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Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System

Report

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The findings and conclusions of this report are those of the authors and do not necessarily represent the views of HHS.

ANALYSES TO INFORM THE POTENTIAL USE OF STANDARDIZED PATIENT
ASSESSMENT DATA ELEMENTS IN THE INPATIENT REHABILITATION FACILITY
PROSPECTIVE PAYMENT SYSTEM

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EXECUTIVE SUMMARY

The purpose of this report is to provide analyses to inform the potential use of standardized patient assessment data elements collected on admission in the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). The report summarizes the use of assessment data in the current IRF PPS, describes the process used to substitute standardized patient assessment data elements collected on admission into the IRF PPS, presents the case-mix groups (CMGs) and payment weights based on those elements, and assesses potential impacts to IRF providers.

The analyses were conducted under the assumption that all other aspects of the inpatient rehabilitation facility (IRF) payment system would remain unchanged, including the rehabilitation impairment category (RIC) structure, the assignment of comorbidity tiers, and the methodology for calculating the payment weights. The only focus of this work was ensuring that the CMGs within RICs would accurately reflect patient costs when using standardized patient assessment data elements collected on admission in place of the current elements, Functional Independence Measure (FIM™) items.

The data used in these analyses were drawn from the Fiscal Year (FY) 2017 Medicare Inpatient National Claims History and Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) data files. Consistent with the approach used in the development of the current IRF PPS (Carter et al., 2002), RTI International used Classification and Regression Tree (CART) analysis to develop CMGs using standardized patient assessment data elements collected on admission, including motor function, cognitive function, and age.

The CART models using the standardized patient assessment data elements collected on admission yielded 88 CMGs. There are 92 CMGs in the FY 2017 IRF PPS. Although the overall number of CMGs is similar, the number of CMGs per RIC sometimes shifted. For example, RIC 1 contains 10 CMGs in the FY 2017 IRF PPS, but 6 when using the standardized patient assessment data elements. Motor score emerged as the key function variable in the definition of the CMGs across all RICs. Cognitive function is not used to define the CMGs emerging from the use the standardized patient assessment data elements, though it was included in the CART modeling.

Impact analyses focused on the percent change in mean standardized payment across providers with different characteristics and in different geographic areas to assess whether providers with specific characteristics are disproportionately affected, either negatively or positively, by the use of CMGs based on standardized patient assessment data elements. On average, across all IRF providers, using CMGs based on standardized patient assessment data elements collected at admission is not expected to change the average payment amount. We do, however, estimate some redistribution of payments at the provider level.

IRF providers in rural areas would experience a 2.25% increase in mean payment using the CMGs generated by the standardized patient assessment data elements, but IRF providers in urban areas would experience a slight decrease (0.15%). Freestanding IRFs would see a decrease in mean payment (2.43% for urban, 1.37% for rural), and IRF units would see increases (2.77% for urban, 3.03% for rural). Note that the standardized payment is not the final payment made to providers; the final payment accounts for outlier payments, wage adjustment, rural versus urban status, low-income status, and teaching status. The current analysis assumes that the approach for applying these adjustments remains constant.

SECTION 1 BACKGROUND

1.1 Introduction

The purpose of this report is to provide analyses to inform the potential use of standardized patient assessment data elements collected on admission in the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS).

The current IRF PPS, implemented in 2002, is based on Functional Independence Measure (FIM™) items collected in the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). In the current IRF PPS, patients are assigned to one of 87 case-mix groups (CMGs) on the basis of diagnosis requiring rehabilitation, motor function, cognitive function, and age. An additional five CMGs are used if the patient either dies or is discharged in 3 days or less.

Beginning in October 2016, standardized patient assessment data elements that measure functional status were introduced to the IRF-PAI. Collection of these items began as part of the IRF Quality Reporting Program (QRP). The standardized patient assessment data elements were also introduced to the Minimum Data Set, which is the assessment instrument used for skilled nursing facilities, and the Long-Term Care Hospital Continuity Assessment Record and Evaluation (CARE) data set, which is the assessment instrument used for long-term care hospitals.¹ The IRF Quality Reporting Program includes four functional outcome measures related to self-care and mobility that are based on standardized patient assessment data elements. These quality measures were finalized in the Fiscal Year 2016 IRF PPS Final Rule (80 FR 47111 through 47117). Since October 2016, IRF providers have collected both standardized patient assessment data elements and FIM™ items (along with function modifier items that are used to generate FIM™ items).

The next sections of this report summarize the use of assessment data in the current IRF PPS, describe the process RTI International used to substitute standardized patient assessment data elements collected on admission into the IRF PPS, present the CMGs and payment weights based on the use of the standardized patient assessment data elements collected on admission, and assess impacts to IRF providers.

1.2 Overview of the IRF PPS

Under the IRF PPS, Medicare fee-for-service payments are made to IRFs on a per-discharge basis, and patients are assigned to one of 92 CMGs. Of the 92 CMGs, 87 are assigned based on diagnoses requiring rehabilitation, motor function, cognitive function, and age. Five

¹ Note that standardized patient assessment data elements will be collected on the Outcome and Assessment Information Set (OASIS), the home health patient assessment instrument, beginning in January 2019.

CMGs assignments are based on short-stay status or death during the IRF stay. Data on motor function and cognitive function are obtained from IRF-PAI assessments collected by all IRF providers at admission. The Fiscal Year 2017 IRF-PAI can be found in **Appendix A**.

Each of the diagnosis-based rehabilitation impairment categories (RICs), derived from the admission impairment group code on the IRF-PAI, has a RIC-specific set of CMGs based on the characteristics of the patients in that RIC. The number of CMGs can vary by RIC. For example, in the current IRF PPS, there are 10 CMGs for RIC 1, "stroke," but only 4 CMGs for RIC 14, "cardiac." The CMGs reflect differences in costs by different levels of motor function, cognitive function, and age. **Table 1** shows the 23 RICs in the IRF PPS.

Payment weights are based on a combination of CMG and comorbidity tier using an established comorbidity list applicable to all CMGs (with the exception of RIC 50, "short stay," and RIC 51, "expired"). There are four comorbidity tiers, each reflecting an increasing level of severity. Each year, CMS updates a national base payment amount (called a standard payment conversion factor) and payment weights for each CMG and comorbidity tier combination. The IRF PPS CMGs and relative weights for Fiscal Year 2017 are shown in **Appendix B**. To derive payment, the standard payment conversion factor is multiplied by the payment weight associated with each CMG. Payments are also adjusted for geographic differences in wages, by the proportion of each facility's care furnished to low-income individuals, by rural status, and by teaching status, as applicable. Finally, patients who are transferred to another inpatient setting after a below-average length of stay in the IRF (specific to each CMG) are paid for on a per-diem basis.

Table 1. RICs in the IRF PPS

1. Stroke	13. Rheumatoid, other arthritis
2. Traumatic brain injury	14. Cardiac
3. Non-traumatic brain injury	15. Pulmonary
4. Traumatic spinal cord injury	16. Pain syndrome
5. Non-traumatic spinal cord injury	17. Major multiple trauma without brain or spinal cord injury
6. Neurological	18. Major multiple trauma with brain or spinal cord injury
7. Fracture of lower extremity	19. Guillain-Barré
8. Replacement of lower extremity	20. Miscellaneous
9. Other orthopedic	21. Burns
10. Amputation, lower extremity	50. Short stay
11. Amputation, non-lower extremity	51. Expired
12. Osteoarthritis	

1.3 Use of Assessment Data in the IRF PPS: Motor Function and Cognitive Function

The IRF PPS uses admission FIM™ items from the IRF-PAI to construct a motor score and a cognitive score. These scores in turn are used for CMG assignment. The FIM™ items used to create the motor score are shown in **Table 2**. The IRF PPS uses a weighted motor score that was developed as part of the initial payment system development work by RAND and CMS (Carter et al., 2002). Rather than applying an equal weight to each FIM™ item to generate a motor score, items are weighted to reflect their relative contribution to costs of care. The weights associated with each item in constructing the motor score are reported in **Table 2**. **Table 3** shows the rating scale for the FIM™ Items. The rating scale reflects a patient’s need for assistance and differentiates between total dependence and complete independence. Activities that did not occur, originally coded to “0,” are recoded to the most dependent level on the rating scale (Level 1, “Total Assistance”), except for toilet transfer, where “0” is recoded to Level 2, “Maximal Assistance.” The range for the motor function score is 12–84 (12 items assessed on a scale of 1–7), with higher scores indicating higher ability.

Table 2. IRF-PAI FIM™ Items Used in IRF PPS Motor Score

Item	Number	Weight
Eating	39Aa	0.6
Grooming	39Ba	0.2
Bathing	39Ca	0.9
Dressing—upper	39Da	0.2
Dressing—lower	39Ea	1.4
Toileting	39Fa	1.2
Bladder	39Ga	0.5
Bowel	39Ha	0.2
Bed, chair, wheelchair transfer	39Ia	2.2
Toilet transfer	39Ja	1.4
Walk/wheelchair	39La	1.6
Stairs	39Ma	1.6

SOURCE: IRF-PAI.

Table 3. FIM™ levels

No Helper	
7	Complete independence (timely, safely)
6	Modified independence (device)
Helper—Modified Dependence	
5	Supervision (subject = 100%)
4	Minimal assistance (subject = 75% or more)
3	Moderate assistance (subject = 50% or more)
Helper—Complete Dependence	
2	Maximal assistance (subject = 25% or more)
1	Total assistance (subject less than 25%)
0	Activity does not occur; use this code only at admission

SOURCE: IRF-PAI.

Five cognitive function items based on FIM™ are included in the cognitive score (**Table 4**). To calculate the cognitive score for payment, these items are summed (with equal weighting). The range for the cognitive score is 5–35 (5 items assessed on a scale of 1–7), with higher scores indicating higher ability. The cognitive items use the same rating scale as the motor function items.

Table 4. IRF-PAI FIM™ Items Used in the IRF PPS Cognitive Score

Item	Number
Comprehension	39N
Expression	39O
Social interaction	39P
Problem solving	39Q
Memory	39R

SOURCE: IRF-PAI.

1.4 Standardized Patient Assessment Data Elements

Beginning in October 2016, Medicare required IRFs to complete standardized patient assessment data elements for Hearing, Speech, and Vision (Section B); Cognitive Patterns (Section C); Functional Abilities and Goals (Section GG); and Bladder and Bowel (Section H) on the IRF-PAI. Though the content of the FIM™ items (and the function modifier items that are used to generate the FIM™ items) overlaps with the standardized patient assessment

data elements (e.g., eating, dressing, transfer), the items differ in the specific item definitions and the rating scale used for scoring. Standardized patient assessment data elements and FIM™ items (and the function modifier items that are used to generate the FIM™ items) are both collected within a 3-day period from a patient's admission, but the instructions for assessing patient performance differ. The standardized patient assessment data elements assess a patient's usual performance during the assessment period, in contrast to FIM™ items (and the function modifier items that are used to generate the FIM™ items), which assess a patient's most-dependent status (i.e., lowest score) during the assessment period. The standardized patient assessment data elements use a six-level rating scale for motor function items, whereas FIM™ (and the function modifiers that are used to generate the FIM™ items) uses a seven-level scale.

Tables 5a and **5b** outline the standardized patient assessment data elements used in RTI's current analysis of the IRF PPS, and **Table 6** shows the rating scale for the motor function items. Additional function items are available among the standardized patient assessment data elements on the IRF-PAI (e.g., walking on uneven surfaces, car transfer, picking up object), but not included in the current analyses. The excluded activities are more challenging and less likely to be assessed on admission, as the patient's medical condition or safety concerns may prevent assessment.

Given the differences in the item definitions and rating scales, using the standardized patient assessment data elements in place of FIM™ items would require more than a simple substitution into the current IRF PPS for the purposes of assigning patients to payment groups and computing payments. To incorporate the standardized patient assessment data elements into the payment system analysis, RTI considered the range of available items to construct a motor score and to account for cognition. RTI then generated a revised set of CMGs based on the standardized patient assessment data elements collected on admission to reflect the differences in items, definitions, and rating scales. Section 2 describes the data used and the complete analytic approach.

Table 5a. IRF-PAI Standardized Patient Assessment Data Elements: Motor Score

Motor Score	
GG0130A1	Eating
GG0130B1	Oral hygiene
GG0130C1	Toileting hygiene
GG0130E1	Shower/bathe self
GG0130F1	Upper-body dressing
GG0130G1	Lower-body dressing
GG0130H1	Putting on/taking off footwear
GG0170A1	Roll left and right
GG0170B1	Sit to lying
GG0170C1	Lying to sitting on side of bed
GG0170D1	Sit to stand
GG0170E1	Chair/bed-to-chair transfer
GG0170F1	Toilet transfer
GG0170I1	Walk 10 feet
GG0170J1	Walk 50 feet with two turns
GG0170K1	Walk 150 feet
GG0170M1	One-step curb
H0350	Bladder continence
H0400	Bowel continence

Table 5b. IRF-PAI Standardized Patient Assessment Data Elements: Cognitive Function

Cognitive Items	
BB0700	Expression of ideas and wants
BB0800	Understanding verbal content
C0500	Brief Interview for Mental Status (BIMS) summary score

Table 6. Self-Care and Mobility Rating Scale for Standardized Patient Assessment Data Elements

Activities may be completed with or without assistive devices

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent

If activity was not attempted, code reason

- 07. Patient refused
 - 09. Not applicable
 - 88. Not attempted because of medical condition or safety concerns
-

Source: IRF-PAI

SECTION 2 ANALYTIC APPROACH

This section outlines the overall analytic approach for generating case-mix groups (CMGs) and corresponding payment weights using standardized patient assessment data elements collected on admission. The analyses were conducted under the assumption that all other aspects of the inpatient rehabilitation facility (IRF) payment system would remain unchanged, including the rehabilitation impairment category (RIC) structure, the assignment of comorbidity tiers, and the methodology for calculating the payment weights. The only focus of this work was ensuring that the CMGs within RICs would accurately reflect patient costs when using standardized patient assessment data elements collected on admission in place of the Functional Independence Measure (FIM™) items.

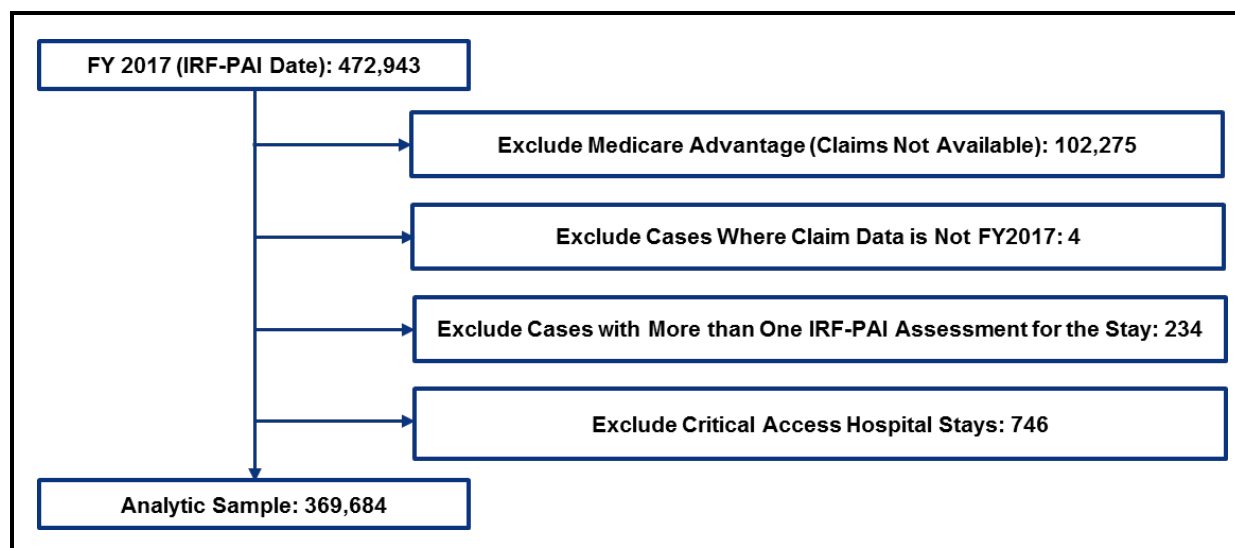
2.1 Data and Sample

The data used in these analyses were drawn from the Fiscal Year (FY) 2017 Medicare Inpatient National Claims History and Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) data files. Medicare Cost Report data were used to construct IRF stay-level costs.

The initial set of FY 2017 IRF-PAI assessments included 472,943 observations (data were pulled in November 2017). Assessments were matched to IRF claims where Medicare Part A was the primary payer for the stay and the Medicare Part A payment amount was greater than zero. Claims were matched to IRF-PAI assessments by beneficiary ID (Health Insurance Claim [HIC] number) and admission date. IRF-PAI assessment item 20A (Payment Source) was used to confirm the primary payer. More than 95 percent of assessments coded as Medicare Fee-For-Service on this item were matched to claims.

Figure 1 presents additional sample exclusion criteria. A small number of cases had different discharge dates on the claim and on the IRF-PAI. For these cases, the dates on the claim were used to validate whether the patient was discharged during FY 2017 (N = 4 exclusions). Several claims matched more than one IRF-PAI assessment. Because the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) uses the IRF-PAI functional assessment at admission to assign beneficiaries to CMGs, the earliest assessment attributed to the claim was selected. Any subsequent assessments (N = 234) were excluded. IRF stays occurring at critical access hospitals were excluded. The overall analytic sample included 369,684 IRF claims and assessments. **Appendix C** contains descriptive statistics on this sample for all items used in the FY 2017 IRF PPS and for the standardized patient assessment data elements used in the current analyses.

Figure 1. IRF PPS Analytic Sample, FY 2017



2.2 Classification and Regression Tree Analysis: Using Standardized Patient Assessment Data Elements to Generate CMGs

Consistent with the approach used in the development of the current IRF PPS (Carter et al., 2002), RTI International used Classification and Regression Tree (CART) analysis to develop CMGs using standardized patient assessment data elements collected on admission, including motor score, cognitive score, and age. CART uses a stepwise process in which the data are split into “nodes,” or groups based on an outcome of interest. In this case, data were grouped using IRF claim costs by identifying the covariate and cut-point at each split that contribute most to the model fit (Morgan, 2014). The CART approach continues to split the sample until the contribution to model fit of any further splitting falls below a user-determined threshold. RTI set CART parameters to require a minimum node size of 100 stays and to require that any additional splits yield a 0.5 percentage point increase in explanatory power. This process results in a “tree” of rules that can be used to assign cases to CMGs.

RTI used a subset of the analytic sample in the CART analysis. The subset is meant to reflect the most-typical cases and therefore excluded beneficiaries who died during the IRF stay (N = 613), those whose stay lasted 3 days or fewer (N = 8,646), and those who were transferred to another inpatient setting (N = 88,637). As previously noted, decedents and short stays have separate CMGs under the IRF PPS, whereas transfers with a below-average length of stay are reimbursed using per diem rates. Stays with excessively high cost amounts (where cost is more than 3 standard deviations from the mean) were also excluded so that a small number of very high costs cases would not drive the results.

Ultimately, RTI used a sample of 270,103 IRF stays to generate the set of CMGs using standardized patient assessment data elements.

The independent variables used in the CART regression included motor score, cognitive function (specifically memory and communication), and age. The specification of these variables based on the standardized patient assessment data elements is described below. The dependent variable in the CART regression was IRF stay costs. The construction of the cost variable is also described in the following sections. CART models were run separately for each RIC, using the same methodology that was used when the IRF payment system was initially developed. This allows for diagnosis-specific splits on motor score, cognitive function, and age to reflect the characteristics and resource use of the patients within each RIC.

2.3 Motor Score Using Standardized Patient Assessment Data Elements

RTI constructed a motor score using the standardized patient assessment data elements collected on admission presented in **Table 5a (Section 1)**. Additional function items are available among the standardized patient assessment data elements (e.g., walking on uneven surfaces, car transfer, picking up object) but were not included the motor score calculation. The excluded elements are typically too challenging for patients on admission to IRFs and therefore are less likely to be assessed on admission. The frequency with which these items are not assessed on admission in the IRF decreases their relevance for predicting costs.

Each of the motor function items among the standardized patient assessment data elements is scored on a six-point scale, with higher scores indicating greater independence (**Table 6**). Additional codes can be used to indicate why the activity did not occur. If one of these codes was recorded for the case or a dash was entered or a caret because of a skip pattern, the score for that item was recoded to 1 (Dependent) for all items except GG0170F (Toilet Transfer), which was recoded to 2 (Substantial/Maximal Assistance). This recoding approach is consistent with the current recoding approach in the IRF PPS.

The standardized data elements for bladder (H0350) and bowel (H0400) continence were included in the motor score to be consistent with the current Functional Independence Measure (FIM™) motor score used in the IRF payment system. Because the higher response codes reflect more impairment and higher resource use would be associated with higher codes (i.e., 0 = Always Continent, 4 = Always Incontinent), scores on the bowel and bladder items were reversed for inclusion in the motor score calculation. Scores were also adjusted so that the minimum score was 1 for bowel and bladder items to be consistent with the minimum score for other items in the motor score.

The item recoding approach for the bowel and bladder items differed from the approach used for the self-care and mobility items. This recoding approach was informed by clinical review and consultation with the IRF-PAI Training Manual. See **Table 7** for a summary of the recoding for H0350 (Bladder Continence) and **Table 8** for a summary of the recoding for H0400 (Bowel Continence). Cases coded as 9 (not applicable, e.g., indwelling catheter) were recoded to “Always Incontinent” for the bladder item and “Frequently Incontinent” for the bowel item, and missing codes (i.e., dash use) were recoded to “Always Continent” for both items. Cases coded as “No Urine Output” (e.g., renal failure) on the bladder item were recoded to “Always Continent.” This recoding is consistent with the current approach, because patients who do not void are coded as 7, “Complete Independence,” for the FIM Bladder item. We also note that dependence on renal dialysis is accounted for in the comorbidity tiers. Finally, on the bladder item, “Always Continent” and “Stress Incontinence Only” were combined to a single level representing no incontinence.

Table 7. Recoding for IRF-PAI Item H0350: Bladder Continence

		Recode for Use in Motor Score			
N		4—Always Continent	3—Incontinent Less Than Daily	2—Incontinent Daily	1—Always Incontinent
H0350—Bladder Continence	0—Always continent	X			
	1—Stress incontinence only	X			
	2—Incontinent less than daily		X		
	3—Incontinent daily			X	
	4—Always incontinent				X
	5—No urine output	X			
	9—Not applicable				X
	Missing	X			

Table 8. Recoding for IRF-PAI Item H0400: Bowel Continence

		Recoded for Use in Motor Score			
		4—Always Continent	3— Occasionally Incontinent	2— Frequently Incontinent	1—Always Incontinent
N					
H0400— Bowel Continence	0—Always continent	X			
	1—Occasionally incontinent		X		
	2—Frequently incontinent			X	
	3—Always incontinent				X
	9—Not rated			X	
	Missing	X			

The motor score used in the CART model was calculated by summing the scores for each of the 19 items. The range of scores for the motor score is 19 to 110, with a higher score indicating higher functional status and greater level of independence.

2.4 Cognitive Function Using Standardized Patient Assessment Data Elements

Standardized data elements related to cognitive function are collected in Section B and Section C of the IRF-PAI. Section B contains two items pertaining to communication: item BB0700 measures expression of ideas and wants, and Item BB0800 measures understanding verbal content. Section C contains an item measuring memory, the Brief Interview for Mental Status (BIMS). Though the IRF PPS includes a single cognitive score in the current CMG structure, the data elements in Section B and Section C cannot easily be summed. For this reason, two separate variables were used as independent variables in the CART model: first, a sum score of the two communication items in Section B, and second, memory using the BIMS in Section C.

Each of the communication items in Section B is scored on a 4-point scale, with higher scores indicating greater function. These two items were summed to a single communication score for inclusion in the CART model.

Section C of the IRF-PAI assesses memory using the BIMS. The BIMS consists of interview items and responses that sum to an overall score of 0 to 15, with a higher score indicating better memory skills. If the patient cannot complete the BIMS, a Staff Assessment of Mental Status is completed assessing memory. A three-level scale for memory using BIMS or the Staff Assessment of Mental Status was used in the CART model, as described in **Table 9**.

Table 9. Memory Using BIMS and Staff Assessment of Mental Status

Memory Category	BIMS Score	Staff Assessment Details Recalled
1	0–7	0–1
2	8–12	2
3	13–15	3–4

2.5 Costs

Costs of care are defined in this analysis as wage-adjusted costs for the IRF stay. IRF costs were calculated in three steps using data from the Medicare Cost Reports and Medicare Provider Analysis and Review claims. First, routine costs for the claim were calculated by multiplying the facility-specific routine cost per day (derived from the Cost Report) by the number of utilization days (length of stay) on the claim. Next, claim ancillary costs were calculated by multiplying a set of 14 ancillary cost to charge ratios (derived from the facility-specific Cost Report) by the claim charges for those cost centers and summing. Finally, total claim cost was calculated as the sum of routine and ancillary costs. Total claim cost was then capped at the 99.9th percentile (Coomer, Ingber, Coots, & Morley, 2017). Wage-adjusted costs were calculated as follows:

$$\text{Wage-Adjusted Cost} = \text{Claim Cost} / (0.293 + 0.707 * \text{Wage Index})$$

where 0.707 is the labor share of total costs of care (Centers for Medicare & Medicaid Services [CMS], 2017).

2.6 Results of CART Analysis

For each of the 21 RICs, RTI conducted CART analysis using the dependent variable of wage-adjusted cost of care for the stay, and four independent variables: (1) motor score, (2) communication (IRF-PAI Section B), (3) memory (IRF-PAI Section C BIMS), and (4) beneficiary age on the date of admission. CART analysis was conducted using R statistical software. Each regression tree was terminated when the next split would contribute less than 0.005 to model fit (R-squared).

Results of initial regression tree runs for each RIC were reviewed to ensure monotonicity (i.e., that the level of impairment and average cost associated with each node increased across nodes within RIC) and consistency with clinical judgement (i.e., that a split occurred where such a split would be a clinically reasonable predictor of cost).

The CART models using the standardized patient assessment data elements collected on admission resulted in 88 CMGs, including RICs 50 (“short stay,” one CMG) and 51 (“expired,” four CMGs), which remained unchanged. The CMGs based on the standardized

patient assessment data elements collected on admission and age ranges used to group beneficiaries are presented in **Table 10**. The next section discusses calculation of the payment weights. For reference, the 92 CMGs in the FY 2017 IRF PPS are shown in **Appendix B**.

RTI adjusted the CART-generated trees for two RICs: RIC 16, "pain syndrome," and RIC 17, "major multiple trauma without brain or spinal cord injury." A similar issue was observed in each of these RICs; the communication items emerged as a splitting variable in the CART analysis, but the threshold for the split was very high and not in line with clinical expectations. Specifically, the communication item was distinguishing beneficiaries with no impairment from all others (splitting at 7 out of 8 in RIC 16, and 8 out of 8 in RIC 17) and attributing considerably higher cost for what could amount to a small level of impairment. Because of the very high threshold for this split, the inconsistency with clinical expectations, and the low number of observations in this RIC, the team removed the split from the final CMG definitions.

Although the overall number of CMGs is similar to the FY 2017 CMGs using the standardized patient assessment data elements, the number of CMGs per RIC sometimes shifted. For example, RIC 1 contains 10 CMGs in the FY 2017 IRF PPS, but 6 when using the standardized patient assessment data elements. Each of the final CMGs is monotonic within each RIC. For a model using the CMGs based on the standardized patient assessment data elements and comorbidity tiers to predict wage-adjusted costs of care, the r-squared value is 0.3239; the r-squared value is 0.3040 for the CMGs used in the current IRF PPS. In a model that also controls for the variation between providers, this value increases to 0.5248, compared with 0.5332 using the CMGs from the current IRF PPS. The r-squared value is higher in models controlling for variation between providers. Overall, there is little difference between the model r-squares using the CMGs from the current IRF PPS and the model r-squares using the CMGs based on the standardized patient assessment data elements.

Motor score is the key function variable emerging in the definition of the CMGs across all RICs. Though included in the CART modeling, neither the communication items (IRF-PAI Section B) nor the memory items (IRF-PAI Section C BIMS) are reflected in the final CMG definitions. However, cognitive score is included in the CMG definitions for RIC 1, "stroke, and RIC 2, "traumatic brain injury," in the FY 2017 IRF PPS. Though cognitive status is considered an important factor in resource use, current cognitive status items may not sufficiently measure the complexity of cognitive status, which may contribute to these results. Even without the explicit use of cognitive items in the CMG definitions, the function rating scale for the standardized patient assessment data elements may capture aspects of cognitive status; the scale measures need for assistance, including supervision.

Table 10. CMG Definitions Using Standardized Patient Assessment Data Elements

RIC	CMG	CMG Description		Relative Weight			
		Rule 1	Rule 2	Tier 1	Tier 2	Tier 3	None
Stroke	0101	Motor ≥ 77		1.0570	0.9232	0.8492	0.8050
Stroke	0102	Motor < 77	Motor ≥ 68	1.3370	1.1678	1.0741	1.0182
Stroke	0103	Motor < 68	Motor ≥ 55	1.6848	1.4715	1.3535	1.2831
Stroke	0104	Motor < 55	Motor ≥ 47	2.1484	1.8764	1.7260	1.6361
Stroke	0105	Motor < 47	Age ≥ 85	2.4137	2.1081	1.9391	1.8382
Stroke	0106	Motor < 47	Age < 85	2.7956	2.4417	2.2460	2.1291
Traumatic brain injury	0201	Motor ≥ 73		1.2418	1.0426	0.9376	0.8708
Traumatic brain injury	0202	Motor < 73	Motor ≥ 64	1.4929	1.2534	1.1272	1.0468
Traumatic brain injury	0203	Motor < 64	Motor ≥ 51	1.7699	1.4859	1.3363	1.2411
Traumatic brain injury	0204	Motor < 51	Motor ≥ 36	2.1753	1.8263	1.6424	1.5254
Traumatic brain injury	0205	Motor < 36		2.6959	2.2634	2.0355	1.8904
Non-traumatic brain injury	0301	Motor ≥ 70		1.2192	1.0096	0.9348	0.8735
Non-traumatic brain injury	0302	Motor < 70	Motor ≥ 57	1.5403	1.2755	1.1810	1.1034
Non-traumatic brain injury	0303	Motor < 57	Motor ≥ 45	1.8496	1.5316	1.4182	1.3251
Non-traumatic brain injury	0304	Motor < 45	Age ≥ 79	2.0666	1.7113	1.5846	1.4806
Non-traumatic brain injury	0305	Motor < 45	Age < 79	2.2755	1.8843	1.7447	1.6302
Traumatic spinal cord injury	0401	Motor ≥ 64		1.2999	1.0952	1.0122	0.9370
Traumatic spinal cord injury	0402	Motor < 64	Motor ≥ 57	1.6630	1.4011	1.2949	1.1987
Traumatic spinal cord injury	0403	Motor < 57	Motor ≥ 46	1.9672	1.6574	1.5318	1.4180
Traumatic spinal cord injury	0404	Motor < 46	Motor ≥ 36	2.6209	2.2082	2.0408	1.8892
Traumatic spinal cord injury	0405	Motor < 36	Age < 63	3.1923	2.6895	2.4857	2.3010
Traumatic spinal cord injury	0406	Motor < 36	Age ≥ 63	3.6963	3.1142	2.8782	2.6643
Non-traumatic spinal cord injury	0501	Motor ≥ 75		1.1291	0.9068	0.8382	0.7642
Non-traumatic spinal cord injury	0502	Motor < 75	Motor ≥ 63	1.4096	1.1322	1.0464	0.9541

(continued)

Table 10. CMG Definitions Using Standardized Patient Assessment Data Elements (continued)

RIC	CMG	CMG Description		Relative Weight			
		Rule 1	Rule 2	Tier 1	Tier 2	Tier 3	None
Non-traumatic spinal cord injury	0503	Motor < 63	Motor ≥ 52	1.7905	1.4381	1.3292	1.2119
Non-traumatic spinal cord injury	0504	Motor < 52	Motor ≥ 44	2.2191	1.7823	1.6473	1.5020
Non-traumatic spinal cord injury	0505	Motor < 44		2.8377	2.2792	2.1065	1.9206
Neurological	0601	Motor ≥ 69		1.3205	1.0500	0.9795	0.8873
Neurological	0602	Motor < 69	Motor ≥ 57	1.6324	1.2981	1.2109	1.0969
Neurological	0603	Motor < 57	Motor ≥ 47	1.9170	1.5244	1.4220	1.2882
Neurological	0604	Motor < 47		2.2218	1.7667	1.6481	1.4929
Fracture of lower extremity	0701	Motor ≥ 67		1.1960	0.9851	0.9487	0.8595
Fracture of lower extremity	0702	Motor < 67	Motor ≥ 55	1.5308	1.2608	1.2142	1.1001
Fracture of lower extremity	0703	Motor < 55	Motor ≥ 45	1.8510	1.5245	1.4682	1.3302
Fracture of lower extremity	0704	Motor < 45		2.0790	1.7124	1.6491	1.4941
Replacement of lower-extremity joint	0801	Motor ≥ 67		1.0475	0.8892	0.8044	0.7437
Replacement of lower-extremity joint	0802	Motor < 67	Motor ≥ 56	1.2925	1.0972	0.9926	0.9176
Replacement of lower-extremity joint	0803	Motor < 56	Motor ≥ 47	1.5469	1.3132	1.1880	1.0982
Replacement of lower-extremity joint	0804	Motor < 47		1.8517	1.5719	1.4220	1.3146
Other orthopedic	0901	Motor ≥ 69		1.1749	0.9376	0.8792	0.8083
Other orthopedic	0902	Motor < 69	Motor ≥ 55	1.5103	1.2052	1.1302	1.0390
Other orthopedic	0903	Motor < 55	Motor ≥ 47	1.8117	1.4457	1.3557	1.2463
Other orthopedic	0904	Motor < 47		2.0393	1.6273	1.5261	1.4029
Amputation lower extremity	1001	Motor ≥ 67		1.3231	1.1340	1.0276	0.9487
Amputation lower extremity	1002	Motor < 67	Motor ≥ 59	1.6372	1.4032	1.2715	1.1739
Amputation lower extremity	1003	Motor < 59	Motor ≥ 49	1.8961	1.6251	1.4726	1.3596
Amputation lower extremity	1004	Motor < 49		2.1617	1.8527	1.6788	1.5500
Amputation non-lower extremity	1101			1.8322	1.3022	1.3022	1.0585

(continued)

Table 10. CMG Definitions Using Standardized Patient Assessment Data Elements (continued)

RIC	CMG	CMG Description		Relative Weight			
		Rule 1	Rule 2	Tier 1	Tier 2	Tier 3	None
Osteoarthritis	1201	Motor ≥ 65		1.3071	1.0757	0.9575	0.8777
Osteoarthritis	1202	Motor < 65	Motor ≥ 49	1.6787	1.3816	1.2297	1.1273
Osteoarthritis	1203	Motor < 49		1.9145	1.5756	1.4024	1.2857
Rheumatoid other arthritis	1301	Motor ≥ 69		1.1111	0.9753	0.9076	0.8570
Rheumatoid other arthritis	1302	Motor < 69	Motor ≥ 58	1.3176	1.1567	1.0764	1.0164
Rheumatoid other arthritis	1303	Motor < 58	Age ≥ 72	1.6691	1.4652	1.3635	1.2875
Rheumatoid other arthritis	1304	Motor < 58	Age < 72	1.7642	1.5487	1.4412	1.3609
Cardiac	1401	Motor ≥ 70		1.1839	0.9920	0.8991	0.8023
Cardiac	1402	Motor < 70	Motor ≥ 59	1.4635	1.2263	1.1115	0.9918
Cardiac	1403	Motor < 59	Motor ≥ 51	1.7034	1.4272	1.2936	1.1544
Cardiac	1404	Motor < 51		1.9704	1.6510	1.4964	1.3353
Pulmonary	1501	Motor ≥ 84		1.0149	0.9214	0.8346	0.7907
Pulmonary	1502	Motor < 84	Motor ≥ 74	1.2323	1.1187	1.0133	0.9601
Pulmonary	1503	Motor < 74	Motor ≥ 59	1.4557	1.3215	1.1970	1.1341
Pulmonary	1504	Motor < 59	Motor ≥ 46	1.7464	1.5853	1.4360	1.3606
Pulmonary	1505	Motor < 46		2.0273	1.8404	1.6670	1.5794
Pain syndrome	1601	Motor ≥ 70		1.2293	0.9242	0.8776	0.7774
Pain syndrome	1602	Motor < 70	Motor ≥ 61	1.5216	1.1439	1.0863	0.9622
Pain syndrome	1603	Motor < 61		1.8391	1.3826	1.3129	1.1630
Major multiple trauma without brain or spinal cord injury	1701	Motor ≥ 62		1.4355	1.1154	1.0668	0.9504
Major multiple trauma without brain or spinal cord injury	1702	Motor < 62	Motor ≥ 51	1.7939	1.3938	1.3330	1.1876
Major multiple trauma without brain or spinal cord injury	1703	Motor < 51	Motor ≥ 47	2.0059	1.5585	1.4906	1.3280
Major multiple trauma without brain or spinal cord injury	1704	Motor < 47	Motor ≥ 39	2.1848	1.6975	1.6236	1.4465
Major multiple trauma without brain or spinal cord injury	1705	Motor < 39		2.4250	1.8841	1.8020	1.6055

(continued)

Table 10. CMG Definitions Using Standardized Patient Assessment Data Elements (continued)

RIC	CMG	CMG Description		Relative Weight			
		Rule 1	Rule 2	Tier 1	Tier 2	Tier 3	None
Major multiple trauma with brain or spinal cord injury	1801	Motor \geq 72		1.1980	1.0351	0.8752	0.8233
Major multiple trauma with brain or spinal cord injury	1802	Motor < 72	Motor \geq 58	1.5335	1.3250	1.1204	1.0539
Major multiple trauma with brain or spinal cord injury	1803	Motor < 58	Motor \geq 42	2.0608	1.7806	1.5056	1.4162
Major multiple trauma with brain or spinal cord injury	1804	Motor < 42		2.9220	2.5248	2.1348	2.0081
Guillain-Barré	1901	Motor \geq 54		1.5211	1.2331	1.1228	1.0834
Guillain-Barré	1902	Motor < 54		3.4558	2.8014	2.5507	2.4613
Miscellaneous	2001	Motor \geq 70		1.2339	1.0047	0.9349	0.8447
Miscellaneous	2002	Motor < 70	Motor \geq 58	1.5240	1.2410	1.1547	1.0433
Miscellaneous	2003	Motor < 58	Motor \geq 49	1.7837	1.4525	1.3515	1.2211
Miscellaneous	2004	Motor < 49		2.0373	1.6589	1.5436	1.3947
Burns	2101			1.9058	1.5390	1.5118	1.3015
Short stay	5001			-	-	-	0.1801
Mortality (orthopedic) LOS \leq 13	5101			-	-	-	0.6240
Mortality (orthopedic) LOS \geq 14	5102			-	-	-	1.7071
Mortality (non-orthopedic) LOS \leq 15	5103			-	-	-	0.6795
Mortality (non-orthopedic) LOS \geq 16	5104			-	-	-	2.1069

NOTE: LOS = length of stay.

2.7 Payment Weight Calculations for Standardized Patient Data Element–Based CMGs

After generating new CMGs using the standardized patient assessment data elements collected at admission, RTI calculated payment weights for these groups. Payment weights are calculated for each CMG and comorbidity tier combination. Standardized payment amounts can then be calculated by multiplying the standard payment conversion factor by the relative weight associated with the CMG and comorbidity tier combination. CMS recalibrates these weights on an annual basis using cost report data for IRF stays from the prior year. RTI implemented the same approach to calculating payment weights as CMS uses in the current IRF PPS. The sections below describe the process.

Average Length of Stay

To calculate payment weights, first, the average length of stay (LOS) for every combination of CMG and comorbidity tier was calculated. This is done using an iterative process, where outlier cases with a length of stay more than three standard deviations from the mean are trimmed after each iteration. This process is repeated over five iterations, at which point the average length of stay is stabilized.

Comorbidity-Adjusted Costs

The second step of this process involves removing the effect of comorbidities from the wage-adjusted cost of care for each IRF stay. The effect of comorbidities on cost was estimated using ordinary least squares regression with provider fixed effects. The dependent variable in this analysis was log-transformed, wage-adjusted costs for the IRF stay. The model controlled for RIC, CMG (nested within RIC), and an interaction between RIC and comorbidity tier that accounted for a differential effect of comorbidities across RICs. Short transfers (defined as a transfer with a length of stay less than the average for that CMG and tier) and cases with log-transformed costs of care more than three standard deviations from the overall mean were excluded to reduce the effect of extreme value cases in the model. The cost of care for each case assigned to a comorbidity tier was then divided by the exponentiated regression coefficient for the corresponding RIC-tier combination to estimate what the stay's cost of care would have been without comorbidities (tier-adjusted).

Calculating CMG-Level Relative Weights

The third step of this process estimates the relative payment weight for every CMG using the tier-adjusted costs of care. These weights are calculated using the Hospital-Specific Relative Value (HSRV) methodology described in detail in earlier work (Carter et al., 2002). The HSRV methodology uses an iterative process to determine the relative costliness of the IRF stays assigned to a particular CMG while adjusting for the relative costliness of the providers who cared for those patients. For example, consider two patients assigned to the same CMG with the same total costs of care. If patient A was treated at an IRF with higher

average costs of care than patient B, patient A would have a lower relative cost under the HSRV approach. The case-mix index (CMI), or relative costliness of each provider, is determined by the average cost of care across all of the provider's patients. Short transfers are included in this step and given reduced weight in the calculation.

The weight for each case is set to 1 for all cases except short transfers, where weight equals the following:

$$\text{Case Weight} = (\text{LOS} + 0.5) / \text{Average LOS}$$

The CMG-level payment weight is initially calculated as follows:

$$\text{Pmt. Weight} = \text{sum}(\text{Cost of Care}) / \text{sum}(\text{Case Weight})$$

CMI is then calculated for each provider as a function of payment weights and case weights:

$$\text{CMI} = \text{sum}(\text{Pmt. Weight}) / \text{sum}(\text{Case Weight})$$

The CMG-level payment weight for each stay is then multiplied by the CMI for the provider in which the stay occurred, which yields a new CMG-level average payment weight, and subsequently, a new value for the CMI for each provider. This process is repeated over five iterations, at which point the values for CMG-level payment weight and CMI stabilize. At this stage, the case-weighted average payment weight across all cases is equal to 1.

Calculating Comorbidity-Level Weights

The final step in this process is adjusting the newly calculated payment weight for the effect of comorbidities. Essentially, the process used to remove the effect of comorbidities in the earlier step is reversed. The CMG-level payment weights are multiplied by the exponentiated RIC-Tier-level regression coefficients, which were initially used to estimate the tier-adjusted costs of care, to calculate a payment weight for every combination of CMG and comorbidity tier. The same tier-level multiplier is applied to every CMG within a RIC. For example, the RIC-Tier multiplier for RIC 1 ("stroke") Tier B is approximately 1.31. Therefore, the payment weights for each CMGs under RIC 1 are multiplied by 1.31 to generate payment weights for patients assigned to comorbidity Tier B in each CMG in RIC 1.

Budget Neutrality Adjustment

Because costs of care can vary from year to year, CMS typically adjusts the final payment weights to ensure budget neutrality across years. To make this adjustment, first, the case-weighted average payment weight is calculated across all cases for the new and current payment weights. Next, the new payment weights are multiplied by the ratio of the case-weighted average of the legacy weights to the new weights.

$$\text{Budget Neutral Factor} = \frac{\text{sum(Pmt. Weights Current)}/\text{sum(Case Weights Current)}}{\text{sum(Pmt. Weights New)}/\text{sum(Case Weights New)}}$$

$$\text{Budget Neutral Weight} = \text{Pmt. Weight} * \text{Budget Neutral Factor}$$

The final list of payment weights by CMG and comorbidity tier is presented in **Table 10**.

Table 11 presents descriptive statistics of the budget-neutral payment weights using standardized patient assessment data elements and the FY17 IRF PPS payment weights at the RIC level. At the RIC level, the changes in mean weight are relatively small.

Table 11. Comparison of RIC-Level Average Payment Weights

	RIC	Payment Weights Using Standardized Patient Assessment Data Elements		FY 2017 IRF PPS Payment Weights		Obs.
		Mean	Std. Dev.	Mean	Std. Dev.	
1	Stroke	1.555	0.496	1.551	0.521	74,640
2	Traumatic brain injury	1.370	0.389	1.392	0.412	11,683
3	Non-traumatic brain injury	1.315	0.314	1.333	0.335	26,386
4	Traumatic spinal cord injury	1.927	0.742	1.967	0.794	2,779
5	Non-traumatic spinal cord injury	1.449	0.462	1.463	0.481	14,853
6	Neurological	1.328	0.299	1.344	0.319	52,974
7	Fracture of lower extremity	1.335	0.255	1.336	0.260	37,564
8	Replacement of lower extremity joint	0.986	0.211	0.966	0.214	15,981
9	Other orthopedic	1.182	0.239	1.187	0.258	29,037
10	Amputation lower extremity	1.497	0.339	1.464	0.318	9,378
11	Amputation non-lower extremity	1.413	0.278	1.396	0.324	409
12	Osteoarthritis	1.148	0.191	1.180	0.194	748
13	Rheumatoid other arthritis	1.187	0.226	1.240	0.265	917
14	Cardiac	1.166	0.262	1.159	0.256	20,999
15	Pulmonary	1.259	0.254	1.239	0.263	7,514
16	Pain syndrome	1.089	0.204	1.082	0.222	1,220
17	Major multiple trauma without brain or spinal cord injury	1.374	0.287	1.377	0.301	6,616
18	Major multiple trauma with brain or spinal cord injury	1.593	0.535	1.636	0.525	1,797

(continued)

Table 11. Comparison of RIC-Level Average Payment Weights (continued)

RIC	Payment Weights Using Standardized Patient Assessment Data Elements		FY 2017 IRF PPS Payment Weights		Obs.
	Mean	Std. Dev.	Mean	Std. Dev.	
19 Guillain-Barré	2.011	0.797	1.979	0.788	689
20 Miscellaneous	1.235	0.269	1.229	0.281	44,037
21 Burns	1.451	0.160	1.498	0.123	204
50 Short stay	0.180	0.000	0.159	0.000	8,646
51 Mortality	0.846	0.458	0.944	0.424	613
Total	1.314	0.420	1.314	0.437	369,684

SECTION 3 IMPACT ANALYSES

This section presents the results of impact analyses of the percent change in mean standardized payment across providers with different characteristics and in different geographic areas. The purpose of this analysis is to examine whether providers with specific characteristics are disproportionately affected, negatively or positively, by the use of case-mix groups (CMGs) based on standardized patient assessment data elements.

3.1 Impact Analysis Sample and Provider Characteristics

The impact analyses were conducted using the same sample of inpatient rehabilitation facility (IRF) stays used to generate the revised payment weights. Note that this sample includes transfers to another institutional setting with a length of stay less than the CMG-Tier-level average; however, these cases are paid on a per-diem basis if the length of stay exceeds 3 days. These cases would not be affected by the changes to the CMG structure, but are included in the sample because they are included in the weight calculations.

The key outcome examined in the impact analysis was percent change in mean standardized payment. The standardized payment is the weight for each comorbidity tier within each CMG multiplied by the Fiscal Year (FY) 2017 standard payment conversion factor of \$15,708. The standardized payment is not the final payment made to providers; the final payment accounts for outlier payments, wage adjustment, rural versus urban status, low-income status, and teaching status. This analysis assumes that the approach for applying these adjustments remains constant, however. Therefore, those adjustments were not applied. Only standardized payments were used to assess the effect of the changes to the CMGs based on the use of the standardized patient assessment data elements collected on admission.

Provider characteristics considered in the impact analyses included urban versus rural location, for-profit versus nonprofit versus government ownership status, region, teaching status, and bed size. Provider characteristics were determined through analysis of the 2017 Provider of Services File.

3.2 Results of Impact Analyses

On average, across all IRF providers, the use of CMGs based on standardized patient assessment data elements collected at admission is not expected to change the average payment amount. We do, however, estimate some redistribution of payments at the provider level. Understanding how these changes affect providers with different characteristics is an important aspect of understanding the potential impact of changes to the IRF industry. Impacts by IRF provider characteristic are shown in **Table 12**. We

estimate that IRF providers in rural areas would experience a 2.25% increase in mean payment using the CMGs generated by the standardized patient assessment data elements, but IRF providers in urban areas would experience a slight decrease (0.15%). Freestanding IRFs would see a decrease in mean payment (2.43% for urban, 1.37% for rural), and IRF units would see increases (2.77% for urban, 3.03% for rural). Urban for-profit providers would see decreases in mean payment (2.10%), but rural for-profit providers, as well as all nonprofit and government hospitals, would see increases. Teaching hospitals would see increased mean payments of 2.46%, but non-teaching settings would see a smaller decrease (0.52%). Breakdowns by census region are also presented in **Table 12**. For urban providers, those in New England would experience the greatest decrease in mean payment (2.15%), and those in the Pacific region would experience the greatest increase (3.77%). For rural providers, New England would experience the greatest decrease (5.60%), and East South Central would experience the greatest increase (4.29%). Finally, hospitals with fewer than 50 beds would see increases in mean payment, but larger hospitals would see decreases. This likely correlates with the differences observed between freestanding IRFs and IRF units, as units tend to have fewer beds than freestanding facilities.

Table 12. Impact Analysis by IRF Provider Characteristic

Provider Characteristic	Number of IRFs	Number of Cases	% Change in Mean Standardized Payment
(1)	(2)	(3)	(4)
Total	1,111	369,684	0.00%
Urban unit	702	155,121	2.77%
Rural unit	133	20,074	3.03%
Urban hospital	265	190,431	-2.43%
Rural hospital	11	4,058	-1.37%
Urban for-profit	339	185,702	-2.10%
Rural for-profit	37	7,388	1.56%
Urban nonprofit	529	137,321	2.10%
Rural nonprofit	84	13,338	2.15%
Urban government	99	22,529	2.74%
Rural government	23	3,406	4.20%
Urban	967	345,552	-0.15%
Rural	144	24,132	2.25%

(continued)

Table 12. Impact Analysis by IRF Provider Characteristic (continued)

Provider Characteristic	Number of IRFs	Number of Cases	% Change in Mean Payment
(1)	(2)	(3)	(4)
Urban by Region			
Urban New England	29	15,514	-2.15%
Urban Middle Atlantic	134	48,194	-1.80%
Urban South Atlantic	144	69,040	-0.24%
Urban East North Central	173	46,132	2.61%
Urban East South Central	56	24,250	-0.95%
Urban West North Central	73	18,333	0.07%
Urban West South Central	180	75,717	-0.69%
Urban Mountain	81	26,683	-1.37%
Urban Pacific	97	21,689	3.77%
Rural by Region			
Rural New England	4	1,048	-5.60%
Rural Middle Atlantic	11	1,244	2.91%
Rural South Atlantic	16	3,491	-0.59%
Rural East North Central	21	3,599	2.33%
Rural East South Central	21	4,174	4.29%
Rural West North Central	21	2,829	1.92%
Rural West South Central	40	6,765	3.67%
Rural Mountain	7	722	4.08%
Rural Pacific	3	260	1.74%
Teaching Status			
Non-teaching	842	303,102	-0.52%
Teaching	269	66,582	2.46%
Bed Size			
< 25	563	85,835	2.52%
25–49	314	107,858	0.66%
50–74	134	85,923	-1.35%
75–99	58	48,564	-2.06%
100–124	19	14,527	-1.91%
125+	23	26,977	-1.14%

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APPENDIX A
IRF PATIENT ASSESSMENT INSTRUMENT

PRA Disclosure Statement*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0842**. The time required to complete this information collection is estimated to average **54.5 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*This statement applies to the 2015 release of the IRF-PAI (version 1.3) and not to any additional burden related to the addition of new data elements added for the purpose of informing CMS' newly adopted measures, which were finalized through the FY 2016 IRF PPS Final Rule, including those quality measures related to the IMPACT Act of 2014.

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

Identification Information*	Payer Information*																													
<p>1. Facility Information</p> <p>A. Facility Name _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>B. Facility Medicare Provider Number _____</p> <p>2. Patient Medicare Number _____</p> <p>3. Patient Medicaid Number _____</p> <p>4. Patient First Name _____</p> <p>5A. Patient Last Name _____</p> <p>5B. Patient Identification Number _____</p> <p>6. Birth Date _____ MM / DD / YYYY</p> <p>7. Social Security Number _____</p> <p>8. Gender (1 - Male; 2 - Female) _____</p> <p>9. Race/Ethnicity (Check all that apply)</p> <p style="margin-left: 40px;">American Indian or Alaska Native A. _____</p> <p style="margin-left: 120px;">Asian B. _____</p> <p style="margin-left: 40px;">Black or African American C. _____</p> <p style="margin-left: 80px;">Hispanic or Latino D. _____</p> <p style="margin-left: 40px;">Native Hawaiian or Other Pacific Islander E. _____</p> <p style="margin-left: 120px;">White F. _____</p> <p>10. Marital Status _____ <i>(1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced)</i></p> <p>11. Zip Code of Patient's Pre-Hospital Residence _____</p> <p>12. Admission Date _____ MM / DD / YYYY</p> <p>13. Assessment Reference Date _____ MM / DD / YYYY</p> <p>14. Admission Class _____ <i>(1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)</i></p> <p>15A. Admit From _____ <i>(01 - Home (private home/apt., board/care, assisted living, group home, transitional living); 02 - Short-term General Hospital; 03 - Skilled Nursing Facility (SNF); 04 - Intermediate care; 06 - Home under care of organized home health service organization; 50 - Hospice (home); 51 - Hospice (institutional facility); 61 - Swing bed; 62 - Another Inpatient Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital; 99 - Not Listed)</i></p> <p>16A. Pre-hospital Living Setting _____ <i>Use codes from 15A. Admit From</i></p> <p>17. Pre-hospital Living With _____ <i>(Code only if item 16A is 01 - Home: Code using 01 - Alone; 02 - Family/Relatives; 03 - Friends; 04 - Attendant; 05 - Other)</i></p> <p>18. DELETED</p> <p>19. DELETED</p>	<p>20. Payment Source _____ <i>(02 - Medicare Fee For Service; 51 - Medicare-Medicare Advantage; 99 - Not Listed)</i></p> <p>A. Primary Source _____</p> <p>B. Secondary Source _____</p> <tr style="background-color: black; color: white;"> <th colspan="2" style="text-align: center;">Medical Information*</th> </tr> <p>21. Impairment Group _____ Admission Discharge</p> <p>Condition requiring admission to rehabilitation; code according to Appendix A.</p> <p>22. Etiologic Diagnosis _____ <i>(Use ICD codes to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation)</i></p> <p style="margin-left: 250px;">A. _____ B. _____ C. _____</p> <p>23. Date of Onset of Impairment _____ MM / DD / YYYY</p> <p>24. Comorbid Conditions Use ICD codes to enter comorbid medical conditions</p> <table style="width: 100%; border: none;"> <tr> <td>A. _____</td> <td>J. _____</td> <td>S. _____</td> </tr> <tr> <td>B. _____</td> <td>K. _____</td> <td>T. _____</td> </tr> <tr> <td>C. _____</td> <td>L. _____</td> <td>U. _____</td> </tr> <tr> <td>D. _____</td> <td>M. _____</td> <td>V. _____</td> </tr> <tr> <td>E. _____</td> <td>N. _____</td> <td>W. _____</td> </tr> <tr> <td>F. _____</td> <td>O. _____</td> <td>X. _____</td> </tr> <tr> <td>G. _____</td> <td>P. _____</td> <td>Y. _____</td> </tr> <tr> <td>H. _____</td> <td>Q. _____</td> <td></td> </tr> <tr> <td>I. _____</td> <td>R. _____</td> <td></td> </tr> </table> <p>24A. Are there any arthritis conditions recorded in items #21, #22, or #24 that meet all of the regulatory requirements for IRF classification (in 42 CFR 412.29(b)(2)(x), (xi), and (xii))? _____ <i>(0 - No; 1 - Yes)</i></p> <p>25. DELETED</p> <p>26. DELETED</p> <p>Height and Weight <i>(While measuring if the number is X.1-X.4 round down, X.5 or greater round up)</i></p> <p>25A. Height on admission (in inches) _____</p> <p>26A. Weight on admission (in pounds) _____ <i>Measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.)</i></p> <p>27. Swallowing Status _____ Admission Discharge</p> <p>3- <u>Regular Food</u>: solids and liquids swallowed safely without supervision or modified food consistency</p> <p>2- <u>Modified Food Consistency/Supervision</u>: subject requires modified food consistency and/or needs supervision for safety</p> <p>1- <u>Tube/Parenteral Feeding</u>: tube/parenteral feeding used wholly or partially as a means of sustenance</p> <p>28. DELETED</p>	Medical Information*		A. _____	J. _____	S. _____	B. _____	K. _____	T. _____	C. _____	L. _____	U. _____	D. _____	M. _____	V. _____	E. _____	N. _____	W. _____	F. _____	O. _____	X. _____	G. _____	P. _____	Y. _____	H. _____	Q. _____		I. _____	R. _____	
Medical Information*																														
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G. _____	P. _____	Y. _____																												
H. _____	Q. _____																													
I. _____	R. _____																													

Function Modifiers*	39. FIM™ Instrument*		
Complete the following specific functional items prior to scoring the FIM™ Instrument:	Admission	Discharge	Goal
29. Bladder Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>	
30. Bladder Frequency of Accidents (Score as below) 7 - No accidents 6 - No accidents; uses device such as a catheter 5 - One accident in the past 7 days 4 - Two accidents in the past 7 days 3 - Three accidents in the past 7 days 2 - Four accidents in the past 7 days 1 - Five or more accidents in the past 7 days <i>Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above</i>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Bowel Level of Assistance (Score using FIM Levels 1 - 7)	<input type="checkbox"/>	<input type="checkbox"/>	
32. Bowel Frequency of Accidents (Score as below) 7 - No accidents 6 - No accidents; uses device such as an ostomy 5 - One accident in the past 7 days 4 - Two accidents in the past 7 days 3 - Three accidents in the past 7 days 2 - Four accidents in the past 7 days 1 - Five or more accidents in the past 7 days <i>Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
33. Tub Transfer	<input type="checkbox"/>	<input type="checkbox"/>	
34. Shower Transfer (Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) <i>See training manual for scoring of Item 39K (Tub/Shower Transfer)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
35. Distance Walked	<input type="checkbox"/>	<input type="checkbox"/>	
36. Distance Traveled in Wheelchair (Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 - activity does not occur)	<input type="checkbox"/>	<input type="checkbox"/>	
37. Walk	<input type="checkbox"/>	<input type="checkbox"/>	
38. Wheelchair (Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) <i>See training manual for scoring of Item 39L (Walk/Wheelchair)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
SELF-CARE			
A. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Dressing - Upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Dressing - Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPHINCTER CONTROL			
G. Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRANSFERS			
I. Bed, Chair, Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Tub, Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LOCOMOTION			
L. Walk/Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION			
N. Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOCIAL COGNITION			
P. Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R. Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FIM LEVELS			
<i>No Helper</i>			
7	Complete Independence (Timely, Safely)		
6	Modified Independence (Device)		
<i>Helper - Modified Dependence</i>			
5	Supervision (Subject = 100%)		
4	Minimal Assistance (Subject = 75% or more)		
3	Moderate Assistance (Subject = 50% or more)		
<i>Helper - Complete Dependence</i>			
2	Maximal Assistance (Subject = 25% or more)		
1	Total Assistance (Subject less than 25%)		
0	Activity does not occur; Use this code only at admission		

* The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. ©1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.

Discharge Information*	Therapy Information																																																												
<p>40. Discharge Date ____/____/____ MM / DD / YYYY</p> <p>41. Patient discharged against medical advice? _____ (0 - No; 1 - Yes)</p> <p>42. Program Interruption(s) _____ (0 - No; 1 - Yes)</p> <p>43. Program Interruption Dates (Code only if item 42 is 1 - Yes)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>A. 1st Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> <td style="width: 50%; vertical-align: top;"> <p>B. 1st Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p>C. 2nd Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> <td style="vertical-align: top;"> <p>D. 2nd Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> </tr> <tr> <td style="vertical-align: top;"> <p>E. 3rd Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> <td style="vertical-align: top;"> <p>F. 3rd Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p> </td> </tr> </table> <p>44C. Was the patient discharged alive? _____ (0 - No; 1 - Yes)</p> <p>44D. Patient's discharge destination/living setting, using codes below: (answer only if 44C = 1; if 44C = 0, skip to item 46)</p> <p style="font-size: small; margin-left: 20px;">(01 - Home (private home/apt., board/care, assisted living, group home, transitional living); 02 - Short-term General Hospital; 03 - Skilled Nursing Facility (SNF); 04 - Intermediate care; 06 - Home under care of organized home health service organization; 50 - Hospice (home); 51 - Hospice (institutional facility); 61 - Swing bed; 62 - Another Inpatient Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility; 66 - Critical Access Hospital; 99 - Not Listed)</p> <p>45. Discharge to Living With _____ (Code only if item 44C is 1 - Yes and 44D is 01 - Home; Code using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other)</p> <p>46. Diagnosis for Interruption or Death _____ (Code using ICD code)</p> <p>47. Complications during rehabilitation stay (Use ICD codes to specify up to six conditions that began with this rehabilitation stay)</p> <table style="width: 100%; border: none; margin-top: 10px;"> <tr> <td style="width: 50%;">A. _____</td> <td style="width: 50%;">B. _____</td> </tr> <tr> <td>C. _____</td> <td>D. _____</td> </tr> <tr> <td>E. _____</td> <td>F. _____</td> </tr> </table>	<p>A. 1st Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>B. 1st Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>C. 2nd Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>D. 2nd Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>E. 3rd Interruption Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	<p>F. 3rd Return Date <input style="width: 100%; height: 20px;" type="text"/> MM / DD / YYYY</p>	A. _____	B. _____	C. _____	D. _____	E. _____	F. _____	<p>O0401. Week 1: Total Number of Minutes Provided</p> <p>O0401A: Physical Therapy</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0401B: Occupational Therapy</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0401C: Speech-Language Pathology</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0402. Week 2: Total Number of Minutes Provided</p> <p>O0402A: Physical Therapy</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0402B: Occupational Therapy</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. Total minutes of group therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>d. Total minutes of co-treatment therapy</td><td style="text-align: right;">_____</td></tr> </table> <p>O0402C: Speech-Language Pathology</p> <table style="width: 100%; border: none;"> <tr><td>a. Total minutes of individual therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>b. Total minutes of concurrent therapy</td><td style="text-align: right;">_____</td></tr> <tr><td>c. 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* The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. © 1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.

Patient _____ Identifier _____ Date _____

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

QUALITY INDICATORS

ADMISSION

Section B Hearing, Speech, and Vision

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

- | | |
|---|--|
| Enter Code
<input style="width: 100%;" type="text"/> | <p>Expression of Ideas and Wants (consider both verbal and non-verbal expression and excluding language barriers)</p> <ol style="list-style-type: none"> 4. Expresses complex messages without difficulty and with speech that is clear and easy to understand 3. Exhibits some difficulty with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear 2. Frequently exhibits difficulty with expressing needs and ideas 1. Rarely/Never expresses self or speech is very difficult to understand |
|---|--|

BB0800. Understanding Verbal Content (3-day assessment period)

- | | |
|---|---|
| Enter Code
<input style="width: 100%;" type="text"/> | <p>Understanding Verbal Content (with hearing aid or device, if used and excluding language barriers)</p> <ol style="list-style-type: none"> 4. Understands: Clear comprehension without cues or repetitions 3. Usually Understands: Understands most conversations, but misses some part/intent of message. Requires cues at times to understand 2. Sometimes Understands: Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand 1. Rarely/Never Understands |
|---|---|

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be conducted? (3-day assessment period)

Attempt to conduct interview with all patients.

- | | |
|---|--|
| Enter Code
<input style="width: 100%;" type="text"/> | <ol style="list-style-type: none"> 0. No (patient is rarely/never understood) → <i>Skip to C0900. Memory/Recall Ability</i> 1. Yes → <i>Continue to C0200. Repetition of Three Words</i> |
|---|--|

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue and bed**. Now tell me the three words."

- | | |
|---|--|
| Enter Code
<input style="width: 100%;" type="text"/> | <p>Number of words repeated by patient after first attempt:</p> <ol style="list-style-type: none"> 3. Three 2. Two 1. One 0. None |
|---|--|

After the patient's first attempt say: "I will repeat each of the three words with a cue and ask you about them later: *sock, something to wear; blue, a color; bed, a piece of furniture.*" You may repeat the words up to two more times.

Patient _____

Identifier _____

Date _____

Section C**Cognitive Patterns****Brief Interview for Mental Status (BIMS) - Continued****C0300. Temporal Orientation: Year, Month, Day**

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

C0400. Recall

Enter Code <input type="checkbox"/>	<p>Ask patient: "Let's go back to the first question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word.</p> <p>A. Recalls "sock?" 2. Yes, no cue required 1. Yes, after cueing ("something to wear") 0. No, could not recall</p>
Enter Code <input type="checkbox"/>	<p>B. Recalls "blue?" 2. Yes, no cue required 1. Yes, after cueing ("a color") 0. No, could not recall</p>
Enter Code <input type="checkbox"/>	<p>C. Recalls "bed?" 2. Yes, no cue required 1. Yes, after cueing ("a piece of furniture") 0. No, could not recall</p>

C0500. BIMS Summary Score

Enter Score <input type="text"/>	<p>Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview</p>
-------------------------------------	--

C0600. Should the Staff Assessment for Mental Status (C0900) be Conducted?

Enter Code <input type="checkbox"/>	<p>0. No (patient was able to complete Brief Interview for Mental Status) → <i>Skip to GG0100. Prior Functioning: Everyday Activities</i> 1. Yes (patient was unable to complete Brief Interview for Mental Status) → <i>Continue to C0900. Memory/Recall Ability</i></p>
--	---

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed.

C0900. Memory/Recall Ability

↓ Check all that the patient was normally able to recall

<input type="checkbox"/>	A. Current season
<input type="checkbox"/>	B. Location of own room
<input type="checkbox"/>	C. Staff names and faces
<input type="checkbox"/>	E. That he or she is in a hospital/hospital unit
<input type="checkbox"/>	Z. None of the above were recalled

Patient _____

Identifier _____

Date _____

Section GG**Functional Abilities and Goals**

GG0100. Prior Functioning: Everyday Activities. Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. 2. Needed Some Help - Patient needed partial assistance from another person to complete activities. 1. Dependent - A helper completed the activities for the patient. 8. Unknown 9. Not Applicable	↓	Enter Codes in Boxes
	<input type="checkbox"/>	A. Self-Care: Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
	<input type="checkbox"/>	B. Indoor Mobility (Ambulation): Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	<input type="checkbox"/>	C. Stairs: Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	<input type="checkbox"/>	D. Functional Cognition: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓	Check all that apply
<input type="checkbox"/>	A. Manual wheelchair
<input type="checkbox"/>	B. Motorized wheelchair or scooter
<input type="checkbox"/>	C. Mechanical lift
<input type="checkbox"/>	D. Walker
<input type="checkbox"/>	E. Orthotics/Prosthetics
<input type="checkbox"/>	Z. None of the above

Patient _____

Identifier _____

Date _____

Section GG

Functional Abilities and Goals

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

- 07. **Patient refused**
- 09. **Not applicable**
- 88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
<input type="text"/>	<input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
<input type="text"/>	<input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="text"/>	<input type="text"/>	E. Shower/bathe self: The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
<input type="text"/>	<input type="text"/>	F. Upper body dressing: The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
<input type="text"/>	<input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/>	<input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

- 07. **Patient refused**
- 09. **Not applicable**
- 88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back.
<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="text"/>	<input type="text"/>	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
<input type="text"/>	<input type="text"/>	<p>H1. Does the patient walk?</p> <p>0. No, and walking goal is not clinically indicated → <i>Skip to GG0170Q1. Does the patient use a wheelchair/scooter?</i></p> <p>1. No, and walking goal is clinically indicated → <i>Code the patient's discharge goal(s) for items GG0170I, J, K, L, M, N, O, and P. For admission performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter?</i></p> <p>2. Yes → <i>Continue to GG0170I. Walk 10 feet</i></p>
<input type="text"/>	<input type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.
<input type="text"/>	<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section GG Functional Abilities and Goals

GG0170. Mobility (3-day assessment period) - Continued

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code the reason:

- 07. **Patient refused**
- 09. **Not applicable**
- 88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
<input type="text"/>	<input type="text"/>	M. 1 step (curb): The ability to step over a curb or up and down one step.
<input type="text"/>	<input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail.
<input type="text"/>	<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	<input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="text"/>	<input type="text"/>	Q1. Does the patient use a wheelchair/scooter? 0. No → Skip to H0350. Bladder Continence 1. Yes → Continue to GG0170R. Wheel 50 feet with two turns
<input type="text"/>	<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	RR1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
<input type="text"/>	<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="text"/>	<input type="text"/>	SS1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

Patient _____

Identifier _____

Date _____

Section H**Bladder and Bowel****H0350. Bladder Continence (3-day assessment period)**

Enter Code

Bladder continence - Select the one category that best describes the patient.

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

H0400. Bowel Continence (3-day assessment period)

Enter Code

Bowel continence - Select the one category that best describes the patient.

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

Section I**Active Diagnoses****Comorbidities and Co-existing Conditions****Check all that apply****I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)****I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)**I7900. None of the above****Section J****Health Conditions****J1750. History of Falls**

Enter Code

Has the patient had two or more falls in the past year or any fall with injury in the past year?

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

J2000. Prior Surgery

Enter Code

Did the patient have major surgery during the 100 days prior to admission?

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

Section K**Swallowing/Nutritional Status****K0110. Swallowing/Nutritional Status (3-day assessment period)** Indicate the patient's usual ability to swallow.**Check all that apply****A. Regular food** - Solids and liquids swallowed safely without supervision or modified food or liquid consistency.**B. Modified food consistency/supervision** - Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.**C. Tube/parenteral feeding** - Tube/parenteral feeding used wholly or partially as a means of sustenance.

Patient _____

Identifier _____

Date _____

Section M**Skin Conditions**

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcer(s)

Enter Code	<input type="checkbox"/> Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 0. No → Skip to O0100. Special Treatments, Procedures, and Programs 1. Yes → Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage
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M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number	A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Number of Stage 1 pressure ulcers
Enter Number	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. 1. Number of Stage 2 pressure ulcers
Enter Number	C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. 1. Number of Stage 3 pressure ulcers
Enter Number	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. 1. Number of Stage 4 pressure ulcers
Enter Number	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device
Enter Number	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar
Enter Number	G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution

Section O**Special Treatments, Procedures, and Programs****O0100. Special Treatments, Procedures, and Programs**

↓	Check if treatment applies at admission
<input type="checkbox"/>	N. Total Parenteral Nutrition

Patient _____

Identifier _____

Date _____

DISCHARGE

Section GG

Functional Abilities and Goals

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code the reason:

- 07. **Patient refused**
- 09. **Not applicable**
- 88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input style="width: 50px; height: 20px;" type="text"/>	A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
<input style="width: 50px; height: 20px;" type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
<input style="width: 50px; height: 20px;" type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
<input style="width: 50px; height: 20px;" type="text"/>	E. Shower/bathe self: The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
<input style="width: 50px; height: 20px;" type="text"/>	F. Upper body dressing: The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
<input style="width: 50px; height: 20px;" type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input style="width: 50px; height: 20px;" type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

Patient _____

Identifier _____

Date _____

Section GG

Functional Abilities and Goals

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code the reason:

- 07. **Patient refused**
- 09. **Not applicable**
- 88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
[]	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back.
[]	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
[]	C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
[]	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
[]	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
[]	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
[]	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
[]	H3. Does the patient walk? 0. No → Skip to GG0170Q3. Does the patient use a wheelchair/scooter? 2. Yes → Continue to GG0170I. Walk 10 feet
[]	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space
[]	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns
[]	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space

Patient _____

Identifier _____

Date _____

Section GG**Functional Abilities and Goals****GG0170. Mobility** (3-day assessment period) - Continued

Code the patient's usual performance at discharge for each activity using the 6-point scale. If activity was not attempted at discharge, code the reason.

CODING:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code the reason:

07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
<input type="text"/>	M. 1 step (curb): The ability to step over a curb or up and down one step.
<input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail.
<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="text"/>	Q3. Does the patient use a wheelchair/scooter? 0. No → Skip to J1800. Any Falls Since Admission 1. Yes → Continue to GG0170R. Wheel 50 feet with two turns
<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="text"/>	RR3. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="text"/>	SS3. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

Patient _____

Identifier _____

Date _____

Section J**Health Conditions****J1800. Any Falls Since Admission**

Enter Code <input type="checkbox"/>	Has the patient had any falls since admission ?
	0. No → Skip to M0210. Unhealed Pressure Ulcer(s)
	1. Yes → Continue to J1900. Number of Falls Since Admission

J1900. Number of Falls Since Admission

CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	<input type="checkbox"/>	A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	<input type="checkbox"/>	B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	<input type="checkbox"/>	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section M**Skin Conditions**

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcer(s)

Enter Code <input type="checkbox"/>	Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
	0. No → Skip to M0900A. Healed Pressure Ulcer(s)
	1. Yes → Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number <input type="checkbox"/>	A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Number of Stage 1 pressure ulcers
Enter Number <input type="checkbox"/>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. 1. Number of Stage 2 pressure ulcers <i>If 0</i> → Skip to M0300C. Stage 3 2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission - enter how many were noted at the time of admission
Enter Number <input type="checkbox"/>	
Enter Number <input type="checkbox"/>	C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. 1. Number of Stage 3 pressure ulcers <i>If 0</i> → Skip to M0300D. Stage 4 2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission - enter how many were noted at the time of admission
Enter Number <input type="checkbox"/>	

Patient _____

Identifier _____

Date _____

Section M

Skin Conditions

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued

Enter Number <input type="text"/>	<p>D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</p> <p>1. Number of Stage 4 pressure ulcers <i>If 0 → Skip to M0300E. Unstageable - Non-removable dressing</i></p> <p>2. Number of these Stage 4 pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>
Enter Number <input type="text"/>	<p>E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers due to non-removable dressing/device <i>If 0 → Skip to M0300F. Unstageable - Slough and/or eschar</i></p> <p>2. Number of these unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>
Enter Number <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar <i>If 0 → Skip to M0300G. Unstageable - Deep tissue injury</i></p> <p>2. Number of these unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>
Enter Number <input type="text"/>	<p>G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution</p> <p>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution <i>If 0 → Skip to M0800. Worsening in Pressure Ulcer Status Since Admission</i></p> <p>2. Number of these unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>

M0800. Worsening in Pressure Ulcer Status Since Admission

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission.
 If no current pressure ulcer at a given stage, enter 0.

Enter Number <input type="text"/>	A. Stage 2
Enter Number <input type="text"/>	B. Stage 3
Enter Number <input type="text"/>	C. Stage 4
Enter Number <input type="text"/>	D. Unstageable - Non-removable dressing
Enter Number <input type="text"/>	E. Unstageable - Slough and/or eschar
Enter Number <input type="text"/>	F. Unstageable - Deep tissue injury

Patient _____

Identifier _____

Date _____

Section M**Skin Conditions****M0900. Healed Pressure Ulcer(s)**

Indicate the number of pressure ulcers that were: (a) present on **Admission**; and (b) have completely closed (resurfaced with epithelium) upon **Discharge**. If there are no healed pressure ulcers noted at a given stage, enter 0.

Enter Number

A. Stage 1

Enter Number

B. Stage 2

Enter Number

C. Stage 3

Enter Number

D. Stage 4**Section O****Special Treatments, Procedures, and Programs****O0250. Influenza Vaccine - Refer to current version of IRF-PAI Training Manual for current influenza vaccination season and reporting period.**

Enter Code

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

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

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

M M D D Y Y Y Y

Enter Code

C. If influenza vaccine not received, state reason:

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

Item Z0400A. Signature of Persons Completing the Assessment*

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that patients receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.

Signature	Title	Date Information is Provided	Time
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

APPENDIX B FY 2017 IRF PPS CMGS AND PAYMENT WEIGHTS

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weight			
		Tier 1	Tier 2	Tier 3	None
0101	Stroke M > 51.05	0.7992	0.7117	0.6511	0.6215
0102	Stroke M > 44.45 and M < 51.05 and C > 18.5	1.0130	0.9020	0.8252	0.7877
0103	Stroke M > 44.45 and M < 51.05 and C < 18.5	1.1836	1.0540	0.9642	0.9204
0104	Stroke M > 38.85 and M < 44.45	1.2598	1.1218	1.0263	0.9796
0105	Stroke M > 34.25 and M < 38.85	1.4572	1.2976	1.1871	1.1331
0106	Stroke M > 30.05 and M < 34.25	1.6296	1.4511	1.3275	1.2671
0107	Stroke M > 26.15 and M < 30.05	1.8187	1.6195	1.4815	1.4142
0108	Stroke M < 26.15 and A > 84.5	2.2893	2.0386	1.8649	1.7801
0109	Stroke M > 22.35 and M < 26.15 and A < 84.5	2.0584	1.8329	1.6768	1.6005
0110	Stroke M < 22.35 and A < 84.5	2.7320	2.4327	2.2255	2.1243
0201	Traumatic brain injury M > 53.35 and C > 23.5	0.7753	0.6341	0.5715	0.5343
0202	Traumatic brain injury M > 44.25 and M < 53.35 and C > 23.5	1.0945	0.8951	0.8067	0.7542
0203	Traumatic brain injury M > 44.25 and C < 23.5	1.2173	0.9955	0.8973	0.8388
0204	Traumatic brain injury M > 40.65 and M < 44.25	1.3455	1.1003	0.9918	0.9272
0205	Traumatic brain injury M > 28.75 and M < 40.65	1.6224	1.3269	1.1959	1.1181
0206	Traumatic brain injury M > 22.05 and M < 28.75	1.9239	1.5734	1.4182	1.3258
0207	Traumatic brain injury M < 22.05	2.5284	2.0678	1.8637	1.7424
0301	Non-traumatic brain injury M > 41.05	1.1424	0.9432	0.8571	0.8002
0302	Non-traumatic brain injury M > 35.05 and M < 41.05	1.4063	1.1610	1.0551	0.9850

(continued)

Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weight			
		Tier 1	Tier 2	Tier 3	None
0303	Non-traumatic brain injury M > 26.15 and M < 35.05	1.6490	1.3614	1.2372	1.1550
0304	Non-traumatic brain injury M < 26.15	2.1336	1.7614	1.6007	1.4944
0401	Traumatic spinal cord injury M > 48.45	0.9799	0.8616	0.7947	0.7213
0402	Traumatic spinal cord injury M > 30.35 and M < 48.45	1.4052	1.2357	1.1396	1.0344
0403	Traumatic spinal cord injury M > 16.05 and M < 30.35	2.2165	1.9492	1.7976	1.6316
0404	Traumatic spinal cord injury M < 16.05 and A > 63.5	3.8702	3.4033	3.1387	2.8489
0405	Traumatic spinal cord injury M < 16.05 and A < 63.5	3.4395	3.0246	2.7894	2.5319
0501	Non-traumatic spinal cord injury M > 51.35	0.8524	0.6715	0.6395	0.5751
0502	Non-traumatic spinal cord injury M > 40.15 and M < 51.35	1.1600	0.9139	0.8703	0.7827
0503	Non-traumatic spinal cord injury M > 31.25 and M < 40.15	1.4557	1.1469	1.0921	0.9822
0504	Non-traumatic spinal cord injury M > 29.25 and M < 31.25	1.7087	1.3462	1.2819	1.1529
0505	Non-traumatic spinal cord injury M > 23.75 and M < 29.25	1.9607	1.5447	1.4709	1.3229
0506	Non-traumatic spinal cord injury M < 23.75	2.7151	2.1391	2.0369	1.8320
0601	Neurological M > 47.75	1.0352	0.8205	0.7577	0.6939
0602	Neurological M > 37.35 and M < 47.75	1.3322	1.0560	0.9751	0.8930
0603	Neurological M > 25.85 and M < 37.35	1.6411	1.3008	1.2012	1.1001
0604	Neurological M < 25.85	2.1752	1.7241	1.5922	1.4581
0701	Fracture of lower extremity M > 42.15	0.9991	0.8136	0.7767	0.7052
0702	Fracture of lower extremity M > 34.15 and M < 42.15	1.2759	1.0390	0.9919	0.9006
0703	Fracture of lower extremity M > 28.15 and M < 34.15	1.5383	1.2527	1.1958	1.0858
0704	Fracture of lower extremity M < 28.15	1.9943	1.6240	1.5503	1.4076

(continued)

Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weight			
		Tier 1	Tier 2	Tier 3	None
0801	Replacement of lower extremity joint M > 49.55	0.7983	0.6443	0.5958	0.5476
0802	Replacement of lower extremity joint M > 37.05 and M < 49.55	1.0333	0.8340	0.7713	0.7089
0803	Replacement of lower extremity joint M > 28.65 and M < 37.05 and A > 83.5	1.3823	1.1156	1.0317	0.9482
0804	Replacement of lower extremity joint M > 28.65 and M < 37.05 and A < 83.5	1.2445	1.0044	0.9289	0.8537
0805	Replacement of lower extremity joint M > 22.05 and M < 28.65	1.4806	1.1949	1.1051	1.0157
0806	Replacement of lower extremity joint M < 22.05	1.7987	1.4517	1.3425	1.2339
0901	Other orthopedic M > 44.75	0.9839	0.7940	0.7356	0.6693
0902	Other orthopedic M > 34.35 and M < 44.75	1.2583	1.0155	0.9408	0.8560
0903	Other orthopedic M > 24.15 and M < 34.35	1.5810	1.2760	1.1821	1.0755
0904	Other orthopedic M < 24.15	2.0014	1.6153	1.4965	1.3615
1001	Amputation, lower extremity M > 47.65	1.0715	0.9448	0.8199	0.7400
1002	Amputation, lower extremity M > 36.25 and M < 47.65	1.3906	1.2261	1.0641	0.9604
1003	Amputation, lower extremity M < 36.25	1.9639	1.7317	1.5029	1.3564
1101	Amputation, non-lower extremity M > 36.35	1.3222	1.1985	0.9739	0.8842
1102	Amputation, non-lower extremity M < 36.35	1.8953	1.7181	1.3961	1.2676
1201	Osteoarthritis M > 37.65	1.0379	1.0241	0.9306	0.8231
1202	Osteoarthritis M > 30.75 and M < 37.65	1.2061	1.1900	1.0813	0.9564
1203	Osteoarthritis M < 30.75	1.5370	1.5165	1.3780	1.2188
1301	Rheumatoid, other arthritis M > 36.35	1.1939	0.9393	0.8690	0.8007
1302	Rheumatoid, other arthritis M > 26.15 and M < 36.35	1.6397	1.2900	1.1935	1.0997
1303	Rheumatoid, other arthritis M < 26.15	2.0215	1.5904	1.4715	1.3558

(continued)

Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weight			
		Tier 1	Tier 2	Tier 3	None
1401	Cardiac M > 48.85	0.8666	0.7324	0.6639	0.6025
1402	Cardiac M > 38.55 and M < 48.85	1.1810	0.9981	0.9047	0.8211
1403	Cardiac M > 31.15 and M < 38.55	1.4079	1.1899	1.0785	0.9788
1404	Cardiac M < 31.15	1.7805	1.5048	1.3640	1.2379
1501	Pulmonary M > 49.25	1.0089	0.8543	0.7888	0.7436
1502	Pulmonary M > 39.05 and M < 49.25	1.2746	1.0793	0.9966	0.9394
1503	Pulmonary M > 29.15 and M < 39.05	1.5543	1.3162	1.2153	1.1456
1504	Pulmonary M < 29.15	1.9370	1.6402	1.5145	1.4276
1601	Pain syndrome M > 37.15	0.9889	0.8933	0.8321	0.7677
1602	Pain syndrome M > 26.75 and M < 37.15	1.2901	1.1654	1.0855	1.0015
1603	Pain syndrome M < 26.75	1.6155	1.4592	1.3592	1.2540
1701	Major multiple trauma without brain or spinal cord injury M > 39.25	1.1345	0.9258	0.8520	0.7671
1702	Major multiple trauma without brain or spinal cord injury M > 31.05 and M < 39.25	1.4253	1.1631	1.0704	0.9637
1703	Major multiple trauma without brain or spinal cord injury M > 25.55 and M < 31.05	1.6987	1.3862	1.2758	1.1486
1704	Major multiple trauma without brain or spinal cord injury M < 25.55	2.1821	1.7806	1.6387	1.4753
1801	Major multiple trauma with brain or spinal cord injury M > 40.85	1.2932	1.0595	0.9203	0.8254
1802	Major multiple trauma with brain or spinal cord injury M > 23.05 and M < 40.85	1.8234	1.4939	1.2976	1.1639
1803	Major multiple trauma with brain or spinal cord injury M < 23.05	2.8692	2.3507	2.0419	1.8314

(continued)

Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weight			
		Tier 1	Tier 2	Tier 3	None
1901	Guillain-Barré M > 35.95	1.2267	1.0516	0.9270	0.9134
1902	Guillain-Barré M > 18.05 and M < 35.95	2.2288	1.9106	1.6843	1.6595
1903	Guillain-Barré M < 18.05	3.6684	3.1447	2.7722	2.7315
2001	Miscellaneous M > 49.15	0.9225	0.7562	0.6942	0.6285
2002	Miscellaneous M > 38.75 and M < 49.15	1.2097	0.9916	0.9104	0.8241
2003	Miscellaneous M > 27.85 and M < 38.75	1.5124	1.2397	1.1381	1.0303
2004	Miscellaneous M < 27.85	1.9412	1.5912	1.4608	1.3224
2101	Burns M > 0	1.6899	1.6899	1.5061	1.3813
5001	Short-stay cases, length of stay is 3 days or fewer				0.1585
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.6785
5102	Expired, orthopedic, length of stay is 14 days or more				1.6606
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.8002
5104	Expired, not orthopedic, length of stay is 16 days or more				2.1200

SOURCE: Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2017; Final Rule

**APPENDIX C
STANDARDIZED PATIENT ASSESSMENT DATA ELEMENTS AND
FUNCTIONAL INDEPENDENCE MEASURE (FIM™) ITEM
DESCRIPTIVES**

C.1 Standardized Patient Assessment Data Elements

Motor Score—Section GG (Range 19-110)	Mean	SD
Motor Score	55.67	15.03

Motor Items—Section GG	1	2	3	4	5	6	7	9	88	Missing
GG0130A1 Admission Performance Eating Code	10,180	7,178	16,989	50,359	163,663	111,143	1,399	1,884	6,785	104
GG0130B1 Admission Performance Oral Hygiene Code	11,005	12,726	36,989	93,243	176,790	23,901	6,815	1,470	6,599	146
GG0130C1 Admission Performance Toileting Hygiene Code	81,419	76,108	78,924	82,657	16,803	11,270	6,526	3,886	11,929	162
GG0130E1 Admission Performance Bathing Code	32,976	70,887	155,658	63,141	11,694	2,042	11,320	2,029	19,739	198
GG0130F1 Admission Performance Upper Body Dressing Code	25,222	49,208	104,669	80,574	93,727	6,133	2,975	1,937	5,108	131
GG0130G1 Admission Performance Lower Body Dressing Code	93,729	113,112	86,094	55,264	10,063	2,314	2,831	1,225	4,944	108
GG0130H1 Admission Performance Footwear Code	136,442	90,045	55,574	43,569	25,271	3,874	3,195	2,733	8,839	142
GG0170A1 Admission Performance Roll Left Right Code	18,475	43,112	105,366	125,287	16,165	40,960	2,625	1,528	16,043	123
GG0170B1 Admission Performance Sit to Lying Code	26,618	56,044	125,627	116,574	12,631	22,032	1,742	1,221	7,085	110
GG0170C1 Admission Performance Lying to Sit Code	26,010	61,107	129,052	112,372	11,751	20,675	1,580	930	6,094	113
GG0170D1 Admission Performance Sit to Stand Code	33,395	51,866	151,672	107,986	4,247	3,899	1,303	1,796	13,414	106

(continued)

Motor Items—Section GG	1	2	3	4	5	6	7	9	88	Missing
GG0170E1 Admission Performance Chair/Bed to Chair Transfer Code	46,654	61,450	153,636	94,205	3,587	2,349	1,100	434	6,168	101
GG0170F1 Admission Performance Toilet Transfer Code	43,489	53,221	132,413	92,052	4,757	3,173	6,981	5,563	27,857	178
GG0170I1 Admission Performance Walk 10 Feet Code	30,319	15,017	114,184	111,677	2,777	1,945	1,878	730	30,889	60,268
GG0170J1 Admission Performance Walk 50 Feet Code	16,068	4,934	68,414	87,348	2,333	1,455	3,626	2,932	122,284	60,290
GG0170K1 Admission Performance Walk 150 Feet Code	13,010	2,454	25,706	47,509	1,759	1,212	5,040	6,414	206,249	60,331
GG0170M1 Admission Performance 1 Step Code	11,267	8,489	63,215	49,161	1,034	827	5,631	6,057	163,673	60,330

Bowel and Bladder—Section H	0	1	2	3	4	5	9	Missing
H0350 Urinary Continence Code	211,108	18,445	48,263	36,816	22,182	4,601	28,218	51
H0400 Bowel Continence Code	270,598	36,257	20,207	22,515			20,058	49

The findings and conclusions of this report are those of the authors and do not necessarily represent the views of HHS.

Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System

BIMS (Memory)—Section C (Range 1-15)	Mean	SD	Not Completed	Missing
C0500 Brief Interview for Mental Status (BIMS) Score Number	12.55	3.27	5,995	21,232

BIMS (Memory) Staff Assessment—Section C	0	1	Missing
C0900A Staff Assessment of Mental Status—Recalls Current Season Code	17,768	8,785	343,131
C0900B Staff Assessment of Mental Status—Recalls Location of Room Code	20,592	5,929	343,163
C0900C Staff Assessment of Mental Status—Recalls Staff Name Code	20,445	6,081	343,158
C0900E Staff Assessment of Mental Status—Recalls Hospital Code	13,812	12,760	343,112
C0900Z Staff Assessment of Mental Status—Recalls None of Above Code	14,332	12,246	343,106

Communication—Section B	1	2	3	4	Missing
BB0700 Expression Idea Want Code: Admission	9,958	30,616	135,731	193,085	294
BB0800 Understands Other Code: Admission	6,109	34,438	140,227	188,616	294

C.2 FIM™ Items Used in IRF PPS

	FIM™ Motor Score (Range 12-84)	Mean	SD
Motor Score		28.49	10.51

Motor Items—FIM™	0	1	2	3	4	5	6	7
39AA Self-Care—Eating: Admission	1,021	26,806	8,153	11,199	35,352	228,168	30,599	28,386
39BA Self-Care—Grooming: Admission	3,012	47,328	20,295	38,797	95,135	158,424	3,784	2,909
39CA Self-Care—Bathing: Admission	16,171	77,467	54,276	105,412	90,398	24,878	822	260
39DA Self-Care—Dressing Upper: Admission	6,635	79,592	38,116	56,033	93,789	93,017	1,354	1,148
39EA Self-Care—Dressing Lower: Admission	4,875	184,126	66,535	49,023	52,041	12,452	418	214
39FA Self-Care—Toileting: Admission	6,346	163,188	62,673	51,008	68,045	16,440	1,470	514
39GA Sphincter Control—Bladder: Admission	0	162,376	25,971	27,395	30,540	74,725	23,730	24,947
39HA Sphincter Control—Bowel: Admission	0	104,714	24,866	24,176	27,834	52,644	114,942	20,508
39IA Transfers—Bed	1,629	120,184	72,728	93,464	75,480	5,710	372	117
39JA Transfers—Toilet: Admission	15,549	92,125	67,168	87,943	96,906	9,123	734	136
39LA Locomotion—Walk/Wheelchair: Admission	23,546	188,194	96,513	5,428	40,907	13,157	1,753	186
39MA Locomotion—Stairs: Admission	196,179	64,639	84,144	1,768	17,376	5,008	518	52

	FIM™ Cognitive Score (Range 5-35)	Mean	SD
Cognitive Score		22.01	6.92

Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System

Cognitive Items— FIM™	0	1	2	3	4	5	6	7
39NA Communication— Comprehension: Admission	0	11,240	24,796	46,992	74,901	106,330	81,576	23,849
39OA Communication— Expression: Admission	0	14,032	24,118	41,992	67,800	102,693	79,842	39,207
39PA Social Cognition— Social Interaction: Admission	0	11,580	19,398	36,369	61,581	105,840	93,091	41,825
39QA Social Cognition— Problem Solving: Admission	0	30,458	42,706	67,411	86,965	90,453	38,101	13,590
39RA Social Cognition— Memory: Admission	0	25,301	43,400	65,063	80,412	87,672	48,826	19,010