Centers for Medicare & Medicaid Services

INPATIENT REHABILITATION FACILITY-PATIENT ASSESSMENT INSTRUMENT (IRF-PAI)

CHANGE TABLE SUMMARIZING REVISIONS TO THE IRF-PAI VERSION 4.0

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IRF-PAI 4.0 Item Set

Below is a list of items added to IRF-PAI 4.0

Section	Item #	At Admission/Discharge	Item Description
Section A	A1005	At Admission	Ethnicity
Section A	A1010	At Admission	Race
Section A	A1110	At Admission	Language
Section A	A1250	At Admission and Discharge	Transportation
Section A	A2121	At Discharge	Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Section A	A2122	At Discharge	Route of Current Reconciled Medication List Transmission to Subsequent Provider
Section A	A2123	At Discharge	Provision of Current Reconciled Medication List to Patient at Discharge
Section A	A2124	At Discharge	Route of Current Reconciled Medication List Transmission to Patient
Section B	B0200	At Admission	Hearing
Section B	B1000	At Admission	Vision
Section B	B1300	At Admission and Discharge	Health Literacy
Section C	C1310	At Admission and Discharge	Signs and Symptoms of Delirium
Section D	D0150	At Admission and Discharge	Patient Mood Interview (PHQ-2 to 9)
Section D	D0160	At Admission and Discharge	Total Severity Score
Section D	D0700	At Admission and Discharge	Social Isolation
Section J	J0510	At Admission and Discharge	Pain Effect on Sleep
Section J	J0520	At Admission and Discharge	Pain Interference with Therapy Activities
Section J	J0530	At Admission and Discharge	Pain Interference with Day-to-Day Activities
Section K	K0520	At Admission and Discharge	Nutritional Approaches
Section N	N0415	At Admission and Discharge	High-Risk Drug Classes: Use and Indication
Section O	O0110	At Admission and Discharge	Special Treatments, Procedures, and Programs O0110 A1 to O0110 O1

Note: Guidance has been added to the Manual pages for all the new items listed above.

All Sections

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 3.0 – Effective October 1, 2019	IRF-PAI Manual Version 4.0 – Effective October 1, 2022	Description of Change
0.1	All sections	N/A	Where applicable the manual is edited for the following: formatting, grammar, pronouns, stylistic edits, to improve clarity, updated email ID, updated phone numbers, updated dates, updated references, updated resources, reorganized information, updated version number from 3.0 to 4.0.	--
0.2	All sections	CMS IRF-PAI Quality Reporting Program Manual	CMS IRF-PAI Manual	Where applicable, updated header.
0.3	All sections	Revised Version 3.0, Effective July 1, 2018	Version 4.0, Effective October 1, 2022	Updated version and effective date in the footer.
0.4	Appendix A	Revised Version 3.0, Effective July 1, 2018	Version 4.0, Effective October 1, 2022	Updated version and effective date in the footer. No other substantive edits.
0.5	Appendix D	Revised Version 3.0, Effective July 1, 2018	Version 4.0, Effective October 1, 2022	Updated version and effective date in the footer. No other substantive edits.
0.6	Appendix E	Revised Version 3.0, Effective July 1, 2018	Version 4.0, Effective October 1, 2022	Updated version and effective date in the footer. No other substantive edits.

Note: Through this document substantive changes from IRF-PAI Version 3.0 to IRF-PAI Version 4.0 are reflected in red font.

Chapter 1

Chapter 1				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
1.1	Chapter 1, Section 1.1, Page 1-1	**NOTE:** This manual is a guide and revisions will be made as the IRF PPS is refined. These revisions may include, but are not limited to, changes resulting from research supporting the IRF PPS, legislation, regulation and refinements. Please refer to the following web site to obtain the most recent updates: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html	This manual is intended to provide guidance on use of the IRF-PAI instrument. Content contained in this document may be time-limited and may be superseded by guidance published by CMS at a later date. Please refer to the following web site to obtain the most recent updates: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-PAI-Manual	Revised disclaimer.

Chapter 2
Chapter 2, Overview

Chapter 2, Overview				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.0.1	Chapter 2, Overview, Section 2.1, Page 2-1	**Did not exist**	Please Note: The coding scenarios found throughout this chapter are intended to provide examples of how guidance instructions are applied in order to select an accurate code to one or more IRF-PAI items. The scenarios are not intended to imply that the patients portrayed in these examples would necessarily meet coverage or program eligibility requirements for this setting. Likewise, the scenarios are not intended to suggest or prescribe clinical practice, nor do the scenarios provide the comprehensive clinical presentation that would be required for planning, delivering and documenting medically necessary patient care.	Added disclaimer.
2.0.2	Chapter 2, Overview, Section 2.1, Page 2-2, Table 2-1	**Section A – Intent** This section includes Payer Information, Medical Information, Discharge Information, and Therapy Information.	**Section A – Intent** This section includes Payer Information, Medical Information, Discharge Information, and Therapy Information. Additionally, it includes Ethnicity, Race, Language, and Transportation.	Updated Section A: Administrative Information.
2.0.3	Chapter 2, Overview, Section 2.1, Page 2-2, Table 2-1	**Section B – Intent** This section includes BB0700. Expression of Ideas and Wants and BB0800. Understanding Verbal and Non-Verbal Content. The intent of these items is to document the patient's ability to understand and communicate with others.	**Section B – Intent** This section includes B0200. Hearing, B1000. Vision, B1300. Health Literacy, BB0700. Expression of Ideas and Wants and BB0800. Understanding Verbal and Non-Verbal Content.	Updated Section B: Hearing, Speech, and Vision.
2.0.4	Chapter 2, Overview, Section 2.1, Page 2-2, Table 2-1	**Section C – Intent** This section includes the Brief Interview for Mental Status (BIMS) and Staff Assessment for Mental Status.	**Section C – Intent** This section includes the Brief Interview for Mental Status (BIMS), Staff Assessment for Mental Status, and Signs and Symptoms of Delirium (from CAM©).	Updated Section C: Cognitive Patterns.

Chapter 2, Overview				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.0.5	Chapter 2, Overview, Section 2.1, Page 2-2, Table 2-1	**Did not exist**	**Section D – Intent** This section includes the Patient Mood Interview (PHQ-2 to 9).	Added Section D: Mood.
2.0.6	Chapter 2, Overview, Section 2.1, Page 2-2, Table 2-1	**Section J – Intent** This section includes J1750 History of Falls, J2000 Prior Surgery, J1800 Any Falls Since Admission, and J1900 Number of Falls Since Admission.	**Section J – Intent** This section includes J0510. Pain Effect on Sleep, J0520. Pain Interference with Day-to-Day Activities, J0530. Pain Interference with Therapy Activities, J1750. History of Falls, J2000. Prior Surgery, J1800. Any Falls Since Admission, and J1900. Number of Falls Since Admission.	Updated Section J: Health Conditions.
2.0.7	Chapter 2, Overview, Section 2.1, Page 2-2, Table 2-1	**Section K – Intent** This section includes K0110. Swallowing/Nutritional Status. These items indicate the patient's usual ability to swallow.	**Section K – Intent** This section includes Nutritional Approaches.	Updated Section K: Swallowing/ Nutritional Status.
2.0.8	Chapter 2, Overview, Section 2.1, Page 2-2, Table 2-1	**Section N – Intent** This section includes Drug Regimen Review, Medication Follow-up, and Medication Intervention.	**Section N – Intent** This section includes High-Risk Drug Classes: Uses and Indication, Drug Regimen Review, Medication Follow-up, and Medication Intervention.	Updated Section N: Medications.
2.0.9	Chapter 2, Overview, Section 2.1, Page 2-2, Table 2-1	**Section O – Intent** This section includes O0100. Special Treatments, Procedures, and Programs. The intent of the item in this section is to identify any special treatments, procedures, and programs that the patient received during the stay.	**Section O – Intent** This section includes O0110 Special Treatments, Procedures, and Programs. The intent of the item in this section is to identify any special treatments, procedures, and programs that the patient received during the stay.	Updated Section O: Special Treatments, Procedures, and Programs.

Chapter 2, Section A				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.A.1	Chapter 2, Section A, Page A-3	**NOTE:** If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days.	**NOTE:** If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days, although assessment data gathered on the discharge date (the day the patient is admitted to Acute Care from the IRF) may be used to code the admission quality improvement (QI) items.	Edited to improve clarity.
2.A.2	Chapter 2, Section A, Page A-4	**15. Admit From/16. Pre-Hospital Living Setting:** *01- Home (Private home/apt., board/care, assisted living, group home, transitional living)* *51- Hospice (institutional facility)*	**15. Admit From/16. Pre-Hospital Living Setting:** *01- Home (Private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)* *51- Hospice (medical facility)*	Updated definitions of 01: Home, and 51: Hospice (medical facility).
2.A.3	Chapter 2, Section A, Page A-11	**25A. Height on admission** **Coding Instructions** **Did not exist**	**25A. Height on admission** **Coding Instructions** • Only enter a height that has been directly measured by your facility staff. Do not enter a height that is self-reported or derived from documentation from another provider setting. • When reporting height for a patient with bilateral lower extremity amputations, measure and record the patient's current height (i.e., height after bilateral amputations).	Added new coding instructions for 25A.
2.A.4	Chapter 2, Section A, Page A-11	**26A. Weight on admission** **Coding Instructions** **Did not exist**	**26A. Weight on admission** **Coding Instructions** • Only enter weight that has been directly measured by your facility staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.	Added new coding instructions for 26A.

Chapter 2, Section A				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.A.5	Chapter 2, Section A, Page A13	**44D. Patient's discharge destination/living setting, using codes below:** (Answer only if 44C= 1; if 44C= 0, skip to item 46) *01- Home (Private home/apt., board/care, assisted living, group home, transitional living)* *51- Hospice (institutional facility)*	**44D. Patient's discharge destination/living setting, using codes below:** (Answer only if 44C= 1; if 44C= 0, skip to item 46) *01- Home (Private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)* *51- Hospice (medical facility)*	Updated definitions of 01: Home, and 51: Hospice (medical facility).
2.A.6	Chapter 2, Section A, Page A-19 to A-20	**Did not exist**	**A1005. Ethnicity**	Added a new assessment item.
2.A.7	Chapter 2, Section A, Page A-21 to A-23	**9. Race/Ethnicity** Replaced with new item	**A1010. Race**	Replaced 9. Race/Ethnicity with A1010. Race. All content under A1010 is new.

Chapter 2, Section B

Chapter 2, Section B				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.B.1	Chapter 2, Section B, Page B-1	**Intent**: The intent of these items is to document the patient's ability to understand and communicate with others.	**Intent:** The intent of these items is to document the patient's ability to hear (with assistive devices, if they are used), understand and communicate with others, and the patient's ability to see objects nearby in their environment.	Updated guidance.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.C.1	Chapter 2, Section C, Page C-1	**Intent:** The items in this section are intended to determine the patient's attention, orientation, and ability to register and recall new information.	**Intent:** The items in this section are intended to determine the patient's attention, orientation, and ability to register and recall new information and if the patient has signs and symptoms of delirium.	Updated intent.
2.C.2	Chapter 2, Section C, Page C-1	**Item Rationale** – Structured cognitive interviews assist in identifying needed supports.	**Item Rationale** **Removed**	Removed an item rationale for C0100.
2.C.3	Chapter 2, Section C, Page C-1	**Steps for Assessment** Assessment Period: The 3-day assessment period for the IRF-PAI admission assessment includes the first day of admission and the following two days, ending at 11:59 PM. The Brief Interview for Mental Status (BIMS) should be attempted with all patients. It only needs to be conducted once during the 3-day assessment period. If the BIMS is not conducted or the patient is unable to complete the BIMS, C0900, Memory/Recall Ability (which is a staff assessment of mental status) is completed.	**Steps for Assessment** **Removed**	Removed assessment period from steps for assessment.
2.C.4	Chapter 2, Section C, Page C-1	**Steps for Assessment** 1. Determine if the patient is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0900, Memory/Recall Ability. 2. Determine if the patient needs or wants an interpreter. If the patient needs or wants an interpreter, complete the interview with an interpreter.	**Steps for Assessment** 1. Interact with the patient using their preferred language. Be sure they can hear you and/or has access to their preferred method for communication. If the patient appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. 2. Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip items C0200-C0500, Brief Interview for Mental Status (BIMS).	Edited to improve clarity.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.C.5	Chapter 2, Section C, Page C-2	**Coding Instructions** Record whether the cognitive interview should be attempted with the patient. Complete during the 3-day admission assessment period. • **Code 0, no**, if the interview should not be attempted because the patient is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to **C0900, Memory/Recall Ability**. • **Code 1, yes**, if the interview should be attempted because the patient is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to **C0200, Repetition of Three Words**.	**Coding Instructions** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible. Record whether the cognitive interview should be attempted with the patient. • **Code 0, No**, if the interview should not be conducted because the patient is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip items C0200-C0500, Brief Interview for Mental Status (BIMS). • **Code 1, Yes,** if the interview should be conducted because the patient is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.	Edited to improve clarity and accuracy for C0100.
2.C.6	Chapter 2, Section C, Page C-2	**Coding Tips** • If the patient needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete item C0900, Memory/Recall Ability (which is a staff assessment of mental status), instead of items C0200-C0500, Brief Interview for Mental Status. • Includes patients who use American Sign Language (ASL).	**Coding Tips** **Removed**	Removed coding tip for C0100.
2.C.7	Chapter 2, Section C, Page C-2	**Coding tips** **Did not exist**	**Coding Tips** • Attempt to conduct the interview with ALL patients	Added new coding tip for C0100.

Chapter 2, Section C				
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2.C.8	Chapter 2, Section C, Page C-3	**Item Rationale** • Assessment of a patient's mental status provides a direct understanding of patient function that may: – enhance future communication and assistance; and – direct clinician interventions to facilitate greater independence such as posting or providing reminders for self-care activities. • An abrupt change in cognitive status may indicate delirium and may be the only indication of a potentially life threatening illness. • A decline in mental status may also be associated with a mood disorder. • Awareness of possible impairment may be important for maintaining a safe environment and providing safe, comprehensive discharge planning.	**Item Rationale** **Removed**	Removed final four bullets under the item rationale for C0200-C0500.
2.C.9	Chapter 2, Section C, Page C-4	**Steps for Assessment: Basic Interview Instructions for BIMS (C0200-C0500)** **Did not exist**	**Steps for Assessment: Basic Interview Instructions for BIMS (C0200-C0500)** 1. Refer to Supplement B for a review of basic approaches to effective interviewing techniques.	Added new step for assessment for C0200-C0500.
2.C.10	Chapter 2, Section C, Page C-4	**Coding Instructions** Collect BIMS items during the 3-day admission assessment period.	**Coding Instructions** If admission assessment, complete as close to the time of admission (preferably during the first 3 days) as possible. If discharge assessment, complete as close to the time of discharge as possible. • See coding instructions for individual items.	Edited to improve clarity.
2.C.11	Chapter 2, Section C, Page C-5	**Definition** **Did not exist**	**Definition** **Complete Interview** The BIMS interview is considered complete if the patient attempted and provided relevant answers to at least four of the questions included in C0200-C0400C. Relevant answers do not have to be correct, but need to be related to the question.	Added a new definition.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.C.12	Chapter 2, Section C, Page C-5	**Coding Tips** • Nonsensical responses should be coded as zero. The clinician should determine if the patient provides irrelevant or nonsensical responses throughout the interview and should document this behavior. The clinician would further seek clinical staff documentation of disorganized thinking in the medical record that would indicate this behavior is constant. … o Stop the interview after completing (C0300C) "Day of the Week" if: ▪ responses to C0300A, C0300B and C0300C have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR … 4. Complete the Staff Assessment for Mental Status. (C0900) 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.	**Coding Tips** • Nonsensical responses, incorrect answers, and questions the patient chooses not to answer should be coded as zero. • 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, BIMS Summary Score. … o Stop the interview after completing (C0300C) "Day of the Week" if: ▪ responses to all items have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR … • When staff identify that the patient's primary method of communication is in written format, the BIMS can be administered in writing. o See Supplement A for details regarding how to administer the BIMS in writing. • If all responses to C0200, C0300A, C0300B and C0300C are 0 because answers are incorrect, continue interview.	Edited to improve clarity of guidance for C0200-C0500.
2.C.13	Chapter 2, Section C, Page C-5	**Examples of Incorrect and Nonsensical Responses** **Did not exist**	**Examples of Incorrect Answers, Refusals, and Nonsensical Responses** Code 0 is used to represent three types of responses: incorrect answers (unless the item itself provides an alternative response code), nonsensical responses, and questions the patient chooses not to answer (or "refusals"). Since zeros resulting from these three situations are treated differently when coding the summary score in C0500, the interviewer may find it valuable to track the reason for the zero reponse to aid in accurately calculating the summary score.	Edited to improve clarity.

Chapter 2, Section C				
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2.C.14	Chapter 2, Section C, Page C-8	**Coding Instructions** • Coding Tips If the patient is unable to complete the BIMS verbally, it may be administered using alternative methods. Directions and guidance on alternative methods that may be used to conduct the BIMS interview are provided at the end of Section C instructions.	**Coding Instructions** **Removed**	Removed a coding instruction for C0200.
2.C.15	Chapter 2, Section C, Page C-10	**Item Rationale** • If staff know that a patient has a problem with orientation, they can provide reorientation aids and verbal reminders that may reduce anxiety and encourage patient participation in activities. • Reorienting those who are disoriented or at risk of disorientation may be useful in treating symptoms of delirium and cognitive problems associated with other medical conditions. • Patients who are not oriented may need further assessment for delirium, especially if this fluctuates or is recent in onset.	**Item Rationale** **Removed**	Removed three item rationale items for C0300.
2.C.16	Chapter 2, Section C, Page C-10	**Coding Instructions for C0300A, Able to Report Correct Year** • **Code 0, Missed by >5 years or no answer**, if the patient's answer is incorrect and is greater than 5 years from the current year or the patient chooses not to answer the item.	**Coding Instructions for C0300A, Able to Report Correct Year** • **Code 0, Missed by >5 years or no answer**, if the patient's answer is incorrect and is greater than 5 years from the current year or the patient chooses not to answer the item, or the answer is nonsensical.	Edited to improve clarity.
2.C.17	Chapter 2, Section C, Page C-11	**Coding Instructions for C0300B, Able to Report Correct Month** • **Code 0, Missed by >1 month or no answer**, if the patient's answer is incorrect by more than 1 month or if the patient chooses not to answer the item.	**Coding Instructions for C0300B, Able to Report Correct Month** • **Code 0, Missed by >1 month or no answer**, if the patient's answer is incorrect by more than 1 month or if the patient chooses not to answer the item or the answer is nonsensical.	Edited to improve clarity.

Chapter 2, Section C				
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2.C.18	Chapter 2, Section C Page C-12	**Coding Instructions for C0300C, Able to Report Correct Day of the Week** • **Code 0, Incorrect**, or no answer, if the answer is incorrect or the patient chooses not to answer the item.	**Coding Instructions for C0300C, Able to Report Correct Day of the Week** • **Code 0, Incorrect**, or no answer, if the answer is incorrect or the patient chooses not to answer the item or the answer is nonsensical.	Edited to improve clarity.
2.C.19	Chapter 2, Section C Page C-13	**Coding Tips** **Did not exist**	**Coding Tips** • In order to code 1, Correct, the patient must be able to report the correct day of the week. Reporting the date is not considered a day of the week.	Added new coding tips section for C0300 and new coding tip.
2.C.20	Chapter 2, Section C, Page C-16	**Item Rationale** • The BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all possible aspects of cognitive impairment. The final determination of the level of impairment should be made by the patient's physician or mental health care specialist; however, these practitioners can be provided specific BIMS results and the following guidance: The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where patients can hear all questions and the patient is not delirious suggest the following distributions: 13–15: cognitively intact 8–12: moderately impaired 0–7: severe impairment • Abrupt changes in cognitive status (as indicative of a delirium) often signal an underlying potentially life threatening illness and a change in cognition may be the only indication of an underlying problem.	**Item Rationale** **Removed**	Removed two item rationale for C0500.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.C.21	Chapter 2, Section C, Page C-16	**Coding Instructions** **Did not exist**	**Coding Instructions** Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a patient had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.	Added coding instruction for C0500.
2.C.22	Chapter 2, Section C, Page C-19	**Coding Tips** Guidance for Completing the BIMS Using Alternative Methods	**Removed**	Removed from Section C and moved the sections to the "Supplements" section.
2.C.23	Chapter 2, Section C, Page C-20	**Coding Instructions** Complete during the 3-day admission assessment period.	**Coding Instructions** Complete as close to the time of admission as possible.	Edited time point instructions to improve clarity for C0900.
2.C.24	Chapter 2, Section C, Page C-28	**Supplement A: Interviewing to Increase Patient Voice in IRF-PAI** Supplement B. Cue Cards for BIMS	**Removed**	Removed supplements from Section C and moved the sections to the "Supplements" section.

Chapter 2, Section D

Chapter 2, Section D				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.D.1	Chapter 2, Section D, Page D-1 to D-12	**Did not exist**	**Section D: Mood** **D0150. Patient Mood Interview (PHQ-2 to 9)** **D0160. Total Severity Score** **D0700. Social Isolation**	Added new section. All items and content under this section are new.

Chapter 2, Section GG				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.GG.1	Chapter 2, Section GG, Page GG-1	**Coding Instructions** Complete during the 3-day admission assessment period. • Code 3, Independent: if the patient completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper. • Code 2, Needed Some Help: if the patient needed partial assistance from another person to complete the activities. • Code 1, Dependent: if the helper completed the activities for the patient, or the assistance of two or more helpers was required for the patient to complete the activities.	**Coding Instructions** Complete during the 3-day admission assessment period. • Code 3, Independent, if the patient completed all the activities by themself with or without an assistive device, with no assistance from a helper. • Code 2, Needed Some Help, if the patient needed partial assistance from another person to complete any activities. • Code 1, Dependent, if the helper completed all the activities for the patient, or the assistance of two or more helpers was required for the patient to complete the activities.	Added additional guidance for coding accuracy for GG0100 codes 3, 2, and 1.
2.GG.2	Chapter 2, Section GG, Page GG-2	**Coding Tips** • Record the patient's usual ability to perform self-care, indoor mobility (ambulation), stairs and functional cognition prior to the current illness, exacerbation, or injury.	**Coding Tips** • Record 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.	Added guidance at end of coding tip to specify timeframe.

2.GG.3	Chapter 2, Section GG, Page GG-2	**Coding Tips**
		
		Did not exist
			Coding Tips
			• For GG0100, Prior Functioning:
			  ○ If a patient completed all of the activities by themself, with or without an assistive device, with no assistance from a helper, code as 3, Independent.
			  ○ If a patient needed partial assistance from another person to complete any of the activities, code as 2, Needed Some Help.
			  ○ If a helper completed all of the activities for the patient because the patient could not assist, code as 1, Dependent.
				Added new coding tips for GG0100.

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2.GG.3 (cont.)	Chapter 2, Section GG, Page GG-2	**Coding Tips** **Did not exist**	**Coding Tips** • Completing the stair activity for GG0100C indicates that a patient went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment (such as a cane, crutch, walker, or stair lift), and/or with or without some level of assistance. • For the GG0100C stair activity, "by any safe means" may include a patient scooting up and down stairs on buttocks. • Going up and down a ramp is not considered stairs for coding GG0100C.	Added new coding tips for GG0100.
2.GG.4	Chapter 2, Section GG, Page GG-6	**GG0110: Prior Device Use** **Coding Tips** • For GG0110C, Mechanical lift, includes sit-to-stand, stand assist, stair lift, and full-body-style lifts.	**GG0110: Prior Device Use** **Coding Tips** • For GG0110C, Prior Device Use, Mechanical lift: **"Mechanical lift" includes any device a patient or caregiver requires for lifting or supporting the patient's bodyweight. Examples include, but are not limited to:** stair lift, Hoyer lift, bath tub lift, sit-to-stand lift, stand assist, electric recliner, and full-body style lifts. Clinical judgment may be used to determine whether other devices meet the definition provided.	Edited existing coding tip to reflected updated coding guidance.
2.GG.5	Chapter 2, Section GG, Page GG-6	**GG0110: Prior Device Use** **Coding Tips** **Did not exist**	**GG0110: Prior Device Use** **Coding Tips** • Report the devices used by the patient prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is more recent, that initiated this episode of care. • For the response categories in GG0110 (e.g., Mechanical lift, Orthotics/Prosthetics), CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use. • Devices may have been used indoors and/or outdoors.	Added new coding tips.

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2.GG.6	Chapter 2, Section GG, Page GG-8	**GG0130. Self-Care** **GG0170. Mobility** **Steps for Assessment** 1. Assess the patient's mobility performance based on direct observation, as well as the patient's self-report, and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period. 2. Patients should be allowed to perform activities as independently as possible, as long as they are safe. 4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** 1. Assess the patient's self-care and mobility performance based on direct observation, incorporating the patient's self-report and reports from clinicians, care staff, or family documented in the patient's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period. 2. Allow the patient to complete each activity as independently as possible, as long as they are safe regardless of how the patient performed the activity prior to the current illness, exacerbation, or injury. Activities may be completed with or without an assistive device. This includes the use of any new or previously utilized assistive device(s) or equipment. Use of a device or equipment may result in the patient needing less assistance from a helper.	Revised guidance to reflect the consolidation of sections between GG0130 and GG0170. Also refined text to reflect updated guidance.

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2.GG.7	Chapter 2, Section GG, Page GG-8	**GG0130. Self-Care** **GG0170. Mobility** **Steps for Assessment** **Assessment period:** The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. Clinicians should code the patient's admission functional status, based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The admission functional assessment, when possible, should occur prior to the patient benefiting from treatment interventions in order to determine the patient's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** **Assessment period:** The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. At the admission assessment, the self-care or mobility performance code is to be based on a functional assessment that occurs soon after the patient's admission, and reflects the patient's baseline ability to complete the activity. This functional assessment must be completed within the first three days (3 calendar days). The assessment should occur, when possible, prior to the patient benefiting from services. Treatment should not be withheld in order to conduct the functional assessment.	Added refined guidance required for coding accuracy for GG0130 and GG0170.
2.GG.8	Chapter 2, Section GG, Page GG-8 to GG-9	**GG0130. Self-Care** **GG0170. Mobility** **Steps for Assessment** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** The patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, prior to the benefit of services provided by your facility staff.	Added new step for assessment.

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2.GG.8 (cont.)	Chapter 2, Section GG, Page GG-8 to GG-9	**GG0130. Self-Care** **GG0170. Mobility** **Steps for Assessment** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Steps for Assessment** "Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding. Introducing a new device should not automatically be considered as "providing a service". Whether a device used during the clinical assessment is new to the patient or not, use clinical judgment to code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your facility. If the patient was not able to complete an activity (e.g., go up and down the stairs) 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 use the appropriate "activity not attempted" code. Assessment of the GG self-care and mobility items is based on the patient's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking may be assessed for a patient who did/does/will use a wheelchair as their primary mode of mobility, stair activities may be assessed for a patient not routinely accessing stairs). Communicating an activity request to the patient (e.g., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity ("Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Section GG Decision Tree.	Added new steps for assessment.

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2.GG.9	Chapter 2, Section GG, Page GG-9	**GG0130. Self-Care** **Coding Instructions** Complete at the time of admission and discharge.	**GG0130. Self-Care & GG0170. Mobility** **Coding Instructions** If Admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.	Updated time point instruction.
2.GG.10	Chapter 2, Section GG, Page GG-9 to GG-10	**GG0130. Self-Care** **GG0170. Mobility** **Coding Instructions** • **Code 04, Supervision or touching assistance** • **Code 03, Partial/moderate assistance** • **Code 01, Dependent** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Coding Instructions** • **Code 04, Supervision or touching assistance,** … Code 04, Supervision or touching assistance if the patient requires only verbal cueing to complete the activity safely. • **Code 03, Partial/moderate assistance,** … o Code 03 - Partial/moderate assistance, if the patient performs exactly half of the effort required to complete an activity. • **Code 01, Dependent,** … o Code 01 - Dependent, if two helpers are required for the safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands on assistance. o Code 01 - Dependent, 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 activity to be completed).	Added new coding instructions.

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2.GG.11	Chapter 2, Section GG, Page GG-10	**GG0130. Self-Care** **GG0170. Mobility** **Coding Instructions** • **Code 88, Not attempted due to medical condition or safety concerns,** if the activity was not attempted due to medical condition or safety concerns.	**GG0130. Self-Care & GG0170. Mobility** **Coding Instructions** Use of an "activity not attempted" code should occur only after determining that an activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities. • **Code 88, Not attempted due to medical condition or safety concerns,** if the activity was not attempted due to medical condition or safety concerns, but the patient could perform the activity prior to the current illness, exacerbation, or injury.	Clarified coding instructions and added new examples of code use.
2.GG.12	Chapter 2, Section GG, Page GG-11	**GG0130: Self-Care** **Decision Tree** Use this decision tree to code the patient's performance on the assessment instrument. If helper assistance is required because the patient's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the patient did not perform the activity and a helper did not perform that activity for the patient.	**GG0130. Self-Care & GG0170. Mobility** **Decision Tree** Use this decision tree to code the patient's performance. If helper assistance is required because the patient's performance is unsafe or of poor quality, score according to the type and amount of assistance provided. Use of an "activity not attempted" code should occur only after determining that the activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.	Added refined guidance required for coding accuracy for GG0130 and GG0170.
2.GG.13	Chapter 2, Section GG, Page GG-12	**GG0130: Self-Care** **Admission and Discharge Performance Coding Tips** **General coding tips:** • Licensed clinicians may assess the patient's performance based on direct observation as well as reports from patient's self-report, clinicians, care staff, or family during the 3-day assessment period. We anticipate that a multi-disciplinary team of clinicians is involved in assessing the patient during the 3-day assessment period. • If two or more helpers are required to assist the patient in completing the activity, code as 01, Dependent.	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips** **Removed**	Removed due to redundancy with steps for assessment.

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2.GG. 13 (cont.)	Chapter 2, Section GG, Page GG-12	**GG0130: Self-Care** **Admission and Discharge Performance Coding Tips** **General coding tips** • If the patient does not attempt the activity and a helper does not complete the activity for the patient during the entire 3-day assessment period, code the reason the activity was not attempted. For example, code as 07 if the patient refused to attempt the activity during the entire 3-day assessment period, code as 09 if the activity is not applicable for the patient (the activity did not occur at the time of the assessment, and prior to the current illness, injury, or exacerbation), code as 10 if the patient was not able to attempt the activity due to environmental limitations, or code as 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips** **Removed**	Removed due to redundancy with steps for assessment.
2.GG. 14	Chapter 2, Section GG, Page GG-12 to GG-13	**GG0130: Self-Care** **GG0170: Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips:** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips:** • If the patient only completes a portion of the activity (e.g., performs a partial bath or transfers into but not out of a vehicle) and does not complete the entire activity during the assessment time period, use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines the partial activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code.	Added new coding tips for GG0130 and GG0170.

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2.GG.14 (cont.)	Chapter 2, Section GG, Page GG-12 to GG-13	**GG0130: Self-Care** **GG0170: Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips:** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **General coding tips:** • For GG0130 and GG0170, 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. • CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Clinical assessments may include any device or equipment that the patient can use to allow them to safely complete the activity as independently as possible. o Do not code self-care and mobility activities with use of a device that is restricted to patient use during therapy sessions (i.e. parallel bars, exoskeleton, or overhead track and harness systems).	Added new coding tips for GG0130 and GG0170.
2.GG.15	Chapter 2, Section GG, Page GG-13	**GG0130: Self-Care** **GG0170: Mobility** **Admission and Discharge Performance Coding Tips** **Coding tips for patients with incomplete stays** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Admission and Discharge Performance Coding Tips** **Coding tips for patients with incomplete stays** • If a patient's IRF stay is less than 3 days (incomplete stay), and the patient is discharged before an admission assessment is completed, code GG0130 and GG0170 **admission** performance to the best of your abilities. If you are unable to assess the patient because of medical issues, enter code 88, Not attempted due to medical condition or safety concerns. • If a patient's IRF stay is 3 or more days, and the patient meets the criteria for an incomplete stay, skip the GG0130 and GG0170 **discharge** performance items.	Added new coding tips for GG0130 and GG0170.

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2.GG.16	Chapter 2, Section GG, Page GG-14	**GG0130: Self-Care** **GG0170: Mobility** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Definition** **Qualified Clinician** Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.	Added a new definition for GG0130 and GG0170.
2.GG.17	Chapter 2, Section GG, Page GG-14	**GG0130: Self-Care** **GG0170: Mobility** **Discharge Goal(s): Coding Tips:** • If the performance of an activity was coded 88, Not attempted due to medical condition or safety concerns during the admission assessment, a discharge goal may be coded using the 6-point scale if the patient is expected to be able to perform the activity by discharge.	**GG0130. Self-Care & GG0170. Mobility** **Discharge Goal(s): Coding Tips** • If the performance of an activity was coded with an "activity not attempted" code during the admission assessment, a discharge goal may be coded using the 6-point scale if the patient is expected to be able to perform the activity by discharge.	Edited coding tips for GG0130 and GG0170.
2.GG.18	Chapter 2, Section GG, Page GG-14	**GG0130: Self-Care** **GG0170: Mobility** **Discharge Goal(s): Coding Tips** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Discharge Goal(s): Coding Tips** • Once a discharge goal is established on the IRF-PAI, there is no need to update it if circumstances change or additional information becomes available either within or after the 3-day admission time period. However, the patient's care plan may need to be updated. • If an activity was not completed prior to the current illness, exacerbation, or injury, and is not expected to occur for the patient, even with assistance and/or an assistive device, the discharge goal would be Code 09, Not applicable.	Added new coding tips for coding of discharge goals for GG0130 and GG0170.

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2.GG.19	Chapter 2, Section GG, Page GG-15 to GG-16	**Discharge Goal Coding Examples** **Example 3** **Did not exist**	**GG0130. Self-Care & GG0170. Mobility** **Discharge Goal Coding Examples** **Example 3: Discharge Goal Code Is *Lower* Than Admission Performance Code** The qualified clinician determines that a patient with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the discharge goal code is *lower* than the patient's admission performance code. **Toileting Hygiene Admission Performance:** The patient has a progressive neurological illness that affects their strength, coordination, and endurance. The patient prefers to use a bedside commode for as long as possible rather than using incontinence undergarments. The certified nursing assistant currently supports the patient while the patient is standing so that the patient can release their hand from the grab bar (next to their bedside commode) and pull down their underwear before sitting onto the bedside commode. When the patient has finished voiding, they wipe their perineal area. The patient then requires the helper to support their trunk while the patient pulls up their underwear. The clinician codes the admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for the patient's toileting hygiene. The patient's participation in skilled therapy is expected to slow down the pace of their anticipated functional deterioration. The patient's discharge goal code will be lower than the admission performance code.	Added new example.

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2.GG.19 (cont.)	Chapter 2, Section GG, Page GG-15 to GG-16	**Discharge Goal Coding Examples** **Example 3** **Did not exist**	**Discharge Goal Coding Examples** **Example 3: Discharge Goal Code Is *Lower* as Admission Performance Code** **Toileting Hygiene Discharge Goal:** By discharge, it is expected that the patient will need assistance with toileting hygiene and that the helper will perform more than half the effort. The clinician codes their discharge goal as 02, Substantial/maximal assistance.	Added new example.
2.GG.20	Chapter 2, Section GG, Page GG-19	**GG0130. Self-Care** **Coding Tips for GG0130A** **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130A** • 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. • The administration of tube feedings and parenteral nutrition is not considered when coding this activity. • If a patient requires assistance (e.g., supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding and safe swallowing. • If a patient requires assistance (e.g., supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding and safe swallowing. • If a patient swallows safely without assistance, exclude swallowing from consideration when coding GG0130A, Eating. • If the patient eats finger foods using their hands, then code GG0130A, Eating based on the type and amount of assistance required. If the patient eats finger foods with their hands independently, for example, the patient would be coded as 06, Independent.	Added new coding tips for GG0130A.

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2.GG.20 (cont.)	Chapter 2, Section GG, Page GG-19	**GG0130. Self-Care** **Coding Tips for GG0130A** **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130A** • If the patient eats finger foods using their hands, then code GG0130A, Eating based on the type and amount of assistance required. If the patient eats finger foods with their hands independently, for example, the patient would be coded as 06, Independent. • For a patient taking only fluids by mouth, the item may be coded based on ability to bring liquid to mouth and swallow liquid, once the drink is placed in front of the patient.	Added new coding tips for GG0130A.
2.GG.21	Chapter 2, Section GG, Page GG-22	**GG0130. Self-Care** **Coding Tips for GG0130B** **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130B** • For a patient who is edentulous (without teeth), code GG0130B, Oral hygiene based on the type and amount of assistance required from a helper to clean the patient's gums.	Added a new coding tip for GG0130B.
2.GG.22	Chapter 2, Section GG, Page GG-23 to GG-24	**GG0130. Self-Care** **Coding Tips for GG0130C, Toileting hygiene** • Toileting hygiene includes the tasks of managing undergarments, clothing and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the patient does not usually use undergarments, then assess the patient's need for assistance to manage lower-body clothing and perineal hygiene. • If the patient has an indwelling urinary catheter and has bowel movements, code the Toileting hygiene item based on the amount of assistance needed by the patient when moving his or her bowels.	**GG0130. Self-Care** **Coding Tips for GG0130C** • Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal. If the patient completes a bowel toileting program in bed, code the item Toileting hygiene based on the patient's need for assistance for managing clothing and perineal cleansing. • If a patient has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment. ○ For example: If the patient has an indwelling urinary catheter and has bowel movements, code GG0130C, Toileting hygiene based on the type and amount of assistance needed by the patient before and after moving their bowels. This may include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.	Edited existing coding tips for GG0130C.

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2.GG.23	Chapter 2, Section GG, Page GG-23 to GG-24	**GG0130. Self-Care**
		Coding Tips for GG0130C, Toileting hygiene
		
		Did not exist
			GG0130. Self-Care
			Coding Tips for GG0130C
			• …Includes:
			  o Performing perineal hygiene
			  o Managing clothing (including undergarments, and incontinence briefs) before and after voiding or having a bowel movement.
			  o Adjusting clothing relevant to the individual
			• The toileting hygiene activity can be assessed and coded regardless of the patient's need to void or have a bowel movement at the time of the assessment.
			• When the patient requires different levels of assistance to perform toileting hygiene after voiding vs after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity.
			• If a patient manages an ostomy, toileting hygiene includes wiping the opening of the ostomy or colostomy bag, but not management of the equipment.
				Added new coding tips for GG0130C.

2.GG.24	Chapter 2, Section GG, Page GG-24	**GG0130. Self-Care** **Examples for GG0130C, Toileting hygiene** Example #4	**GG0130. Self-Care** **Examples for GG0130C, Toileting hygiene** **Removed**	Removed an example for GG0130C.

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2.GG.25	Chapter 2, Section GG, Page GG-25	**GG0130. Self-Care** **Coding Tips for GG0130E, Shower/bathe self** **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130E, Shower/bathe self** • Code 05, Setup or clean-up assistance, if the only help a patient requires is assistance before the bathing activity to cover wounds or devices for water-protection during bathing. • Use clinical judgment to determine if completing a partial bath or simulating the shower/bath allows the clinician to adequately assess the patient's ability to complete the activity of shower/bathe self (GG0130E). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the shower/bathing activity.	Added new coding tips for GG0130E.
2.GG.26	Chapter 2, Section GG, Page GG-26	**GG0130. Self-Care** **Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H,** Putting on/taking off footwear • If donning and doffing an elastic bandage, compression stockings, or an orthosis or prosthesis occurs while the patient is dressing/undressing, then count the elastic bandage/compression stocking/orthosis/prosthesis as a piece of clothing when determining the amount of assistance, the patient needs when coding the dressing item.	**GG0130. Self-Care** **Coding Tips for GG0130f, GG0130G, & GG0130H** **Removed**	Removed coding tips for GG0130F, GG0130G, and GG0130H.

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2.GG.27	Chapter 2, Section GG, Page GG-26	**GG0130. Self-Care** **Coding Tips** GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H, Putting on/taking off footwear • Upper body dressing items used for coding include: bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown. • When coding upper body dressing and lower body dressing, helper assistance with buttons and/or fasteners is considered touching assistance.	**GG0130. Self-Care** **Coding Tips for GG0130F, GG0130G, & GG0130H** • Upper body dressing items used for coding include: bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, and pajama top. • If a patient requires assistance with dressing including assistance with buttons, fasteners and/or fastening a bra, code based on the type and amount of assistance required to complete the entire dressing activity.	Edited coding tips for GG0130F, GG0130G, and GG0130H.
2.GG.28	Chapter 2, Section GG, Page GG-27	**GG0130. Self-Care** **Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H,** Putting on/taking off footwear **Did not exist**	**GG0130. Self-Care** **Coding Tips for GG0130f, GG0130G, & GG0130H** • Consider an item that covers all or part of the foot as footwear, even if it extends up the leg, and do not also consider it as a lower body dressing item. • If the patient wears just shoes or just socks (e.g., grip socks) that are safe for mobility, then GG0130H, Putting on/taking off footwear, may be coded.	Added new coding tips for GG0130F, GG0130G, and GG0130H.
2.GG.29	Chapter 2, Section GG, Page GG-28	**GG0130. Self-Care** **Examples for GG0130F, Upper body dressing** Example # 2	**GG0130. Self-Care** **Examples for GG0130F, Upper body dressing** **Removed**	Removed two coding examples for GG0130F.

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2.GG.30	Chapter 2, Section GG, Page GG-35	**GG0170: Mobility** **Coding Tips for GG0170A, GG0170B, & GG0170C** **Did Not Exist**	**GG0170. Mobility** **Coding Tips for GG0170A, GG0170B, & GG0170C** • For GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for the patient. For example, a clinician could determine that a patient's preferred slightly elevated resting position is "lying" for a patient. • If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns. For example, if a clinician determines that a patient's new medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170A, Roll left and right as 88, Not attempted due to medical or safety concerns. • If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions and could not perform the activity prior to the current illness, exacerbation or injury, then code 09, Not applicable. • If the patient does not sleep in a bed, assess bed mobility activities using the preferred or necessary sleeping surface used by the patient.	Added new coding tips for GG0170A, GG0170B, and GG0170C.

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2.GG.31	Chapter 2, Section GG, Page GG-35	**GG0170: Mobility** **Coding Tip for GG0170A, Roll left and right** • If the clinician determines the patient's medical condition does not allow for the patient to complete all tasks of the activity (roll left, roll right, roll to back) for the entire 3-day assessment period then code Roll left to right as 88, Not attempted due to medical condition or safety concerns. This can include patient refused due to intolerable pain for any tasks required of the activity.	**GG0170. Mobility** **Coding Tips for GG0170A, Roll left and right** **Removed**	Removed coding tip for GG0170A.
2.GG.32	Chapter 2, Section GG, Page GG-35	**GG0170: Mobility** **Coding Tip for GG0170A, Roll left and right** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170A, Roll left and right** • The activity includes the patient rolling to both the left and to the right while in a lying position, on their preferred or necessary sleeping surface. • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated due to the patient's medical condition, code GG0170A, Roll left and right using the appropriate "activity not attempted" code. • If the patient does not sleep in a bed, assess the patient rolling to both the left and to the right while in a lying position, and returning to lying on their back on the preferred or necessary sleeping surface.	Added new coding tips for GG0170A.

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2.GG.33	Chapter 2, Section GG, Page GG-37	**GG0170. Mobility** **Examples for GG0170A, Roll left and right** **Did not exist**	**GG0170. Mobility** **Examples for GG0170A, Roll left and right** 5. **Roll left and right:** Example of a probing conversation between a nurse determining a patient's score for roll left and right and a certified nursing assistant regarding the patient's bed mobility: **Nurse:** "Describe to me how the patient moves themself in bed. Once they are in bed, how do they turn from lying on their back to lying on their left and right sides and then return to lying on their back?" **Certified nursing assistant:** "The patient can roll to their sides by themself." **Nurse:** "The patient rolls from side to side and returns to lying on their back without any instructions or physical help?" **Certified nursing assistant:** "No, I have to remind the patient to bend their left leg and roll to their right side, and then to roll to their back and then to do the same on their left side and back to their back, but once I remind them they can do it themself." In this example, the nurse inquired specifically about how the patient moves from lying on their back to lying on their sides and then returns to lying on their back. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, the nurse would not have received enough information to make an accurate assessment of the actual assistance the patient received. **Coding:** GG0170A, Roll left and right would be **coded 04, Supervision or touching assistance**. **Rationale:** The certified nursing assistant provides verbal instructions as the patient moves from lying on their back to lying on their sides and then returns to lying on their back.	Added probing conversation example for GG0170A.

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2.GG.34	Chapter 2, Section GG, Page GG-37	**GG0170. Mobility** **Coding Tip for GG0170B, Sit to lying** • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern	**GG0170. Mobility** **Coding Tip for GG0170B, Sit to lying** **Removed**	Removed coding tip for GG0170B.
2.GG.35	Chapter 2, Section GG, Page GG-37	**GG0170. Mobility** **Coding Tip for GG0170B, Sit to lying** **Did not exist**	**GG0170. Mobility** **Coding Tip for GG0170B, Sit to lying** • The activity includes the ability to move from sitting on side of bed to lying flat on the bed, or on their preferred or necessary sleeping surface. • If the patient does not sleep in a bed, assess the patient's ability to move from sitting on the side of the patient's preferred or necessary sleeping surface to lying flat on the patient's preferred or necessary sleeping surface. • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activity GG0170B, Sit to lying using the appropriate activity not attempted code.	Added new coding tips for GG0170B.

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2.GG.36	Chapter 2, Section GG, Page GG-38 to GG-39	**GG0170. Mobility** **Examples for GG0170B, Sit to lying** **Did not exist**	**GG0170. Mobility** **Examples for GG0170B, Sit to lying** 4. **Sit to lying:** The patient has multiple sclerosis and a swallowing disorder. A medical order requires the head of their bed to be slightly elevated at all times and serves as their lying position. The patient needs help to transition from sitting to lying. The patient begins the activity by balancing themself while sitting at the edge of the bed with their feet on the floor. The certified nursing assistant lifts and swivels the patient's legs from the side of the bed to the middle of the bed while simultaneously supporting and lifting the patient's trunk. The patient assists by scooting themself toward the middle or toward edge of the bed. **Coding:** GG0170B, Sit to lying would be **coded 02, Substantial, maximal assistance**. **Rationale:** The helper completes more than half the effort in transitioning the patient from sitting to lying. 5. **Sit to lying:** Example of a probing conversation between nurse determining a patient's score for sit to lying and a certified nursing assistant regarding the patient's bed mobility: **Nurse:** "Please describe how the patient moves themself from sitting on the side of the bed to lying flat on the bed. When they are sitting on the side of the bed, how do they move to lying on their back?" **Certified nursing assistant:** "They can lie down with some help."	Added new coding examples for GG0170B.

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2.GG.36 (cont.)	Chapter 2, Section GG, Page GG-38 to GG-39	**GG0170. Mobility** **Examples for GG0170B, Sit to lying** **Did not exist**	**GG0170. Mobility** **Examples for GG0170B, Sit to lying** 5. **Nurse:** "Please describe how much help they need and how exactly you help them." **Certified nursing assistant:** "I have to lift a bit and position their right leg, but once I do that, they can use their arms to position their upper body." In this example, the nurse inquired specifically about how The patient moves from a sitting position to a lying position. The nurse asked about physical assistance. **Coding:** GG0170B, Sit to lying would be **coded 03, Partial/moderate assistance.** **Rationale:** The certified nursing assistant lifts the patient's right leg and helps them position it as the patient moves from a sitting position to a lying position. The helper does less than half the effort.	Added new coding examples for GG0170B.
2.GG.37	Chapter 2, Section GG, Page GG-39	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** • If the patient's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment or a foot stool is required to accommodate foot placement on the floor/footstool. • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** **Removed**	Removed coding tips for GG0170C.

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2.GG.38	Chapter 2, Section GG, Page GG-39	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** • The activity includes patient transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support. The patient's ability to perform each of the tasks within this activity and how much support the patient requires to complete the tasks within this activity is assessed.	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** • The activity includes the patient transitioning from lying on their back to sitting on the side of the bed and sitting upright on the bed, or alternate sleeping surfaces, without back support	Edited coding tips for GG0170C.
2.GG.39	Chapter 2, Section GG, Page GG-39	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170C, Lying to sitting on side of bed** • If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, code the activity GG0170C, Lying to sitting on side of bed using the appropriate "activity not attempted" code.	Added new coding tips for GG0170C.

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2.GG.40	Chapter 2, Section GG, Page GG-40	**GG0170. Mobility** **Examples for GG0170C, Lying to sitting on side of bed** **Examples of a Probing Conversation with Staff** **Did not exist**	**GG0170. Mobility** **Examples for GG0170C, Lying to sitting on side of bed** **Examples of a Probing Conversation with Staff** 5. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining a patient's score for lying to sitting on side of bed, and a certified nursing assistant regarding the patient's bed mobility: **Nurse:** "Please describe how the patient moves themself in bed. When they are in bed, how do they move from lying on their back to sitting up on the side of the bed?" **Certified nursing assistant:** "They can sit up by themself." **Nurse:** "They sit up without any instructions or physical help?" **Certified nursing assistant:** "No, I have to remind them to check on the position of their arm that has limited movement and sensation as they move in the bed, but once I remind them to check their arm, they can do it themself." In this example, the nurse inquired specifically about how the patient moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance. **Coding:** GG0170C, Lying to sitting on side of bed would be **coded 04, Supervision or touching assistance**. **Rationale:** The certified nursing assistant provides verbal instructions as the patient moves from a lying to sitting position.	Added example of probing conversation with staff for GG0170C.

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2.GG.41	Chapter 2, Section GG, Page GG-40	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** • If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer, and the patient is not able to complete Sit to stand due to medical condition or safety issues, then GG0170D, Sit to stand would be coded 88, Not attempted due to medical condition or safety issues. However, if the patient did not attempt to perform sit to stand during the assessment and did not perform this activity prior to the current illness, exacerbation, or injury, then use code 09, Not applicable.	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** **Removed**	Removed coding tips for GG0170D.
2.GG.42	Chapter 2, Section GG, Page GG-40	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** • The activity includes the patient coming to a standing position from any siting surface. • Code 05 – Setup or clean-up assistance, if the only help a patient requires to complete the sit to stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle foot orthosis. • If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer, and even with assistance the patient is not able to complete the sit to stand activity, code GG0170D, Sit to stand with the appropriate activity not attempted code.	Added new coding tips for GG0170D.
2.GG.43	Chapter 2, Section GG. Page GG-41	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** • If a sit to stand lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.	**GG0170. Mobility** **Coding Tips for GG0170D, Sit to stand** • If a sit to stand lift is used and the patient requires the assistance of two helpers to get from a sitting to standing position, code as 01, Dependent.	Edited coding tips for GG0170D.
2.GG.44	Chapter 2, Section GG, Page GG-41	**GG0170. Mobility** **Examples for GG0170D, Sit to stand** Example #4	**GG0170. Mobility** **Examples for GG0170D, Sit to stand** **Removed**	Removed an example for GG0170D.

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2.GG.45	Chapter 2, Section GG, Page GG-42	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** • Item GG0170E, Chair/bed-to-chair transfer, begins with the patient sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying and GG0170C, Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E. • If a patient performs a stand pivot transfer due to inability to fully stand upon rising and instead rises to a squat, then pivots, turns and sits, this style of chair/bed-to-chair transfer is acceptable and should be coded based upon the amount of assistance required to perform this style of transfer.	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** **Removed**	Removed coding tips for GG0170E.
2.GG.46	Chapter 2, Section GG, Page GG-42	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** • Depending on the patient's abilities, the transfer may be a stand-pivot, squat-pivot, or a slide board transfer. • For item GG0170E, Chair/bed-to-chair transfer: o When assessing the patient getting out of bed, the assessment begins with the patient sitting at the edge of the bed (or alternative sleeping surface) and ends with the patient sitting in a chair or wheelchair. o When assessing the patient getting from the chair to the bed, the assessment begins with the patient sitting in a chair or wheelchair and ends with the patient returning to sitting at the edge of the bed (or alternative sleeping surface). o The activities of GG0170B, Sit to lying and GG0170C, Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E.	Added new coding tips for GG0170E.

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2.GG.46 (cont.)	Chapter 2, Section GG, Page GG-42	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170E, Chair/bed-to-chair transfer** • When possible, the transfer should be assessed in an environmental situation where taking more than a few steps would not be necessary to complete the transfer.	Added new coding tips for GG0170E.
2.GG.47	Chapter 2, Section GG, Pages GG-44	**GG0170. Mobility** **Coding Tips for GG0170F, Toilet transfer** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170F, Toilet transfer** • The Toilet transfer activity can be assessed and coded regardless of the patient's need to use a toilet or commode to void or have a bowel movement in conjunction with the toilet transfer assessment. • Code 01, Dependent if the patient requires assistance from two or more helpers to get on and off the toilet or commode.	Added new coding tips for GG0170F.
2.GG.48	Chapter 2, Section GG, Page GG-46	**GG0170. Mobility** **Coding Tips for GG0170G, Car transfers** • In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period then use of code 10, Not attempted due to environmental limitations.	**GG0170. Mobility** **Coding Tips for GG0170G, Car transfers** **Removed**	Removed coding tips for GG0170G.
2.GG.49	Chapter 2, Section GG, Page GG-46	**GG0170. Mobility** **Coding Tips for GG0170G, Car transfers** • For item GG0170G, Car transfer, use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin. • The Car transfer item does not include transfers into the driver's seat, opening/closing the car door, fastening/unfastening the seat belt. The Car transfer item includes the patient's ability to transfer in and out of the passenger seat of a car or car simulator.	**GG0170. Mobility** **Coding Tips for GG0170G, Car transfers** • When assessing GG0170G, Car transfer, an indoor car can be used to simulate outdoor car transfers. • The Car transfer does not include getting to or from the vehicle, opening/closing the car door, or fastening/unfastening the seat belt.	Edited coding tips for GG0170G.

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2.GG.50	Chapter 2, Section GG, Page GG-46 to GG-47	**GG0170. Mobility** **Coding Tips for GG0170G, Car transfers** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170G, Car transfers** • The activity includes the patient's ability to transfer in and out of a car or van seat on the passenger seat. Any vehicle model available may be used for the assessment of GG0170G, Car transfer. • If the patient remains in a wheelchair and does not transfer in and out of a car or van seat, then the activity is not considered completed and the appropriate "activity not attempted" code would be used. The setup and/or clean-up of assistive device that is used for walking to and from the car, but not used for the transfer in and out of the car seat, would not be considered when coding the car transfer activity. Clinicians may use clinician judgment to determine if observing a patient performing a portion of the transfer activity (e.g., getting into the car) allows the clinician to adequately assess the patient's ability to complete the entire GG0170G, Car transfer activity (transferring in and out of a car). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the activity. • If using clinical judgment, simulating the car transfer using a mat 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. • Assessment of a car transfer can still be completed while accommodating medical restrictions such as long sitting. • Use of an "activity not attempted" code should only occur after determining that the car transfer is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.	Added new coding tips for GG0170G.

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2.GG.51	Chapter 2, Section GG, Page GG-48	**GG0170: Mobility** **Coding Tips for Walking items** • Walking activities do not need to occur during one session. Allowing a patient to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities. • The turns included in the items GG0170J (Walk 50 feet with two turns) are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).	**GG0170. Mobility** **Coding Tips for Walking items** **Removed**	Removed coding tips for GG walking items.
2.GG.52	Chapter 2, Section GG, Page GG-48	**GG0170. Mobility** **Coding Tips for Walking items** • When coding GG0170 walking items, do not consider the patient's mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.	**GG0170. Mobility** **Coding Tips for Walking items** • Do not code walking activities with the use of a device that is restricted to patient use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).	Edited existing coding tips for GG walking items.
2.GG.53	Chapter 2, Section GG, Page GG-48	**GG017.: Mobility** **Coding Tips for Walking items** **Did not exist**	**GG0170. Mobility** **Coding Tips for Walking items** • Assessment of the walking activities starts with the patient in a standing position. • A walking activity cannot be completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance A helper cannot complete a walking activity for a patient. • During a walking activity, a patient may take a brief standing rest break. If the patient needs to sit to rest during a GG walking activity, consider the patient unable to complete that walking activity.	Added new coding tips for GG walking items.

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2.GG. 53 (cont.)	Chapter 2, Section GG, Page GG-48	**GG0170: Mobility** **Coding Tips for Walking items** **Did not exist**	**GG0170: Mobility** **Coding Tips** • Clinicians can use clinical judgment to determine how the actual patient assessment of walking is conducted. If a clinician chooses to combine the assessment of multiple walking activities, use clinical judgement to determine the type and amount of assistance needed for each individual activity. • Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type and amount of assistance needed for each individual activity. • All of the GG walking activities do not need to occur during a single session. • If the patient, who participates in walking, requires the assistance of two helpers to complete the activity, code 01, Dependent. • If the help a patient requires to complete the walking activity is for a helper to retrieve and place the walker and/or put it away after patient use, then enter code 05 – Setup or clean-up assistance.	Added new coding tips for GG walking items.
2.GG. 54	Chapter 2, Section GG, Page GG-48	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170I, Walk 10 feet** • Starting from standing, the activity includes the patient's ability to walk 10 feet.	Added new coding tip for GG0170I.

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2.GG.55	Chapter 2, Section GG, Page GG-50	**GG0170. Mobility** **Coding Tips for Walking Items** **Did not exist**	**GG0170. Mobility** **Coding Tip for GG0170J, Walk 50 feet with two turns** • Starting from standing, the activity includes the patient's ability to walk 50 feet, making two turns. • The turns included in the items GG0170J, Walk 50 feet with two turns are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).	Added new coding tips for GG0170J.
2.GG.56	Chapter 2, Section GG, Page GG-51 to GG-52	**GG0170. Mobility** **Coding Tips for GG0170K, Walk 150 feet** **Did not exist**	**GG0170. Mobility** **Coding tips for GG0170K, Walk 150 feet** • Starting from standing, the activity includes the patient's ability to walk 150 feet. • When coding GG0170K, Walk 150 feet if the patient's environment does no accommodate a walk of 150 feet with turns, but the patient demonstrates the ability to walk with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.	Added new coding tips for GG0170K.
2.GG.57	Chapter 2, Section GG, Page GG-53	**GG0170. Mobility** **Coding Tips for GG0170L, Walking 10 feet on uneven surfaces** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170L, Walking 10 feet on uneven surfaces** • Starting from standing, the activity includes the patient's ability to walk 10 feet on uneven surfaces. • The activity can be assessed inside or outside. Examples of uneven surfaces include uneven or sloping surfaces, turf or gravel. Use clinical judgment to determine if a surface is uneven	Added new coding tips for GG0170L.

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2.GG.58	Page GG-53 to GG-54	**GG0170. Mobility** **Coding tips for GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps** **Did not exist**	**GG0170. Mobility** **Coding tips for GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps** • Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (for example, railing or stair lift), and with or without some level of assistance. • Going up and down the stairs by any safe means includes the patient walking up and down stairs on their feet or bumping or scooting up and down stairs on their buttocks. • Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up the stairs and then down the stairs occurs sequentially, the patient may take a standing or seated rest break between ascending and descending the 4 steps or 12 steps. • If the patient goes up and down steps (1, 4, or 12) by any safe means (for example, walking on their feet, in a wheelchair, or bumping/scooting on their buttocks), with or without an assistive device, and with no set-up assistance or verbal or physical assistance, code 06 - Independent. • If the patient requires a helper to provide total assist, code 01, Dependent (for example, a patient requires total assist from a helper to move up and down a curb in their wheelchair). • A patient who is a wheelchair user may be assessed going up and down stairs (including 1 step/curb) in a wheelchair. Code based on the type and amount of assistance required from the helper. • Getting to/from the stairs is not included when coding the curb/step activities	Added new coding tips for GG0170M, GG0170N, and GG0170O.

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2.GG. 58 (cont.)	Page GG-53 to GG-54	**GG0170: Mobility** **Coding Tips for GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170M, 1 step (curb), GG0170N, 4 steps, GG0170O, 12 steps** • If, at the time of the assessment, the patient is unable to complete the activity due to a physician prescribed restriction (for instance, no stair climbing for two weeks), but could perform this activity prior to the current illness, exacerbation, or injury, code 88, Not attempted due to medical condition or safety concerns.	Added new coding tips for GG0170M, GG0170N, and GG0170O.
2.GG. 59	Chapter 2, Section GG, Page GG-54	**GG0170. Mobility** **Coding Tips for GG0170M, 1 step (curb)** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170M, 1 step (curb)** • Assess the patient going up and down 1 step or up and down a curb. If both are assessed, and the patient's performance going up and down a curb is different than their performance going up and down one step (e.g., because the step has a railing), code GG0170M, 1 step (curb) based on the activity with which the patient requires the most assistance.	Added new coding tips for GG0170M.
2.GG. 60	Chapter 2, Section GG, Page GG-55	**GG0170: Mobility** **Coding Tip for GG0170O, 12 steps** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170O, 12 steps** • If a patient's environment does not have 12 steps, the combination of going up and down 4 stairs three times consecutively in a safe manner is an acceptable alternative to meet the intention of this activity.	Added new coding tip for GG0170O.

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2.GG.61	Chapter 2, Section GG, Page GG-55	**GG0170: Mobility** **Coding Tips for GG0170P, Picking up object** **Did not exist**	**GG0170: Mobility** **Coding Tips for GG0170P, Picking up object** • The activity includes the patient bending/stooping from a standing position to pick up a small object, such as a spoon, from the floor. • Picking up object must be assessed while the patient is in a standing position. If the patient is not able to stand, the activity did not occur and the appropriate "activity not attempted" code would be used. • If a standing patient is unable to pick up a small object from the floor, therefore requiring the helper to pick up the object, code 01, 02, or 03, depending on whether the helper is providing all the effort, more than half of the effort, or less than half of the effort. Clinicians should use clinical judgment to apply guidance regarding the patient's degree of participation in picking up an object • Assistive device(s) and adaptive equipment may be used, for example a cane to support standing balance and/or a reacher to pick up the object.	Added new coding tips for GG0170P.
2.GG.62	Chapter 2, Section GG, Page GG-56	**GG0170. Mobility** **Coding Tips for Wheelchair Items** • The intent of the wheelchair mobility items is to assess the ability of patients who are learning how to self- mobilize using a wheelchair, or those who used a wheelchair prior to admission. Use clinical judgment to determine whether a patient's use of a wheelchair is for self-mobilization as a result of the patient's medical condition or a safety concern. • Do not code wheelchair mobility if the patient uses a wheelchair only when transported between locations within the facility for staff convenience (e.g. because the patient walks slowly). Only code wheelchair mobility based on an assessment of the patient's ability to mobilize in the wheelchair.	**GG0170. Mobility** **Coding Tips for Wheelchair Items** **Removed**	Removed coding tips for GG wheelchair items.

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2.GG.63	Chapter 2, Section GG, Page GG-56	**GG0170. Mobility** **Coding Tips for Wheelchair Items** • If the patient walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility for staff convenience (e.g. because the patient walks slowly) code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the patient use a wheelchair/scooter?—as 0, No, and skip all remaining wheelchair questions. • Admission assessment for wheelchair items should be coded for patients who used a wheelchair prior to admission. • The responses for gateway admission and discharge wheelchair items (GG0170Q1 andGG0170Q3) do not have to be the same on the admission and discharge assessments. • The turns included in the items GG0170R (wheeling 50 feet with 2 turns) are 90-degreeturns. The turns may be in the same direction (two 90-degree turns to the right or two 90 -degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level.	**GG0170. Mobility** **Coding Tips for Wheelchair Items** **Removed**	Removed coding tips for GG wheelchair items.

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2.GG.63 (cont.)	Chapter 2, Section GG, Page GG-56	**GG0170: Mobility** **Coding Tips for Wheelchair Items** • If a wheelchair is used for transport purposes only, then GG0170Q1 and/or GG0170Q3, Does the patient use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment. — Example of using a wheelchair for transport convenience: A patient is transported in a wheelchair by staff between her room and the therapy gym or by family to the facility cafeteria, but the patient is not expected to use a wheelchair after discharge.	**GG0170. Mobility** **Coding Tips for Wheelchair Items** **Removed**	Removed coding tips for GG wheelchair items.
2.GG.64	Chapter 2, Section GG, Page GG-56	**GG0170: Mobility** **Coding Tips for GG0170Q1, Does the patient use a wheelchair and/or scooter?** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170Q1, Does the patient use a wheelchair and/or scooter?** • The intent of the wheelchair mobility items is to assess the ability of patients who are using a wheelchair under any condition. • Only code 0 – No if at the time of the assessment the patient does not use a wheelchair or scooter under any condition. • The responses for gateway wheelchair items (GG0170Q1 and GG0170Q3) might not be the same on the admission and discharge assessments.	Added new coding tips for GG0170Q.

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2.GG.65	Chapter 2, Section GG, Page GG-57	**GG0170. Mobility** **GG0170R, GG0170RR, GG0170S, GG0170SS** **Coding Tips** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170R, GG0170RR, GG0170S, GG0170SS** • 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. • A helper can assist a patient to complete the wheelchair distance or make turns if required. When a patient is unable to wheel the entire distance themselves the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity. • If a patient uses both a manual and a motorized wheelchair or scooter at the time of the assessment, code the activity based on the type of wheelchair/scooter with which the patient requires the most assistance.	Added new coding tips for GG0170R, GG017RR, GG0170S, and GG0170SS.
2.GG.66	Chapter 2, Section GG, Page GG-57	**GG0170. Mobility** **GG0170R, Wheel 50 feet with two turns, GG0170RR, Indicate the type of wheelchair or scooter used** **Coding Tips** **Did not exist**	**GG0170. Mobility** **GG0170R, Wheel 50 feet with two turns, GG0170RR, Indicate the type of wheelchair or scooter used** **Coding Tips** • The turns included in the items GG0170R, Wheel 50 feet with two turns are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level.	Added new coding tips for GG0170R.

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2.GG.67	Chapter 2, Section GG, Page GG-59	**GG0170. Mobility** **Coding Tips for GG0170S,Wheel 150 feet, GG0170SS, Indicate the type of wheelchair or scooter used** **Did not exist**	**GG0170. Mobility** **Coding Tips for GG0170S,Wheel 150 feet, GG0170SS, Indicate the type of wheelchair or scooter used** • If the patient's environment does not accommodate wheelchair/scooter use of 150 feet without turns, but the patient demonstrates the ability to mobilize the wheelchair/scooter with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale. • A helper can assist a patient to complete the wheelchair distance or make turns if required. When a patient is unable to wheel the entire distance themselves the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.	Added new coding tips for GG0170S.

Chapter 2, Section H				
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2.H.1	Chapter 2, Section H, Page H-2	**Coding Instructions** – Code 2, Incontinent less than daily, if during the 3-day assessment period the patient was incontinent of urine once or twice. – Code 3, Incontinent daily, if during the 3-day assessment period the patient was incontinent of urine at least once a day. – Code 4, Always incontinent, if during the 3-day assessment period the patient had no continent voids.	**Coding Instructions** • Code 2, Incontinent less than daily, if during the 3-day assessment period the patient was incontinent of urine once or twice, and had at least one continent void during the 3-day assessment period. • Code 3, Incontinent daily, if during the 3-day assessment period the patient was incontinent of urine at least once a day, and had at least one continent void during the 3-day assessment period. • Code 4, Always incontinent, if during the 3-day assessment period the patient had no continent voids and no catheterization.	Edited coding instructions to improve clarity for H0350.
2.H.2	Chapter 2, Section H, Page H-6	**Coding Instructions** • Code 1, Occasionally incontinent, if during the 3-day assessment period the patient was incontinent for bowel movement once. This includes incontinence of any amount of stool at any time.	**Coding Instructions** • Code 1, Occasionally incontinent, if during the 3-day assessment period the patient was incontinent for bowel movement once, but also had at least one continent bowel movement. This includes incontinence of any amount of stool at any time.	Edited coding instructions to improve clarity.

Chapter 2, Section J				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.J.1	Chapter 2, Section J, Page J-9	**Definition** **Fall** An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall.	**Definition** **Fall** 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, an anticipated 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.	Edited to improve clarity for J1750.
2.J.2	Chapter 2, Section J, Page J-11	**Coding Tips** • 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.	**Removed**	Removed a coding tip for J1800 that appeared on page J-2 of the IRF-PAI Version 3.0 Manual.
2.J.3	Chapter 2, Section J, Page J-12	**Examples** **Rationale:** The patient stumbled, which was not anticipated by the therapist, and the therapist intervened to prevent a fall. An intercepted fall is considered a fall.	**Examples** **Rationale:** The patient unexpectedly stumbled, which was not anticipated by the therapist, and the therapist intervened to prevent a fall. An intercepted fall is considered a fall if it is not an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training.	Edited to improve clarity for J1800.
2.J.4	Chapter 2, Section J, Page J-13	**J1900: Number of Falls Since Admission** **Item Rationale** **Did not exist**	**J1900: Number of Falls Since Admission** **Item Rationale** • Falls are a leading cause of morbidity and mortality. • Fear of falling can limit an individual's activity and negatively impact quality of life.	Added item rationale to J1900.

Chapter 2, Section K

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2.K.1	Chapter 2, Section K, Page K-1	**Intent:** These items assess the patient's swallowing/nutritional status.	**Intent:** The items in this section are intended to assess the many conditions that could affect the patient's ability to maintain adequate nutrition and hydration. This section covers nutritional approaches.	Added additional intent item.
2.K.2	Chapter 2, Section K, Page K-1	**K0110: Swallowing/Nutritional Status**	**K0110: Swallowing/Nutritional Status** **Removed**	Removed item.

Chapter 2, Section M				
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2.M.1	Chapter 2, Section M, Page M-1	**Item Rationale** • Throughout Section M, terminology referring to "healed" versus "unhealed" ulcers refer to whether the ulcer is "closed" versus "open." When considering this, recognize that Stage 1, Deep Tissue Injury (DTI), and unstageable pressure ulcers, although closed, (i.e., may be covered with tissue, eschar, slough), would not be considered healed.	**Item rationale** **Removed**	Removed parts of item rationale.
2.M.2	Chapter 2, Section M, Page M-2	**Item Rationale** • For the IRF-PAI assessment, the initial (at admission) numerical staging of pressure ulcers/injuries and the initial numerical staging of ulcers/injuries after debridement, or a DTI that declares itself, should be coded in terms of what is assessed (i.e., seen and palpated, such as visible tissue, palpable bone) as close to admission as possible.	**Item Rationale** • For the IRF-PAI assessment, the initial (at admission) numerical staging of pressure ulcers/injuries should be coded in terms of what is assessed (i.e., seen and palpated, such as visible tissue, palpable bone) as close to admission as possible.	Edited existing guidance statements to reflect refined rationale for M0210.
2.M.3	Chapter 2, Section M, Page M-3	**Coding Instructions** Code based on the presence of any pressure ulcer/injury (regardless of stage) at the time of admission and discharge. **Code 0, No,** if the patient did not have a pressure ulcer/injury in the 3-day assessment period. **Code 1, Yes,** if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 3-day assessment period.	**Coding Instructions** If Admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible. • **Code 0, No,** if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day assessment period (or the last skin assessment in the 3-day assessment period at discharge). • **Code 1, Yes,** if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) on the first skin assessment in the 3-day assessment period (or the last skin assessment in the 3-day assessment period at discharge).	Revised assessment period instructions and coding instructions for M0210.

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2.M.4	Chapter 2, Section M, Page M-3	**Coding Tips** **Did not exist**	**Coding Tips** Review for location and stage at the time of admission. If the pressure ulcer/injury was observed at the time of admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer/injury is coded at the initial stage on the Admission assessment, and the higher stage should not be coded on the admission assessment.	Added new coding tips to M0210.
2.M.5	Chapter 2, Section M, Page M-5	**Steps for Completing M0300A-G** **Step 1: Determine Deepest Anatomical Stage** 3. Review the history of each pressure ulcer/injury in the medical record. If the pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. IRFs that carefully document and monitor pressure ulcers/injuries will be able to code this item more accurately. 5. …Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed.	**Steps for Completing M0300A-G** **Step 1: Determine Deepest Anatomical Stage** At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. 3. Review the history of each pressure ulcer/injury in the medical record. If the stageable pressure ulcer/injury was previously classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage until healed, unless it becomes unstageable. IRFs that carefully document and monitor pressure ulcers/injuries will be able to code this item more accurately. 5. …Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed, unless it becomes unstageable.	Edited steps for assessment for M0300A-G.
2.M.6	Chapter 2, Section M, Page M-6	**Steps for Completing M0300A-G** **Step 1: Determine Deepest Anatomical Stage** **Did not exist**	**Steps for Completing M0300A-G** **Step 1: Determine Deepest Anatomical Stage** 6. A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.	Added new steps for assessment for M0300A-G.

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2.M.7	Chapter 2, Section M, Page M-6	**Step 2: Identify Unstageable Pressure Ulcers/Injuries** 2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.	**Step 2: Identify Unstageable Pressure Ulcers/Injuries** 2. If a pressure ulcer/injury's anatomical tissues are obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.	Edited steps for assessment for M0300.
2.M.8	Chapter 2, Section M, Page M-6	**Step 3: Determine "Present on Admission"** 1. Review for location and stage at the time of admission. If the pressure ulcer/injury was observed at the time of admission and subsequently increased in numerical stage during the patient's stay, the pressure ulcer/injury is coded at the initial stage on the Admission assessment, and the higher stage should not be coded on the Admission assessment.	**Step 3: Determine "Present on Admission"** **Removed**	Removed coding tip for M0300A-G.
2.M.9	Chapter 2, Section M, Page M-6	**Step 3: Determine "Present on Admission"** **Did not exist**	**Step 3: Determine "Present on Admission"** 2. If a patient has a pressure ulcer that was documented on admission, and at discharge is documented at the same stage, it would be considered as "present on admission". o This guidance is true even if during the stay the original pressure ulcer healed and reopened.	Added new step under step 3 for M0300A-G.
2.M. 10	Chapter 2, Section M, Page M-10	**Coding Instructions for M0300B2: Number of these Stage 2 Pressure Ulcers that were present upon admission** • **Enter 0,** if no Stage 2 pressure ulcers were first noted at the time of admission.	**Coding Instructions for M0300B2: Number of these Stage 2 Pressure Ulcers/Injuries that were present upon admission** • **Enter 0**, if the Stage 2 pressure ulcer(s) present at discharge was/were not noted at the time of admission.	Edited coding instruction for M0300B.
2.M. 11	Chapter 2, Section M, Page M-10	**Coding Tips** • When a pressure ulcer/injury presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2.	**Coding Tips** • When a pressure ulcer/injury presents as an intact serum-filled blister, examine the adjacent and surrounding area for signs of DTI. When a DTI *is* determined, **do not code as a Stage 2.**	Edited coding tips for M0300B.

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2.M. 12	Chapter 2, Section M, Page M-12	**Coding Instructions for M0300C2: Number of these Stage 3 Pressure Ulcers that were present upon admission** • **Enter 0,** if no Stage 3 pressure ulcers were first noted at the time of admission.	**Coding Instructions for M0300C2: Number of these Stage 3 Pressure Ulcers/Injuries that were present upon admission** • **Enter 0,** if the Stage 3 pressure ulcer(s) present at discharge was/were not noted at the time of admission.	Revised coding instruction for M0300C.
2.M. 13	Chapter 2, Section M, Page M-19	**Coding Instructions for M0300D2: Number of these Stage 4 Pressure Ulcers that were present upon admission** • **Enter 0,** if no Stage 4 pressure ulcers were first noted at the time of admission.	**Coding Instructions for M0300D2: Number of these Stage 4 Pressure Ulcers/Injuries that were present upon admission** • **Enter 0**, if the Stage 4 pressure ulcer(s) present at discharge was/were not noted at the time of admission.	Edited coding instruction for M0300D.
2.M. 14	Chapter 2, Section M, Page M-21	**Coding Instructions for M0300E2: Number of these Unstageable Pressure Ulcers that were present upon admission** • **Enter 0,** if no unstageable pressure ulcers/injuries due to non-removable dressing/device were first noted at the time of admission.	**Coding Instructions for M0300E2: Number of these Unstageable Pressure Ulcers/Injuries that were present upon admission** • **Enter 0**, if the unstageable pressure ulcers/injuries due to non-removable dressing/device present at discharge was/were not noted at the time of admission.	Edited coding instruction for M0300E.
2.M. 15	Chapter 2, Section M, Page M-25	**Coding Instructions for M0300F2: Number of these Unstageable Pressure Ulcers that were present upon admission** • **Enter 0,** if no unstageable pressure ulcers/injuries due to slough and/or eschar were first noted at the time of admission.	**Coding Instructions for M0300F2: Number of these Unstageable Pressure Ulcers that were present upon admission** • **Enter 0**, if the unstageable pressure ulcer(s) due to slough and/or eschar present at discharge was/were not noted at the time of admission.	Edited coding instruction for M0300F.
2.M. 16	Chapter 2, Section M, Page M-25	**Coding Tips** • If a Stage 3 or 4 pressure ulcer observed on admission is unstageable due to slough or eschar on discharge, the unstageable pressure ulcer would be coded on the discharge assessment and would not be coded as present on admission, so M0300F2 would be coded 0.	**Coding Tips** **Removed**	Removed coding tip for M0300F.

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2.M. 17	Chapter 2, Section M, Page M-25	**Coding Tips** • Once the pressure ulcer/injury is debrided of enough slough and/or eschar such that the anatomic depth of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for reclassification of the ulcer to occur. • If a Stage 1 or 2 pressure ulcer/injury observed at the time of admission further deteriorates and eventually becomes unstageable due to slough or eschar at discharge, the unstageable pressure ulcer would be coded on the discharge assessment and would not be considered as present on admission, so M0300F2 would be coded 0. This is because the pressure ulcer/injury that is assessed on discharge was not present on admission at the same stage it is observed at the time of discharge.	**Coding Tips** • Even in the presence of slough and/or eschar, if the anatomic depth of soft tissue damage within the wound bed can be identified, the ulcer can then be numerically staged. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue for classification of the ulcer to occur. • If a stageable pressure ulcer/injury observed at the time of admission further deteriorates and eventually becomes unstageable due to slough or eschar at discharge, the unstageable pressure ulcer would be coded on the discharge assessment and would not be considered as present on admission, so M0300F2 would be coded 0. This is because the pressure ulcer that is assessed on discharge was not present on admission at the same stage it is observed at the time of discharge.	Edited coding tips for M0300F.
2.M. 18	Chapter 2, Section M, Page M-31	**Coding Instructions for M0300G2: Number of these Unstageable Pressure Injuries that were present upon admission** • **Enter 0,** if no unstageable pressure injuries presenting as DTI were noted at the time of admission.	**Coding Instructions for M0300G2: Number of these Unstageable Pressure Injuries that were present upon admission** • **Enter 0**, if the unstageable pressure injury(ies) presenting as DTI at discharge was/were not noted at the time of admission.	Edited to improve clarity.

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2.M. 19	Chapter 2, Section M, Page M-31	**Coding Tips** **Did not exist**	**Coding Tips** • A pressure ulcer/injury presenting with characteristics of a DTI is reported as a DTI unless full thickness tissue loss is present. For example, a DTI presenting as purple localized discoloration with tenderness caused by pressure, but without full thickness tissue loss would be coded as a DTI, even though the wound is not completely intact. • If a DTI that was observed on admission evolves and is subsequently able to be numerically staged, and remains at the same stage at discharge, it would be considered and coded as present on admission on the discharge assessment at the stage at which it first becomes numerically stageable (M0300x1=1 and M0300x2=1). • If a DTI that was observed on admission does not evolve to be numerically staged, but is subsequently classified as another type of unstageable pressure ulcer/injury, it would be considered and coded as present on admission on the discharge assessment in that unstageable pressure ulcer/injury category (M0300x1=1 and M0300x2=1).	Added new coding tips
2.M. 20	Chapter 2, Section M, Page M-31	**Coding Tips** • Once a DTI has opened to an ulcer, the ulcer should be reassessed, staged numerically, and coded on the IRF-PAI at the appropriate stage.	**Coding Tips** • Once a DTI has fully opened, exposing the level of tissue damage, reassess the wound via observation and/or palpation and code based on clinical assessment and staging criteria.	Edited to improve clarity for M0300G.

Chapter 2, Section N				
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2.N.1	Chapter 2, Section N, Page N-5	**Steps for Assessment** **Did not exist**	**Steps for Assessment** 4. Potential or actual clinically significant medication issues may include, but are not limited to: • Medication prescribed despite documented medication allergy or prior adverse reaction. • Excessive or inadequate dose. • Adverse reactions to medication (such as a rash). • Ineffective drug therapy (such as an analgesic that does not reduce pain. • Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions). • Duplicate therapy (such as generic-name and brand-name equivalent drugs that are both prescribed). • Wrong patient, drug, dose, route, and time errors. • Medication dose, frequency, route, or duration not consistent with patient's condition, manufacturer's instructions, or applicable standards of practice. • Use of a medication without evidence of adequate indication for use. • Omissions (medications missing from a prescribed regimen). • Non-adherence (purposeful or accidental). • Any of the circumstances listed above must reach a level of clinical significance that 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 for the purpose of the drug regimen review items.	Edited to improve clarity for N2001.

Chapter 2, Section N				
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2.N.2	Chapter 2, Section N, Page N-6	**Coding Instructions** • **Code 0. No - No issues found during review,** if a drug regimen review was conducted upon admission and no potential or actual clinically significant issues were identified • **Code 1. Yes - Issues found** during review, if a drug regimen review was conducted upon admission and potential or actual clinically significant issues were identified.	**Coding Instructions** • **Code 0, No – No issues found during review,** if a drug regimen review was conducted upon admission and based on the assessing clinician's professional judgment, no potential or actual clinically significant issues were identified. • **Code 1, Yes – Issues found during review**, if a drug regimen review is conducted and based on assessing clinician's professional judgment, potential or actual clinically significant medication issues are identified.	Edited to improve clarity for N2001.
2.N.3	Chapter 2, Section N, Page N-9	**Item Rationale** • A critical time and opportunity for identifying potential and actual clinically significant medication issues occurs when the patient is admitted to the IRF.	**Item Rationale** **Removed**	Removed from item rationale for N2003.
2.N.4	Chapter 2, Section N, Page N-9	**Item Rationale** • Physician (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a timeframe that reduces the risk for medication errors and patient harm.	**Item Rationale** • Physician (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician by midnight of the next calendar day at the latest to reduce patient harm.	Edited to improve clarity for N2003.
2.N.5	Chapter 2, Section N, Page N-10	**Coding Instructions** • **Code 0. No**, if **all** identified potential or actual clinically significant medication issues were **not** addressed **by midnight of the next calendar day**. • **Code 1. Yes,** if the two-way communication AND completion of the prescribed/recommended actions occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified.	**Coding Instructions** • **Code 0, No,** if the facility did not contact the physician and complete prescribed/recommended actions in response to each potential or actual clinically significant medication issue by midnight of the next calendar day. • **Code 1, Yes,** if the facility contacted the physician AND completed the prescribed/recommended actions by midnight of the next calendar day after each potential or actual clinically significant medication issue was identified.	Edited to improve clarity for N2003.

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2.N.6	Chapter 2, Section N, Page N-12	**Examples** **Did not exist**	**Examples** 2. The patient was admitted to an IRF from an acute care hospital. During the admitting nurse's review of the patient's hospital discharge records, it was noted that the patient had been prescribed metformin. However, laboratory tests at admission indicated the patient had a serum creatinine of 2.4, consistent with renal insufficiency. The IRF admitting nurse contacted the IRF physician-designee to ask whether this medication would be contraindicated with the patient's current serum creatinine level. Three hours after the patient's admission to the IRF, the IRF physician-designee provided orders to discontinue the metformin and start the patient on a short-acting sulfonylurea for ongoing diabetes management. These medication changes were implemented within the hour. **Coding:** N2003, Medication Follow-up, would be **coded 1, Yes**. *(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review.)* **Rationale:** The physician communication occurred, and the nurse completed the physician-designee-prescribed actions by midnight of the next calendar day. In this case, medication had been ordered that was contraindicated for the patient's current condition. The IRF clinicians' two-way communications resulted in discontinuing the contraindicated medication and replacing with an appropriate medication.	Added new example.

Chapter 2, Section N				
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2.N.7	Chapter 2, Section N, Page N-13	**Item Rationale** • Every time a clinically significant medication issue is identified throughout the patient stay, the clinically significant medication issue must be communicated to a physician (or physician-designee), and the physician (or physician-designee) prescribed/recommended actions must be completed by the clinician in a timeframe that reduces the risk for medication errors and patient harm.	**Item Rationale** **Removed**	Removed from item rationale.
2.N.8	Chapter 2, Section N, Page N-13	**Item Rationale** • Physician (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a timeframe that reduces the risk for medication errors and patient harm.	**Item Rationale** • Physician (or physician–designee)-prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician by midnight of the next calendar day at the latest to reduce patient harm.	Edited to improve clarity for N2005.
2.N.9	Chapter 2, Section N, Page N-15	**Examples** Example #2	**Examples** **Removed**	Removed example from N2005.
2.N.10	Chapter 2, Section N, Page N-17 to N-19	**Did not exist**	**Additional Coding Scenarios**	Added additional coding scenarios for clarity. This entire section is new.

Chapter 2, Section O

Chapter 2, Section O				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
2.O.1	Chapter 2, Section O, Page O-1	**Intent:** The intent of this section is to identify any special treatments, procedures, and programs that the patient received during the stay, including total parenteral nutrition.	**Intent:** The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient.	Revised for brevity.
2.O.2	Chapter 2, Section O, Page O-1 to O-10	**O0100. Special Treatments, Procedures, and Programs**	**O0100 Special Treatments, Procedures, and Programs** **Item is removed**	Removed item O0100.

Chapter 3

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
3.1	Chapter 3, Page 3-1	**Did not exist**	**Board and care, assisted living, group home** — A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.	Added a new term and definition.

Chapter 4

Chapter 4				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 3.0 – Effective October 1, 2019**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**Description of Change**
4.1	Chapter 4, Page 4-1	jIRVEN software is a computer program available to all IRFs and can be downloaded free of charge from the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html The diagram on the next page illustrates the role of jIRVEN software in the flow of data within an IRF.	**Removed**	Removed outdated guidance in section 4.2 CMS Patient Data System Flow of the IRF-PAI Version 3.0 Manual.

Chapter 4				
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4.2	Chapter 4, Page 4-2	***9-step flowchart:*** The above diagram depicts the following steps: 1. Complete the assessment. 2. Enter assessment information into the jIRVEN software. 3. Export the assessment out of jIRVEN into a .xml file. 4. Submit the exported assessment file from step 3 to the Assessment Submission And Processing system (ASAP). 5 and 6. Once accepted by ASAP, the data will reside in the National Database/CMS Repository. 7. After entering in the (discharge) assessment information into the jIRVEN software (step 2), you can obtain the CMG value. 8. The IRF submits a Medicare claim. 9. The MAC processes the claim through its software system that includes pricing programming called the "Pricer" software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data to adjust the IRF's prospective payment.	***6-step flowchart*** The above diagram depicts the following steps: 1. Complete the assessment. 2. Enter assessment information into the iQIES software. Once all sections are complete, save the assessment. 3. Submit the assessment in iQIES. After entering in the (discharge) assessment information, the assessments go to the National Database/CMS Repository. 4. The CMG is assigned after entering in the (discharge) assessment information into iQIES software (step 2). 5. The IRF submits a Medicare claim. 6. The MAC processes the claim through its software system that includes pricing programming called the "Pricer" software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data to adjust the IRF's prospective payment.	Updated flowchart and steps for CMS Patient Data System Flow and moved it from section 4.3 to 4.2.

Appendix C

Appendix C				
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C.1	Appendix C, Page C-1	*Data Submission VPN Secure Connection (CMSNet)*	**Removed**	Removed section.
C.2	Appendix C, Page C-1	*IRF-PAI Clinical Items*	**Removed**	Removed section.
C.3	Appendix C, Page C-3	**IRF Vendor Issues** Email: IRFTechIssues@cms.hhs.gov Examples of issues this resource can help you with: • IRF-PAI data specifications • VUT (vendor tool to ensure software meets CMS requirements and will pass ASAP edits) • Technical questions that are related to IRF-PAI data specifications	**Removed**	This resource appeared on page C-3 of the IRF-PAI Version 3.0 Manual. IRFs can seek assistance with vendor issues at iqies@cms.hhs.gov

Appendix D

Appendix D				
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D.1	Appendix D, All pages	**Did not exist**	Added COVID-19 Vaccination Coverage among Healthcare Personnel data under the IRF QRP information.	Updated with new CDC measure information.