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

March 2025

Consolidated June 2020 to March 2025

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Introduction

The Centers for Medicare & Medicaid Services (CMS) is publishing the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Quarterly Q&As, so that all IRF providers have the benefit of the clarifications to existing guidance. Through inquiries to the IRF Post-Acute Care (PAC) Quality Reporting Program (QRP) Help Desk, CMS identifies the opportunity to clarify or refine guidance.

CMS has archived some Q&As either because the guidance has been added to the IRF-PAI 4.2 Manual, or the Q&As have been retired. The archived Q&As can be found in the IRF Quality Reporting Archives here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Archives

New Q&As Added in March 2025

1. Quality Indicators (QI)

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Quality Indicators (QI): General Questions

Question 1: Archived June 2022

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Question 4: Several of the items have a copyright. Does a facility need to get permission to include the items in the IRF medical record for data collection?

Answer 4: The IRF-PAI includes a few copyright items such as D0150 - Patient Mood Interview (PHQ-2 to 9). CMS has obtained permission to use these items in the IRF-PAI 4.2. Your facility has permission to use these items within the IRF-PAI assessment only.

Added: September 2022, Edited: December 2024

Question 5: Can information collected prior to admission to an IRF be used when completing items such as A1005 - Ethnicity, A1010 - Race, A1110 - Language, A1250 - Transportation, B1300 - Health Literacy, and D0700 - Social Isolation? Our EMR is able to pull this information directly into the IRF-PAI from the information collected during the preadmission screening.

Answer 5: If information used to complete the IRF-PAI is gathered prior to the patient's admission this information should be verified, and coded following applicable coding guidance, during an assessment that occurs during the 3-day admission assessment time period.

A facility's software should not answer or generate IRF-PAI responses for the assessing clinician.

Please note that based on coding guidance, the medical record should not be used as the data source for coding Health Literacy and Social Isolation. Also note that the medical record should not be used as the data source for coding Ethnicity, Race, Language, and Transportation unless the patient and proxy are unable to respond during the admission or discharge assessment time periods.

Added: September 2022

Question 6: If a patient has an unplanned discharge within the first 3 days of admission, would it be acceptable for C1310 - Signs and Symptoms of Delirium, to have the same score on admission and discharge since the assessment time periods overlap?

Answer 6: Each IRF-PAI item should be considered individually and coded based on the guidance provided for that item at each assessment time period.

It is possible that the admission and discharge coding for an item like C1310 will be the same when an unplanned discharge occurs within the first 3 days of admission.

Added: March 2023, Edited: March 2024

Question 7: Can CMS provide clarification on when item 14 - Admission Class should be coded as 4 - Unplanned Discharge? We thought that 4 was coded when there was an unplanned discharge in the first 3 days of admission to the IRF. However, the definition of an unplanned discharge in recent guidance only includes the following situations:

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

Does this mean any time a patient is discharged from the IRF for one of these reasons, item 14 should be coded as an unplanned discharge?

Answer 7: For the purposes of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) V4.2, an unplanned discharge is defined as:

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

For item 14 - Admission Class, response 4 - Unplanned Discharge specifically states this is a stay that lasts less than 3 calendar days because of an unplanned discharge.

Any of the scenarios from the unplanned discharge definition that occur within the first 3 days of the IRF stay would meet the intent of reporting an unplanned discharge for item 14 - Admission Class.

If the patient's stay is more than 3 days and any of the scenarios from the unplanned discharge definition occur, then the IRF stay would be considered an unplanned discharge for purposes of utilizing general unplanned discharge coding guidance. The stay would not meet the intent of reporting an unplanned discharge for item 14 - Admission Class.

Added: June 2023, Edited: December 2024

Question 8: Archived March 2024

Question 9: If a patient is confused and consistently does not respond appropriately to questions, is the clinician required to ask the questions for the social determinants of health (SDOH) IRF-PAI items, such as A1005 - Ethnicity, A1010 - Race, A1250 - Transportation, B1300 - Health Literacy, and D0700 - Social Isolation?

Answer 9: Each IRF-PAI item should be considered individually and coded based on guidance specific to that item.

For A1005 - Ethnicity, A1010 - Race, and A1250 - Transportation, use clinical judgment to determine if the patient is able to respond. If the patient is unable to respond, a proxy response may be used. If neither the patient nor a proxy is able to provide a response to this item, medical record documentation may be used.

If it is determined that the patient is unable to respond, Code X - Patient unable to respond. If response(s) is/are determined via proxy input, and/or medical record documentation, check **all** boxes that apply, including Code X - Patient unable to respond.

For B1300 - Health Literacy and D0700 - Social Isolation use clinical judgment to determine if the patient is able to respond. These items are intended to be patient self-report items. No other source should be used to identify the response. If the patient is unable to respond, Code 8 - Patient unable to respond.

Added: September 2024

Question 10: Is submission of a completed IRF-PAI required for patients under the age of one?

Answer 10: Submission of the IRF-PAI is not required for patients under the age of one. Additional details can be found in the IRF PAI Chapter 2 Overview Errata: https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual.

Added: December 2024; Edited: March 2025

[NEW] Question 11: If a patient's payer source changes during the IRF stay (even after only one day), does a new IRF-PAI need to be completed?

Answer 11: If a patient has a payer change during an IRF stay, a new IRF-PAI may be required. (See page A-30 of the IRF-PAI Manual, V4.2, for examples.) This is dependent on the requirements of the prior and/or the new payer(s). For example, if the patient becomes a Medicare fee-for-service beneficiary, IRF PAI admission assessment data for the effective FFS coverage date would be needed for a case mix group to be assigned. Therefore, in this example, a new IRF PAI would be needed.

For questions about Managed Medicare, please contact the specific payer.

For questions about Medicare FFS (fee-for-service), please contact your local MAC. You can contact your MAC by visiting the link copied here. Click on your state on the map or select it from the drop-down list below the map. Contact information for your state will then be displayed below the map. You can find your Regional Office at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/Index

Added: March 2025

Section A: Administrative Information

25A, 26A

Question 1: Archived June 2022

Question 2: If a patient's height and/or weight was not measured within the 3-day admission assessment period for 25A - Height on admission and 26A - Weight on admission, is it okay to use a height and/or weight that was measured day 5?

Answer 2: In order to be compliant, the admission assessment must be completed by the end of the 3-day assessment period (i.e., midnight of the third calendar day). If a patient's height and/or weight cannot be measured during the 3-day assessment period, enter a dash (–) to indicate "no information" for 25A - Height on admission and/or for 26A - Weight on admission. CMS expects dash use to be a rare occurrence.

Added: June 2021

25A

Question 1: Archived June 2022

44D

Question 1: Archived June 2022

Question 2: A patient who was admitted to IRF was planning on being discharged to a SNF on 2/14/22 however prior to discharge the patient was sent to the emergency department (ED). The ED then discharged the patient home with home care services the following day, on 2/15, rather than sending them to the SNF. How do we code 44D - Patient's discharge disposition/living setting for this scenario?

Answer 2: When a patient is transported from the IRF to an emergency department (ED) or observation status, and they do not return to the IRF within 3 days, complete a discharge assessment and code the discharge destination as the first subsequent provider setting the patient is admitted to immediately following the ED and/or observation stay. If a patient remains in ED and/or observation status for > 3 days, code the discharge destination as Code 99 - Not listed.

A subsequent provider is defined as a short-term general hospital, a SNF, intermediate care, home under care of an organized home health service organization or hospice (home), hospice in an institutional facility, an IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a Critical Access Hospital (CAH).

In the scenario, if the patient was transported from the IRF to an ED and within 3 days is discharged home from the ED to receive home care from a Medicare-certified home health agency, code 44D – Patient's discharge destination/living setting as 06 - Home under care of an organized home health service organization.

Added: March 2022

Question 3: If a patient is being discharged from the IRF and will receive homemaker services should code 06 - Home under care of organized home health service organization be coded for item 44D - Patient's discharge destination/living setting?

Answer: Code 44D - Patient's discharge destination/living setting based on the information known at discharge regarding where the patient will reside, and the services the patient is expected to receive after discharge from the facility.

If a patient is discharged home to receive any services from a Medicare-certified home health agency, code 06 - Home under care of organized home health service organization.

If a patient is discharged home (private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) without any services from a Medicare-certified home health agency, code 01 - Home.

The updated guidance for Code 06 - Home under care of organized home health service organization also applies to coding items 15A - Admit From and 16A - Pre-Hospital Living Setting.

Added: December 2023

A1250

Question 1: Please provide an example of where the codes for A1250 - Transportation change from admission to discharge.

Answer 1: The intent of A1250 - Transportation is to identify if a lack of transportation has kept the patient from medical appointments, meetings, work, or from getting things needed for daily living over the past 6 to 12 months. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how this item applies for each individual patient at both the admission and discharge time points.

It is possible that the admission and discharge coding are the same.

Added: September 2022

Question 2: Archived March 2024

A1400

Question 1: If the payer source is not Medicare, how is the IRF-PAI completed for an interrupted stay?

Answer 1: CMS considers an interrupted stay as a transfer which lasts 3 calendar days or less and returns to the same IRF as one combined IRF stay. Regardless of the payer source, an IRF-PAI is completed for all patients. Therefore, the IRF would complete and submit one IRF-PAI for a combined stay.

Operational policies and procedures for collecting IRF-PAI data on all patients regardless of payer would be developed by IRFs to meet the IRF QRP data collection requirements.

Each facility self-determines its policies and procedures for patient documentation practices in compliance with state and federal requirements.

For additional questions on the rules/requests of private insurers, please reach out to those other payers.

Added: December 2024

[NEW] Question 2: What is the difference between Private Insurance/Medigap (Medicare supplement plan) and Private Managed Care?

Answer 2: Private Health Insurance is traditional (non-managed care) health insurance.

Medigap is extra insurance Medicare beneficiaries can buy from a private health insurance company to help pay their share of out-of-pocket costs in Original Medicare.

Private Managed Health Insurance is a type of private health insurance that contracts with a network of providers to deliver care at lower costs. Examples include HMO, PPO, EPO, POS plans that use a network of providers.

For comprehensive definitions and descriptions of health insurance types, including Medigap/Medicare supplement plans, commercial insurance, managed care plans (HMOs, PPOs), and other structures, please review the information available at: https://www.healthcare.gov/.

Added: March 2025

[NEW] Question 3: I am looking for additional guidance regarding where Auto Insurance fits as a payer source for A1400 on the IRF-PAI. It is not specified in the IRF-PAI Manual, V4.2, and I am not sure where else to look.

Answer 3: The payer-type in your situation is not specifically listed and would be best categorized as Y. Other. The IRF-PAI Manual, V4.2 also provides some explanations and examples of coding A1400, which can be found in the downloads section of this page here: https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual.

Also note that on page A-28 of the IRF-PAI Manual, V4.2, the following is stated regarding coding A1400:

- Include all payment sources that will be billed
- Do not include any pending payment sources

Added: March 2025

A2122, A2124

Question 1: Archived March 2024

Section B: Hearing and Vision

B0200, B1000

Question 1: For B0200 - Hearing and B1000 - Vision, what if aids (glasses, hearing aids, etc.) are unavailable to the patient at the time of assessment? For example, if the patient reports they can read newspaper headlines with their glasses on, but they do not have their glasses and are unable to read that size print when provided upon assessment, what should be coded?

Answer 1: The intent of B0200 - Hearing is to assess the patient's ability to hear (with hearing aid or hearing appliances if normally used).

The intent of B1000 - Vision is to assess the patient's ability to see in adequate light (with glasses or other visual appliances).

The patient may not have their normal hearing appliances or visual aids available to them during the 3-day admission assessment period. In addition to observation, ask about hearing/vision function by interviewing the patient, family, caregivers, direct care staff, specialists, etc., and review the clinical record or other available documentation to determine the most accurate response for B0200 and B1000.

Added: September 2022

B1300

Question 1: Please provide an example of where the codes for B1300 - Health Literacy change from admission to discharge.

Answer 1: The intent of B1300 - Health Literacy is to identify how often the patient needs to have someone help them when they read instructions, pamphlets, or other written material from their doctor or pharmacy. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how this item applies for each individual patient at both the admission and discharge time points.

It is possible that the admission and discharge coding are the same.

Added: September 2022

Section C: Cognitive Patterns

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

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: I know we can administer the BIMS either verbally or written and there are specific directions around this. My question is, when administering it in writing can we present the cue card questions via laptop, rather than an actual paper form for those patients who are hearing impaired etc., or does it need to be given in paper or card format?

Answer 3: Facilities may develop their own process for administering the BIMS. However, regardless of processes used, facilities must follow the exact language from the IRF-PAI 4.2 assessment instrument.

Added: December 2022, Edited: December 2024

Question 4: Archived March 2024

Question 5: As a vendor, when configuring C0200-C0500 - Brief Interview for Mental Status (BIMS) in our EMR system, would it be compliant if additional prompts were added to clarify the reason for coding a 0 response to each BIMS item? The 0 can have different meanings and the reason for coding the 0 may influence the scoring of C0500 - BIMS Summary Score.

Answer 5: The intent of C0200-C0500 - Brief Interview for Mental Status (BIMS) is to determine the patient's attention, orientation, and ability to register and recall information.

As stated in the coding tips for C0200-C0500, the interviewer should track the reason for coding answers as zero because this information will be used later for the coding of the summary score in C0500.

IRFs are required to incorporate the IRF-PAI data items exactly as written.

In addition to any required IRF-PAI items, a facility may determine what other assessment items will be included in the patient assessment to meet regulatory, coverage, and clinical needs.

In the development and maintenance of the IRF-PAI assessment user tools, vendors are advised to reference the Data Specifications (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/DataSpecs).

While the Data Specifications dictate the assessment instrument items, their applicable time point(s) in the assessment instrument, the exact language of the items, and each item's allowable response options, the Data Specifications do not dictate the presentation of the items in the assessment instrument. While the item language and response options may not be modified, reformatting of the presentation of the item is left to the user's discretion, as long as such

modification does not impact the accuracy of the item scoring, and is presented in a way that makes it clear which items (assessment questions and response options) are part of the IRF-PAI, and which are not.

Added: March 2023

C0600

Question 1: Archived March 2024

C1310

Question 1: If the Brief Interview for Mental Status (BIMS) is not completed, are we allowed to skip C1310 - Signs and Symptoms of Delirium? There is language in C1310 that states to complete after the BIMS is completed.

Answer 1: Each IRF-PAI item should be considered individually and coded using all available guidance provided for that item. There is no guidance or data specification edit directing providers to skip C1310A, C1310B, C1310C, and/or C1310D when the BIMS interview was not completed.

As stated in the Steps for Assessment for C1310, code C1310 after:

1. Observing the patient behavior during the cognitive assessment (BIMS items (C0200-C0400), Staff Assessment (C0900), if completed, or other cognitive assessment) for the signs and symptoms of delirium.
2. Reviewing medical record documentation to determine the patient's baseline status, fluctuations in behavior, and behaviors that might have occurred during the assessment period that were not observed during the cognitive assessment (e.g., BIMS).
3. Observing patient's behavior during patient interactions and consulting with other staff, family members/caregivers, and others in a position to observe the patient's behavior during the assessment period.

Added: December 2022

Question 2: Archived March 2024

Question 3: How should C1310 - Signs and Symptoms of Delirium (from CAM©) be coded when a patient is comatose at baseline and at the time of assessment?

Answer 3: C1310 - Signs and Symptoms of Delirium identifies any signs or symptoms of acute mental status change as compared to the patient's baseline status and if there are any signs or symptoms of delirium present at the time of assessment.

If the patient was comatose at baseline and at the time of assessment, code the items as follows:

C1310A - Acute Onset of Mental Status Change as 0 - No.
C1310B - Inattention as Code 1 - Behavior continuously present, does not fluctuate.

C1310C - Disorganized thinking as Code 0 - Behavior not present.
C1310D - Altered level of consciousness as Code 1 - Behavior continuously present, does not fluctuate.

Added: September 2023

Question 4: We understand that if we do not complete C0200-C0500 (the BIMS interview), C1310 - Signs and Symptoms of Delirium must still be completed. However, in the case of an unplanned discharge, how should C1310 be answered if the patient is not available to complete the CAM?

Answer 4: Each IRF-PAI item should be considered individually and coded using all available guidance provided for that item. The assessment for C1310 - Signs and Symptoms of Delirium can still be conducted even in the case of an unplanned discharge. When direct observation is no longer possible, as may be the case with an unplanned discharge, the assessment strategies for C1310 include medical record review. Data from the record review could be used to determine the patient's baseline discharge status, fluctuations in behavior, and behaviors that might have occurred during the 3-day discharge assessment time period (i.e., the discharge Assessment Reference Date (ARD) and the two previous days).

If you are unable to determine a response to one or more of the C1310 items, a dash (-) is a valid response. Please note that while the coding of a "dash" is an optional response value for C1310, its use does not count favorably toward meeting the AIF minimum submission threshold. Failure to meet the minimum threshold may result in a 2-percentage point reduction in the IRF's AIF.

Added: June 2024

Section D: Mood

D0150

Question 1: Archived March 2024

Section GG: Functional Abilities and Goals

GG0100A

Question 1: A patient who has been admitted to an IRF reports that prior to being admitted to the hospital they were receiving assistance for bathing and dressing once per week but could safely complete the activities alone on the other days when the assistance was not available. When coding GG0100A - Prior Level of Functioning: Everyday Activities; Self-Care, would this scenario indicate Code 2 - Needed Some Help or Code 3 - Independent?

Answer 1: The intent of GG0100 - Prior Functioning: Everyday Activities is to record the patient's ability with everyday activities prior to the current illness, exacerbation, or injury.

GG0100A - Self Care identifies the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury.

If the patient required assistance prior to the most recent illness, injury or exacerbation to complete any of the GG0100A activities, code 2 - Needed Some Help.

If assistance was provided but not required prior to the most recent illness, injury or exacerbation, and the patient could complete all of the GG0100A activities themself, code 3 - Independent.

Added: June 2024

[NEW] Question 2: Can you provide guidance on scoring when a patient, for cultural or any other reason, chooses not to perform a specific ADL? For example, the family always completes dressing prior to admission. The patient could do it, but chooses not to and, at baseline, does not do the specific ADL task. Would this be a dependent score, or would it fall under 'Not Applicable'?

Answer 2: The intent of GG0100 - Prior Functioning: Everyday Activities is to record the patient's ability with everyday activities prior to the current illness, exacerbation, or injury.

GG0100A – Self Care identifies the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury.

If the patient required assistance prior to the most recent illness, injury or exacerbation, to complete any of the GG0100A activities then code 2 - Needed Some Help.

If assistance was provided but not required prior to the most recent illness, injury or exacerbation, and the patient could complete all of the GG0100A activities themself, code 3 – Independent.

For additional coding tips and coding examples for item GG0100, Prior Functioning: Everyday Activities, please review Section GG in the IRF-PAI Manual, V4.2, available for download here: https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual

Added: March 2025

GG0100C

Question 1: Archived June 2022

GG0100C, GG0170M, GG0170N, GG0170O

Question 1: Archived June 2022

GG0100, GG0110

Question 1: We have questions regarding prior level of functioning and prior device use. A patient is admitted to our facility for rehab, has a medical issue, and is discharged to an acute care hospital for a week. When the patient returns to our facility, would the prior level of functioning reported in GG0100 - Prior Functioning reflect the patient's status prior to the original admission (which is the reason we are still treating the patient) or is the prior level of functioning based on what the patient was doing during the hospital stay? Would this also apply to GG0110 - Prior Device Use?

Answer 1: The intent of GG0100 - Prior Functioning is to report the patient's need for assistance with everyday activities, prior to the current illness, exacerbation, or injury. The intent of GG0110 - Prior Device Use is to indicate which devices and aids were used by the patient prior to the current illness, exacerbation, or injury. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how prior functioning and prior device use apply for each individual patient.

In responding to GG0100 - Prior Functioning: Everyday Activities, the activities should be reported based on the patient's usual ability prior to the current illness, exacerbation, or injury. This is the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is most recent, that initiated this episode of care. Clinicians should use clinical judgment within these parameters in determining the timeframe that is considered "prior to the current illness, exacerbation, or injury."
The same approach should be used in determining Prior Device Use for GG0110.

Added: September 2020, Edited March 2024

GG0110

Question 1: Archived June 2022

GG0130, GG0170

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: I am seeking clarification on how to accurately code the admission assessments for GG0130 - Self-care and GG0170 - Mobility when a patient leaves AMA before the admission assessment is completed.

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

Answer 3: For Section GG, 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 admission performance to the best of your abilities. If the patient refused assessment of an activity and left AMA before the admission assessment was completed, use Code 07 - Patient refused for that activity.

Added: June 2020, Edited March 2024

Question 4: Archived June 2022

Question 5: Archived June 2022

Question 6: We understand that if a patient initially refuses to attempt an activity during the assessment period, but later agrees to perform the activity, the code that represents the patient's actual performance supersedes the refusal code (07). What if on day 1 or day 2 a safety or medical issue prevents the patient from attempting an activity, but on day 3, after benefiting from therapeutic intervention, the patient can now perform the activity? Which code should be reported on the IRF-PAI: Code 88 - Not attempted due to medical condition or safety concerns, or one of the performance codes, 01-06?

Answer 6: 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.

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

If this is the case in your scenario, code 88 - Not attempted due to medical condition or safety concerns even if the patient's status changes and the patient is able to complete the activity on a later day during the assessment period.

Added: September 2020

Question 7: Archived June 2022

Question 8: How should the following situation be coded for the GG0130 - Self-Care and GG0170 - Mobility items? On discharge a patient was nonadherent with spinal precautions. The patient was able to demonstrate completing functional tasks independently with good balance and strength and was cognitively intact. By the patient's report, they were choosing not to routinely adhere to spinal precautions in their day-to-day activities, although they were aware of the precautions and risks. Should the GG activities be coded based on the patient's ability, which is independent, or based on the fact that they knowingly break their precautions?

Answer 8: The GG activities focus on the patient's ability to complete the activities as independently as possible as long as they are safe; willingness and nonadherence are not the focus of the coding.

If, in your scenario, you have assessed the patient being able to independently complete the GG activities safely, code 06 - Independent.

Added: June 2021

Question 9: For GG0130 - Self-Care and GG0170 - Mobility, it is our facility's policy that a patient always have a staff member present during walking or toileting activities. Is it possible for the GG activity to be assessed and coded 06 - Independent, for situations where a staff member is required to be present per facility policy, but is not required to assist or supervise the patient in any way?

Answer 9: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe.

If a helper is present (only due to facility policy) code the activity based on the type and amount of assistance the patient requires to complete the activity as independently as possible, as long as they are safe. If no assistance/supervision/set-up is required, then code 06 - Independent.

Added: September 2021

Question 10: When determining the appropriate performance code at admission for the GG self-care and mobility activities there are times when the score on Day 1 differs from the scores on Days 2 and 3. For example:

- **On Day 1 when attempting to perform a sit to stand transfer, even with assist from the therapist the patient is unable to complete the transfer due to pain. The therapist scores GG0170D - Sit to stand as a Code 88 - Not attempted due to medical condition or safety concerns in Day 1 notes. On Day 2, per therapy notes the patient was able to complete the sit to stand transfer with assistance of two people. Which code would I use? Code 88 - Not attempted due to medical condition or safety concerns or Code 01 - Dependent?**
- **On Day 1 there is no mention of sit to stand noted in documentation. On Day 2 documentation reports that the patient requires partial/moderate assistance of 1 (Code 03) and later that day the therapy note shows that the patient required the assistance of two people to stand. How would this scenario be coded? Does any source take priority? Do I look at all three days and select usual performance from all sources?**

Answer 10: At Admission, the self-care or mobility performance code is to be based on a functional assessment that occurs at or soon after the patient's admission, and reflects 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.

When the baseline function code differs from the usual performance during the assessment period, report the baseline function code.

If in your first scenario, the patient being unable to complete the sit to stand activity due to medical conditions or safety concerns represents their baseline ability, then code 88 - Not attempted due to medical condition or safety concerns.

In your second scenario, as in all admission scenarios, select the code that represents the patient's baseline ability to complete the activity as independently as possible as long as they are safe, prior to the benefit of services provided by your facility staff.

Added: December 2021

Question 11: The guidance for GG0130 and GG0170 states "the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely, not based on the availability of such assistance." Can you provide an example of "not based on the availability of such assistance"?

Answer 11: When assessing and coding GG activities, allow the patient to perform the activity as independently as possible, as long as they are safe. Select the code based on the type and amount of assistance required to complete the activity, not based on the availability of assistance.

For example, a patient requires a physical therapist to provide assistance to ambulate 10 feet safely. However, when the therapist is not available, the patient is unable to ambulate 10 feet safely. The walking activity would be coded based on the type and amount of assistance required (assistance to walk 10 feet), even though a physical therapist may not always be available to provide the needed assistance.

Added: September 2022

Question 12: Archived March 2025

GG0130A

Question 1: Archived June 2022

Question 2: A patient is admitted to an Inpatient Rehabilitation Facility (IRF) with quadriparesis from a previous spinal cord injury. Once an occupational therapist applies a universal cuff to the patient's hand, the patient is able to eat the entire meal without further assistance. What is the performance code for GG0130A - Eating?

Answer 2: The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

In the scenario provided, if the patient only requires assistance to apply a universal cuff and no further assistance is required during the eating activity, then code 05 - Setup or clean-up assistance. This is because assistance is only required prior to or following the activity, but not during the activity.

Added: December 2020

Question 3: Archived June 2022

Question 4: Archived March 2024

GG0130B

Question 1: Archived June 2022

GG0130C

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Archived June 2022

Question 4: I understand that if a helper provides setup before toileting hygiene or clean-up after, and the patient completes the activity of toileting hygiene without additional assistance, the correct code is 05 - Setup or clean-up assistance.

What would the correct code be if a helper provided assistance (contact guard or touching assistance) to the patient as the patient gathered their incontinence products but then the patient completed the toileting hygiene activity without further assistance?

Answer 4: The intent of GG0130C - Toileting hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothes (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

It is not the type of assistance that is provided that determines the 05 - Setup or clean-up assistance code but rather when (related to the completion of the activity) the needed assistance is provided.

If the assistance provided is necessary only before or after the activity is completed, and no assistance is needed during the completion of the activity, select Code 05 - Setup or clean-up assistance.

Added: December 2021

Question 5: Archived March 2024

GG0130E

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Archived March 2024

Question 4: Archived June 2022

Question 5: Archived June 2022

GG0130F, GG0130G, GG0130H

Question 1: Archived June 2022

GG0130G, GG0130H

Question 1: Archived June 2022

GG0130G

Question 1: Archived June 2022

GG0130H

Question 1: Archived June 2022

Question 2: We have a question regarding the following scenario. On day 2 of the patient's stay, the occupational therapist (OT) evaluates and assesses all the GG self-care activities. During that evaluation, for footwear, the patient only dons hospital socks (regular shoes and socks are not available) and requires only cueing. Toward the end of the session (after the assessment), the OT initiates the intervention of ADL re-training. On day 3, after the initiation of ADL re-training, the patient's spouse brings in socks and tennis shoes with laces, which are the patient's preferred footwear. The patient now requires greater than 50% assistance of one helper for donning footwear. Even though it is post intervention, can the "greater than 50% assistance" score be reported since it is still within the assessment timeframe?

Answer 2: The intent of GG0130H - Footwear is to assess the patient's ability to put on and take off socks and shoes or other footwear that is appropriate for safe transfer and/or ambulation (mobility), including fasteners (if applicable).

When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe.

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.

Clinicians should use clinical judgment to determine if observing the patient putting on and taking off the footwear (i.e., hospital socks) worn during the first assessment allows the clinician to adequately assess the patient's baseline ability to complete the activity of putting on/taking off footwear (GG0130H). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the activity.

Added: September 2020

GG0170

Question 1: Archived June 2022

Question 2: If a patient is dependent for all GG bed mobility activities would it be acceptable to code the patient as dependent for all other GG mobility activities even if those activities were not specifically assessed?

Answer 2: At Admission, the mobility performance code is to reflect the patient's baseline ability to complete the activity, and is based on observation of activities, to the extent possible. Clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient and/or family, assessment of similar activities, collaboration with other facility staff, and other relevant strategies to complete all GG items.

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

It is important to determine whether the appropriate code for each GG activity is a performance code (including 01 - Dependent) vs. an "activity not attempted" code.

It is also important to note that a helper cannot complete the walking activities for a patient. A walking activity cannot be considered completed without some level of patient participation that allows patient ambulation to occur the entire stated distance. For instance, if even with assistance a patient was not able to participate in walking a distance of 10 feet, an "activity not attempted" code (rather than 01 - Dependent) would be selected.

Added: December 2020

GG0170A, GG0170B, GG0170C

[NEW] Question 1: How would you recommend items GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C Lying to sitting on side of bed, be scored on a sand bed? Due to this bed's instability, would the patient be scored "Not attempted"?

Answer 1: When coding GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C Lying to sitting on side of bed at admission and discharge, 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 they are safe. Code based on the type and amount of assistance required to complete the entire activity.

If the clinician determines that bed mobility cannot be assessed because of limitations with the type of bed used by the patient, then code the activity GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C Lying to sitting on side of bed an "activity not attempted."

Added: March 2025

GG0170C

Question 1: Archived June 2022

GG0170E

Question 1: We have a patient who at discharge requires max assistance to perform a transfer, so is coded as 02 - Substantial/maximal assistance for GG0170E - Chair/bed-to-chair transfer. This maximal assist transfer will not be safe for the patient and elderly family to attempt once at home, so two family members will be using a Hoyer lift to transfer the patient from bed to chair. At discharge, would the correct code for GG0170E be 02 - Substantial/maximal assistance, based on the patient's performance in the facility; or would the correct code be 01 - Dependent, because that is what the patient's "usual" status will be at home?

Answer 1: The intent of GG0170E - Chair/bed-to-chair transfer is to assess the patient's ability to transfer to and from a bed to a chair (or wheelchair).

When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe.

If the patient performed the activity during the discharge assessment period, code based on that assessment. Use the GG 6-point scale codes to identify the patient's usual performance on the

discharge assessment.

If in your scenario, at discharge, when allowed to complete the activity as independently as possible, the patient was able to safely complete the transfer activity with max assist, then code 02 - Substantial/maximal assistance.

Added: December 2020

GG0170F

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Please provide clarification on if the following scenarios would be acceptable simulations for the GG0170F - Toilet transfer activity in situations where a patient does not need to use the toilet during an assessment:

1. **An Occupational Therapist (OT) takes the patient to the toilet and simulates a toileting experience, with patient pulling down pants and transferring onto the toilet and then back to the chair.**
2. **Using the functional performance of the patient's chair/bed-to-chair transfer performance code to code toilet transfer.**
3. **Using the functional performance of the patient's ability to transfer on and off a bedside commode in the therapy gym to code toilet transfer.**

Answer 3: The intent of GG0170F - Toilet transfer is to assess the patient's ability to get on and off a toilet or commode. Do not consider or include GG0130C - Toileting hygiene item tasks (managing clothing, undergarments, or perineal hygiene) when coding the toilet transfer item. The toilet transfer activity can be assessed and coded regardless of the patient's need to void or have a bowel movement in conjunction with the toilet transfer assessment.

Use clinical judgment to determine if each situation described adequately represents the patient's ability to transfer on and off the toilet or commode. If the clinician determines that simulating the toilet transfer adequately represents the patient's ability to complete the GG0170F activity, code based on the type and amount of assistance the patient requires to complete the activity.

In each scenario, if the patient was not able to transfer on/off the toilet or commode and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities, use the appropriate "activity not attempted" code.

Added: December 2020

GG0170G

Question 1: In the assessment of a patient's ability to perform a car transfer, does adjusting the car seat constitute 05-Setup or clean-up assistance? 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 1: 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 Car transfer activity would be coded as 05 - Setup or clean-up assistance.

Added: June 2020

Question 2: Archived June 2022

Question 3: Archived June 2022

Question 4: Archived June 2022

Question 5: Archived June 2022

Question 6: When coding GG0170G - Car transfer based on a simulation, what equipment or environmental setup would we need to have in order to make the activity similar enough to the car transfer?

Answer 6: The intent of GG0170G - Car transfer is to assess the patient's ability to transfer in and out of a car or van seat on the passenger side.

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

In situations where specific equipment may not be available (e.g., 12 steps, a vehicle), the assessing clinician may determine that assessment of a similar activity adequately represents the patient's ability to complete the activity. This practice will serve to minimize the use of an "activity not attempted" code in favor of a performance code determined to represent the patient's status in the given self-care or mobility activity. While CMS does not provide specific parameters or a complete list of what is and is not an acceptable proxy activity, providers are expected to use clinical judgment in determining if the "similar activity" meets the intent of the target activity to make it a reasonable substitute when making a coding determination.

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

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

Added: March 2021, Edited: March 2025

Question 7: Archived June 2022

Question 8: Archived June 2022

GG0170I, GG0170J, GG0170K, GG0170L

Question 1: 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 1: The intent of the walking items (GG0170I, GG0170J, GG0170K, and GG0170L) is to assess the patient's ability to ambulate the stated distances, 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.

Added: June 2020

Question 2: Can you give some clarification regarding scoring a performance with the help of a second person (if this second person is helping push an oxygen tank, IV pole, or wheelchair following the patient) because the first helper is physically assisting the patient during the walking activity? Both helpers are needed to complete the activity safely. The IRF-PAI manual says "Code 01, Dependent - if the assistance of two or more helpers is required for the patient to complete the activity."

Answer 2: The intent of the GG0170 walking items is to assess the patient's ability once standing to safely walk the stated distances and circumstances in each item.

You are correct that if a patient requires the assistance of two helpers to complete an activity (one to provide support to the patient and a second to manage the necessary equipment to allow the safe walk), Code 01 - Dependent is the appropriate code.

If a single helper only manages the oxygen tank or the IV pole and otherwise the patient needs no assistance to safely complete the walking activity, code the walking activity as 04 - Supervision or touching assistance. This is because the helper is required to be present during the activity for the patient to complete the activity safely.

Added: September 2020

Question 3: If a patient requires a therapist to provide steadying assistance/contact guard assist and manage an oxygen tank while the patient is ambulating how would the walking activities be coded?

Answer 3: The intent of the GG0170 walking items is to assess the patient's ability once standing to safely walk the stated distances and circumstances in each item.

If the helper is required to manage the oxygen tank and/or oxygen tubing and/or provide steadying assistance/contact guard, to allow the patient to complete an activity safely, then code 04 - Supervision or touching assistance.

Added: March 2021

Question 4: Archived June 2022

GG0170I

Question 1: Archived June 2022

GG0170J

Question 1: Archived March 2024

GG0170M, GG0170N, GG0170O

Question 1: 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 1: 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.

Added: June 2020

Question 2: Archived June 2022

Question 3: Archived March 2024

[NEW] Question 4: If a patient utilizes a shower chair to ascend/descend stairs, and they only need assistance from a caregiver to move the shower chair, no physical assistance is required. What would the score be for the patient?

Answer 4: The intent of Sections GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps 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.

Code 05 – Setup or clean-up assistance when a helper provided only setup and/or clean-up assistance, prior to and/or following the "activity," BUT NOT DURING the "activity."

Code 04 – Supervision when the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as the patient completes the activity.

For more information on coding section GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps, please refer to the IRF PAI Manual, V4.2, located in the downloads section of the IRF PAI Manual webpage: https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual.

Added: March 2025

GG0170M

Question 1: Archived June 2022

GG0170N, GG0170O

Question 1: Archived March 2024

Question 2: Archived June 2022

Question 3: Archived March 2024

GG0170P

Question 1: 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 clean-up assistance or Code 04 - Supervision or touching assistance?

Answer 1: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are 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 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 for the patient to complete the activity safely, then the verbal cues would be considered 05 - Setup or clean-up assistance.

Added: June 2020

GG0170Q

Question 1: Archived June 2022

Question 2: Archived June 2022

GG0170R

Question 1: Archived March 2024

GG0170R, GG0170S

Question 1: Archived June 2022

Question 2: How are the GG0170 wheelchair mobility activities, GG0170R - Wheel 50 feet with two turns and GG0170S - Wheel 150 feet, coded if the patient is able to propel the full distance, however, needs multiple rest breaks?

Answer 2: The intent of GG0170R - Wheel 50 feet with two turns is to assess the patient's ability, once seated in wheelchair/scooter, to wheel at least 50 feet and make two turns.

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

When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe.

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

If based on the guidance above the patient is able to complete the activity of wheeling 50 feet with two turns (or wheeling 150 feet), code based on the type and amount of assistance required regardless of the amount of time it takes to safely complete the activity.

Added: September 2024

GG0170S

Question 1: Archived June 2022

Section H: Bladder and Bowel

H0350

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3: Please provide clarification on how the following scenario would be coded for H0350 - Bladder Continence on Admission?

Day One: Admitted with Indwelling catheter

Day Two: Indwelling removed, 1 incontinent episode, 2 Continent

Day Three: 1 incontinent episode, 2 Continent

Answer 3: The intent of H0350 - Bladder Continence is to gather information on bladder continence. If the use of a catheter is intermittent (e.g., the indwelling catheter is in use during part of the 3-day assessment period, but not used for the entire 3-day assessment period), code continence level based on when catheter is not in use during the 3-day assessment period.

If the incontinent episodes during the 3 days occur only with stress, then code 1 - Stress Incontinence Only. If a patient is incontinent 1 or 2 times or incontinent any number of times on one or two days, but at least one full day with no incontinent episodes, then code 2 - Incontinent Less than Daily.

Added: June 2022

Question 4: How should H0350 - Bladder Continence be coded when a patient has a unilateral nephrostomy tube in place during the 3-day admission assessment period? Should episodes of incontinence, that might occur due to the patient not having bilateral nephrostomy tubes in place, be considered for coding of this item?

Answer 4: The intent of H0350 - Bladder Continence is to gather information on bladder continence.

If the patient has a unilateral nephrostomy tube in place and has episodes of continence and/or incontinence, code continence level based on the episodes of incontinence during the 3-day admission assessment period.

Added: June 2024

H0400

Question 1: Archived June 2022

Section J: Health Conditions

J0520

Question 1: Archived March 2024

J1800, J1900

Question 1: Archived March 2024

Question 2: When coding J1800 - Any Falls Since Admission and J1900 - Number of Falls since Admission, if a patient has a seizure which causes them to fall, is this considered a fall?

Answer 2: Falls that occur due to a medical event, such as a seizure, are considered a fall for the purposes of coding J1800 - Any Falls Since Admission and J1900 - Number of Falls since Admission.

Added: June 2024

[NEW] Question 3: Is it considered a fall if a patient throws themselves to the ground during an episode of agitation?

Answer 3: In the IRF-PAI Manual, V4.2, the following definition (Section J, Page J-9) is provided for what constitutes as a fall:

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).

An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall.

Please use clinical judgment to report the code that best your scenario.

For more information, you can find the IRF-PAI Manual, V4.2, in the downloads section of this page https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual

Added: March 2025

J1900

Question 1: Archived March 2024

Section K: Nutritional Approaches

K0520

Question 1: Archived March 2024

Question 2: Archived March 2024

Question 3: If a patient is placed on a full liquid diet for a bowel cleanse should this be considered a mechanically altered diet when coding K0520 - Nutritional Approaches?

Answer 3: The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

K0520C - Nutritional Approaches; Mechanically altered diet reports if the patient requires a mechanically altered diet.

Mechanically altered diet is defined as a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids for patients having trouble chewing and/or swallowing foods or thin liquids.

If, in your scenario, the diet texture is altered for a reason other than to facilitate oral intake, it would not be considered a mechanically altered diet when coding K0520C.

Added: December 2022

Question 4: Please provide guidance as to the accurate response for K0520Z - Nutritional Approaches; None of the Above in the following scenario:

> **K0520A - Parenteral/IV Feeding = checked**
>
> **K0520B - Feeding Tube = not checked**
>
> **K0520C - Mechanically altered diet = Dash to indicate there was no available information**
>
> **K0520D - Therapeutic diet = not checked**

Should K0520Z be unchecked because K0520A is checked, or dashed because K0520C is dashed?

Answer 4: When one or more items for K0520A - K0520D is checked, to indicate that the specified nutritional approach applies to the patient, then K0520Z should be left unchecked. This is true even if one of the other items K0520A - K0520D is dashed.

This same concept applies to N0415 - High Risk Drug Classes: Use and Indication and O0110 - Special Treatments, Procedures, and Programs.

Added: March 2023

Question 5: We are having difficulty determining when we should consider food modifications as a mechanically altered diet for K0520C - Nutritional Approaches; Mechanically altered diet. Is there a specific reference CMS suggests utilizing to determine this?

Answer 5: The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

K0520C - Nutritional Approaches; Mechanically altered diet reports if the patient requires a mechanically altered diet.

Mechanically altered diet is defined as a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake.

A specific cross-walk does not exist between any diet classification system and the coding of K0520. Utilizing a diet classification system to code may lead to inaccuracies in K0520.

If the diet texture is altered for a reason other than to facilitate oral intake, it would not be considered a mechanically altered diet when coding K0520C.

Added: March 2023

Question 6: Archived March 2024

Question 7: If a patient has an order to be NPO in anticipation of a procedure/ surgery, is this considered either a mechanically altered diet or a therapeutic diet when coding K0520 - Nutritional Approaches?

Answer 7: The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

NPO related to a procedure/surgery is not considered a nutritional approach for the purposes of coding K0520C - Mechanically altered diet and K0520D - Therapeutic diet.

Added: September 2023

Section M: Skin Conditions

M0210, M0300

Question 1: Archived June 2022

Question 2: Would a Kennedy ulcer be considered a pressure ulcer for the purpose of coding Section M - Skin Conditions?

Answer 2: The intent of Section M - Skin Conditions, is to document the presence, appearance, and change of pressure ulcer/injuries. If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the ulcer/injury should be included in Section M as a pressure ulcer/injury.

End-of-life ulcers (also known as Kennedy ulcers or terminal ulcers) result from organ failure and are not considered pressure ulcers and therefore not reported on the IRF-PAI pressure ulcer items.

Added: June 2024

M0300

Question 1: Archived June 2022

Question 2: Archived June 2022

Question 3 & 4: Archived June 2022

Question 5: Archived June 2022

Question 6: Can you please provide guidance on how to stage a pressure ulcer on the IRF-PAI when the deepest anatomic soft tissue damage is unknown? We have a newly admitted patient who has had a pressure ulcer for over a year, but there is no documentation available to indicate the highest stage of the ulcer.

Answer 6: For M0300 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage at admission, code based on the findings from the first skin assessment that is conducted on or after and as close to the admission as possible. Do not reverse or back-stage. Consider current and historical levels of tissue involvement.

For a stageable pressure ulcer/injury, code based on the ulcer/injury's deepest anatomic soft tissue damage that is visible or palpable, unless the ulcer/injury was previously classified at a higher numerical stage than what it is observed now.

If historical information is not available to inform the assessment of whether the ulcer/injury was previously classified at a higher numerical stage than what it is observed as now, code based on the current observation of the wound.

Added: June 2024

Section N: Medications

N0415

Question 1: Archived March 2024

Question 2: Archived March 2024

Question 3: Please provide guidance as to the accurate response for N0415Z - High-Risk Drug Classes; None of the Above in the following scenario:

> **N0415A - Antipsychotic; Column 1 (Is Taking) = checked**
>
> **N0415E - Anticoagulant; Column 1 (Is Taking) = not checked**
>
> **N0415F - Antibiotic; Column 1 (Is Taking) = Dash to indicate there was no available information**
>
> **N0415H - N0415J; Column 1 (Is taking) = not checked**

Should N0415Z be unchecked because N0415A is checked, or dashed because N0415F is dashed?

Answer 3: When one or more items for N0415 is checked, to indicate that the patient is taking a medication in one or more of the high-risk drug classes, then N0415Z should be left unchecked. This is true even if one of the other N0415 items is dashed.

This same concept applies to K0520 - Nutritional Approaches and O0110 - Special Treatments, Procedures, and Programs.

Added: March 2023

Question 4: Archived March 2024

Question 5: Are the following scenarios acceptable approaches when determining if a patient-specific indication is documented for N0415 - High-Risk Drug Classes: Use and Indication:

- **A clinician finds the patient-specific indication noted on the discharge paperwork from the referring facility/provider (e.g., coumadin for atrial fibrillation)**
- **There is no patient-specific indication noted for a medication, so the clinician contacts the physician to verify why the patient is taking the med and adds the physician response to the IRF medical record**
- **The patient or family member verbally tells the clinician why the medication is being used (e.g., "for my back pain," "for my infection") and the clinician documents this reason(s) in the IRF medical record**

- **A clinician sees a diagnosis documented in discharge or referral paperwork (e.g., diabetes, schizophrenia) and the patient is taking related medications (e.g., hypoglycemic, antipsychotic) so considers the documented diagnosis as the patient-specific indication**

Answer 5: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

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

Sources include medical records received from providers or facilities where the patient received health care, the patient's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

Discussions (including with the acute care hospital, other staff and clinicians, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.

CMS does not provide an exhaustive list of examples for determining the source for the documented patient-specific indication. Use available resources along with clinical judgment to determine if the scenarios you suggest meet the criteria for a patient-specific indication for the purposes of N0415.

Added: March 2023

Question 6: Archived March 2024

Question 7: Archived March 2024

Question 8: Archived March 2024

N0415 & O0110

Question 1: We have a question regarding how to code N0415 - High-Risk Drug Classes and O0110 - Special Treatments, Procedures, and Programs for a patient who has an interrupted stay within the admission assessment period.

Our patient was admitted on 11/4, went out to an acute facility on 11/5, and returned on 11/7. Therefore, the admission assessment days will be 11/4, 11/7, and 11/8.

Guidance for N0415 states to consider medications that are included in the patient's prescribed drug regimen as well as to include any of these medications used by any route in any setting (e.g., at IRF, in a hospital emergency room, at physician office or clinic) while a patient of the setting.

Guidance for O0110 states, "Check all treatments, programs, and procedures that are part of the patient's current care/treatment plan during the 3-day admission (or 3-day discharge) assessment time period. Include treatments, programs, and procedures performed by others and those the patient performed themselves independently or after setup by facility staff or family/caregivers. Check treatments, procedures, and programs that are performed in the care setting, or in other settings (e.g., dialysis performed in a dialysis center)."

Using this guidance, does this mean that we will need to consider what occurs during the interrupted stay in order to accurately code these items?

Answer 1: Each IRF-PAI item should be considered individually and coded based on the guidance provided for that item at each assessment time period.

N0415 - High-Risk Drug Classes and O0110 - Special Treatments, Procedures, and Programs should be completed based on an assessment that occurs within the 3-day admission assessment time period or the 3-day discharge assessment time period.

As stated, the coding for N0415 and O0110 includes medications, special treatments, procedures, and programs that are included in the patient's drug regimen/current care/treatment plan during the 3-day assessment time period, even if the medication or treatment is received outside of the assessment time period and/or while at another setting.

When coding N0415 and O0110 during the 3-day admission assessment time period, there may be situations in which a medication or treatment provided in another setting (e.g., acute care hospitalization during an interrupted stay within the admission assessment time period) would be reported. Review of documentation from other provider settings may be helpful in order to code N0415 and O0110 accurately.

Added: March 2023

N2001, N2003, N2005

Question 1: If the physician or physician-designee in the IRF finds clinically significant medication issues when completing the drug regimen review is this considered a potential (or actual) clinically significant medication issue when coding N2001 - Drug Regimen Review, N2003 - Medication Follow-up, and N2005 - Medication Intervention?

Answer: For N2001 - Drug Regimen Review, N2003 - Medication Follow-up, and N2005 - Medication Intervention a potential (or actual) clinically significant medication issue is an issue that in the care provider's clinical judgment warrants notification of the physician (or physician-designee) for orders or recommendations by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential (or actual) clinically significant medication issue.

If the facility (i.e., facility physician) identified a potential (or actual) clinically significant medication issue that warranted contacting another physician or pharmacist for orders or recommendations by midnight of the next calendar day, then this meets the definition of a potential (or actual) clinically significant medication issue.

Added: December 2023

Question 2: When we complete a drug regimen review, our Electronic Medical Record (EMR) software runs an interaction check between all the patient's medications and flags any pertinent potential interactions. Our facility policy is to notify the physician within 3 days if any high or medium alerts are triggered.

We want to confirm that our facility policy regarding this can be interpreted differently than the criteria used to identify a potential (or actual) clinically significant medication issue for N2001 - Drug Regimen Review. For example, we can comply with our facility policy to notify a physician when a high medication alert is triggered by our EMR software, and still not consider it a potential clinically significant medication issue, if the assessing clinician does not feel the situation warrants communication with the physician by midnight of the next calendar day. Is there anything related to our approach, as described, that does not align with the instructions for coding of N2001 - Drug Regimen Review?

Answer 2: N2001 - Drug Regimen Review identifies if a drug regimen review was conducted, and whether any potential or actual clinically significant medication issues were found.

A potential (or actual) clinically significant medication issue is defined as a potential or actual issue that, in the clinician's professional judgment, warrants physician/allowed practitioner (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).

Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.

If, in your scenario, the potential medication interactions triggered by the EMR software do not meet this definition of a potential (or actual) clinically significant medication issue, then they would not be reported as such when coding N2001 - Drug Regimen Review, N2003 - Medication Follow-up, or N2005 - Medication Intervention.

Added: June 2024

N2005

Question 1: Can the response for N2005 - Medication Intervention be determined at any time during the discharge window (day of discharge and 2 calendar days preceding the day of discharge) or does this item need to be completed on the day of discharge?

Answer 1: The intent of N2005 - Medication Intervention is to indicate if the facility contacted and completed physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission.

In order to report on all potential clinically significant medication issues, N2005 should be completed at the time of discharge.

Added: September 2021

Section O: Special Treatments, Procedures, and Programs

O0110

Question 1: Archived March 2024

Question 2: For O0110C - Special Treatments, Procedures, and Programs; Oxygen therapy: If the oxygen is ordered PRN, is that considered intermittent because it is ordered PRN or only if the patient uses it PRN during the 3-day assessment period?

Answer 2: The intent of O0110 - Special Treatments, Procedures, and Programs identifies if any of the listed special treatments, procedures, and programs apply to the patient.

O0110 should be completed based on an assessment that occurs within the 3-day admission assessment period or the 3-day discharge assessment period.

Check all treatments, programs, and procedures that are part of the current care/treatment plan during the 3-day admission assessment or the 3-day discharge assessment period.

If oxygen is part of the patient's current care/treatment plan regardless of reason for its use, O0110C1 - Oxygen therapy should be checked. Regardless of whether the oxygen is ordered continuously or intermittently, apply the IRF-PAI specific definitions in determining whether oxygen is coded as continuous (delivered for greater than/equal to 14 hours per day) or intermittent (oxygen was not delivered continuously for at least 14 hours per day).

Added: September 2022, Edited: March 2024

Question 3: For Special Treatments, Procedures, and Programs: Non-Invasive Mechanical Ventilator O0110G2 - BiPAP and O0110G3 - CPAP, are these only selected if the BiPAP/CPAP was used during the assessment window? Sometimes treatment may be ordered and available, but the patient will refuse to wear it.

Answer 3: If the BiPAP or CPAP is part of the patient's current care/treatment plan, then mark O0110G1 - Non-Invasive Mechanical Ventilator and O0110G2 or O0110G3 - CPAP.

Added: September 2022

Question 4: Archived March 2024

Question 5: Please provide guidance as to the accurate response for O0110Z - Special Treatments, Procedures, and Programs; None of the Above for the following scenario. At least one of the listed treatments, procedures, and programs is checked to indicate it applies to the patient but another of the listed treatments, procedures, and programs must be dashed because there is no information available.

Should O0110Z be unchecked because at least one of the other O0110 items is checked, or dashed because one of the O0110 items is dashed?

Answer 5: When one or more items for O0110 - Special Treatments, Procedures, and Programs is checked, to indicate that the treatment, procedure, or program applies to the patient, then O0110Z should be left unchecked. This is true even if one of the other O0110 items is dashed.

This same concept applies to K0520 - Nutritional Approaches and N0415 - High-Risk Drug Classes: Use and Indication.

Added: March 2023

Question 6: Archived March 2024

Question 7: A patient's intake orders include an order for PRN IV Lasix. At the time of the assessment and during the assessment time period the patient did not meet the parameters to administer the Lasix. We understand that we would report this on O0110H1 - IV Medications, since the PRN IV Lasix is part of the patient's drug regimen, even though it is not being received during the assessment time period. Would we also report O0110O1 - IV Access, even though the IV Access is not in place or needed during the assessment time period?

Answer 7: The intent of O0110 - Special Treatment, Procedures, and Programs is to identify any listed special treatments, procedures, or programs that apply to the patient.

Check all treatments, procedures, and programs that are part of the current care/treatment plan during the 3-day admission assessment period or the 3-day discharge assessment period, even if it is not received during the 3-day assessment period. However, if there is no current IV access in place at the time of assessment do not code IV access for O0110O1, even if a treatment which would require an IV access is part of the patient's current care/treatment plan.

Added: March 2023

Question 8: Archived March 2024

Question 9: A patient is currently using a Trilogy 202 ventilator, which can provide either invasive ventilation support or non-invasive ventilation support. Should O0110 - Special Treatments, Procedures, and Programs be coded based on the type of device (invasive ventilator vs. non-invasive ventilator) that is used or the type of support (invasive ventilation vs. non-invasive ventilation) that is being provided?

Answer 9: The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

Code O0110F1 - Invasive Mechanical Ventilator (ventilator or respirator), if any type of electrically or pneumatically powered closed-system mechanical ventilator support device is used that ensures adequate ventilation in the patient who is or who may become (such as during weaning attempts) unable to support their own respiration.

Code O0110G1 - Non-Invasive Mechanical Ventilator, if any type of respiratory support device is used that prevents airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle.

Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day admission assessment or the discharge assessment, even if not received during the 3-day assessment time period.

If your scenario meets the criteria for invasive mechanical ventilation, code O0110F1. If your scenario meets the criteria for non-invasive mechanical ventilation, code O0110G1.

Added: March 2023

Question 10: Archived March 2024

Question 11: If during the 3-day admission (or discharge) assessment time period, a patient who utilizes oxygen wears it one day for greater than 14 hours continuously but other days uses it less than 14 hours continuously, can both O0110C3 - Oxygen Therapy; Intermittent and O0110C4 - Oxygen Therapy; Continuous be checked?

Answer 11: The intent of O0110 - Special Treatments, Procedures, and Programs identifies if any of the listed special treatments, procedures, and programs apply to the patient.

Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day admission (or discharge) assessment time period.

That may include marking both intermittent and continuous oxygen for a patient where both apply during the assessment time period.

Regardless of how the oxygen is ordered (i.e., continuously or intermittently), for O0110 apply the specific definitions in determining whether oxygen is coded as continuous (delivered for ≥ 14 hours per day) or intermittent (oxygen was not delivered continuously for at least 14 hours per day).

Added: June 2023

Question 12: We know that we code O0110 - Special Treatments, Procedures, and Programs based on what is part of the current care/treatment plan during the 3-day assessment time period. Can CMS provide further clarification on how to code O0110O1 - IV Access and O0110O4 - IV Access; Central if a PICC line is being pulled during the discharge assessment?

Answer 12: The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan at the time of assessment, even if not used during the 3-day assessment time period.

This includes a PICC line that is being discontinued at the time of the assessment.

Added: June 2023

Question 13: When would IV access provided during dialysis be checked in O0110O1 - Special Treatments, Procedures, and Programs; IV access?

For example, a patient has an AV fistula and IV access is temporarily obtained during hemodialysis at an outside dialysis center. Would the IV access be considered for O0110O1 or would it be excluded since it is only accessed during dialysis, similar to the exclusions with medications and transfusions that were administered during dialysis in item O0110?

Answer 13: If there is a current IV access in place at the time of assessment that is used for dialysis, for example a central venous catheter, then check O0110O1 - Special Treatments, Procedures and Programs; IV Access. If there is no current IV access in place at the time of assessment, and no other treatments, procedures, or programs listed in O0110 apply to the patient then check O0110Z - None of the above.

An AV fistula, whether it is being accessed or not, does not meet the definition of IV Access for O0110O1.

Added: December 2023

O0350

Question 1: How should O0350 - Patient's COVID-19 Vaccination Is Up to Date be completed on patients who are under 6 months of age?

Answer 1: The intent of O0350 - Patient's COVID-19 Vaccination Is Up to Date is to report if a patient is up to date with their COVID-19 vaccine status.

In this scenario, because the patient is under 6 months of age, they are not yet eligible for a COVID-19 vaccination per the current CDC guidelines. Code 1 - Yes, patient is up to date.

Added: September 2024

Question 2: How do we code O0350 if during the discharge assessment time period, it is determined that the patient is not up to date with their COVID-19 vaccination and the facility then administers the vaccine just prior to discharge?

Answer 2: The intent of O0350 - Patient's COVID-19 Vaccination Is Up to Date is to report if a patient is up to date with their COVID-19 vaccine status.

This item is collected on the discharge IRF-PAI. Complete the item as close to the time of discharge as possible.

Based on your scenario, if the patient became up to date due to a vaccination provided within the 3-day discharge assessment time period, code O0350 as 1 - Yes, patient is up to date.

Added: September 2024

Questions 3: For O0350 - Patient's COVID-19 Vaccination is Up to Date, the Coding Instructions for Code 0 - No states that this code is used when the patient is not up to date per CDC's definition of "up to date" as well as using this code when a patient has not received one or more recommended COVID-19 vaccine doses.

Please clarify the definition of "up to date" for the new COVID-19 item. Specifically, if we admit a patient who just received a single dose COVID-19 vaccination (e.g., Pfizer or Moderna), and is currently not due for an additional dose or booster, can they still be considered up to date if this is the first time they've received the COVID-19 vaccine? Or, would they never be considered up to date, as they have missed multiple recommended doses prior to finally getting vaccinated?

Answer 3: The intent of O0350 - Patient's COVID-19 Vaccination Is Up to Date is to report if a patient is up to date with their COVID-19 vaccine status.

Code 1 - Yes, for O0350 if a patient meets the current CDC definition for "up to date". This is true even if they missed receiving previously recommended doses.

Added: September 2024