CHAPTER 5: SUBMISSION AND CORRECTION OF THE INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT (IRF-PAI) ASSESSMENT RECORDS

This chapter details the submission and correction process for IRF-PAI assessment records and requirements for data submission by IRFs for the IRF Quality Reporting Program (QRP).

5.1   Submitting the IRF-PAI

All Medicare-participating IRFs must complete and submit required IRF-PAI assessment records to the Centers for Medicare & Medicaid Services (CMS) Internet Quality Improvement and Evaluation System (iQIES) for all patients, regardless of payer. After completion of the required assessment(s), each provider must create electronic transmission files that meet the technical requirements detailed in the current IRF-PAI Data Submission Specifications, available on the CMS IRF Quality Reporting Program Technical Information website at https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-technical-information. Alternatively, the IRF can complete the IRF-PAI assessments online within iQIES.

When the submission file is received by iQIES, the system performs a series of validation edits to evaluate whether the data submitted meet the required data specifications. IRF-PAI assessment records are edited to verify that responses are within valid ranges and are consistent, dates are reasonable, and the submitted record does not overlap with other IRF-PAI records with similar stay dates that were previously accepted by iQIES for the same patient. The provider is notified of the results of this evaluation, including any fatal and warning errors encountered during file processing on the IRF-PAI Facility Final Validation Report. All error and warning messages are detailed and explained in the IRF-PAI Error Message Reference Guide of the *IRF Submission User's Guide,* which is available on the QIES Technical Support Office (QTSO) website at https://qtso.cms.gov/providers/inpatient-rehabilitation-facility-irf-pai-providers/reference-manuals.

5.2   Timeliness Criteria

- **Completion Timing for IRF-PAI:** Refer to Chapter 2 section 2.2 for additional information on completion timing for the IRF-PAI.

- **Data Must Be Encoded By:** Refer to Chapter 2 section 2.2 for additional information on completion timing for the IRF-PAI.

- **Assessment Submission:** Because all the assessment data for admission and discharge assessments must be transmitted together after the patient is discharged, the admission assessment data must be transmitted at the same time the discharge data are transmitted. All IRF-PAI assessment records should be submitted electronically by the 7th calendar day in the period beginning with the last permitted discharge patient assessment "encoded by" date.

- **Examples** of applying timeliness criteria to the IRF-PAI assessments can be found in Chapter 2: Overview of this manual.

5.3   Validation of Records and Files

The iQIES validation edits are designed to monitor timeliness and to ensure that the submitted records conform to the IRF-PAI Data Submission Specifications. The most recent version of these specifications can be found on the following website: https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/data-specification.

If submitted IRF-PAI assessment records do not meet the edit requirements, the system will provide fatal error and/or warning messages on the IRF-PAI Facility Final Validation Report. The following describes the validation, storage, and reporting of records in a submission file.

1. **Submission Feedback.** For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by iQIES. An IRF-PAI Facility Final Validation Report containing the file submission ID and submission date, along with other details about the processing of the IRF-PAI records will be auto-generated for review.

2. **Validation and Editing Process.** Each time a user accesses iQIES and submits a zip file of one or more IRF-PAI files, iQIES performs three types of validation:

   - **Fatal File Errors.** The file structure is validated to ensure that it follows the requirements outlined in the IRF-PAI Submission Specifications provided by CMS. The file is rejected by iQIES if the file structure does not meet these requirements. Examples of Fatal File Errors include the following:

     o   The file is not a ZIP file.

     o   The records in the ZIP file cannot be extracted.

     o   The file cannot be read.

     The provider cannot be identified when these Fatal File Errors occur with the submission file. Therefore, the IRF-PAI Facility Final Validation Report cannot be automatically generated.

     The Fatal File Errors instead will appear only on the IRF-PAI Submitter Final Validation Report.

     Files that are rejected must be corrected and resubmitted.

   - **Fatal Record Errors.** If the file structure is acceptable, then each IRF-PAI assessment record in the file is validated individually for Fatal Record Errors. These errors include, but are not limited to, the following:

     o   Out-of-range responses (e.g., the valid codes for an item are 1, 2, 3, and 4, and the submitted value is 6).

     o   Inconsistent relationships between items (e.g., an inconsistent date pattern, such as the patient's Birth Date [6] is later than the Admission Date [12]).

Fatal Record Errors result in rejection of individual records by iQIES. The provider is informed of Fatal Record Error(s) on the IRF-PAI Facility Final Validation Report and IRF-PAI Submitter Validation Report. Rejected records must be analyzed to determine whether correction and resubmission are required; not all Fatal Record Errors require correction and resubmission (e.g., no action is required when the record is rejected with a duplicate record error). If the provider cannot be identified in the rejected record, then the rejected record will appear on the IRF-PAI Submitter Final Validation Report and not on the automatically generated IRF-PAI Facility Final Validation Report, because the system does not know which provider's report should contain the record.

- **Warnings (Non-Fatal Errors).** The record is also validated for Warnings (Non-Fatal Errors). Warnings include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature.

   Examples of warnings include the following:

   o Timing error

      ▪ Assessment Reference Date (ARD) (13) is more than 3 days after the Admission Date (12).

   o Patient Information Mismatch error

      ▪ Submitted value(s) for the item(s) listed do not match the values in the iQIES database. If the record was accepted, the patient information in the database was updated. Verify that the new information is correct.

   Warnings (Non-Fatal Errors) are reported to the provider in the IRF-PAI Submitter Validation Report and the IRF-PAI Facility Final Validation Report. The provider must evaluate each warning to identify necessary corrective actions.

3. **Storage in iQIES.** If there are any Fatal Record Errors, the record will be rejected and not stored in iQIES. If there are no Fatal Record Errors, the record is stored in iQIES, even if the record has Warnings (Non-Fatal Errors).

Detailed information on the validation of fatal and warning messages is available in Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Error Message Reference Guide of the *IRF-PAI Submission User's Guide*, which is available on the QTSO website at https://qtso.cms.gov/providers/inpatient-rehabilitation-facility-irf-pai-providers/reference-manuals.

5.4   IRF-PAI Correction Policy

The IRF-PAI assessment record should be accurate when submitted and accepted into iQIES. When a provider determines that one or more data elements in an accepted record are inaccurate based on the assessment period as established by the ARD, the provider must take the necessary steps to correct the erroneous record.

When a patient's clinical status changes after the ARD of an IRF-PAI assessment record that has been accepted into iQIES, no action is required by the provider to update the submitted record. Changes in and updates to a patient's clinical status should be noted in the patient's record (e.g., progress notes) in accordance with standards of clinical practice and documentation. Such monitoring and documentation are part of the provider's responsibility to provide necessary care and services. The IRF-PAI assessment record is a "snapshot" of the patient's condition for a specified time period.

The electronic IRF-PAI assessment record submitted to and accepted by iQIES is an assessment of the patient as of the ARD. Any corrections or changes made to the provider's copy of the IRF-PAI assessment record *after* the record is accepted into iQIES will not be recognized by the system. The same corrections or changes must also be made to the electronic version of the IRF-PAI assessment record, and that record must be submitted to and accepted by iQIES. It is the provider's responsibility to correct any errors that exist in an accepted IRF-PAI assessment record according to the IRF-PAI assessment record Correction Policy. This ensures that the information in iQIES accurately reflects the patient's identification, location, and overall clinical status, as of the ARD. A correction can be submitted for any record accepted by the system, up to 24 months from the Discharge Date, even if there has been a submission and acceptance of subsequent records for the patient. Further, it is the provider's responsibility to ensure that the record is complete and accurate prior to submission to iQIES.

Several processes have been put in place to ensure that the IRF-PAI assessment records are accurate both at the provider level and in iQIES:

- Software used by the provider to create electronic IRF-PAI records must run all standard edits as defined in the IRF-PAI Data Submission Specifications released by CMS (available at the following website: https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/data-specification).

- Record rejection standards have been implemented in iQIES whereby, if an IRF-PAI assessment record contains responses that are out of range (e.g., the valid codes for a specific item are 0-3 and the submitted value is 4) or item responses are inconsistent (e.g., a skip pattern is not followed), the record is rejected. Rejected records are not stored in the iQIES database.

- If an error is discovered in a record that has been accepted by iQIES, modification or inactivation procedures *must* be implemented by the provider to ensure that iQIES information is corrected.

- Specific user roles within iQIES allow the provider to modify or inactivate assessments originally submitted electronically to CMS. It is the provider's responsibility to ensure

that any corrections or changes made to an accepted record using the iQIES user tool are reflected in its provider software system.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps.

5.5   Correcting Errors in IRF-PAI Assessment Records That Have Not Yet Been Accepted into iQIES

If an IRF-PAI assessment record is found to have errors that incorrectly reflect the patient's clinical status within the respective assessment period as established by the ARD, then that assessment must be corrected. The correction process depends on the type of error. IRF-PAI assessment records that have not yet been accepted in iQIES include records that have been submitted and rejected, or records that have not been submitted at all. Records that have been submitted and rejected and records that have not been submitted at all can usually be corrected and resubmitted/submitted without any special correction procedures because they had never been accepted by iQIES. IRFs are responsible for correcting any errors to the record prior to submission or resubmission of the record to iQIES.

5.6   Correcting Errors in IRF-PAI Records That Have Been Accepted into iQIES

Providers must correct any errors identified in an IRF-PAI assessment record to ensure that the information in iQIES accurately reflects the patient's identification, location, or clinical status. A record may be corrected even if subsequent records have been accepted for the patient.

Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors, or other errors. The following two processes exist for the correction of IRF-PAI assessment records that have been accepted into iQIES:

- **Modification Request**
- **Inactivation Request**

Completion of a **Modification Request record** will archive the inaccurate IRF-PAI assessment record within iQIES and replace the record with the new, corrected record. Completion of an **Inactivation Request record** will also archive an inaccurate IRF-PAI assessment record within iQIES, but it will not replace the record with the new record.

It is suggested that the IRF maintain the original IRF-PAI assessment records electronically or in hard copy, along with any corrected versions of the IRF-PAI assessment records, in the clinical file to track what was modified. In addition, it is suggested that the IRF keep a copy of inactivated records.

5.6.1 Modification Requests

A Modification Request (Transaction Type Code = 2) is used when an IRF-PAI assessment record is accepted into iQIES, but the information in the record contains clinical or non-key demographic errors.

The Modification Request record is used to correct most IRF-PAI assessment record items that are erroneous. However, there are items that **cannot be corrected** with a Modification Request; rather, the erroneous record must be inactivated with an Inactivation Request record (Transaction Type Code = 3) and a new IRF-PAI assessment record submitted to iQIES.

These items **cannot** be corrected with a Modification Request:

Record Event Identifiers

- 12: Admission Date
- 13: Assessment Reference Date (ARD)
- 40: Discharge Date

Patient Identifiers

- 4: Patient First Name
- 5A: Patient Last Name
- 6: Birth Date
- 7: Social Security Number (SSN)
- 8: Gender

Note: To make corrections to one or more patient identifiers above, you must complete an **Inactivation Request record** for the incorrect record and create a new record with the correct information.

When an error is discovered (except for those items listed in the preceding bullets) in an IRF-PAI assessment record, the provider must submit a Modification Request to iQIES. When completing a Modification Request record, the Modification Request record should contain correct values for all items (not just the values previously in error). This means if Transaction Type Code is coded as 2, the IRF staff should proceed to item 1, Facility Information, and complete all items in all other IRF-PAI assessment record sections.

Note: File creation software varies in how Modification Request records are created. Please contact your software vendor for specific instructions.

When a Modification Request record is submitted, iQIES will process the record as follows:

1. The system will attempt to locate the existing record in the iQIES database for this IRF using specific items, which are located in Chapter 2, Section A, and this includes the patient identifiers (e.g., last name, first name, SSN, birth date, gender), the facility identifier (i.e., facility and state code), and the assessment-related dates (i.e., admission date or discharge date).

2. If the existing record is not found, the submitted Modification Request record will be rejected and not accepted in iQIES. A fatal error will be reported to the IRF on the IRF-PAI Submitter Validation Report and the IRF-PAI Facility Final Validation Report.

3. If the existing record is found, then the items in all sections of the submitted Modification Request record will be edited. If there are any fatal errors, the Modification Request record will be rejected and not accepted in iQIES. The fatal error(s) will be reported to the IRF on the IRF-PAI Submitter Validation Report and the IRF-PAI Facility Final Validation Report.

4. If the Modification Request record passes all the edits, it will replace the prior erroneous record in the iQIES database. The prior erroneous record will be stored in an archive file within the iQIES database.

    Note: Specific user roles within iQIES will allow the provider to modify assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.

5.6.2 Inactivation Requests

An Inactivation Request (Transaction Type Code = 3) should be used when a record has been accepted into iQIES but the corresponding event did not occur. For example, an IRF-PAI Discharge assessment record was submitted for a patient but there was no actual discharge. This request should also be used when one or more event identifiers and/or patient identifiers are found to be in error.

An Inactivation Request **must** be completed when any of the following items are inaccurate:

Record Event Identifiers

- 12: Admission Date

- 13: Assessment Reference Date (ARD)

- 40: Discharge Date

Patient Identifiers

- 4: Patient First Name

- 5A: Patient Last Name

- 6: Birth Date

- 7: Social Security Number (SSN)

- 8: Gender

Note: Any item in the previous list that was submitted as part of the original record must also be submitted as part of the Inactivation Request, and values for each item must match in the erroneous record and the inactivation record. For example, if 7, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record.

If an Admission Date (12), ARD (13), or Discharge Date (40) is incorrect or if one or more patient identifiers are found to be in error, the provider must inactivate the erroneous record in iQIES, complete and submit a new IRF-PAI assessment record with the event and patient identifiers, and ensure that the clinical information is accurate.

When an Inactivation Request is submitted, iQIES will process the record as follows:

1. The system will attempt to locate the existing record in the iQIES database for the IRF using specific items (given in Chapter 2, Section A), including the patient identifiers (e.g., last name, first name, SSN, birth date, gender), the facility identifier (i.e., facility ID and state code), and the assessment-related dates (e.g., admission date, or discharge date).

2. If the existing record is not found in the iQIES database, the submitted Inactivation Request will be rejected, and a fatal error will be reported to the IRF on the IRF-PAI Submitter Validation Report and the IRF-PAI Facility Final Validation Report.

3. If the existing record is found, the erroneous record will be removed from the active records in the iQIES database and archived within the iQIES database.

    Note: Specific user roles within iQIES will allow the provider to inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.

5.7   Special Manual Record Deletion Request

A special Manual Record Deletion Request is only necessary when there has been an error in a record that has been accepted into iQIES that cannot be corrected with an automated Modification or Inactivation Request. There are only two items to which this applies. A Manual Record Deletion Request must be performed when the record has the wrong state code and/or facility ID in the control items STATE_CD and FAC_ID. Control items are items created by the file submission software. These error(s) most likely occurred at the time of software development, or when initializing the software, and not during the entry of the provider's administrative or patient's data.

If an iQIES record has the wrong state code or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in iQIES. The record must be resubmitted with the correct STATE_CD and/or FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record.

In the event that this error has occurred, the provider must contact the iQIES Help Desk at iQIES@cms.hhs.gov or 1-800-339-9313 to obtain the IRF-PAI Manual Assessment Deletion Request form. The provider is responsible for completing the form. The provider must submit the completed form to the iQIES Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The iQIES Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the iQIES Help Desk will work through the request with the provider.