

Date: April 13, 2012

To: National Quality Forum (NQF)

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Subject: Review of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678) for expansion to the Long-Term Care Hospital and Inpatient Rehabilitation Facility Settings

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The purpose of this memo is to transmit a formal request from CMS to NQF to initiate the review process for NQF #0678: Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay) to expand this nursing home quality measure to the Long-Term Care Hospital (LTCH) and Inpatient Rehabilitation Facility (IRF) settings, in order to harmonize measures across these three post-acute care settings.

The nursing home measure is a time limited endorsed measure, which is being submitted to NQF on April 13, 2012 for review for full endorsement. This request for expansion to the LTCH and IRF settings is being submitted **concurrently** with the request for full endorsement of the measure in the nursing home setting. It is our understanding that the NQF review panel's decision regarding full endorsement of this measure will be made independently from and will not be affected by the request for expansion of this measure to the LTCH and IRF settings.

This form was developed by CMS and RTI International, the CMS contractor for two measure development projects: (1) Development and Maintenance of Symptom Management Measures contract to implement the Affordable Care Act, Section 3004: Development of Quality Reporting Program for Long-Term Care Hospitals, Inpatient Rehabilitation Facilities and Hospice Programs and (2) Nursing Home Quality Measures contract to support the maintenance and development of quality measures for the Nursing Home Compare.

The information below supplements the NQF form and hence, CMS requests that NQF includes this memo in the packet available to panel members during the review of this measure.

1. For question D of the Conditions section, which asks if the measure has been fully specified and tested for reliability and validity, we have selected: *Untested, but NQF staff approved submission*. While these measures have been tested in the nursing home setting (as detailed in the application), they have not been specifically tested in the LTCH and IRF setting and hence, the selection of this response.
2. In the Importance section, an answer was selected (1c.25 1c.26, and 1c.27), because the NQF submission process does not allow for these questions to be left blank. However, the evidence has not been graded or rated for quantity, quality and consistency.
3. As outlined in the submission form (Measure Specifications section ), the items used to calculate new or worsened pressure ulcer in the LTCH and IRF setting assessments are identical to the MDS 3.0 items for this measure. The measure specifications for each setting identify and note the relevant item names and numbers in each setting's assessment instrument(s) (See Appendix A and Appendix B).
4. RTI and CMS have used item-level reliability for pressure ulcer items from the MDS 3.0 testing and development as evidence for expansion to LTCH and IRF settings, and noted that the data items will be identical across the three post-acute care settings.
5. For the risk adjustment covariates, RTI and CMS have used item-level reliability from the MDS 3.0 and analysis from the CARE data assessment. While the language of the items used for risk adjustment for this measure across the MDS 3.0, LTCH CARE Data set and IRF-PAI are not identical (See Appendix A and Appendix B), analysis of the MDS 3.0 and CARE items suggest that these covariates are relevant risk factors for new and worsening pressure ulcers across the three settings.
6. The items for the functional status/mobility covariate listed in question 2a1.13 of the form are not identical across the three settings. However, the information collected through these items is similar across the three data collection tools (See Appendix A and Appendix B).
7. The covariate for diabetes and peripheral vascular diseases listed in question 2a1.13 of the form is similar for nursing home and LTCH settings. For the MDs 3.0 and LTCH CARE data set, a check box (yes/no) is provided for diabetes and peripheral vascular disease. However, on the IRF-PAI, IRFs list up to 10 ICD-9-CM codes that are comorbidities. In the updated IRF-PAI Training Manual, users are instructed to report any ICD-9-CM codes indicating diabetes or peripheral vascular disease. For the purpose of the measure calculation, data for the diabetes/peripheral vascular disease covariate will be derived from the list of ICD-9-CM codes identified as relevant (See Appendix C).

8. The covariate for bowel incontinence listed in question 2a1.13 of the form is similar for nursing home and LTCH settings. The covariate for bowel incontinence listed is not the same in the IRF-PAI as for the other two settings. The item in the IRF-PAI reflects the same information as the item in the MDS 3.0 and LTCH CARE data set (See Appendix A and Appendix B).
9. Enclosed are Appendices A-D for NQF #0678: Percent of Residents or Patients who Have Pressure Ulcers That Are New or Worsened (Short-Stay).

# **APPENDIX A**

## **SELECT MDS 3.0 ITEMS**

## Section A Administrative Information

### A0310. Type of Assessment

Enter Code <input type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 01. <b>Admission</b> assessment (required by day 14) 02. <b>Quarterly</b> review assessment 03. <b>Annual</b> assessment 04. <b>Significant change in status</b> assessment 05. <b>Significant correction</b> to <b>prior comprehensive</b> assessment 06. <b>Significant correction</b> to <b>prior quarterly</b> assessment 99. <b>Not OBRA required</b> assessment
Enter Code <input type="text"/>	<b>B. PPS Assessment</b> <b>PPS Scheduled Assessments for a Medicare Part A Stay</b> 01. <b>5-day</b> scheduled assessment 02. <b>14-day</b> scheduled assessment 03. <b>30-day</b> scheduled assessment 04. <b>60-day</b> scheduled assessment 05. <b>90-day</b> scheduled assessment 06. <b>Readmission/return</b> assessment <b>PPS Unscheduled Assessments for a Medicare Part A Stay</b> 07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant correction assessment) <b>Not PPS Assessment</b> 99. <b>Not PPS</b> assessment
Enter Code <input type="text"/>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> record 10. <b>Discharge</b> assessment- <b>return not anticipated</b> 11. <b>Discharge</b> assessment- <b>return anticipated</b> 12. <b>Death in facility</b> record 99. <b>Not entry/discharge</b> record

## Section M Skin Conditions

### M0800. Worsening in Pressure Ulcer Status Since Prior Assessment

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

Enter Number <input type="text"/>	<b>A. Stage 2</b>
Enter Number <input type="text"/>	<b>B. Stage 3</b>
Enter Number <input type="text"/>	<b>C. Stage 4</b>

# Covariate Items

## Section G

## Functional Status

### G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

#### Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

**If none of the above are met, code supervision.**

#### 1. ADL Self-Performance

Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

#### Coding:

##### Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

##### Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

**1.  
Self-Performance**

Enter Code in Box



**A. Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture

## Section H

## Bladder and Bowel

### H0400. Bowel Continence

Enter Code

**Bowel continence** - Select the one category that best describes the resident

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**, resident had an ostomy or did not have a bowel movement for the entire 7 days

## Section I Active Diagnoses

### Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

<input type="checkbox"/>	<b>Heart/Circulation</b>																		
<input type="checkbox"/>	<b>I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)</b>																		
<input type="checkbox"/>	<b>Metabolic</b>																		
<input type="checkbox"/>	<b>I2900. Diabetes Mellitus (DM)</b> (e.g., diabetic retinopathy, nephropathy, and neuropathy)																		
<input type="checkbox"/>	<b>Other</b>																		
<input type="checkbox"/>	<b>I8000. Additional active diagnoses</b>																		
	Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.																		
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## Section K Swallowing/Nutritional Status

**K0200. Height and Weight** - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

<table border="1"> <tr> <td></td> <td></td> </tr> </table> inches			<b>A. Height</b> (in inches). Record most recent height measure since admission	
<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table> pounds				<b>B. Weight</b> (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)



## SELECT LTCH CARE DATA SET ITEMS

<b>Section A</b>	<b>Administrative Information</b>
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<b>A0250. Reason for Assessment</b>
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Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px 0;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px 0;"></div>	01. <b>Admission</b> 10. <b>Planned discharge</b> 11. <b>Unplanned discharge</b> 12. <b>Expired</b>
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<b>Section M</b>	<b>Skin Conditions</b>
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<b>M0800. Worsening in Pressure Ulcer Status Since Prior Assessment</b>
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Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment.  
 If no current pressure ulcer at a given stage, enter 0

Enter Number <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px 0;"></div>	<b>A. Stage 2</b>
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Enter Number <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px 0;"></div>	<b>B. Stage 3</b>
--	-------------------

Enter Number <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px 0;"></div>	<b>C. Stage 4</b>
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## Covariate Items

### Section GG

### Functional Status: Usual Performance

#### GG0160. Functional Mobility

(Complete during the 3-day assessment period.)

Code the patient's usual performance using the 6-point scale below.

##### 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 task.

07. **Patient refused**

09. **Not applicable**

**If activity was not attempted, code:**

88. Not attempted due to **medical condition or safety concerns**



Enter Code in Box

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**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, no back support.

### Section H

### Bladder and Bowel

#### H0400. Bowel Continence

Enter Code

--

**Bowel continence** - Select the one category that best describes the resident

- 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**, resident had an ostomy or did not have a bowel movement for the entire 7 days

### Section I

### Active Diagnoses

#### Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Heart/Circulation	
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
Metabolic	
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)

## Section K

## Swallowing/Nutritional Status

**K0200. Height and Weight** - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

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inches

**A. Height** (in inches). Record most recent height measure since admission

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pounds

**B. Weight** (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

## **SELECT IRF-PAI ITEMS**

Worsening in Pressure Ulcer Status Since Admission  
 Indicate the number of current pressure ulcers that were not present or were at a lesser stage at admission. If no current pressure ulcer at a given stage, enter 0.

49A. Stage 2. Enter Number: \_\_\_\_\_

49B. Stage 3. Enter Number: \_\_\_\_\_

49C. Stage 4. Enter Number: \_\_\_\_\_

### 39. FIM™ Instrument\*

ADMISSION DISCHARGE GOAL

#### TRANSFERS

I. Bed, Chair, Whlchair

☐
☐
☐

ADMISSION DISCHARGE

31. Bowel Level of Assistance  
 (Score using FIM Levels 1 - 7)

☐
☐

- 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

2. Patient Medicare Number \_\_\_\_\_

### Medical Information\*

24. Comorbid Conditions; Use ICD-9-CM codes to enter up to ten medical conditions

A. \_\_\_\_\_ B. \_\_\_\_\_

C. \_\_\_\_\_ D. \_\_\_\_\_

E. \_\_\_\_\_ F. \_\_\_\_\_

G. \_\_\_\_\_ H. \_\_\_\_\_

I. \_\_\_\_\_ J. \_\_\_\_\_

Appendix B: Pressure Ulcer Data Elements for NH SS PU Measure (NQF #0678) Specifications for MDS 3.0, LTCH CARE Data Set and IRF-PAI			
	MDS 3.0	LTCH CARE Data Set	IRF PAI
Population	All payers	All payers	Medicare (FFS and Managed care) only
Assessment time frame	Reference date of target assessment (items are assessed in the past 7 days) looking back to reference date of prior assessment (items are assessed in past 7 days).	Admission: 3 calendar days with admission day as day 1. Discharge: 3 calendar days, including day of discharge.	Admission: 3 calendar days with admission day as day 1 Discharge: 3 calendar days, including day of discharge. Bowel accidents does include 7 days, but is supposed to include 4 days before IRF admit date and is often challenging data to get.
Time Window for QM calculation	Data is selected for every quarter (3-month period) from the applicable MDS 3.0 assessments from each facility which occurred during the quarter. For patients or residents with more than one admission during the quarter only the last admission will be counted.	Data is selected for every quarter (3-month period) from the applicable LTCH CARE assessments from each facility which occurred during the quarter.	Data is selected for every quarter (3-month period) from the applicable IRF PAI assessments from each facility which occurred during the quarter
Numerator			
Numerator Details	The number of short-stay residents for which a look back scan indicates one or more new or worsening stage 2-4 pressure ulcers: 1) Stage 2 (M0800A) > 0 2) Stage 3 (M0800B) > 0 3) Stage 4 (M0800C) > 0	The number of patients for which the discharge assessment indicates one or more new or worsening stage 2-4 pressure ulcers: 1) Stage 2 (M0800A) > 0 2) Stage 3 (M0800B) > 0 3) Stage 4 (M0800C) > 0	The number of patients for which the discharge assessment indicates one or more new or worsening stage 2-4 pressure ulcers: 1) Stage 2 (49A) > 0 2) Stage 3 (49B) > 0 3) Stage 4 (49C) > 0
New or Worsening Pressure Ulcers	M0800. Worsening in Pressure Ulcer Status Since Prior Assessment. Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment. If no current pressure ulcer at a given stage, enter 0. A. Stage 2 B. Stage 3 C. Stage 4	M0800. Worsening in Pressure Ulcer Status Since Prior Assessment. Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment. If no current pressure ulcer at a given stage, enter 0. A. Stage 2 B. Stage 3 C. Stage 4	49. Worsening in Pressure Ulcer Status Since Prior Assessment. Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment. If no current pressure ulcer at a given stage, enter 0. 49A. Stage 2 Enter Number 49B. Stage 3 Enter Number 49C. Stage 4 Enter Number

Appendix B: Pressure Ulcer Data Elements for NH SS PU Measure (NQF #0678) Specifications for MDS 3.0, LTCH CARE Data Set and IRF-PAI			
MDS 3.0		LTCH CARE Data Set	IRF PAI
Denominator			
Denominator Details	The number of short-stay residents with one or more assessments that are eligible for a look back scan (assessment types include: A0310A = 01, 02, 03, 04, 05, 06; A0310B = 01, 02, 03, 04, 05, 06; A0310F = 10, 11).	The number of patients with an admission assessment (A0250=01) and a discharge assessment (A0250=10,11) .	The number of patients with an assessment, for which the <i>discharge living setting</i> does not indicate patient died. (44A = 01,02,03,04,05,06,07,08,09,10,12,13,14).
Assessment Types	A0310. Type of Assessment A. Federal OBRA Reason for Assessment 1. Admission assessment (required by day 14) 2. Quarterly review assessment 3. Annual assessment 4. Significant change in status assessment 5. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. Not OBRA required assessment B. PPS Scheduled Assessments 1. 5-day scheduled assessment 2. 14-day scheduled assessment 3. 30-day scheduled assessment 4. 60-day scheduled assessment 5. 90-day scheduled assessment 6. Readmission/return assessment 07. Unscheduled assessment 99. Not PPS assessment F. Entry/discharge reporting 01. Entry record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility record 99. Not entry/discharge record	<b>A0250.</b> Reason for Assessment . 01. Admission 10. Planned discharge 11. Unplanned discharge 12. Expired	One assessment form contains both admission and discharge data.



Appendix B: Pressure Ulcer Data Elements for NH SS PU Measure (NQF #0678) Specifications for MDS 3.0, LTCH CARE Data Set and IRF-PAI			
	MDS 3.0	LTCH CARE Data Set	IRF PAI
Denominator Exclusions	<ol style="list-style-type: none"> <li>Residents are excluded from the denominator if missing data precludes calculation of the measure.</li> <li>Assessments performed at the time of resident death are excluded.</li> <li>Nursing facilities, with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.</li> </ol>	<ol style="list-style-type: none"> <li>Patients are excluded from the denominator if missing data precludes calculation of the measure.</li> <li>Assessments performed at the time of patient death are excluded.</li> <li>LTCHS with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.</li> </ol>	<ol style="list-style-type: none"> <li>Patients are excluded from the denominator if missing data precludes calculation of the measure.</li> <li>Assessments with a discharge destination of died are excluded.</li> <li>IRFs with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.</li> </ol>
Denominator Exclusion Details	<ol style="list-style-type: none"> <li>Residents are excluded if none of the assessments that are included in the look-back scan has a usable response for M0800A, M0800B, or M0800C.</li> <li>If all of the assessments that are eligible for the look-back scan are discarded and no usable assessments remain, then the resident is excluded from the numerator and the denominator.</li> <li>Expiration assessments (A0310F = 12) are excluded from the measure.</li> </ol>	<ol style="list-style-type: none"> <li>Patients are excluded if none of the assessments that are included in the look-back scan has a usable response for M0800A, M0800B, or M0800C.</li> <li>If all of the assessments that are eligible for the look-back scan are discarded and no usable assessments remain, then the patient is excluded from the numerator and the denominator.</li> <li>Expiration assessments (A0250 = 12) are excluded from the measure.</li> </ol>	<ol style="list-style-type: none"> <li>Patients are excluded if none of the responses for 49A, 49B, or 49C were usable.</li> <li>Patients are excluded from the denominator if item the assessment indicates that the patient died (44A=11).</li> </ol>

Appendix B: Pressure Ulcer Data Elements for NH SS PU Measure (NQF #0678) Specifications for MDS 3.0, LTCH CARE Data Set and IRF-PAI			
MDS 3.0		LTCH CARE Data Set	IRF PAI
Risk Adjustment			
Risk Adjustment: Mobility/Function	<p>Covariate = [01] if G0110A1 = [02, 03, 04,07,08] Covariate = [0] if G0110A1 = [0, 01, -]</p> <p>G0110A1 ADLS Self Performance &gt; If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time. Activity Occurred 3 or more times 0 – Independent – no help or staff oversight at any time 1 – Supervision – oversight, encouragement or cueing 2 – Limited Assistance – resident highly involved in activity; staff provide guided maneuvering of limbs or other non weight-bearing assistance 3 – Extensive assistance – resident involved in activity, staff provided weight-bearing support 4 – total dependence – full staff performance every time during entire 7 day period Activity Occurred 2 or fewer times 7 – Activity occurred only once or twice – activity did occur but only once or twice 8 – Activity did not occur – activity (or any part of the ADL) was not performed by resident or staff all over the entire 7 day period</p>	<p>Covariate = [01] if GG0160C = [01, 02, 03,04,07,09,88] Covariate = [0] if GG0160C = [05,06, -]</p> <p>GG0160 Functional Mobility If 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. C. Lying to sitting on side of Bed 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. 07. Patient refused 09. Not applicable If activity was not attempted, code: 88. Not attempted due to medical condition or safety concerns</p>	<p>Covariate = [01] if 39I FIM Levels = [0,1,2,3,4] Covariate = [0] if 39I FIM Levels = [7,6,5 -,^ -]</p> <p>39. Transfers: FIM Instrument Bed, Chair Wheelchair No Helper 7. Completely Independent (Timely, Safely) 6. Modified Independence (Device) Helper -Modified Dependence 5. Supervision (Subject = 100%) 4. Minimal Assistance (Subject = 75%) 3. Moderate Assistance (Subject - 50%) Helper - Complete Dependence 2. Maximal Assistance (Subject=25%) 1. Total Assistance (Subject Less than 25%) 0. Activity Does not Occur, Use this code only at admission</p>

**Appendix B: Pressure Ulcer Data Elements for NH SS PU Measure (NQF #0678) Specifications for MDS 3.0, LTCH CARE Data Set and IRF-PAI**

	<b>MDS 3.0</b>	<b>LTCH CARE Data Set</b>	<b>IRF PAI</b>
Risk Adjustment: Bowel Incontinence	<p>Covariate = [01] if H0400 = [01, 02, 03] Covariate = [0] if H0400 = [0, 09, -, ^]</p> <p>H0400. Bowel Continence Bowel continence - Select the one category that best describes the resident 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, resident had an ostomy or did not have a bowel movement for the entire 7 days</p>	<p>Covariate = [01] if H0400 = [01, 02, 03] Covariate = [0] if H0400 = [0, 09, -, ^]</p> <p>H0400. 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</p>	<p>Covariate = [01] if 32= [1,2,3,4,5] Covariate = [0] if 32 = [6,7, -, ^]</p> <p>32. Bowel Frequency of Accidents 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</p>
Risk Adjustment: Diabetes or Peripheral Vascular Disease	<p>Covariate = [01] if any of the following are true: a. I0900 = [01] (checked) b. I2900 = [01] (checked) c. I8000A through I8000J contains any of the following diabetes or peripheral vascular disease diagnosis codes: [250.7, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.31, 440.32, 443.81, 443.9]. Covariate = [0] if I0900 = [0, - ] AND I2900 = [0, - -]AND I8000A through I8000J do not contain any of the peripheral vascular disease diagnosis codes listed above.</p> <p>Active Diagnoses in the last 7 days - Check all that apply 12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)  10900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)  I8000 A-J Additional Active Diagnoses</p>	<p>Covariate = [01] if any of the following are true: a. I0900 = [01] (checked) b. I2900 = [01] (checked) Covariate = [0] if I0900 = [0, -- ] AND I2900 = [0, - -] Active Diagnoses at time of assessment - Check all that apply  12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy) 10900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)</p>	<p>Covariate = [01] if Item 24 contains any of the following diabetes or peripheral vascular disease diagnosis ICD-9-CM codes: [249, 249.0, 249.1, 249.2, 249.3, 249.4, 249.5, 249.6, 249.7, 249.8, 249.9, 250, 250.0, 250.1, 250.2, 250.3, 250.4, 250.5, 250.6, 250.7, 250.8, 250.9, 253.5, 271.4, 275.0, 353.5, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 443.8, 536.3, 581.81, 583.81, 588.1, 648.0, 6] OR [250.7, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.31, 440.32, 443.81, 443.9] Covariate = [0] if item 24 does do not contain any of the diabetes or peripheral vascular disease diagnosis codes listed above.</p> <p>24. Comorbid Conditions; Use ICD-9 CM codes to enter up to ten medical conditions</p>

Appendix B: Pressure Ulcer Data Elements for NH SS PU Measure (NQF #0678) Specifications for MDS 3.0, LTCH CARE Data Set and IRF-PAI			
	MDS 3.0	LTCH CARE Data Set	IRF PAI
Risk Adjustment: BMI	<p>Covariate = [01] if BMI ≥ [12.0] AND ≤ [19.0]  Covariate = [0] if BMI &gt; [19.0] AND ≤ [40.0]  Where: BMI = (weight * 703 / height2) = ((K0200B) * 703) / (K0200A) and the resulting value is rounded to one decimal.  Covariate = missing if K0200A = [-] OR K0200B = [-] OR BMI &lt; [12.0] OR BMI &gt; [40.0].</p> <p>K0200 A. Height (in inches). Record most recent height measure since admission.  K0200B. Weight (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)</p>	<p>Covariate = [01] if BMI ≥ [12.0] AND ≤ [19.0]  Covariate = [0] if BMI &gt; [19.0] AND ≤ [40.0]  Where: BMI = (weight * 703 / height2) = ((K0200B) * 703) / (K0200A2) and the resulting value is rounded to one decimal.  Covariate = missing if K0200A = [-] OR K0200B = [-] OR BMI &lt; [12.0] OR BMI &gt; [40.0].</p> <p>K0200A. Height (in inches). Record most recent height measure since admission.  K0200B. Weight (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)</p>	<p>IRF-PAI which will be in use for data collection beginning Oct 1, 2012 does not include items to capture height and weight.</p> <p>Covariate = [01] if BMI ≥ [12.0] AND ≤ [19.0]  Covariate = [0] if BMI &gt; [19.0] AND ≤ [40.0]  Where: BMI = (weight * 703 / height2) = and the resulting value is rounded to one decimal.  Covariate = missing if Height = [-] OR Weight= [-] OR BMI &lt; [12.0] OR BMI &gt; [40.0].</p> <p>Height and Weight will be added as new items in a future update of the IRF-PAI.</p>

**Appendix C: ICD9 Codes for IRF-PAI Item # 24 (Diabetes or Peripheral Vascular Disease)**

*See NQF submission form question 2a1.13.*

ICD-9 Code	Diagnosis
250.7	Diabetes with peripheral circulatory disorders; Use additional code to identify manifestation, as: diabetic: gangrene (785.4) peripheral angiopathy (443.81)
440.20	Atherosclerosis of the extremities, unspecified
440.21	Atherosclerosis of the extremities with intermittent claudication
440.22	Atherosclerosis of the extremities with rest pain; Any condition classifiable to 440.21
440.23	Atherosclerosis of the extremities with ulceration; Any condition classifiable to 440.21-440.22 Use additional code for any associated ulceration (707.10-707.9)
440.24	Atherosclerosis of the extremities with gangrene; Any condition classifiable to 440.21, 440.22, and 440.23 with ischemic gangrene 785.4 Use additional code for any associated ulceration (707.10-707.9) Excludes: gas gangrene 040.0
440.29	Other
440.31	Of autologous vein bypass graft
440.32	Of nonautologous vein bypass graft
443.81	Peripheral angiopathy in diseases classified elsewhere Code first underlying disease, as: diabetes mellitus
443.9	Peripheral vascular disease, unspecified Intermittent claudication NOS Peripheral: angiopathy NOS vascular disease NOS Spasm of artery Excludes: atherosclerosis of the arteries of the extremities (440.20-440.22) spasm of cerebral artery (435.0-435.9)
249	Secondary diabetes mellitus Includes: diabetes mellitus (due to) (in) (secondary) (with): drug-induced or chemical induced infection Excludes: gestational diabetes (648.8) hyperglycemia NOS (790.29) neonatal diabetes mellitus (775.1) nonclinical diabetes (790.29) Type I diabetes - see category 250 Type II diabetes - see category 250

	<p>The following fifth-digit subclassification is for use with category 249:</p> <p>0 not stated as uncontrolled</p> <p>1 uncontrolled</p> <p>Use additional code to identify any associated insulin use ( V58.67)</p>
249.0	<p>Secondary diabetes mellitus without mention of complication</p> <p>[0-1]</p> <p>Secondary diabetes mellitus without mention of complication or manifestation classifiable to 249.1-249.9</p> <p>Secondary diabetes mellitus NOS</p>
249.1	<p>Secondary diabetes mellitus with ketoacidosis</p> <p>[0-1]</p> <p>Secondary diabetes mellitus with diabetic acidosis without mention of coma</p> <p>Secondary diabetes mellitus with diabetic ketosis without mention of coma</p>
249.2	<p>Secondary diabetes mellitus with hyperosmolarity</p> <p>[0-1]</p> <p>Secondary diabetes mellitus with hyperosmolar (nonketotic) coma</p>
249.3	<p>Secondary diabetes mellitus with other coma</p> <p>[0-1]</p> <p>Secondary diabetes mellitus with diabetic coma (with ketoacidosis)</p> <p>Secondary diabetes mellitus with diabetic hypoglycemic coma</p> <p>Secondary diabetes mellitus with insulin coma NOS</p> <p>Excludes:</p> <p>secondary diabetes mellitus with hyperosmolar coma (249.2)</p>
249.4	<p>Secondary diabetes mellitus with renal manifestations</p> <p>[0-1]</p> <p>Use additional code to identify manifestation, as:</p> <p>chronic kidney disease (585.1-585.9)</p> <p>diabetic nephropathy NOS (583.81)</p> <p>diabetic nephrosis (581.81)</p> <p>intercapillary glomerulosclerosis (581.81)</p> <p>Kimmelstiel-Wilson syndrome (581.81)</p>
249.5	<p>Secondary diabetes mellitus with ophthalmic manifestations</p> <p>[0-1]</p> <p>Use additional code to identify manifestation, as:</p> <p>diabetic blindness (369.00-369.9)</p> <p>diabetic cataract (366.41)</p> <p>diabetic glaucoma (365.44)</p> <p>diabetic macular edema (362.07)</p> <p>diabetic retinal edema (362.07)</p> <p>diabetic retinopathy (362.01-362.07)</p>
249.6	<p>Secondary diabetes mellitus with neurological manifestations</p> <p>[0-1]</p> <p>Use additional code to identify manifestation, as:</p> <p>diabetic amyotrophy (353.5)</p> <p>diabetic gastroparesis (536.3)</p> <p>diabetic gastroparesis (536.3)</p> <p>diabetic mononeuropathy (354.0-355.9)</p>

	diabetic neurogenic arthropathy (713.5) diabetic peripheral autonomic neuropathy (337.1) diabetic polyneuropathy (357.2)
249.7	Secondary diabetes mellitus with peripheral circulatory disorders [0-1] Use additional code to identify manifestation, as: diabetic gangrene (785.4) diabetic peripheral angiopathy (443.81)
249.8	Secondary diabetes mellitus with other specified manifestations [0-1] Secondary diabetic hypoglycemia in diabetes mellitus Secondary hypoglycemic shock in diabetes mellitus Use additional code to identify manifestation, as: any associated ulceration (707.10-707.9) diabetic bone changes (731.8)
249.9	Secondary diabetes mellitus with unspecified complication
250	Diabetes mellitus Excludes: gestational diabetes (648.8) hyperglycemia NOS (790.29) neonatal diabetes mellitus (775.1) nonclinical diabetes (790.29) secondary diabetes (249.0-249.9) The following fifth-digit subclassification is for use with category 250: 0 type II or unspecified type, not stated as uncontrolled Fifth-digit 0 is for use for type II patients, even if the patient requires insulin Use additional code, if applicable, for associated long-term (current) insulin use V58.67 1 type I [juvenile type], not stated as uncontrolled 2 type II or unspecified type, uncontrolled Use additional code, if applicable, for associated long-term (current) insulin use V58.67 Fifth-digit 2 is for use for type II, adult-onset, diabetic patients, even if the patient requires insulin 3 type I [juvenile type], uncontrolled
250.1	Diabetes with ketoacidosis [0-3] Diabetic: acidosis without mention of coma ketosis without mention of coma
250.0	Diabetes mellitus without mention of complication [0-3] Diabetes mellitus without mention of complication or manifestation classifiable to 250.1-250.9 Diabetes (mellitus) NOS
250.2	Diabetes with hyperosmolarity [0-3]

	Hyperosmolar (nonketotic) coma
250.3	Diabetes with other coma [0-3] Diabetic coma (with ketoacidosis) Diabetic hypoglycemic coma Insulin coma NOS Excludes: diabetes with hyperosmolar coma (250.2)
250.4	Diabetes with renal manifestations [0-3] Use additional code to identify manifestation, as: chronic kidney disease (585.1-585.9) diabetic: nephropathy NOS (583.81) nephrosis (581.81) intercapillary glomerulosclerosis (581.81) Kimmelstiel-Wilson syndrome (581.81)
250.5	Diabetes with ophthalmic manifestations [0-3] Use additional code to identify manifestation, as: diabetic: blindness (369.00-369.9) cataract (366.41) glaucoma (365.44) macular edema (362.07) retinal edema (362.07) retinopathy (362.01-362.07)
250.6	Diabetes with neurological manifestations [0-3] Use additional code to identify manifestation, as: diabetic: amyotrophy (353.5) gastroparalysis (536.3) gastroparesis (536.3) mononeuropathy (354.0-355.9) neurogenic arthropathy (713.5) peripheral autonomic neuropathy (337.1) polyneuropathy (357.2)
250.8	Diabetes with other specified manifestations [0-3] Diabetic hypoglycemia NOS Hypoglycemic shock NOS Use additional code to identify manifestation, as: any associated ulceration (707.10-707.9) diabetic bone changes (731.8)
250.9	Diabetes with unspecified complication [0-3]



253.5	Diabetes insipidus Vasopressin deficiency Excludes: nephrogenic diabetes insipidus (588.1)
271.4	Renal glycosuria Renal diabetes
275.0	Disorders of iron metabolism Bronzed diabetes Hemochromatosis Pigmentary cirrhosis (of liver) Excludes: anemia: iron deficiency (280.0-280.9) sideroblastic (285.0)
353.5	Neuralgic amyotrophy Parsonage-Aldren-Turner syndrome Code first any associated underlying disease, such as: diabetes mellitus (249.6, 250.6)
357.2	Polyneuropathy in diabetes Code first underlying disease (249.6, 250.6)
362.0	Diabetic retinopathy Code first diabetes (249.5, 250.5)
362.01	Background diabetic retinopathy Diabetic retinal microaneurysms Diabetic retinopathy NOS
362.02	Proliferative diabetic retinopathy
362.03	Nonproliferative diabetic retinopathy NOS
362.04	Mild nonproliferative diabetic retinopathy
362.05	Moderate nonproliferative diabetic retinopathy
362.06	Severe nonproliferative diabetic retinopathy
362.07	Diabetic macular edema Diabetic retinal edema Note: Code 362.07 must be used with a code for diabetic retinopathy (362.01-362.06)
366.41	Diabetic cataract Code first diabetes (249.5, 250.5)
443.8	Other specified peripheral vascular diseases
536.3	Gastroparesis Gastroparalysis Code first underlying disease, such as: diabetes mellitus (249.6, 250.6)
581.81	Nephrotic syndrome in diseases classified elsewhere Code first underlying disease, as: amyloidosis (277.30-277.39) diabetes mellitus (249.4,250.4) malaria (084.9) polyarteritis (446.0)

	systemic lupus erythematosus (710.0) Excludes: nephrosis in epidemic hemorrhagic fever (078.6)
583.81	Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere Code first underlying disease, as: amyloidosis (277.30-277.39) diabetes mellitus (249.4, 250.4) gonococcal infection (098.19) Goodpasture's syndrome (446.21) systemic lupus erythematosus (710.0) tuberculosis (016.0) Excludes: gouty nephropathy (274.10) syphilitic nephritis (095.4)
588.1	Nephrogenic diabetes insipidus Excludes: diabetes insipidus NOS (253.5)
648.0	Diabetes mellitus [0-4] Conditions classifiable to 249, 250 Excludes: gestational diabetes (648.8)

**Appendix D. Inpatient Rehabilitation Facilities and Long-Term Care Hospitals Quality Measures  
Technical Expert Panel (January 2011, July 2011)**

<b>Name</b>	<b>Title/Organization</b>	<b>Organization</b>
<b>Inpatient Rehabilitation Facilities Quality Measures Technical Expert Panel</b>		
T. Brian Callister, MD	National Medical Director	LifeCare Hospitals
Alfred Chiplin, JD, M.Div	Senior Policy Attorney	Center for Medicare Advocacy
Dexanne Clohan, MD	Senior Vice President and Chief Medical Officer	HealthSouth
Jean M. de Leon, MD	Medical Director Wound Care	Baylor Specialty Hospital
Cathy Ellis, PT	Clinical Director	National Rehabilitation Hospital, AVP Clinical Services, Spinal Cord Program
Bruce Gans, MD	Executive Vice President and Chief Medical Officer	Kessler Institute
Sean Muldoon, MD, MPH	Chief Medical Officer	Kindred Healthcare
Terrence O'Malley, MD	Medical Director	Clark House
Pamela Roberts, PhD	Manager	Cedars-Sinai Medical Center
Elliot Roth, MD	Medical Director, Brain Injury Medicine and Rehabilitation Program	Rehabilitation Institute of Chicago
Asif Saiyed	Infection Preventionist	Rehabilitation Institute of Chicago
M. Elizabeth Sandel, MD	Chief, Physical Medicine & Rehabilitation	Kaiser Permanente
Di Shen, PhD	Chief Research Officer	Commission on Accreditation of Rehabilitation Facilities International
Sharon Sprenger, MPA, RHIA, CPHQ	Senior Advisor, Measurement Outreach, Division of Healthcare Quality Evaluation	The Joint Commission
Suzanne Snyder, MBA, PT, CPUM	Director of Rehabilitation Utilization and Compliance	Carolinas Rehabilitation

Name	Title/Organization	Organization
<b>Long-Term Care Hospitals Quality Measures Technical Expert Panel</b>		
T. Brian Callister, MD	National Medical Director	LifeCare Hospitals
Alfred Chiplin, JD	Senior Policy Attorney	Center for Medicare Advocacy
Dexanne Clohan, MD	Senior Vice President and Chief Medical Officer	HealthSouth
Margaret Crane, RN	CEO	Barlow Respiratory Hospital
Jean M. de Leon, MD	Medical Director Wound Care	Baylor Specialty Hospital
Thomas Durkin, MHA, CRRN, RN	Executive Vice President	Vibra Healthcare
Maura A. Hopkins, RN, MSN, NEA-BC	Vice President, Patient Care Services / Chief Nursing Officer	RML Specialty Hospital
Gary Kempf, RN	Chief Clinical Executive	Christus Dubuis Health System
Dana Mukamel, PhD	Professor	Department of Medicine at the Health Policy Research Institute at the University of California, Irvine
Sean Muldoon, MD, MPH	Chief Medical Officer	Kindred Healthcare
Terrence O'Malley, MD	Medical Director	Clark House
Lisa Snyder, MD, MPH	Chief Quality Officer	Select Medical Corporation

Sharon Sprenger, MPA, RHIA, CPHQ	Senior Advisor, Measurement Outreach, Division of Healthcare Quality Evaluation	The Joint Commission
Patricia M. Stimac, MS, RD, LDN, NHA	Director of Quality Management, Nursing Home Administrator Director of Nutrition	Spartanburg Hospital for Restorative Care
John J. Votto, D.O.	President and CEO	Hospital for Special Care New Britain, CT