORMATION

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

40. Discharge Date: Enter the date that the patient is discharged from the IRF or, in the case of a patient that dies in the IRF, the date of expiration. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD is the day of the month (e.g., from 01 to 31),* and *YYYY* is the full year (e.g., *2014*).

41. Patient discharged against medical advice? Enter one of the following codes:

0- No
1- Yes

42. Program Interruptions: A program interruption is defined as the situation where a Medicare inpatient is discharged from the inpatient rehabilition facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the 3rd calendar day. Use the following codes to indicate that a program interruption occurred:

0- No, there were no program interruptions
1- Yes, there was one or more program interruption(s)

43. Program Interruption Dates: If one or more program interruptions occurred (i.e., Item 42 is coded 1 – Yes), enter the interruption date and return date of each interruption. The interruption date is defined as the day when the interruption began (i.e, the day the patient was discharged from the inpatient rehabilitation facility). The return date is defined as the day when the interruption ended (i.e., the day the patient returned to the inpatient rehabilitation facility). As noted above for Item 42, a program interruption is defined as the situation where a Medicare inpatient is discharged from the inpatient rehabilition facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The dates should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD is the day of the month (e.g., from 01 to 31),* and *YYYY* is the full year (e.g., *2014*).

43A. 1st Interruption Date
43B. 1st Return Date

43C. 2nd Interruption Date
43D. 2nd Return Date

43E. 3rd Interruption Date
43F. 3rd Return Date

44C.Was patient discharged alive?

0- No

1- Yes

44D. Patient's discharge destination/living setting, using codes below:

(answer only if 44C= 1; if 44C= 0, skip to item 46)

01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate Care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (institutional facility)
61- Swing Bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

NOTE: The IRF-PAI discharge date must be the same as the claim date.

45. Discharge to Living With:

(Code only if item 44C is 1- Yes and 44D is 01- Home; Code using 1- Alone; 2- Family/Relatives; 3- Friends; 4- Attendant; 5-Other)

46. Diagnosis for Interruption or Death: Code using the ICD code indicating the reason for the program interruption or death (e.g., acute myocardial infarction, acute pulmonary embolus, sepsis, ruptured aneurysm, etc.). If the patient has more than one interruption, record the most significant diagnosis in this item.

47. Complications during rehabilitation stay: Enter up to six (6) ICD codes reflecting complications. The ICD codes entered here, including E-codes, represent complications or comorbidities that began after the rehabilitation stay started. To clarify the instructions on the IRF-PAI, the word "began" means any condition recognized or identified during the rehabilitation stay. These codes must not include the complications and/or comorbidities recognized on the day of discharge or the day prior to the day of discharge. These data will be used by CMS as part of its ongoing research and to determine what, if any, refinements should be made to the IRF-PPS payment rates. These ICD codes identify complications and/or comorbid conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.

Relationship Between Complications and Comorbid Conditions: All ICD codes listed as

Complications (Item 47) may also appear in Item 24 as Comorbid Conditions. Coding conditions that were identified after the start of the rehabilitation stay separately from conditions identified at the start of the rehabilitation stay will allow CMS as part of its ongoing research to determine what, if any, refinements should be made to the IRF PPS.

THERAPY INFORMATION

O0401. Week 1: Total Number of Minutes Provided: This item will be completed as part of the patient's discharge assessment. In this section, the IRF will record how many minutes of Individual, Concurrent, Group, and Co-Treatment therapy the patient received, according to each therapy discipline (that is, physical therapy, occupational therapy, and speech-language pathology), during the first week of the IRF stay.

NOTE: Week- A week is a 7 consecutive calendar day period starting with the day of admission. This item should be completed regardless of whether the patient stays a full 7 days.

Example: Mr. W is admitted to the IRF on 11/1/2015 and is discharged on 11/5/2015. Week 1 should include therapy minutes provided beginning 11/1/2015 (Day 1 of the IRF stay) through 11/5/2015 (Day 5 of the IRF stay).

O0402. Week 2: Total Number of Minutes Provided: This item will be completed as part of the patient's discharge assessment. In this section, the IRF will record how many minutes of Individual, Concurrent, Group, and Co-Treatment therapy the patient received, according to each therapy discipline (that is, physical therapy, occupational therapy, and speech-language pathology) during the second week of the IRF stay.

NOTE: Week 2 begins on Day 8 of the IRF stay and this item is completed regardless of whether the week is a full 7 days. This item should be completed regardless of whether the patient stays a full 14 days.

Example: Mrs. C is admitted to the IRF on 11/1/2015 and is discharged on 11/14/2015. Week 1 should include therapy minutes provided beginning 11/1/2015 (Day 1 of the IRF stay) through 11/7/2015 (Day 7 of the IRF stay). Week 2 should include therapy minutes provided beginning 11/8/2015 (Day 8 of the IRF stay) through 11/14/2015 (Day 14 of the IRF stay).

Example: Mr. T is admitted to the IRF on 11/1/2015 and is discharged on 11/11/2015. Week 1 should include therapy minutes provided beginning 11/1/2015 (Day 1 of the IRF stay) through 11/7/2015 (Day 7 of the IRF stay). Week 2 should include therapy minutes provided beginning 11/8/2015 (Day 8 of the IRF stay) through 11/11/2015 (Day 11 of the IRF stay).

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

**The therapy items on the IRF-PAI are strictly a data collection exercise *only* for weeks 1 and 2 of the IRF stay and should not be used as a way of documenting the amount of therapy provided. While these therapy data collection items are not being used as verification to ensure providers are meeting the intensive therapy coverage requirements, providers should continue to ensure they are satisfying all coverage requirements regarding intensive therapy.

Helpful Terminology and Information

Individual Therapy: The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) to one patient at a time (this is sometimes referred to as "one-on-one" therapy).

Concurrent Therapy: The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating 2 patients at the same time who are performing different activities.

NOTE: When conducting concurrent and group therapy sessions, start and end times do not need to be the same for all patients participating. The exact time spent for each patient participating in a concurrent or group therapy session should be reported as such. Any additional time either prior to or following participation in a group or concurrent therapy session that a patient receives one-on-one therapy should be recorded as individual therapy. We believe that providers will be able to accurately and effectively document the amount of time that the patient is receiving therapy, as well as the correct mode.

Group Therapy: The provision of therapy services by one licensed/certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating 2-6 patients at the same time who are performing the same or similar activities.

NOTE: The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF.

NOTE: The therapist may only provide therapy to one group at a time. Example: One therapist is not allowed to provide therapy to two groups of 6 patients. This

will NOT meet the definition stated above.

Co-Treatment Therapy: The provision of therapy services by more than one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed therapist) from different therapy disciplines to 1 patient at the same time.

NOTE: Co-treatment is appropriate for specific clinical circumstances and would not be suitable for all patients; therefore, its use should be limited. Co-treatment may not be used for the accommodation of staffing schedules. The specific benefit to the patient of the co-treatment must be well-documented in the IRF medical record.

Examples of Modes of Therapy

Individual Therapy- A speech-language pathologist treats only Patient A for 30 minutes for aphasia therapy following a stroke. Patient A's speech- language therapy would be coded as 30 minutes of individual therapy on the IRF-PAI.

Concurrent Therapy- Patient A begins physical therapy to address lower extremity strengthening at 9:00 am. Patient B enters at 9:30 am and beings working with the same therapist on upper extremity range of motion. Both patients engage with the PT until 10:00 am. At that time, Patient A leaves and Patient B continues her exercises until 10:30 am.

Patient A should be recorded as receiving individual therapy from 9:00 am to 9:30 am and concurrent therapy from 9:30 am to 10:00 am.

Patient B should be recorded as receiving concurrent therapy from 9:30 am to 10:00 am and individual therapy from 10:00 am to 10:30 am.

Thus, a total of 30 minutes of individual physical therapy and 30 minutes of concurrent physical therapy would be recorded for both patients.

Group Therapy- A speech-language pathologist is working with Patients A, B, C, and D in a communication group. At 2:00 pm the group begins with all four patients present. At 2:12 pm, Patient A leaves to go to the bathroom and returns at 2:28 pm. At 2:37 pm, Patient B leaves for an appointment and does not return. The communication group ends at 3:00 pm. This scenario should be coded as follows:

Patient A- Total minutes of Group therapy: 44 minutes (2:00 pm- 2:12 pm, 2:28 pm to 3:00 pm)
Patient B- Total minutes of Group therapy: 37 minutes (2:00 pm to 2:37 pm)
Patient C- Total minutes of Group therapy: 60 minutes (2:00 pm to 3:00 pm)

Patient D- Total minutes of Group therapy: 60 minutes (2:00 pm to 3:00 pm)

NOTE: If at any time, there is only one patient remaining from the original group, then the time spent with this patient would be coded as individual therapy.

Co-Treatment- A physical therapist and occupational therapist do a transfer exercise with Patient D for 30 minutes. A total of 30 minutes of co-treatment time would be coded for each discipline (PT and OT) on the IRF-PAI for this session.

Coding Example

Ms. F. was admitted to the IRF on 10/19/2015 following a stroke. Her therapy regimen was as follows:

On 10/19/2015, she was evaluated by all three therapy disciplines. The Physical Therapist (PT) evaluation took 65 minutes, the Occupational Therapist (OT) evaluation took 50 minutes and the Speech-Language Pathologist (SLP) evaluation took 75 minutes.
Code: Individual PT: 65 minutes, Individual OT: 50 minutes, Individual SLP: 75 minutes

On 10/20/2015, Ms. F. was seen for a one-on-one (individual therapy) PT session in the morning for 30 minutes to work on gait training. Additionally, she worked on lower extremity strengthening in the afternoon at the same time as another patient who was working on upper extremity strengthening with PT for 40 minutes. OT and SLP saw Ms. F. at the same time for 60 minutes to work on feeding and swallowing respectively.
Code: Individual PT: 30 minutes, Concurrent PT: 40 minutes, OT Co-Treatment: 60 minutes, SLP Co-Treatment: 60 minutes

On 10/21/2015, Ms. F. was treated by PT along with 3 other patients in a group balance activity for 45 minutes. Ms. F was then seen for a one-on-one (individual therapy) OT session to address cognitive perception for 60 minutes. Ms. F. was also seen for a one-on-one (individual therapy) SLP session during lunch for dysphagia for 68 minutes.
Code: Group PT: 45 minutes, Individual OT: 60 minutes, Individual SLP: 68 minutes

On 10/22/2015, Ms. F. was seen for a one-on-one (individual therapy) PT session in the morning for 50 minutes for gait training. She was then seen for a one-on-one (individual therapy) PT session in the afternoon for a transfer activity for 30 minutes. Ms. F. was later seen for a one-on-one (individual therapy) OT session for 60 minutes to address ADLs. Lastly, Ms. F. was seen for a one-on-one (individual therapy) SLP session during lunch for dysphagia for 58 minutes.
Code: Individual PT: 80 minutes, Individual OT: 60 minutes, Individual SLP: 58 minutes

On 10/23/2015, Ms. F. was seen for a one-on-one (individual therapy) PT session for endurance training for 65 minutes. She then attended an OT cooking group for 45 minutes along with 4 other patients. Ms. F. was then seen for a one-on-one (individual therapy) SLP session for 30 minutes to do oral motor exercises and another one-on-one (individual therapy) SLP session 40 minutes during lunch for swallowing therapy.
Code: Individual PT: 65 minutes, Group OT: 45 minutes, Individual SLP: 70 minutes

On 10/24/2015, Ms. F. was seen for a one-on-one (individual therapy) PT session for 60 minutes of gait training. OT and speech saw her together for dysphagia and feeding therapy during lunch for 70 minutes.
Code: Individual PT: 60 minutes, OT Co-Treatment: 70 minutes, SLP Co-Treatment: 70 minutes

On 10/25/2015, PT treated Ms. F for 65 minutes in a group of 6 people and they worked on upper and lower extremity strengthening. Ms. F. was seen for a one-on-one (individual therapy) OT session to work on ADL training for 45 minutes and SLP then saw her at the same time as one other person while she worked on oral motor exercises and the other patient was doing a cognitive exercise for 30 minutes.
Code: Group PT: 65 minutes, Individual OT: 45 minutes, Concurrent SLP: 30 minutes

Item O0401. Week 1: Total Number of Minutes Provided should be filled out as follows:

O0401A: Physical Therapy

a) Total minutes of Individual therapy	300
b) Total minutes of concurrent therapy	40
c) Total minutes of group therapy	110
d) Total minutes of co-treatment therapy	0

O0401B: Occupational Therapy

a) Total minutes of Individual therapy	215
b) Total minutes of concurrent therapy	0
c) Total minutes of group therapy	45
d) Total minutes of co-treatment therapy	130

O0401C: Speech-Language Pathology

a) Total minutes of Individual therapy	271
b) Total minutes of concurrent therapy	30
c) Total minutes of group therapy	0
d) Total minutes of co-treatment therapy	130

SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

Coding Tips

- Therapy minutes cannot be rounded for the purposes of documenting therapy provided in an IRF.

- Therapy evaluations do count as the initiation of therapy services.

- The time spent in family conferences does not count towards counting therapy minutes on the IRF-PAI.

- "Therapy time" is time spent in direct contact with the patient. Time spent documenting in the patient's medical record, unsupervised modalities, and significant periods of rest are examples of time not spent in direct contact with the patient and, therefore, may not be documented in this section of the IRF-PAI.

- If the patient has an interrupted stay, record the total number of minutes of therapy the patient received in the IRF for that week the same as if the interrupted stay did not occur. As long as the IRF records the interrupted stay in items 42 and 43 of the IRF-PAI, we will account for the presence of the interrupted stay in analyzing the data.

QUALITY INDICATORS

For information on scoring the IRF-PAI Quality Indicators, see Section 4: Quality Indicators in this manual.

SIGNATURE PAGE

Z0400A. Signature Page: Any staff member that has gathered information from a patient's medical record and used it to complete any section of the IRF-PAI is responsible for signing the signature page. Additionally, each time a staff member completes and/or updates information on the IRF-PAI, they are required to sign the signature page. For example, if a staff member completes an item on the IRF-PAI day 4 of the patients stay and then again on day 14, the staff member should sign the signature page twice, once with the date of day 4 and again with the date of day 14. The title column should be completed with the professional title of the staff person that is completing IRF-PAI information. Lastly, the date column should be completed with the date in which the information was added to and/or updated on the IRF PAI.

The signature page is the last page of the IRF-PAI document. Providers are required to complete the signature page in order to stay in compliance with the IRF-PAI requirement. While the signature page will not be transmitted to CMS, it is a required document for

providers to include in each patient's medical record, to ensure they are compliant with the hospital Conditions of Participation located in the Code of Federal Regulations (CFR) at 482.24(c)(1).

NOTE: This section does not need to be completed by every person that contributes to the patient's medical record. Only the person/people that are completing the IRF-PAI, using information compiled from the patient's medical record, are required to sign the signature page.

NOTE: IRFs may use electronic signatures for the IRF-PAI when permitted to do so by state and local law and when authorized by the IRFs policy. IRFs must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signatures by anyone other than the person to whom the electronic signature belongs.