



Inpatient Rehabilitation Facility Quality Reporting Program Provider Training



Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Refresher Training

August 15, 2017

Acronyms in This Presentation

- Against Medical Advice (AMA)
- Annual Payment Update (APU)
- Automated Submission and Processing (ASAP) System
- Brief Interview for Mental Status (BIMS)
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Certification and Survey Provider Enhanced Reports (CASPER)
- *Clostridium difficile* Infection (CDI)

Acronyms in This Presentation

- Improving Medicare Post-Acute Care Transformation (IMPACT) Act
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Inpatient Rehabilitation Validation and Entry System (jIRVEN)
- Methicillin-Resistant *Staphylococcus aureus* (MRSA)



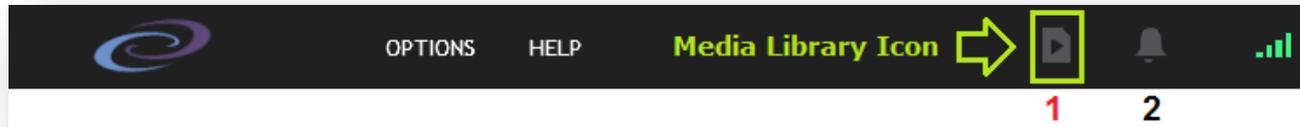
Acronyms in This Presentation

- National Healthcare Safety Network (NHSN)
- National Quality Forum (NQF)
- Present on Admission (POA)
- Quality Improvement and Evaluation System (QIES)
- QIES Technical Support Office (QTSO)
- Quality Measure (QM)
- Quality Reporting Program (QRP)
- Validation Utility Tool (VUT)

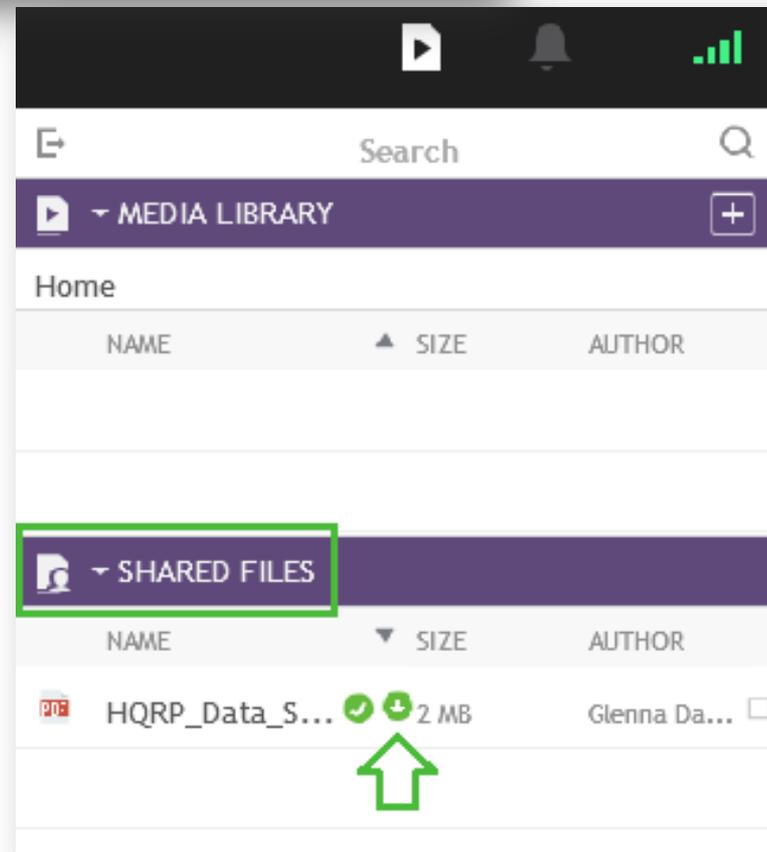
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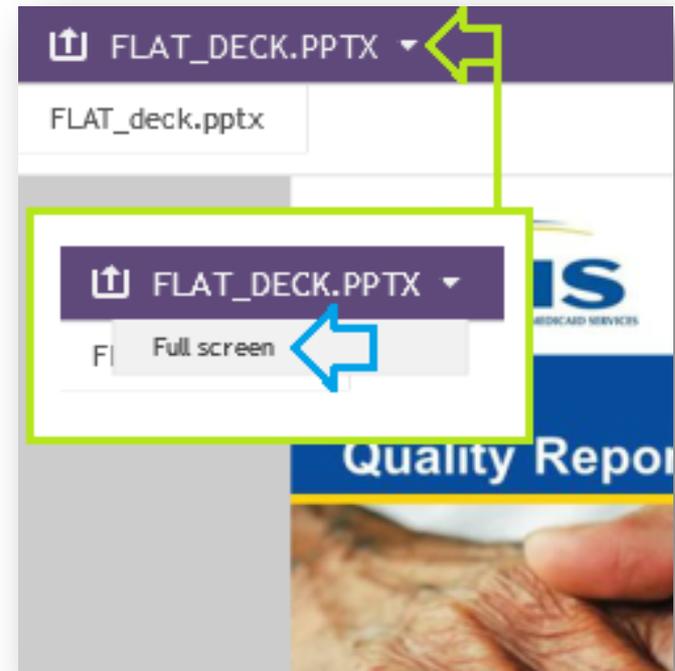


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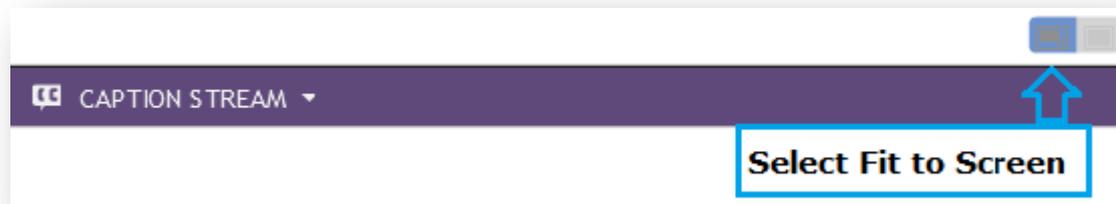
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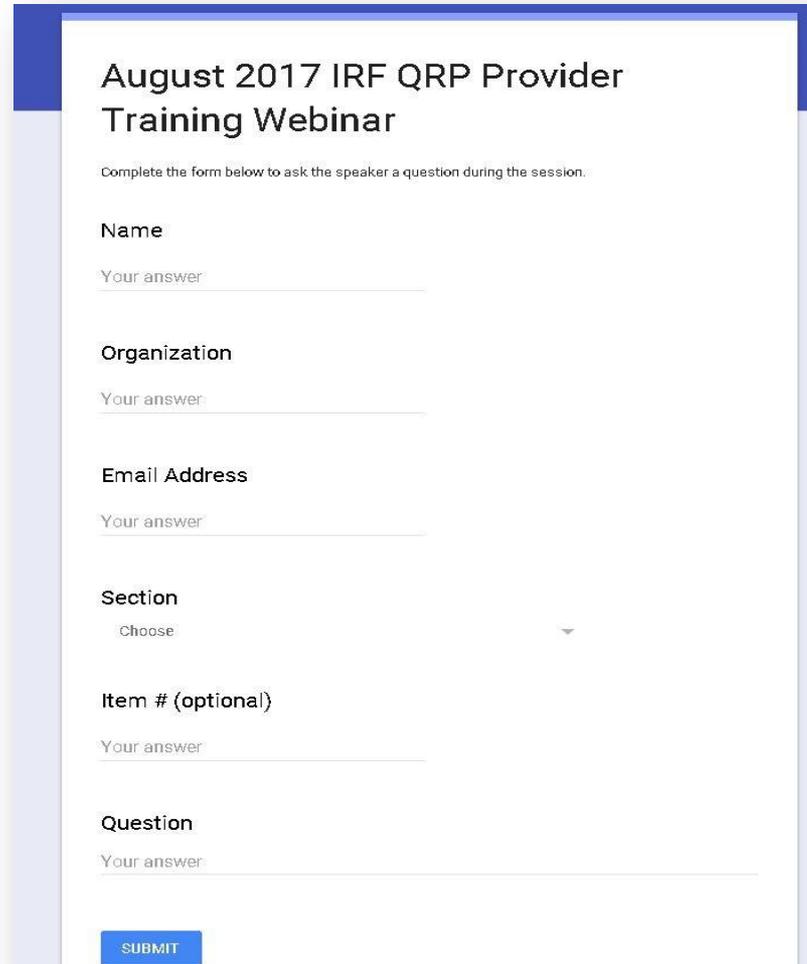
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- D. Five or more people.

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Today's Presenters



**Karen Prior-Topalis, R.N., B.S.N.,
M.B.A., CCM.**

Manager of Quality and Outcomes
Mount Sinai Rehabilitation Hospital



Gina Waltos, COTA/L, B.S.

Team Leader, Quality and Outcomes
Mount Sinai Rehabilitation Hospital

Today's Presenters



Anne Deutsch, R.N., Ph.D., CRRN
Senior Research Public Health Analyst
RTI International

Objectives

Upon completion of the training, the participant will be able to:

- Identify the resources available to guide understanding of the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).
- Demonstrate understanding of section-specific assessment items to correctly interpret and code the IRF-PAI Version 1.4.
- Discuss findings from data analysis on data submissions, including the new assessment items, effective October 1, 2016



Live Demonstration

Karen Prior-Topalis
Gina Waltos

Mount Sinai Rehabilitation Hospital

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

IRF QRP Website



IRF QRP Website: Landing Page

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IRF Quality Reporting

- [IRF Quality Reporting Spotlight & Announcements](#)
- [IRF Quality Reporting Measures Information](#)
- [IRF-PAI and IRF QRP Manual](#)
- [IRF Quality Reporting Technical Information](#)
- [IRF Quality Reporting Training](#)
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- [IRF Quality Reporting FAQs](#)
- [IRF Quality Reporting Data Submission Deadlines](#)
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- [IRF Patient Experience of Care](#)
- [IRF Quality Reporting Help](#)
- [IRF Quality Reporting Archives](#)

Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program

Overview

What's Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP)?

The IRF QRP creates IRF quality reporting requirements, as mandated by Section 3004(a) of the Patient Protection and Affordable Care Act (ACA) of 2010. Every year, by October 1, we publish the quality measures you must report.

Section 3004(b) of the ACA amended section 1886(j)(7) of the Social Security Act (SSA) requiring the Secretary to establish quality reporting requirements for IRFs. Please see below link to text of Section 3004 of the ACA.

What happens if quality data isn't reported?

For fiscal year 2014, and each year after, if an IRF does not submit the required quality data, the IRF will be subject to a two (2) percentage point reduction in the annual payment update.

Who can see the reported data?

We must make quality data available to the public and give you the opportunity to review the data before it's made public. The IRF Compare website will begin reporting quality measure data in late 2016.

Learn more about ACA Section 3004 (Quality Reporting for Long-Term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRF), and Hospice Programs). in the link below: H.R. 3590 Health Care Law P.L. Public Law No: 111-148, the Patient Protection and Affordable Care Act.

Archives

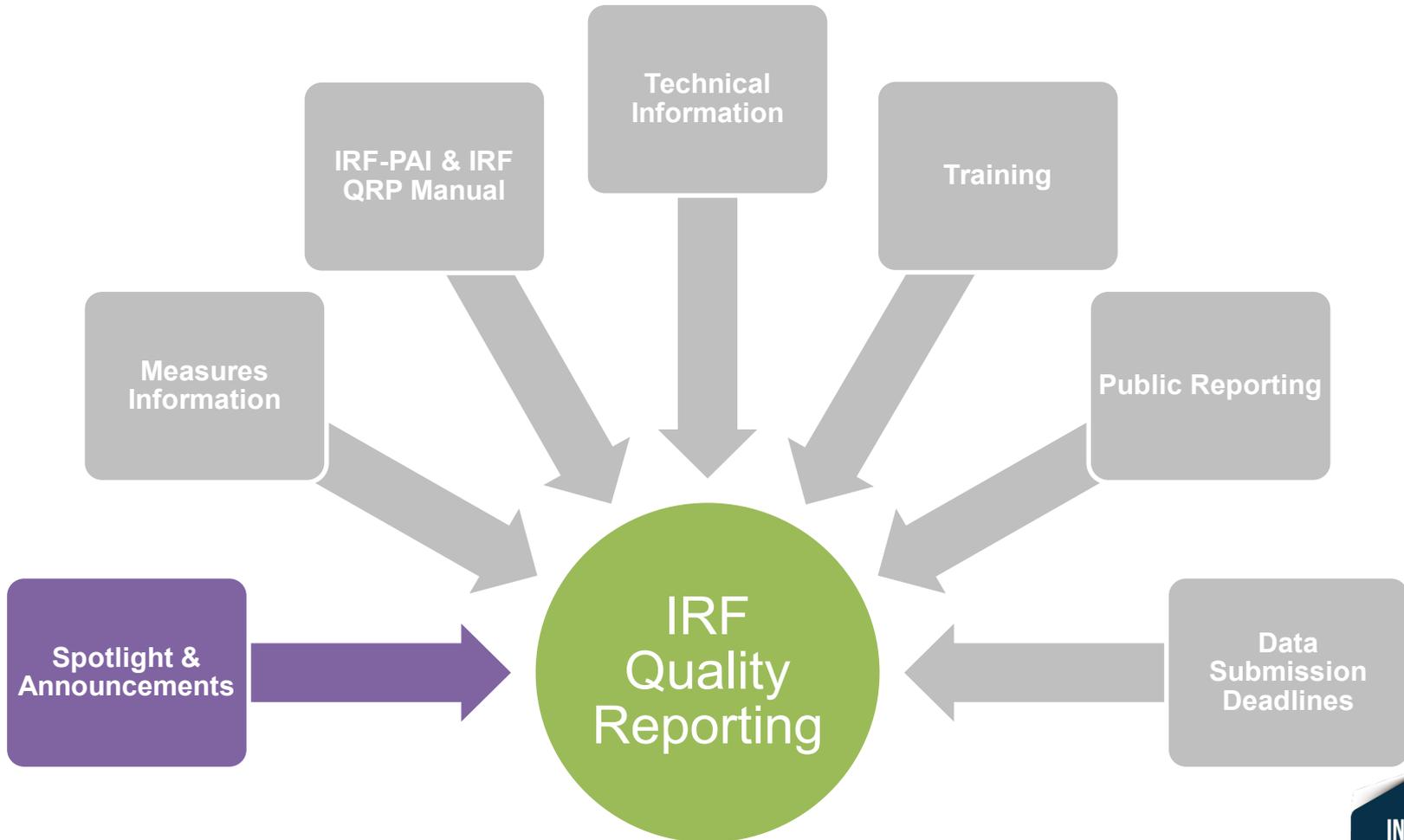
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Related Links

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/>



IRF QRP Website



IRF QRP Website: Spotlight & Announcements

Secure | <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Spotlights-Announcements.html>

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IRF Quality Reporting Spotlight & Announcements

What's new with Inpatient Rehabilitation Facilities (IRFs)

Updates

May 24, 2017

May 2 Review and Correct Reports Provider Training Question and Answer (Q&A) Document Is Now Available

The question and answer (Q+A) document from the **Review and Correct Reports Provider Training** is now available in the "Downloads" section of the [IRF Quality Reporting Training](#) webpage. The Q+A document contains participant questions from the **Live Webcast** which took place on **Tuesday, May 2, 2017**.

May 19, 2017

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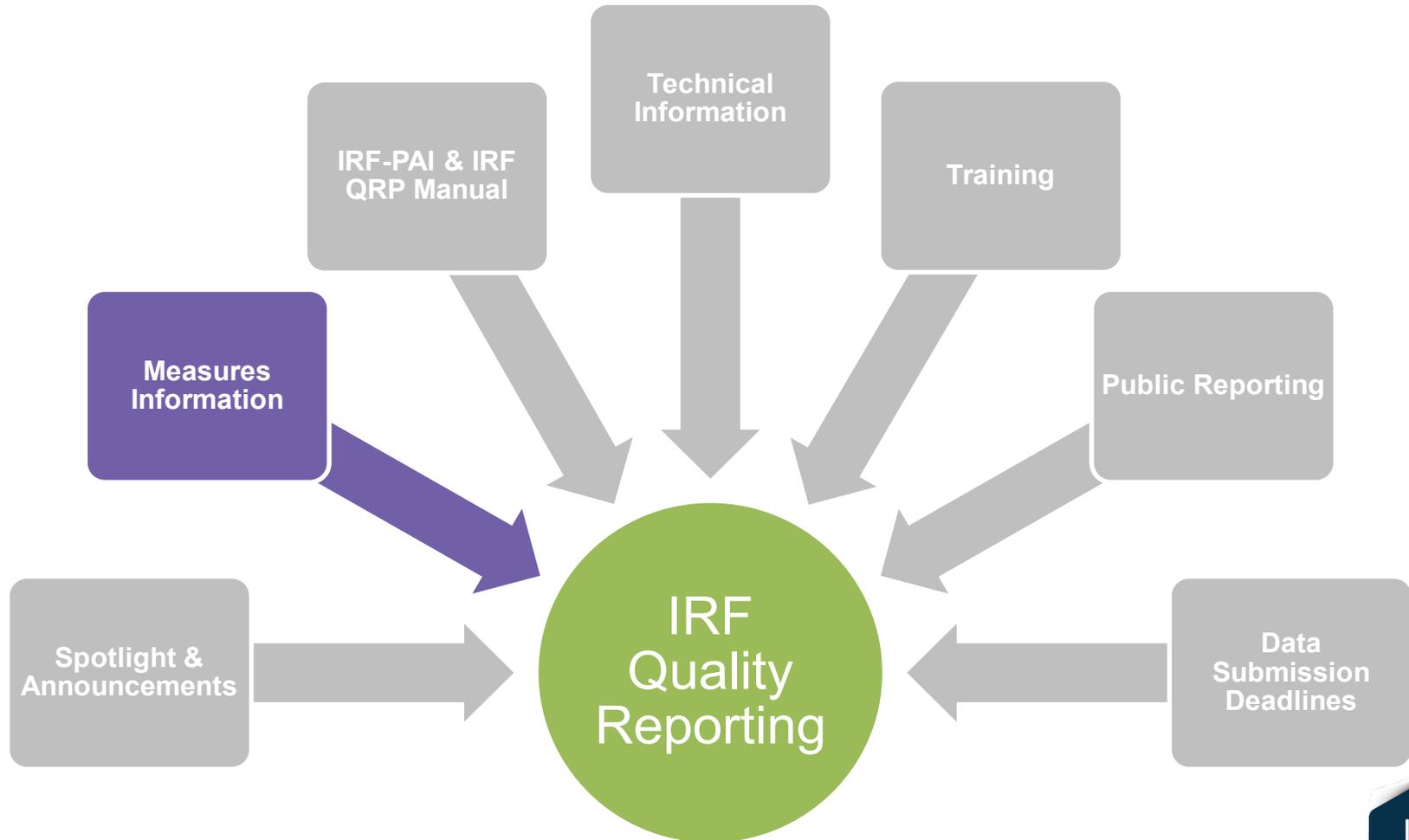
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<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Spotlights-Announcements.html>



IRF QRP Website



IRF QRP Website: Measures Information

Home > Medicare > IRF Quality Reporting > IRF Quality Reporting Measures Information

IRF Quality Reporting

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IRF Quality Reporting Measures Information

What are the Inpatient Rehabilitation Facilities (IRF) quality reporting measures?

In the following table you'll find:

- National Quality Forum (NQF) measure identification numbers and titles
- Measures used in the IRF Quality Reporting Program (QRP) by payment determination year

To learn more about when data are collected and must be submitted, as well as the most current definitions of IRF quality measures please refer to the IRF PAI Manual available under the Downloads section of this web page. Collection periods and submission deadlines for the data are located on the [IRF Data Submission Deadline webpage](#).

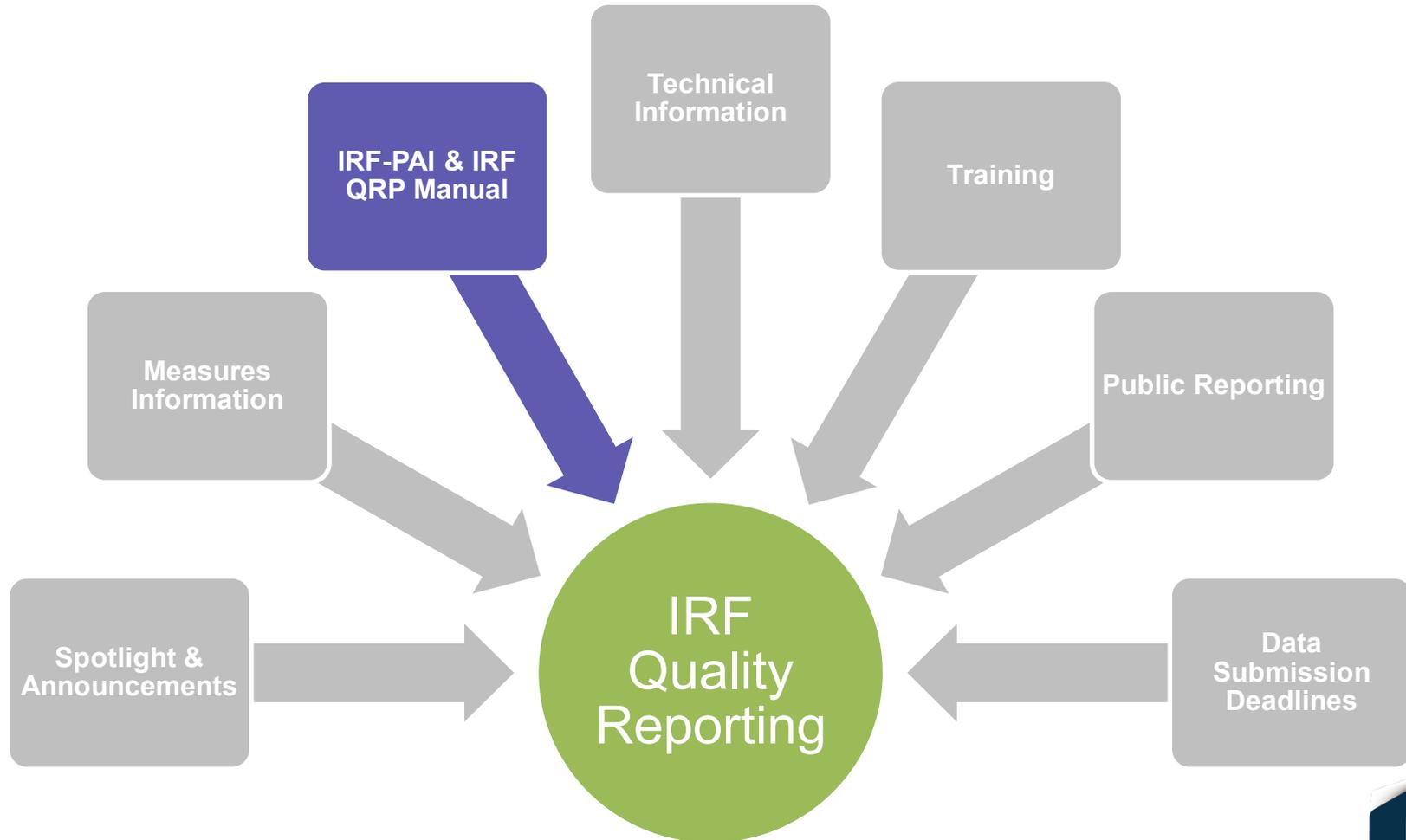
<u>NQF Measure ID</u>	<u>Measure Title</u>	<u>FY 2016</u>	<u>FY 2017</u>	<u>FY 2018</u>
NQF #0138	National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Yes	Yes	Yes
NQF #0678*	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay)	Yes*	Yes*	Yes*
NQF #0431	Influenza Vaccination Coverage among Healthcare Personnel	Yes	Yes	Yes

- IRF Quality Measure (QM) User Manual
- Measure Specifications.
- National Quality Forum (NQF) Measure Identification Numbers and Titles.
- IRF QRP Measures by Payment Determination Year.
- Current Definitions for IRF Quality Measures.
- List of IRF-PAI 1.4 Mandatory and Voluntary Items.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html>



IRF QRP Website



IRF QRP Website: IRF-PAI and IRF QRP Manual

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IRF-PAI and IRF QRP Manual

IRF-PAI & IRF QRP Manual

This page includes the current versions of the IRF-PAI, the Quality Indicator Section of the associated documents. This page will be updated whenever an update is made to either version becomes available, or when important information regarding these tools needs to assessment instrument and quality reporting program requirements are updated, the old documents will remain available for reference in the archives section. Please refer to the additional information related to the IRF PPS requirements.

The Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument (PAI)

The Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument (PAI) is the assessment tool that providers use to collect patient assessment data for quality measure calculation and payment in accordance with the IRF QRP. Completion of the IRF-PAI is required for each Medicare Part A or Medicare Part C patient discharged from an inpatient rehabilitation facility. The current version of the IRF-PAI, effective October 1, 2016, is available in the download section of this webpage. For more information on the collection and submission for the quality reporting program, please refer to the [IRF Quality Reporting Submission Deadlines webpage](#).

- Current versions of the IRF-PAI, the Quality Indicator Section of the IRF-PAI Manual, and associated documents.
- Tool and Manual Updates.
- Change table(s).

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-QRP-Manual.html>

IRF QRP Website: IRF-PAI and IRF QRP Manual

Downloads

[Proposed IRF-PAI Version 1.5 - Effective October 1 2017.pdf \[PDF, 575KB\]](#)

[Proposed IRF-PAI Version 2.0 - Effective October 1 2018.pdf \[PDF, 836KB\]](#)

[Proposed IRF-PAI Versions 1.5 and 2.0 Change Tables.pdf \[PDF, 580KB\]](#)

[IRF-PAI Manual V1.4 Section 4 Change Table - August 2016 \[PDF, 48KB\]](#)

[Section 9 IRF PAI v1 4 Required Voluntary Items Matrix 04-26-16 \[PDF, 199KB\]](#)

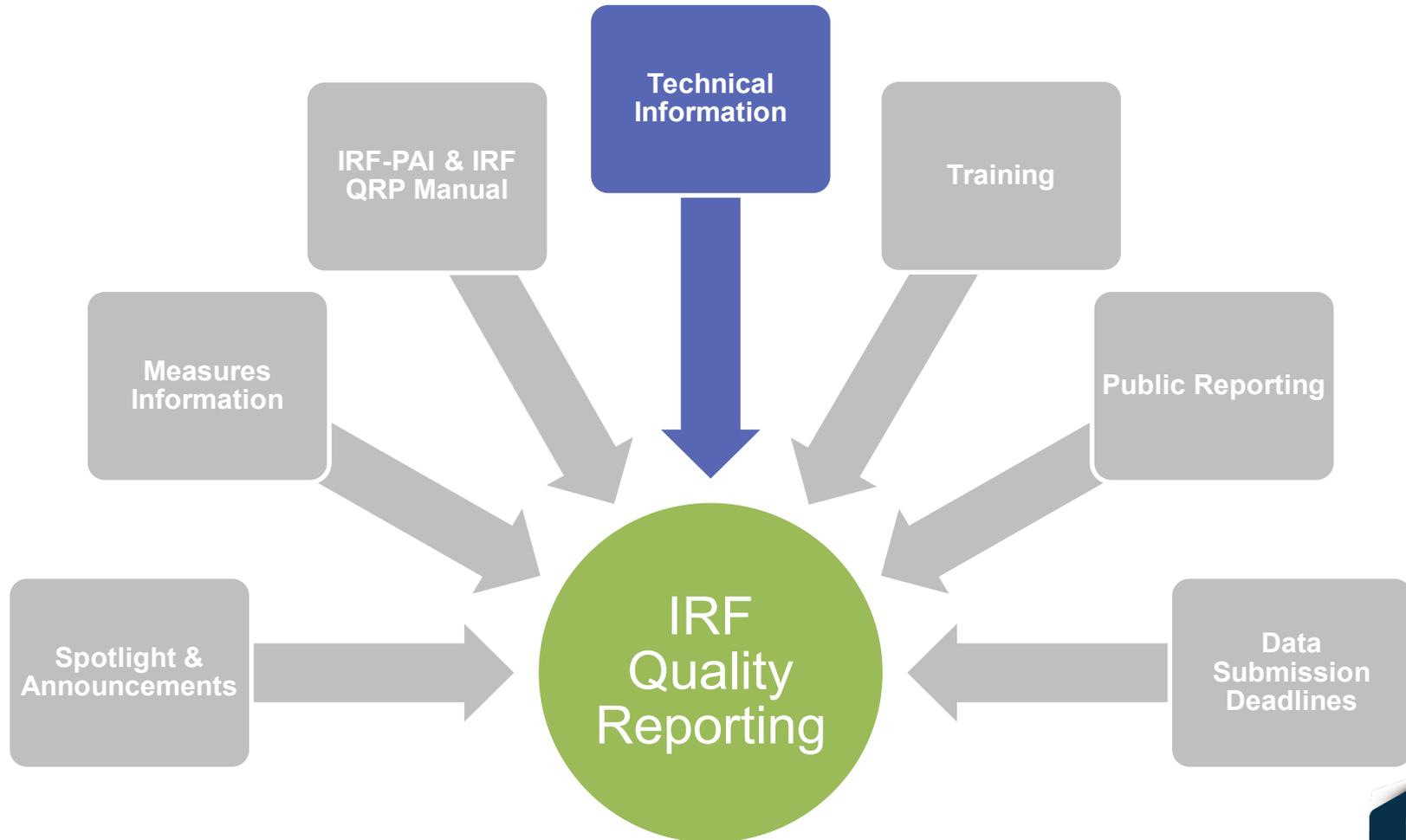
[IRF-PAI Manual Section 4 Quality Indicators V1.4 Revised August 2016 \[ZIP, 2MB\]](#)

[Final IRF-PAI V 1 4_07-24-15 \[PDF, 471KB\]](#)

- Final IRF-PAI version 1.4, effective October 1, 2016.
- Proposed IRF-PAI version 1.5, effective October 1, 2017.
- Proposed IRF-PAI Version 2.0, effective October 1, 2018.
- Change tables.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-QRP-Manual.html>

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IRF Quality Reporting Technical Information

The purpose of this web page is to provide technical updates and resources related to IRF data submission, including information regarding the CDC's National Healthcare Safety Network (NHSN) Assessment Instrument (PAI). Users may also find contact information on this page for where to go for technical issues.

This page is updated periodically as updates to technical information, IRF-PAI Submission Specifications, and other tools related to data submission become available.

Comments and Questions:

For questions about IRF-PAI data coding or IRF-PAI data submission:

Phone: 1-800-339-9313, e-mail: help@qtso.com, or <https://www.qtso.com/irfpai.html>

For questions related to technical issues: IRFTechIssues@cms.hhs.gov

For the Quality Improvement and Evaluation Systems (QIES) Technical Support Office: help@qtso.com

Centers for Disease Control and Prevention's National Healthcare Safety Network Website

Information related to the procedures using the NHSN for data submission for CAUTI, MRSA, CDI, and the Influenza Vaccination Coverage Among Healthcare Personnel measures can be found at: <http://www.cdc.gov/nhsn>

- Technical Updates and Resources.
- Contacts for Technical Issues.
- IRF-PAI Submission Specifications.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Technical-Information.html>



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IRF Quality Reporting Training

The Centers for Medicare & Medicaid Services (CMS) has many sources of information for the Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP) for hospitals and other providers.

- Special Open Door Forum (SODF) Presentations
- Training Materials
- Frequently Asked Questions (FAQ)

Updates

May 24, 2017

May 2 Review and Correct Reports Provider Training Question and Answer (Q&A)

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May 19, 2017

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- Training Updates.
- Training Registration.
- Training Presentations and Collateral Materials.
- Training Q&As.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html>



IRF QRP Website: Training Downloads

Downloads

[May 2 Review Correct Webcast QA- May 2017.pdf \[PDF, 388KB\]](#) 

[May_2017_Review_and_Correct_Reports_Provider_Training.zip \[ZIP, 2MB\]](#) 

[IRF_CollateralMaterials_Chicago_August2016.zip \[ZIP, 3MB\]](#) 

[IRF_SlidePresentationsExceptFAQAndGG_Chicago_August2016.zip \[ZIP, 7MB\]](#) 

[IRF_SlidePresentationsGGand FAQ_Chicago_August2016.zip \[ZIP, 6MB\]](#) 

[PAC_IRF_QRP_Follow_Up_QA_v2 \[PDF, 876KB\]](#) 

[August_IRF_Training_Part_1 \[ZIP, 3MB\]](#) 

[August_IRF_Training_Part_2 \[ZIP, 1MB\]](#) 

[August_IRF_Training_Part_3 \[ZIP, 4MB\]](#) 

[IRF Compliant Packet \[ZIP, 2MB\]](#) 

[IMPACT Act and Assessment Data Element Standardization and Interoperabil... \[ZIP, 6MB\]](#) 

[IRF_QRP_Training_AgendaFINAL \[PDF, 238KB\]](#) 

[IRF Training 1 \[ZIP, 6MB\]](#) 

[IRF Training 2 \[ZIP, 7MB\]](#) 

[IRF Training 3 \[ZIP, 9MB\]](#) 

[May_2016_IRF_QRP_Provider_Training_Day_One \[ZIP, 15MB\]](#) 

[May_2016_IRF_QRP_Provider_Training_Collateral_Material \[ZIP, 983KB\]](#) 

[May_2016_IRF_QRP_Provider_Training_Day_Two \[ZIP, 12MB\]](#) 

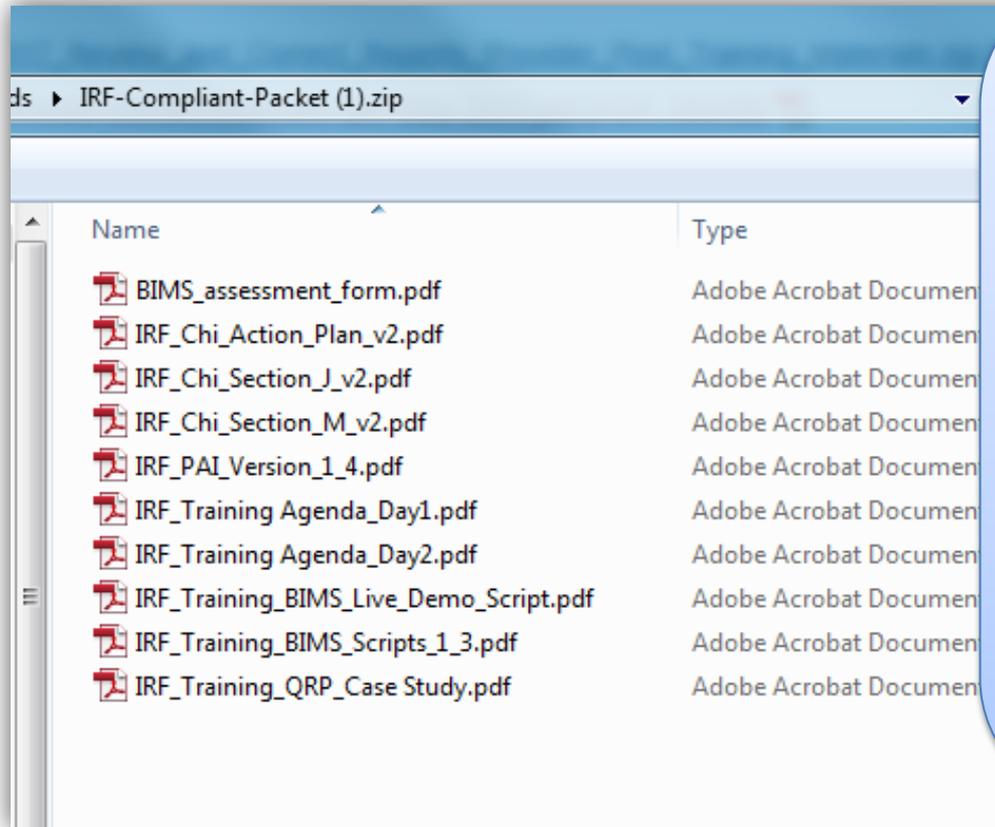
[IRF_QRP_Training_Q&A - August 2016.pdf \[PDF, 388KB\]](#) 

[MLN Connects NPC PPT- LTCH and IRF 12-1-16.pdf \[PDF, 1MB\]](#) 

- May 2017 Review and Correct Reports Webcast Recording & Q&A.
- August 2016 IRF QRP Provider Training Materials, Videos & Q&A.
- May 2016 IRF QRP Provider Training Materials, Videos & Q&A.
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act.
- Act & Interoperability Training Presentation.

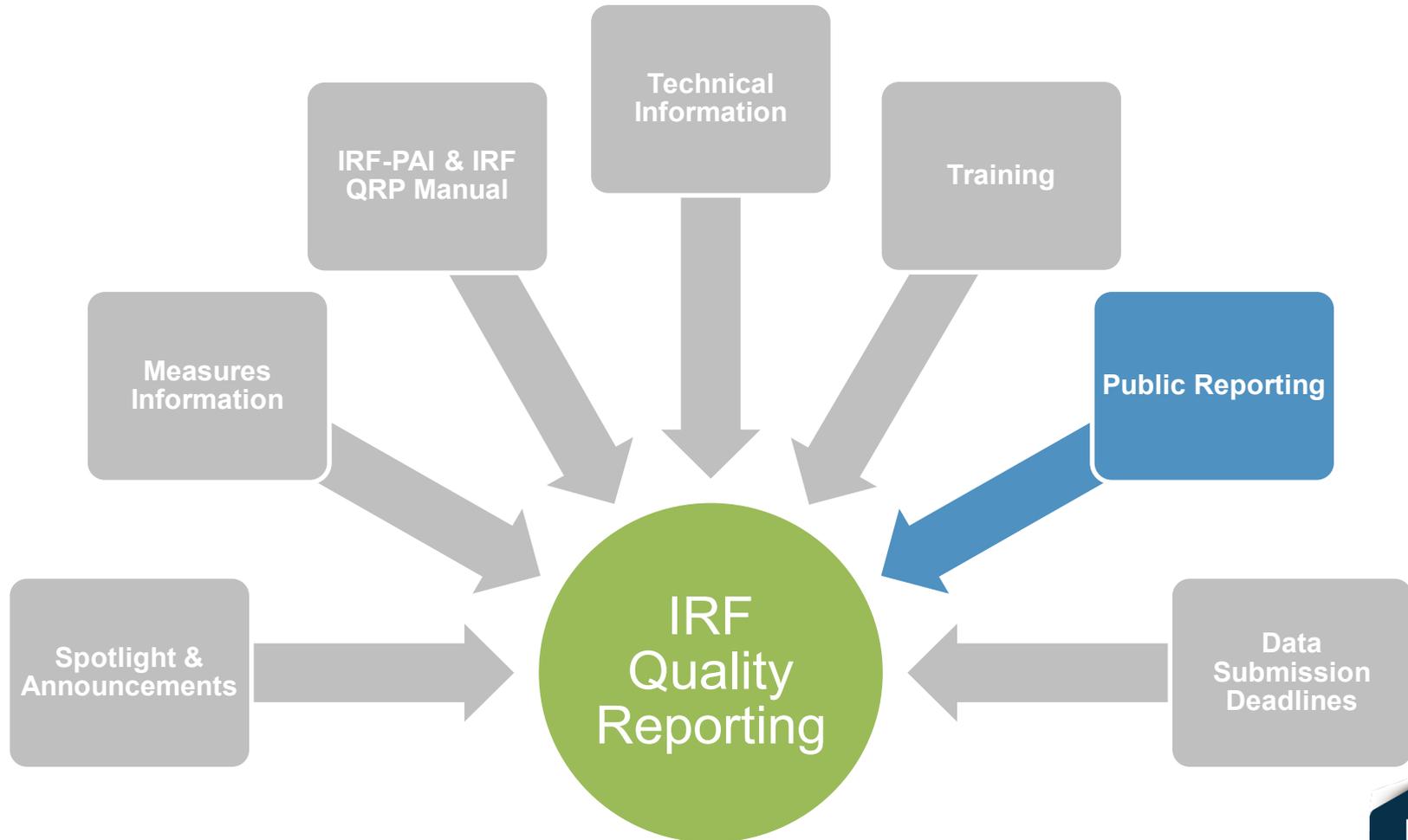
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html>

IRF QRP Website: Training Downloads



- Past in-person IRF QRP Provider Training materials are packaged into zipped folders.
- Each section of the training has a zipped folder containing all related training materials.
- CMS provides training materials (presentations, case studies, action plan templates, etc.) for reuse in your organization.

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IRF Quality Public Reporting

Background:

Section 3004(b) of the Affordable Care Act established the IRF Quality Reporting Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) to collect patient assessment data on quality, resource use, and other measures by Post-acute care facilities, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

IRF Compare Website Now Live

December 14, 2016, CMS unveiled the new IRF Compare website. This new website is a format that can be used more readily by the public to get a snapshot of the quality of care at an instance, this tool will help families compare some key quality metrics, such as patient safety, patient care, and patient experience, across over 1,100 IRFs across the nation. The following quality measures are reported:

- Percent of residents or patients with pressure ulcers that are new or worsened.
- All-cause unplanned readmission measure for 30 days post-discharge from Inpatient Rehabilitation Facility (IRF) - NQF #2502

Procedures for requesting CMS review of an IRF's measure data:

CMS encourages IRFs to review their data as provided in the Preview Reports. If an IRF disagrees with performance data (numerator, denominator, or quality metric) contained within their Preview Report, they will have an opportunity to request review of that data by CMS. In order to make such a request, IRFs must adhere to the process outlined below:

- Public Reporting Updates.
- Public Reporting Resources & Education Materials.
- Downloads.
 - IRF Compare Fact Sheet.
 - NHSN Rebaseline Guidance.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Public-Reporting.html>

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- [IRF Quality Reporting Reconsideration and Exception & Extension](#)
- [IRF Patient Experience of Care](#)
- [IRF Quality Reporting Help](#)
- [IRF Quality Reporting Archives](#)

IRF Quality Reporting Data Submission Deadlines

When does Inpatient Rehabilitation Facility (IRF) quality data have to be submitted?

Each fiscal year (FY), you must report data to meet Inpatient Rehabilitation Facility Quality Reporting Program requirements. You must submit your data no later than 11:59 p.m. Pacific Time on the deadline dates we've listed below. The IRF-Patient Assessment Instrument (PAI) must be submitted to the Assessment Submission and Processing (ASAP) system to the Quality Improvement Extension for the National Healthcare Safety Network (NHSN) measures must be submitted to the NHSN.

CMS strongly encourages all facilities to submit data several days prior to the deadline to avoid submission issues and to provide opportunity to review submissions to ensure data is accurate.

NHSN

Visit [CMS Resources for NHSN Users](#) webpage for:

- Guidance on how to run and interpret NHSN output reports
- Checklist to ensure complete reporting into NHSN.

Visit the [NHSN fact sheet](#):

- When trying to determine when monthly reporting plan, event, and summary data were first entered or last modified.

Please contact the NHSN Helpdesk: NHSN@cdc.gov if you have any questions.

- Data Submission Updates.
- Data Collection & Final Submission Deadlines for FY 2018 Payment Update Determination.
- Downloads.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.html>



Federal Register

- Proposed Rules and Final Rules are published in the Federal Register and typically released each year in April and August.
- Proposed and Final Rules are posted on both of these web pages:
 - <https://www.federalregister.gov>.
 - <http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientRehabFacPPS/List-of-IRF-Federal-Regulations.html>.

Stay Connected

- To receive mailing list notices and announcements about the IRF QRP, sign up at:
<https://public.govdelivery.com/accounts/USCMS/subscriber/new>.
- CMS Open Door Forums and listening sessions. Notices about CMS Open Door Forums related to the IRF QRP are announced on the following web page: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/IRF-Quality-Reporting/Spotlights-Announcements.html>.

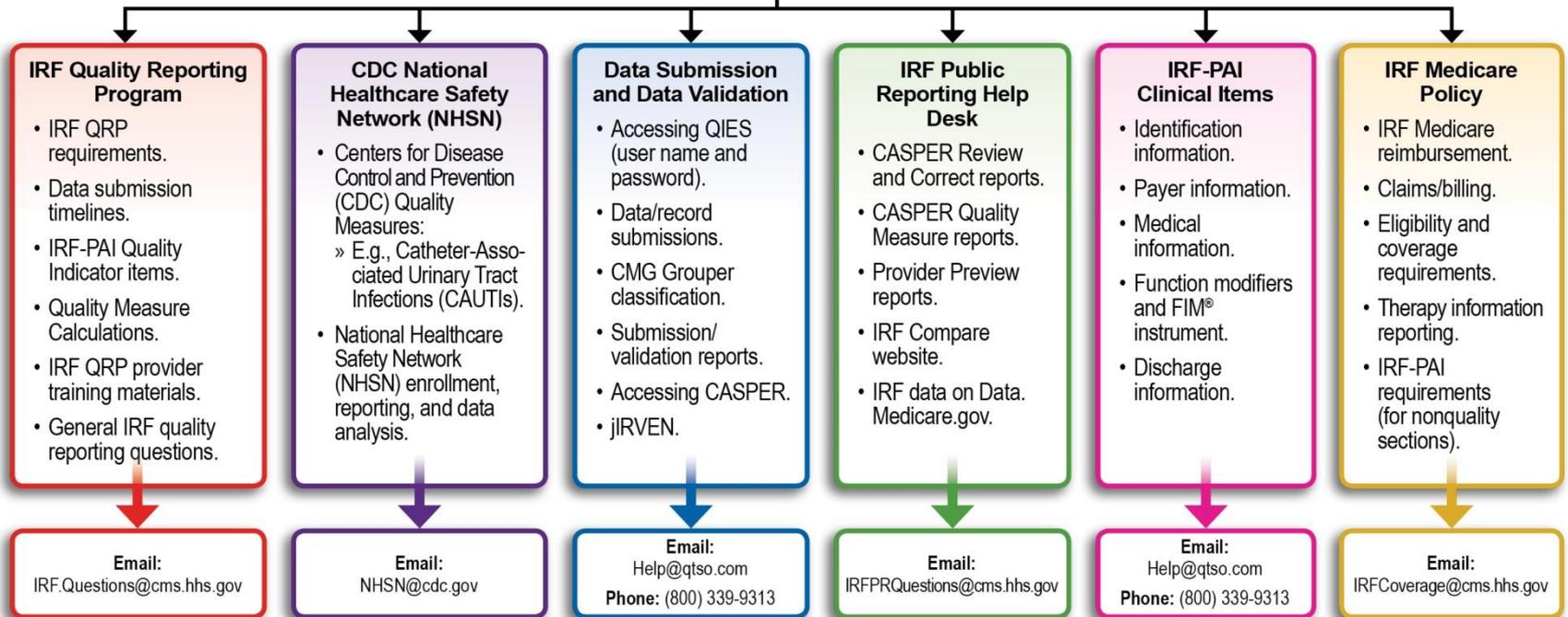
IRF

Help Desks

IRF Help Desks

IRF Rehabilitation Facility Help Desks

IRF Provider, with a question about:



IRF Help Desks

IRF Vendor, with a question about:

IRF Vendor Issues

- IRF-PAI data technical specifications.
- VUT (vendor tool to ensure software meets CMS requirements and will pass ASAP edits).
- Technical questions related to IRF-PAI data specifications.

Email:

IRFTechIssues@cms.hhs.gov

IRF QRP Help Desk



IRF QRP

Email: IRF.Questions@cms.hhs.gov

Examples of issues:

- IRF QRP requirements, including data submission timelines.
- IRF-PAI Quality Indicator items.
- Calculation of Quality Measures.
- IRF QRP provider training materials.
- General IRF quality reporting questions.

If you are unsure which Help Desk to use, e-mail your question to this Help Desk for triage.



CDC/NHSN Help Desk



CDC National Healthcare Safety Network (NHSN)

Email: NHSN@cdc.gov

Examples of issues:

- Centers for Disease Control and Prevention (CDC) Quality Measures:
 - Catheter-Associated Urinary Tract Infections (CAUTIs).
 - Methicillin-Resistant *Staphylococcus aureus* Bacteremia.
 - *Clostridium difficile* Infection.
 - Influenza Vaccination Coverage Among Healthcare Personnel.
- National Healthcare Safety Network (NHSN) enrollment, reporting, and data analysis.



Data Submission and Data Validation Help Desk



Data Submission and Data Validation

Email: Help@qtso.com

Phone: (800) 339-9313

Examples of issues:

- Accessing QIES (username and password).
- Data/record submissions.
- CMG Grouper classification.
- Submission/validation reports.
- Accessing Certification and Survey Provider Enhanced Reports (CASPER).
- Inpatient Rehabilitation Validation and Entry System (jIRVEN).



IRF Public Reporting Help Desk



IRF Public Reporting Help Desk

Email: IRFPRQuestions@cms.hhs.gov

Examples of issues:

- Reporting periods for the CASPER Review and Correct reports.
- Interpretation of results for the CASPER Quality Measure reports.
- Measures included the Provider Preview reports.
- IRF Compare website:
<https://www.medicare.gov/inpatientrehabilitationfacilitycompare/>
- IRF data available on [Data.Medicare.gov](https://data.medicare.gov).



IRF-PAI Clinical Items Help Desk



IRF-PAI Clinical Items

Email: Help@qtso.com

Phone: (800) 339-9313

Examples of issues:

- Identification information.
- Payer information.
- Medical information.
- Function modifiers and FIM[®] instrument.
- Discharge information.

IRF Medicare Policy Help Desk



IRF Medicare Policy

Email: IRFCoverage@cms.hhs.gov

Examples of issues:

- IRF Medicare reimbursement.
- Claims/billing.
- Eligibility and coverage requirements.
- Therapy information reporting.
- IRF-PAI requirements (for nonquality sections).



IRF Vendor Issues Help Desk



IRF Vendor Issues

Email: IRFTechIssues@cms.hhs.gov

Examples of issues:

- IRF-PAI data technical specifications.
- Validation utility tool (VUT) to ensure software meets CMS requirements and will pass Automated Submission and Processing (ASAP) System edits.
- Technical questions that are related to IRF-PAI data specifications.

Polling Question

How often do you visit the IRF QRP web page on the CMS website?

- A. Very frequently (weekly).
- B. Occasionally (monthly).
- C. Rarely (a few times a year).
- D. Never.

Knowledge Check 1

Which resource below is the best reference for guidance in coding the IRF-PAI assessment items?

- A. IRF-PAI Training Manual.
- B. IRF-PAI Change Table.
- C. QIES User Maintenance Application User's Guide.

Knowledge Check 1

Which resource below is the best reference for guidance in coding the IRF-PAI assessment items?

- ✓ A. IRF-PAI Training Manual.
- B. IRF-PAI Change Table.
- C. QIES User Maintenance Application User's Guide.

Knowledge Check 2

You have a question about coding an unstageable pressure ulcer on the IRF-PAI. Which Help Desk should you contact?

- A. IRF Medicare Policy.
- B. CDC/NHSN.
- C. IRF Quality Reporting Program (QRP).
- D. Data Submission and Data Validation.

Knowledge Check 2

You have a question about coding an unstageable pressure ulcer on the IRF-PAI. Which Help Desk should you contact?

A. IRF Medicare Policy.

B. CDC/NHSN.

✓ C. IRF Quality Reporting Program (QRP).

D. Data Submission and Data Validation.

Coding Reminders

Dash Use

- Instances where coding of the dash [–] does not impact Annual Payment Update (APU) determination:
 - Coding Section GG Discharge Goal items.
 - Coding Brief Interview for Mental Status (BIMS) items C0400A, C0400B, and C0400C when the interview is stopped because the patient did not answer the previous questions.

Dash Use: Section GG

Discharge Goals

- Use the six-point scale to code GG0130. Self-Care and GG0170. Mobility Discharge Goal(s).
 - Do not use the “activity was not attempted” codes (07, 09, or 88) to code discharge goal(s).
- At least one discharge goal must be reported for either one self-care or one mobility activity.
- A dash [–] may be used if a goal is not reported for a specific activity.
- Using the dash in this allowed instance does not affect APU determination as long as at least one self-care or mobility goal is reported.

Dash Use: BIMS Interview Stopped

- Use a dash [–] to indicate that the BIMS interview was stopped.
 - Refer to the rules for stopping the interview before it is completed (Guidance Manual, page C-5).
- If the patient refuses to answer the BIMS (specifically C0200 & C0300A–C=0), then using the dash for items C0400A–C does not affect APU determination.
- In this case, where the BIMS is stopped, code C0500 as 99, code C0600 as 1, Yes and check C0900 items if they apply.

Checkbox Items

- For checkbox items, leaving an item unchecked is a valid response indicating that the condition is not present:
 - I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD).
 - I2900. Diabetes Mellitus (DM).
 - OR
 - I7900. None of the above.

I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)	
I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)	
I7900. None of the above	

Comorbidities and Co-existing Conditions	
↓	Check all that apply
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	I7900. None of the above

Checkbox Items

- Leaving an item unchecked is a valid response for:
 - O0100N. Total Parenteral Nutrition

<input type="checkbox"/>	N. Total Parenteral Nutrition
O0100. Special Treatments, Procedures, and Programs	
↓ Check if treatment applies at admission	
<input type="checkbox"/>	N. Total Parenteral Nutrition

Important Timeframes

- The **3-Day Assessment** period is 3 calendar days and is defined in the IRF-PAI Manual.
 - Admission Assessment Period: First day of admission and the following 2 days, ending at 11:59 PM.
 - Discharge Assessment Period: Day of discharge and the 2 calendar days prior to the day of discharge.

Important Timeframes

- J1750. History of Falls asks whether the patient has had two or more falls or any fall with major injury in the **past year**.
- J2000. Prior Surgery asks whether the patient had major surgery during the **100 days prior to admission**.

Knowledge Check 3

If at least one self-care or mobility goal is entered on the IRF-PAI, using a dash for the remaining discharge goal items will not affect the APU determination.

- A. True
- B. False

Knowledge Check 3

If at least one self-care or mobility goal is entered on the IRF-PAI, using a dash for the remaining discharge goal items will not affect the APU determination.

- ✓ A. True
- B. False

Knowledge Check 4

Leaving an item unchecked is an allowable response for which of the assessment items below?

- A. M0300A. Stage 1.
- B. I2900. Diabetes Mellitus (DM).
- C. GG0170G2. Car Transfer Discharge Goal.
- D. H0350. Bladder Continence.

Knowledge Check 4

Leaving an item unchecked is an allowable response for which of the assessment items below?

- A. M0300A. Stage 1.
- ✓ B. I2900. Diabetes Mellitus (DM).
- C. GG0170G2. Car Transfer Discharge Goal.
- D. H0350. Bladder Continence.

Section-Specific Assessment Items

Sections B, C, H, J, M & O

Section B

Hearing, Speech, and Vision

Section B

- Section B is assessed on admission.
 - **BB0700.** Expression of Ideas and Wants.
 - **BB0800.** Understanding Verbal Content.
- Document the patient's ability to understand and communicate with others in his/her primary language, whether in speech, writing, sign language, gestures, or a combination of these.

BB0700 Coding Instructions

- Enter the code that best reflects the patient's ability to express ideas and wants.

Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

BB0700. Expression of Ideas and Wants (3-day assessment)

Enter Code

Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

BB0700 Coding Tips

- Complex messages would include:
 - Discussion about medication administration.
 - Discharge planning.
 - Caregiver issues.

BB0800 Coding Instructions

- Enter the code that best reflects the patient's ability to understand verbal content, however able.

BB0800. Understanding Verbal Content (3-day assessment)	
Enter Code	Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers)
<input type="checkbox"/>	4. Understands: Clear comprehension without cues or repetitions
	3. Usually Understands: Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
	2. Sometimes Understands: Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
	1. Rarely/Never Understands

Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers)

4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**

Section B Coding Example

Q. Clarify the difference between “Code **3**, Some Difficulty” and “Code **2**, Frequently Exhibits Difficulty.”

Section B Coding Example

Q. Clarify the difference between “Code 3, Some Difficulty” and “Code 2, Frequently Exhibits Difficulty.”

A. Not based on just the number of words or the number of gestures if the patient is nonverbal.

Coding should reflect the frequency of the difficulty the patient has expressing wants and ideas.

Observe interactions with others in different locations and circumstances and ask other clinicians during different shifts as well as family members.

Section C

Brief Interview for Mental Status (BIMS) C0200–C0500

Section C: BIMS

- Consists of three components:
 - **C0200.** Repetition of Three Words.
 - **C0300.** Temporal Orientation.
 - **C0400.** Recall.
- Results are totaled into a Summary Score.
 - **C0500.** BIMS Summary Score.

Section C: BIMS Instructions

1. Interview any patient not screened out by item C0100.
 - The interview should not be attempted if the patient is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. *Skip to **C0900, Memory/Recall Ability.***
2. Conduct the interview in a private setting.

Section C: BIMS Instructions

3. Be sure the patient can hear you.
4. Sit so that the patient can see your face.
5. Give an introduction before starting the interview.

Section C: BIMS Instructions

6. If the patient expresses concern, he or she may be more comfortable if you reply:
 - “We ask these questions of everyone so we can make sure that our care will meet your needs.”
7. Conduct the interview in one sitting and in the order provided.
8. If the patient chooses not to answer a particular item, accept his or her refusal and move on to the next question.

Section C: BIMS Coding Tips

- Nonsensical responses should be coded as zero.

DEFINITION:

NONSENSICAL RESPONSE

Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated.

C0200: Repetition of Three Words

Record the maximum number of words that the patient correctly repeated on the **first attempt only.**

C0200. Repetition of Three Words	
Enter Code <input type="checkbox"/>	<p>Ask patient: "I am going to say three words for you to remember. Please repeat them and bed. Now tell me the three words."</p> <p>Number of words repeated by patient after first attempt:</p> <ul style="list-style-type: none">3. Three2. Two1. One0. None <p>After the patient's first attempt say: "I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture." You may repeat the words up to two more times.</p>

Number of words

- 3. Three
- 2. Two
- 1. One
- 0. None

C0200 Tips

- Words may be recalled in any order and in any context.
 - Repeating words in a sentence counts as repeating the words.
- Score the number of words repeated on the first attempt only.
 - Do not score the number of repeated words on the second or third attempt.
 - Do not record the number of attempts that the patient needed to complete.
- If the interviewer cannot say words clearly, have another staff member conduct the interview.

C0300: Temporal Orientation

- Assess ability to report the correct year, month, and day of the week.
- **Code 0** if the patient does not answer.

C0300. Temporal Orientation: Year, Month, Day	
Enter Code <input type="text"/>	A. Ask patient: <i>"Please tell me what year it is right now."</i> Patient's answer is: 3. Correct 2. Missed by 1 year 1. Missed by 2 to 5 years 0. Missed by more than 5 years or no answer
Enter Code <input type="text"/>	B. Ask patient: <i>"What month are we in right now?"</i> Patient's answer is: 2. Accurate within 5 days 1. Missed by 6 days to 1 month 0. Missed by more than 1 month or no answer
Enter Code <input type="text"/>	C. Ask patient: <i>"What day of the week is today?"</i> Patient's answer is: 1. Correct 0. Incorrect or no answer

C0400: Recall

C0400. Recall

Enter Code <input type="checkbox"/>	<p>Ask patient: "Let's go back to the first question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word.</p> <p>A. Recalls "sock?"</p> <ol style="list-style-type: none">2. Yes, no cue required1. Yes, after cueing ("something to wear")0. No, could not recall
Enter Code <input type="checkbox"/>	<p>B. Recalls "blue?"</p> <ol style="list-style-type: none">2. Yes, no cue required1. Yes, after cueing ("a color")0. No, could not recall
Enter Code <input type="checkbox"/>	<p>C. Recalls "bed?"</p> <ol style="list-style-type: none">2. Yes, no cue required1. Yes, after cueing ("a piece of furniture")0. No, could not recall

C0400 Steps for Assessment

1. Ask the patient to repeat the words from the earlier question.
 - Read question as it appears on the IRF-PAI.
2. Allow up to 5 seconds for spontaneous recall of each word.
3. Provide category cues for any word not correctly recalled after 5 seconds.
4. Use category cues only after patient is unable to recall one or more words.
5. Allow up to 5 seconds after category cue for recall.

Section C: Stopping the BIMS Interview

- Stop the interview if necessary.
- Stop the interview after completing (C0300C) “Day of the Week” if:
 - All responses nonsensical, OR
 - No verbal or written response to any of the questions up to this point, OR
 - No verbal or written response to some questions and nonsensical responses to other questions.

Section C: Stopping the BIMS Interview

If the interview is stopped, do the following:

1. **Code “–” (dash)** in C0400A, C0400B, and C0400C.
2. **Code 99** in the summary score in C0500.
3. **Code 1, Yes**, in C0600. Should the Staff Assessment for Mental Status (C0900) be Conducted?
4. Complete the Staff Assessment for Mental Status.

Section C: The BIMS in Writing

- If the patient's primary method of communication is in written format, the BIMS can be administered in writing.
- The administration of the BIMS in writing should be limited to this circumstance.
- Refer to “Guidance for Completing the BIMS Using Alternative Methods” in the Guidance Manual, Pages C-19 and C-20.

Section C: BIMS and Program Interruptions

- If an IRF patient has an interrupted stay, the BIMS assessment that was conducted when the patient was first admitted to the IRF (prior to the program interruption) would be the patient's BIMS assessment.
- No additional BIMS assessments are required for patients who have one or more program interruptions.

Section C: BIMS Not Attempted

- If the BIMS should have been attempted but was not, code Section C as follows:
 1. Indicate that the BIMS should have been conducted by coding C0100 as 1, Yes.
 2. Enter a dash for each of the BIMS items (C0200, C0300A-C, C0400A-C).
 3. Code C0500, BIMS Summary Score as 99.
 4. Code C0600 as 1, Yes.
 5. Complete C0900. Staff Assessment for Mental Status.

Section C: BIMS Video

Visit the CMS YouTube Channel to view the BIMS video and other videos about interviewing techniques:

- <https://www.youtube.com/watch?v=DAj3TA5w11Y>

Section H

H0350 & H0400

Incontinence

- Involuntary loss of urine, when there is a loss of control of the evacuation of urine from the bladder, regardless of whether clothing or linens are soiled.

H0350 Coding Instructions

- Code according to the amount and number of episodes of incontinence that occur during the assessment period.

H0350. Bladder Contenance (3-day assessment period)

Enter Code

Bladder continence - Select the one category that best describes the patient's condition during the assessment period.

0. **Always continent** (no documented incontinence)
1. **Stress incontinence only**
2. **Incontinent less than daily** (e.g., once or twice during the assessment period)
3. **Incontinent daily** (at least once a day)
4. **Always incontinent**
5. **No urine output** (e.g., renal failure)
9. **Not applicable** (e.g., indwelling catheter)

Bladder continence - Select the one category that best describes the patient's condition during the assessment period.

0. **Always continent** (no documented incontinence)
1. **Stress incontinence only**
2. **Incontinent less than daily** (e.g., once or twice during the assessment period)
3. **Incontinent daily** (at least once a day)
4. **Always incontinent**
5. **No urine output** (e.g., renal failure)
9. **Not applicable** (e.g., indwelling catheter)

Stress Incontinence

- Stress incontinence has its own code (Code 1).
- Episodes of a small amount of urine leakage only associated with physical movement or activity such as:
 - Coughing.
 - Sneezing.
 - Laughing.
 - Lifting heavy objects.
 - Exercise.

Stress Incontinence

- There does not need to be a physician diagnosis of stress incontinence.
- Based on the clinician's assessment, patient or family reporting, or physician documentation, a patient can be coded as **1**, Stress incontinence only.
- Staff observations would be helpful in distinguishing incontinence (large amount) from stress incontinence (small amount) in nonverbal patients.

H0350 Coding Tips

- 3-day assessment period only.
- Review all documentation and discuss with staff to determine the frequency.
- If intermittent catheterization is used to drain the bladder, code incontinence level based on continence between catheterizations.
- If the patient is continent but, due to behavior, purposely voids on the floor, it is not an incontinent episode.

H0350 Coding Tips

- If a patient has an indwelling catheter upon admission and the device is removed on day 2 of the stay and the patient has two incontinent episodes during the 3-day assessment period:
 - Code H0350. Bladder Contenance as code 2, Incontinent less than daily.

H0400 Coding Instructions

- Code according to the number of episodes of bowel incontinence that occur during the assessment period.

H0400. Bowel Continence (3-day assessment period)	
Enter Code <input type="checkbox"/>	Bowel continence - Select the one category that best describes t 0. Always continent 1. Occasionally incontinent (one episode of bowel incontinence) 2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. Always incontinent (no episodes of continent bowel movements) 9. Not rated , patient had an ostomy or did not have a bowel movement for the entire 3 days

Bowel continence - Select the one category that best describes t

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated**, patient had an ostomy or did not have a bowel movement for the entire 3 days

H0400 Coding Tips

- Being continent has to do with the ability to voluntarily release stool in a commode, toilet, or bedpan or as a result of a planned bowel movement as part of a bowel program.
- Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, or enema) would be considered *continent* of bowel as long as the result of releasing the stool occurred within a reasonable amount of time.

H0400 Coding Tips

- Patients require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, or enema) would be considered *continent* of bowel as long as the result of releasing the stool was in a commode, toilet, incontinence pad or bedpan.
- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

H0400 Coding Tips

- If the patient has a bowel program that has been developed to induce stool, and the bowel program is performed successfully as a scheduled event, then item H0400. Bowel Continence would be coded **0**, Always continent.
- A bowel program does not have to occur using a toilet or bedpan.

Knowledge Check 5

- **Scenario:** Mrs. B usually has stress incontinence. During the 3-day assessment period, she experienced a large amount of urine leakage daily.
- How would you code H0350?
 - A. Code **0**, Always continent.
 - B. Code **1**, Stress incontinence only.
 - C. Code **2**, Incontinent less than daily.
 - D. Code **3**, Incontinent daily.

Knowledge Check 5

- **Coding:** H0350 would be coded **3**, Incontinent daily.
- **Rationale:**
 - The patient is incontinent of a large amount of urine daily during the Admission Assessment period.
 - Stress incontinence is coded if the patient has **only** stress incontinence. Stress incontinence refers to episodes of a small amount of urine leakage only associated with physical movement or activity, such as coughing, sneezing, laughing, lifting heavy objects, or exercise.

Knowledge Check 6

- **Scenario:** Mr. T has an indwelling catheter in place during Day 1 of the assessment period. On Day 2, the catheter is removed, and Mr. T is incontinent on Days 2 and 3.
- How would you code H0350?
 - A. Code **1**, Stress incontinence only.
 - B. Code **2**, Incontinent less than daily.
 - C. Code **3**, Incontinent daily.
 - D. Code **9**, Not applicable.

Knowledge Check 6

- **Coding:** H0350 would be coded **2**, Incontinent less than daily.
- **Rationale:**
 - The patient is incontinent only on Days 2 and 3 of the Admission Assessment period.
 - The patient cannot be considered incontinent on Day 1 due to the use of an indwelling catheter.

Section J

Health Conditions (Falls)

Fall Definition

- 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.
- May be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground.
- Not a result of an overwhelming external force.
 - e.g., a patient pushes another patient.

Fall Definition

- **An intercepted fall** occurs when the patient:
 - Would have fallen if he or she had not caught him/herself.
 - Had not been intercepted by another person.
- **An intercepted fall is considered a fall.**

Item Intent

- CMS understands that challenging a patient's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

Item Intent

- The intent of items J1800 and J1900 is to maximize patient safety and capture events that represent threats to patient safety.
- Only falls with “major injury” (item J1900C) are used in the calculation of the Quality Measure: *Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)*.

J1750 Steps for Assessment

1. Indicate whether the patient has had:
 - Two or more falls in the past year.
 - Any fall with injury in the past year.
2. Interview the patient if he or she is capable of reliably reporting fall history.
3. Speak with family members or significant others to obtain fall history.

J1750 Coding Instructions

- Complete at the time of admission.

- 0. **No**
- 1. **Yes**
- 8. **Unknown**

J1750. History of Falls	
Enter Code	Has the patient had two or more falls in the past year or any fall with injury in the past year?
<input type="checkbox"/>	0. No 1. Yes 8. Unknown

J1800 & J1900

Steps for Assessment

- Review IRF medical record:
 - Physician, nursing, therapy, and nursing assistant notes.
 - Incident reports.
 - Fall logs.

J1800 Coding Instructions

- Complete only at the time of discharge.

0. **No** → *Skip*
1. **Yes** → *Co*

J1800. Any Falls Since Admission

Enter Code

Has the patient had any falls since admission?

0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)*

1. **Yes** → *Continue to J1900. Number of Falls Since Admission*

J1900 Coding Instructions

- Complete at the time of discharge.
- Determine the number of falls that occurred since admission.
- Code the level of fall-related injury for each.
- Code each fall only once. If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

J1900. Number of Falls Since Admission	
CODING:	↓ Ent
0. None	<input type="checkbox"/>
1. One	<input type="checkbox"/>
2. Two or more	<input type="checkbox"/>

CODING:

- 0. None
- 1. One
- 2. Two or more

	Physical assessment by the nurse or primary care clinician; change in the patient's behavior is noted after the fall
	Minor injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
<input type="checkbox"/>	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definition: Injury Related to a Fall

Injury Related to a Fall:

- Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

Injury Related to a Fall

Examples of Injury (Except Major) Include:

- Skin tears.
- Abrasions.
- Lacerations.
- Superficial bruises.
- Hematomas.
- Sprains.
- Any fall-related injury that causes the patient to complain of pain.

Examples of Major Injury Include:

- Bone fractures.
- Joint dislocations.
- Closed head injuries with altered consciousness.
- Subdural hematoma.

Knowledge Check 7

- **Scenario:** Mr. S has been working with his physical therapist on high-level balance activities. Today during therapy, Mr. S was asked to stand on one leg to challenge his balance. Mr. S leaned to the left, requiring the therapist to provide support and to “right” him.
- How would you code J1800. Any Falls Since Admission?
 - A. Code **0**, No.
 - B. Code **1**, Yes.

Knowledge Check 7

- **Coding:** J1800 would be coded **0**, No.
- **Rationale:** Patient was participating in a therapy session where balance was being challenged in order to improve his mobility. Challenging the patient's balance was part of the treatment session, and it was expected that the patient might need assistance to maintain balance.

Knowledge Check 8

- **Scenario:** Mrs. G was working on stair training with the physical therapist. While Mrs. G was descending the stairs, her left knee gave out, requiring her to be lowered to the bottom step by the therapist. Mrs. G sustained a small superficial bruise on her elbow because she bumped it as she was lowered down.
- How would you code J1800. Any Falls Since Admission?
 - A. Code **0**, No.
 - B. Code **1**, Yes.

Knowledge Check 8

- **Coding:** J1800 would be coded **1, Yes.**
- **Rationale:** Patient was lowered to the bottom step by the therapist. An unintentional change in position coming to rest on a lower surface is considered a fall.
- How would you code J1900. Number of Falls Since Admission?

Knowledge Check 8

- **Coding:** J1900 would be coded as follows:
 - A. No Injury: **0**, None.
 - B. Injury (except major): **1**, One.
 - C. Major Injury: **0**, None.
- **Rationale:** Patient sustained a small superficial bruise on her elbow, which is considered an injury.

Knowledge Check 9

- **Scenario:** Mr. K has limited use of his left side and a left lateral lean due to a stroke. During a therapy session, Mr. K was standing at the parallel bars with the assistance of a therapist who was standing on his left side. Mr. K was using a mirror to help him monitor his balance. Mr. K began to lean heavily to his left side and was bearing some of his weight on the therapist as he attempted to right himself.
- How would you code J1800. Any Falls Since Admission?
 - A. Code **0**, No.
 - B. Code **1**, Yes.

Knowledge Check 9

- **Coding:** J1800 would be coded **0**, No.
- **Rationale:** Mr. K was in a therapeutic session working on his balance and posture. The therapist was aware that he might list to the left and anticipated that he would require support to not fall.

Section M

Skin Conditions

Section M: Intent

Document the presence, appearance, and change in status of pressure ulcers.

PRESSURE ULCER:

Localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

M0300. Current Number of Unhealed Pressure Ulcer(s)

Admission Assessment

- M0300A1-G1
 - Identifies number of unhealed pressure ulcers at each stage.
 - Establishes the patient's baseline assessment.

Discharge Assessment

- M0300A1-G1
 - Identifies number of unhealed pressure ulcers at each stage.
- M0300A2-G2
 - At the time of discharge, identifies if the unhealed pressure ulcer(s) in M0300A1-G1 were present on admission or if the pressure ulcer(s) were acquired or worsened during the stay.

Present on Admission M0300A2-G2

- The present on admission (POA) items (M0300A2-G2) are coded at discharge.
- Address whether the pressure ulcer(s) observed at discharge were:

1. Present on admission

• OR

2. Acquired or worsened during the stay

Present on Admission M0300A2-G2

- A pressure ulcer reported at discharge and coded as **not Present on Admission** on the Discharge Assessment would be interpreted as new or worsened.
- A pressure ulcer reported at discharge and coded as **Present on Admission** on the Discharge Assessment would **not** be considered new or worsened.

Present on Admission: Scenario 1

Admission

Stage 2
pressure
ulcer.

Discharge

Stage 2 pressure
ulcer becomes
unstageable due
to slough/eschar.

This pressure ulcer
was **Not Present
on Admission.**
It has worsened.

Present on Admission: Scenario 1

Coding

Item	Admission Assessment	Discharge Assessment
M0300B1. Number of Stage 2 pressure ulcers	1	0
M0300B2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission		Skip
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar	0	1
M0300F2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission		0
M0800A. Worsening in Pressure Ulcer Status Since Admission: Stage 2		0
M0800E. Worsening in Pressure Ulcer Status Since Admission: Unstageable – Slough and/or eschar		1

Present on Admission: Scenario 1

Coding Rationale

- A Stage 2 pressure ulcer, per definition, does not include slough and/or eschar, as these are signs of a deeper involvement of tissue damage.
- Even though the ulcer itself cannot be staged to a higher numerical stage, characteristically and clinically it is appropriate to assign a worsened status to this ulcer.
- The unstageable ulcer due to slough and/or eschar would not be coded as Present on Admission at the time of discharge, because the ulcer was observed at admission as a Stage 2 pressure ulcer, not as an unstageable ulcer due to slough and/or eschar.
- This ulcer would also be reported as worsened in M0800E Unstageable – Slough and/or Eschar.

Present on Admission: Scenario 2

Admission

Stage 3 pressure ulcer.

Discharge

Stage 3 pressure ulcer becomes unstageable due to slough/eschar.

This pressure ulcer was **Present on Admission**.
It is not considered worsened.

Present on Admission: Scenario 2

Item	Admission Assessment	Discharge Assessment
M0300C1. Number of Stage 3 pressure ulcers	1	0
M0300C2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission		Skip
M0300F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar	0	1
M0300F2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission		1
M0800B. Worsening in Pressure Ulcer Status Since Admission: Stage 3		0
M0800E. Worsening in Pressure Ulcer Status Since Admission: Unstageable – Slough and/or eschar		0

Present on Admission: Scenario 2

Coding Rationale

- We cannot observe the tissues to differentiate between Stage 3 and 4.
- Because we cannot observe the tissues within the ulcer to appropriately numerically stage it, we cannot say whether the ulcer has worsened or not per our definition.
- Because this ulcer was not debrided and the assessor was unable to determine whether the ulcer remained a Stage 3 or had increased in numerical stage to a Stage 4, it would be considered present on admission (at the time of discharge).
- **Clinicians should ensure that an ulcer is as clean as possible (and debrided, if necessary) prior to staging the ulcer and before simply choosing to code the ulcer as unstageable.**

Unstageable Pressure Ulcers

- Visualization of the wound bed is necessary for accurate staging.
- Pressure ulcers that have eschar or slough tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed should be classified as unstageable.

Unstageable Pressure Ulcers

- If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer; do not code this as unstageable.
- Known pressure ulcers covered by a nonremovable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.

Unstageable Pressure Ulcers: Scenario 3

- **Scenario:** A patient is admitted to an IRF with an unstageable pressure ulcer. During the patient's stay, the pressure ulcer opens, is reassessed and staged as a Stage 3. At discharge, the pressure ulcer is healed. There are no other pressure ulcers.
- How would you code this at discharge?

Unstageable Pressure Ulcers: Scenario 3

Coding Rationale

- **Coding:**

M0210. Unhealed Pressure Ulcer(s) = 0, No

M0900C. Healed Stage 3 Pressure Ulcer(s) = 1

- **Rationale:** When completing the discharge items, a pressure ulcer that was unstageable on admission and later becomes numerically stageable during the patient's stay should be coded based on the stage at which it first becomes numerically stageable. This pressure ulcer is staged as a Stage 3 pressure ulcer before it heals. Thus, it would be considered a healed Stage 3 pressure ulcer at discharge.

Discharge: Scenario 4

- **Scenario:** Mr. J develops a Stage 2 pressure ulcer on his left heel while at the IRF. He is transferred to an acute care hospital for treatment of pneumonia. Mr. J returns to the IRF after 5 days with a Stage 3 pressure ulcer in the same anatomical location.
- How would you code this on the second Admission Assessment?

Discharge: Scenario 4

Coding Rationale

- **Coding:**

M0300C1. Number of Stage 3 Pressure Ulcer(s) = 1

- **Rationale:** Even though the patient had a pressure ulcer in the same anatomical location prior to acute care transfer, because it increased in numerical staging to Stage 3 during hospitalization at another facility that lasted longer than 3 calendar days, M0300C1 should be coded as “1” on the second Admission Assessment to indicate that the Stage 3 pressure ulcer was present on the patient’s second admission to the IRF.

Interrupted Stay: Scenario 5

- **Scenario:** Ms. K is admitted to the IRF and has no pressure ulcers noted when the Admission Assessment is completed. She is emergently transferred to an acute care hospital for evaluation and returns to the IRF in less than 3 days with a Stage 2 pressure ulcer on her coccyx. This Stage 2 pressure ulcer was still present at discharge.
- How would you code this on the Discharge Assessment?

Interrupted Stay: Scenario 5

Coding Rationale

- **Discharge Assessment Coding:**

M0300B1. Number of Stage 2 pressure ulcers = **1**

M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission = **0**

M0800A. Worsening Since Admission: Stage 2 = **1**

- **Rationale:** Since the Stage 2 pressure ulcer acquired during the program interruption was still present at discharge, it would be considered a “new” pressure ulcer for that IRF stay.

Coding Tips

- Data reported on the IRF-PAI for Section M are pressure ulcers observed at time of admission and discharge only.
 - While CMS allows a 3-day observation period, the Admission and Discharge Assessments should be completed as close to the time of admission and discharge as possible to most accurately represent a patient's admission and discharge status.
 - Clinical assessments performed on patients in IRFs should be completed according to accepted clinical practice and comply with facility policy and State and Federal regulations.

Coding Tips

- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made.
- Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity, etc.) should not be coded on the IRF-PAI Section M.

Section O

Influenza Vaccination Season

Influenza Vaccination Season

- Influenza Season:
 - Begins July 1 of the current year and ends June 30 of the following year.
- Influenza Vaccination Season:
 - Begins October 1 of the current year.
 - Ends March 31 of the following year.

Influenza Vaccination Season

- IRFs should document year-round, including when a patient has been vaccinated outside the influenza vaccination season.
- For the Quality Measure, only the records of patients in the IRF 1 or more days during the influenza vaccination season (at least 1 day between Oct 1 and Mar 31) are included in the calculation.

O0250. Influenza Vaccine

O0250. Influenza Vaccine - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.

Enter Code

A. Did the patient receive the influenza vaccine *in this facility* for this year's influenza vaccination season?

0. **No** → Skip to O0250C. If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B. Date influenza vaccine received

B. Date influenza vaccine received → Complete date and skip to Z0400A. Signature of Persons Completing the Assessment

<input type="text"/>							
M	M	D	D	Y	Y	Y	Y

Enter Code

C. If influenza vaccine not received, state reason:

1. **Patient not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

Entire Stay is During the Influenza Vaccination Season

October 1



October 8
Patient admitted
to IRF



October 10
Patient vaccinated
by IRF



November 1
Patient discharged
home

Influenza Vaccination Season

Admitted Before the End of the Influenza Vaccination Season

March 31



March 31
Patient admitted
to IRF



April 1
Patient vaccinated
by IRF



April 20
Patient discharged
home

Influenza Vaccination Season

Discharged During the Influenza Vaccination Season



September 3

Patient vaccinated by primary care physician



September 15

Patient admitted to IRF

October 1



October 1

Patient discharged home

Influenza Vaccination Season

IRF QRP

Findings from Data Analysis

Findings from Data Analysis

- Thank you for all the effort you have made to collect accurate data!
- We have examined the data, and much of the data patterns we observed are patterns we expected.

Section GG: Use of Code 07, Patient Refused

- Coding a self-care item as **07, Patient refused** would indicate that the patient did not perform the activity and a helper did not perform the activity for the patient during the 3-day assessment period.
- A therapist would not code **07, Patient refused** because the patient is not assessed performing the activity in therapy.

Section GG: GG0130. Self-Care

- **Example:**

- A therapist is responsible for coding the oral hygiene item.
- She/he does not assess this activity in therapy during the last 3 days of the patient's stay.

- **Coding:**

- The therapist should interview the patient and nurses to determine the patient's level of independence with the activity and code 01-06, as appropriate.”

Section GG: Use of Code 09, Not Applicable

- Code **09, Not applicable**, indicates that:
 - the patient does not perform the activity, and a helper does not perform the activity for the patient and
 - the patient or a helper did not perform the activity prior to the current illness, injury, or exacerbation.
- We do not expect this code to be used frequently for most self-care or mobility items.

Section GG: Use of Code 09, Not Applicable

- **Example:**
 - The patient uses bilateral prosthetics with attached socks and shoes. The patient used both of these prosthetics prior to his acute care and IRF admission.
- **Coding:**
 - Code GG0130H. Putting on/taking off footwear as **09, Not applicable.**

Section GG: Incomplete Stay

- If a patient has an incomplete stay, discharge self-care and mobility items can be coded **88, Not attempted due to medical condition or safety concern.**

Section GG: Incomplete Stay

- Patients with incomplete stay records are identified based on:
 - Discharge to Acute Care: Discharge Destination (Item 44D).
 - 02 = Short-term General Hospital
 - 63 = Long-Term Care Hospital (LTCH)
 - 65 = Inpatient Psychiatric Facility
 - 66 = Critical Access Hospital

OR

- Discharged Against Medical Advice: Patient discharged against medical advice (Item 41 = 1).

OR

- Died while in IRF: Was the patient discharged alive? (Item 44C = 0).

OR

- Length of stay less than 3 days: ([Item 40. Discharge Date] minus [Item 12. Admission Date]) < 3 days.

Section M: Discharge

- At the time of discharge, the skin assessment items are coded based on the following:
 - If a pressure ulcer is observed at discharge, determine whether the pressure ulcer was observed at the time of admission.
 - A pressure ulcer that is coded as “present on admission” on the Discharge Assessment refers to a pressure ulcer that has not worsened or is not new since the time of admission.
 - If a pressure ulcer observed at admission worsens to a higher stage by discharge, it would not be coded as “present upon admission” at discharge.

Section O

- The influenza vaccination season starts October 1 and ends on March 31.
 - Communities may extend an influenza vaccination season.
- If the influenza vaccine was not received, code 1, “Patient not in this facility during this year’s influenza vaccination season,” only if the patient was not in the IRF 1 or more days during the influenza vaccination season.

Section O

- **Example:**

- The patient was admitted to the IRF June 16, 2017, and discharged June 30, 2017.
- The patient did not receive the influenza vaccination for the 2016–2017 season.
- This patient was not in the IRF 1 or more days and did not receive the influenza vaccine.

- **Coding:**

- Code 1, Patient was not in this facility during this year's influenza vaccination season.

Questions?