June 2020 CMS Quarterly IRF-PAI Q&As

Contents

This document is intended to provide guidance on IRF-PAI questions that were received by CMS help desks. Responses contained in this document may be superseded by guidance published by CMS at a later date.

Quality Indicators (QI): General Questions

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

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

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

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

Question 2: Is it allowable to use the BIMS information that was completed on days 4, 5, 7 or 8 on patients to complete the IRF-PAI or would we dash the BIMS items since it was not completed during the 3-day admission assessment period?

Answer 2: The Brief Interview for Mental Status (BIMS) should be attempted with all patients during the 3-day admission assessment period.

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

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

GG0130, GG0170

Question 3: For section GG what is the definition of "therapeutic intervention"?

Answer 3: At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff. "Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding.

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

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

Question 4: Establishing a goal is required for at least one self-care or mobility activity in section GG. Can the GG goals be changed once established during the first 3 days if the patient's status changes?

Answer 4: The GG Self-care and Mobility Discharge Goals are used in the calculation of the Process Measure – Percentage of Patients with an Admission and Discharge Function Assessment and a Care Plan that Addresses Function. The measure reports, in part, that discharge goals were established, and does not take into consideration whether or not the goals were met. Once a goal is established, there is no need to update it if circumstances change or additional information becomes available either within or after the 3-day assessment time period.

Question 5: I am seeking clarification on how to accurately code the admission assessments for Section GG0130 Self-care and GG0170 Mobility when a patient leaves AMA before the admission assessment is completed.

Question # 17 of the CMS document "*Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) Questions and Answers, Current as of October 2019*" regarding incomplete stays asked "What if the patient is discharged before we complete the admission assessment?" A portion of the answer stated that for "GG0130 – Self-Care and GG0170 – Mobility: Admission Self-Care and Mobility Performance – Code to the best of your abilities. If you are unable to assess the patient because of medical issues, enter Code 88, Not assessed due to medical condition or safety issues." This seems to take into consideration when the patient is discharged back to the acute care unit due to a medical condition but not when a patient leaves AMA before the admission assessments are completed.

Would it be appropriate to use Code 07-Patient refused if an assessment was not done because of the patient leaving AMA?

Answer 5: Patients who meet the criteria for incomplete stays include patients who are discharged to an acute care setting (such as short-stay acute hospital, critical access hospital, inpatient psychiatric facility, or long-term care hospital), patients who die while in the IRF, patients who leave the IRF against medical advice (AMA), and patients with a length of stay less than 3 days.

If the patient's IRF stay is less than 3 days, and ends before the admission assessment was completed, code GG0130 and GG0170 performance to the best of your abilities. If the patient refused rehab at the IRF and left AMA before the admission assessment was completed, use Code 07-Patient refused.

Question 6: The IRF-PAI manual for section GG clarifies that a Code 03-Partial/moderate assistance indicates the helper is required to provide less than half the effort and a Code 02-Substantial/maximal assistance indicates the helper is required to provide more than half the effort. If a helper is required to provide exactly half the effort, how would the item be coded?

Answer 6: In the situation described, the helper and patient each are providing exactly half of the effort to complete a GG activity. If the patient performs half of the effort, code the item 03-Partial/moderate assistance.

Question 7: On day 2, during an evaluation, the physical therapist feels the patient is unable to complete an activity such as sit to stand without providing therapy services; for example: skilled instruction on safe body mechanics for transfers or proper technique to maintain weight bearing restrictions. Is it appropriate to code 88 as the admission QI assessment of baseline functional status prior to benefiting from therapy services? PT initiates treatment by providing a walker, instructing in its use, and offering cues for proper technique. The patient performed sit to stand transfers with moderate assistance the rest of the day 2 and day 3.

Answer 7: At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff.

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

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

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

Communicating the activity request (i.e., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity ("Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.

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

GG0130B

Question 8: A helper gathers and sets out the patient's oral hygiene items. The patient is able to brush their teeth with steadying assist from a helper while standing at the sink. What is the code for oral hygiene?

Answer 8: The intent of GG0130B - Oral hygiene is to determine the patient's ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

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

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

GG0130C

Question 9: A patient used a bedpan for both bowel and bladder and was able to lift and lower her hospital gown (no brief or underwear were stated to be present), and the patient was not able to perform any of her own perineal hygiene for bowel or bladder. How is Toileting hygiene coded?

Answer 9: The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes before and after voiding or having a bowel movement.

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

GG0130E

Question 10: If a patient is accustomed to washing their face when they perform grooming tasks and they do not wash their face again while bathing the rest of their body at another time during the day, is it acceptable to combine information to score bathing for item GG0130E?

Answer 10: The intent of GG0130E - Shower/bathe self, is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). The activity does not include transferring in/out of tub/shower.

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

Question 11: We have a patient who agreed to shower with OT on day 2 of admission but would not let the OT help her at all after the tub transfer. The only thing the patient did was wet her body and wash her abdomen. She would not let the therapist complete tasks for thoroughness and cleaning. Could she still be coded as 03 – Partial/moderate assistance because she completed less than half the tasks? OT does not want to put her at supervision level because she did not perform well.

Answer 11: The intent of GG0130E - Shower/bathe self, is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). The activity does not include transferring in/out of tub/shower.

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

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

Question 12: For a patient who stood while showering prior to this illness, should we now be assessing and scoring showering/bathing based on the patient's status standing?

Answer 12: The intent of GG0130E - Shower/bathe self, is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). The activity does not include transferring in/out of tub/shower.

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

GG0130F, GG0130G, GG0130H

Question 13: A patient can dress her upper body, except for requiring assistance with her bra clasp. Should the code be 04-Supervision or touching assistance, or 03-Partial/moderate assistance?

Answer 13: If a patient requires assistance with dressing including assistance with any type of fasteners (e.g. with buttons, zippers and/or fastening a bra) code based on the type and amount of assistance required to complete the entire upper body dressing activity. If a patient requires assistance with fasteners and a helper provides less than half the effort code 03-Partial/moderate assistance. Note that this is a change from previous guidance that considered buttons and/or fasteners as incidental help, which was previously coded as 04-Supervision or touching assistance.

GG0130G

Question 14: If a patient is wearing a hospital gown and underwear the first time a functional assessment is conducted, is this scenario acceptable to rate lower body dressing? Or if on the following day during the assessment period, if the patient is wearing more items including underwear and shorts/pants, should we use this scenario instead as a true baseline of their lower body dressing ability?

Answer 14: The intent of GG0130G – Lower body dressing is to assess the patient's ability to dress and undress below the waist, including fasteners, if applicable.

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

Use clinical judgment to determine if observing the patient dress and undress in the lower body clothing item (i.e. underwear) worn during the first assessment allows the clinician to adequately assess the patient's ability to complete the activity of lower body dressing (GG0130G). If the

clinician determines that this observation is adequate, code based on the type and amount of assistance the patient required to complete the activity.

GG0130H

Question 15: As the definition of "Footwear" states that it "includes the ability to put on and take off socks and shoes", how should coding occur when only one of these items (socks or shoes) is worn by the patient?

Answer 15: The intent of GG0130H – Putting on/taking off footwear is to determine a patient's ability to put on and take off socks and shoes or other footwear.

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

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

GG0170C

Question 16: How do we code lying to sitting on side of bed for a bilateral amputee not wearing their prosthetics, since the definition states "with feet on floor"?

Answer 16: If the patient with a unilateral (or bilateral) lower extremity amputation does not have or is not wearing a prosthesis (or prostheses), use clinical judgment to determine if the patient completes the activity (Lying to sitting on side of bed without back support). Code the activity based upon the type and amount of assistance the patient requires to safely complete the activity.

GG0170G

Question 17: In the assessment of a patient's ability to perform a car transfer, does adjusting the car seat constitute 05-Setup? For example, after the helper reclined the seat to accommodate the patient's total hip precautions, the patient did not need any additional help to get into or out of the car.

Answer 17: The intent of GG0170G – Car transfer is to assess the patient's ability to transfer in and out of a car or van on the passenger side. This does not include the ability to open/close door or fasten seat belt.

Code 05-Setup or clean-up assistance is selected when a patient requires a helper to set up or clean up; patient completes the activity and the helper is required to assist only prior to or following the activity. In the scenario described, assuming the seat adjustment was required for safe completion of the activity, and no assistance was required during the safe transfer in and out of the car, then the seat adjustment would be coded as 05-Setup.

Question 18: If at discharge we assess the patient getting into their car to leave our facility, can we code this OR do we have to see transfers both in and out of car in order to code?

Answer 18: The intent of GG0170G – Car transfer is to assess the patient's ability to transfer in and out of a car seat or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

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

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

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

GG0170I, GG0170J, GG0170K, GG0170L

Question 19: Many of our patients with a stroke ambulate with PT along a railing mounted in the hall. We understand that walking/transferring in the parallel bars would not be used to code the GG activities. Could coding be based on the patient walking in the hallway if using a railing as a support?

Answer 19: The intent of the walking items (GG0170I, GG0170J, GG0170K, and GG0170L) is to assess the patient's ability to ambulate once in a standing position.

As noted in your question, you would not code self-care and mobility activities with use of a device that is restricted to patient use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems). Note that while a patient may use a hallway railing during therapy sessions, its use would not be restricted to therapy sessions only and therefore does not meet the definition described above.

CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Other than the exceptions listed above, clinical assessments may include any device or equipment (including a hallway railing) that the patient can use to allow them to safely complete the activity as independently as possible.

GG0170I

Question 20: How would you code a situation where the patient walks part of the distance, say 4 feet, and then the helper carries them the remaining distance to get to the 10 feet needed for GG0170I – Walk 10 feet? Would this be a Code 02-Substantial/maximal assistance because the helper is carrying the patient the majority of the distance? We understand that with the wheelchair activities a helper can complete the distance needed by pushing the patient in the wheelchair. Is this also true for the walking items?

Answer 20: The intent of the walking item GG0170I – Walk 10 feet is to assess the type and amount of assistance a patient requires to ambulate 10 feet once in a standing position.

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

In your scenario, where the patient participates in walking 4 feet and then requires the helper to carry them for further distances, the activity walking 10 feet (GG0170I) is not considered completed. If the stated distance of 10 feet was not walked by the patient, with or without some level of assistance, GG0170I would be coded with one of the "activity not attempted" codes, for example 88-Not attempted due to the medical condition or safety concerns.

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

GG0170M, GG0170N, GG0170O

Question 21: When we initiate the assessment of GG0170M – 1 step (curb), we determine that the patient is not able to go up/down the curb due to medical/safety reasons. Are we then required to assess using a single step (i.e. the bottom step of a set of practice steps)?

Answer 21: There is no requirement to assess a patient going up and down both a curb AND a step. However, since coding GG0170M – 1 step (curb) with a 07, 09, 10 or 88 results in skipping GG0170N – 4 Steps and GG0170O – 12 Steps, when a patient is unable to go up and down a curb, you may want to consider assessing the patient's ability to go up and down 1 step in order to possibly capture performance codes of 06 through 01 for one or more of the stair items, if that patient can complete them with assist and/or a railing.

GG0170N, GG0170O

Question 22: When assessing the GG activities for 4 and 12 steps, the patient is able to navigate 4 and 12 steps by bumping up and down them with supervision. However, he needs assist getting seated on the step, and again to come to standing once completed with the steps. Is the assist required to sit on the step or to come to standing considered when coding these two stair items?

Answer 22: The intent of Section GG stair activities is to assess the patient's ability to go up and down 1 step/curb, 4 steps, and 12 steps. Clinicians should code based on the type and amount of assistance required for the patient to complete the stair activities as independently and safely as possible. Do not consider the stand-to-sit or sit-to-stand transfer when coding any of the step activities.

GG0170P

Question 23: We understand that verbal cueing during a task should fall under the score of 04-Supervision or touching assistance. Our question is can a verbal cue provided prior to the task be considered set up as long as no further cues were provided during the actual task?

A specific example we just encountered was during the "Picking up an item from the floor" activity. The therapist cued the patient prior to the activity where to place their hand for stability (in a novel environment), and then the patient completed all of the activity safely and without further cues or assistance. Is this Code 05-Setup or Code 04-Supervision?

Answer 23: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe. At admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity prior to benefit of services provided by your facility/staff. This may be achieved by having the patient

attempt the activity prior to providing any instruction that could result in a more independent code, and coding based on the type and amount of assistance required.

Communicating the activity request (i.e., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity ("Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree.

In the scenarios described, assuming the verbal cues were only provided prior to the benefit of services and were required, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues would be considered 05-Setup.

GG0170Q

Question 24: We have a question regarding the appropriate scoring for an IRF patient who does not use a wheelchair during the admission assessment, but then begins to use a wheelchair later during the IRF stay. Our system software will not allow us to upload goals after the 3-day admission assessment has ended. When a patient does begin using a wheelchair later in the stay, would it be appropriate to go back to the initial wheelchair assessment on the IRF-PAI and change GG0170Q to "YES" and add the corresponding goals even though they were established after the admission assessment has ended?

Answer 24: The intent of GG0170Q – Does the patient use a wheelchair and/or scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. Only code 0-No if, at the time of the assessment, the patient does not use a wheelchair or scooter under any condition.

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

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

GG0170S

Question 25: A patient was able to propel his wheelchair for 100 feet with moderate assistance. He was unable to go farther and the therapist pushed the wheelchair the rest of the way to the gym, which was a total of 150 feet. What score would you give this patient for GG0170S - Wheel 150 feet?

Answer 25: The intent of GG0170S – Wheel 150 feet is to assess the patient's ability, once seated in wheelchair/scooter, to wheel at least 150 feet. If the patient is unable to complete the entire distance required for this activity the assessing clinician can assist the patient to complete the activity, and code this item based on the type and amount of assistance required to complete the entire activity.

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

H0400

Question 26: If a patient only has one bowel movement during the admission assessment period, and that bowel movement is incontinent, how would H0400 be coded? With the current verbiage in the IRF-PAI manual, it meets the definition of two scores; code 3 (because all bowel episodes were incontinent) and code 1 (because the patient only had one bowel movement). There was a reference from a training in 2016 that states the scenario would be coded as Code 1-Occasionally incontinent. Is this still true?

Answer 26: The intent of H0400 – Bowel Continence is to gather information on the frequency of bowel continence during the 3-day assessment period. Code 1-Occasionally incontinent should only be selected if during the 3-day assessment period the patient was incontinent for bowel movement once. This includes incontinence of any amount of stool at any time. Code 3-Always incontinent is selected if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).

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

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

M0300

Question 27: I am seeking guidance on how to complete the IRF-PAI accurately in this scenario. Patient is admitted with an Unstageable - Deep Tissue Injury on his right heel. On discharge, the nurse's assessment of the patient right heel was that DTI had become Unstageable - due to the presence of eschar. How do we code M0300 at Discharge?

Answer 27: For each pressure ulcer/injury observed at discharge, consider current and historical levels of tissue involvement. Discharge coding for the scenario described is dependent upon the clinical progression of the wound during the IRF stay.

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

M0300F1. Unstageable - Slough and/or eschar = 1
M0300F2. Unstageable - Slough and/or eschar = 1
M0300G1. Unstageable - Deep tissue injury = 0
M0300G2. Unstageable - Deep tissue injury = skip

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