erehabdata.com

User Manual

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I. INTRODUCTION

eRehabData is a full-service acute rehabilitation outcomes system that provides real-time access to patient assessment and outcomes instruments and includes tools to meet all the requirements of the Medicare Inpatient Rehabilitation Facilities Prospective Payment System (IRF-PPS), The Joint Commission (formerly JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF). eRehabData accepts IRF-PAI (Inpatient Rehabilitation Facility Patient Assessment Instruments) assessments for both Medicare and non-Medicare patients and provides additional capacities for pre-admission and follow-up assessments. eRehabData is owned by the rehabilitation industry through the American Medical Rehabilitation Providers Association (AMRPA [http://www.amrpa.org]).

eRehabData has a two-part mandate to fulfill:

1. To assist facilities through the provision of timely, inexpensive, accurate and responsive analysis of clinical and financial patient data

2. To assist the industry by empowering the national association with access to the most comprehensive patient dataset in the country that will include generation of industry-wide clinical and financial outcomes and benchmarks

You may subscribe to eRehabData by completing and submitting the Service Agreement, which is located on the front page (login screen) of the eRehabData.com website.

I.A. About This User Manual

The eRehabData User Manual is a comprehensive but not wholly inclusive document. In some sections of this manual you will be directed to help documents on the eRehabData site itself for content not included in this manual, but for the most part the documentation available under the ? HELP icons on the eRehabData system is included in this manual. This manual may also include information not found in the help documents available under the ? HELP icons on the system.

Wherever you see colored text referencing a link or button, the colors indicate the following:

Orange text refers to text links on the screen such as the site navigation links on the left side of the home screen.

LIGHT GREEN text in all caps refers to buttons on the screen that are images, such as the IRF-PAI navigation tabs or the **HOME** and **LOG OUT** buttons.

Dark yellow text in upper and lower case refers to submit buttons such as the **Enter** buttons that appear in the display options below the assessments tables on the home screen.

I.B. General Guidelines to Follow when Navigating the eRehabData Website

After you have logged in to eRehabData, you'll see a green **HOME** button on the left side of screen below the eRehabData logo, and a green toolbar in the upper right corner of your screen. This toolbar contains the following buttons: **USER MANUAL**, **AMRPA**, **CONTACT**, and **LOG OUT**.

HOME takes you to the eRehabData home page, also known as the launch screen.
USER MANUAL takes you to this user manual online.
AMRPA opens a new browser window pointed at the AMRPA website.
CONTACT displays contact information for the eRehabData offices.
LOG OUT will log you out of the eRehabData system and end your user session.

The left side of your screen displays a set of links that change depending on what part of the site you are on. When you are working on an assessment, the links will appear as tabs with names representing individual sections of the IRF-PAI. In other areas of the site, the links are grouped under descriptive headers.

If you have the privilege to view patient assessments, you will see tables of assessments on your eRehabData home screen. Below those tables, you will see a **List Options** link, which takes you to the Launch Screen Options screen. Use the Launch Screen Options screen to configure the information displayed in your assessments tables on your home page, and the order of the information. For more information on configuring the assessments display options, please refer to "Configuring List Options" under the "IRF-PAI Features" section of this manual.

Do not use your web browser's Back button. Most of the pages on this site are dynamic, meaning that every time you click on a link, a fresh set of data is retrieved from the server to create the page. Due to the nature of a database-driven website such as eRehabData.com, the data used to create each page may change at any time. Subsequently, each page is set to expire as soon as you move onto the next page. This also enhances security, as expired pages (and therefore, sensitive data) are not "cached" (saved) on your computer.

If you use your browser's Back button to revisit a page, instead of seeing the last page you visited you may see a warning message telling you that the page has expired. To avoid encountering this message, always use the navigation provided on the left side of each page. You can always return to your home page where you see your lists of assessments by clicking **HOME** below the eRehabData logo.

Always log out when you are through. For security reasons, it is important to log out of eRehabData.com when you are finished working on the system or if you are taking a break. If you don't log out of the system, it is still possible to return to the site from your computer and bypass the login screen for up to 2 hours after the last time you accessed an eRehabData.com page. This applies even if you browse to another website. Essentially, this means that if you leave the site without logging out and then leave your computer unattended, anyone with access to your computer can potentially access eRehabData using your account. If you log out first there is no way for anyone else to access the system using your account unless they know your username and password. So for security's sake, make sure you click the **LOG OUT** button in the top navigation bar at the conclusion of every visit or if you step away from your computer.

Only work in one browser window or tab at a time. Your web browser can only track one patient record at a time. If you attempt to open multiple patient records in separate browser windows or tabs, you will see a **Multiple Windows Warning** message that will prevent you from opening more than one record simultaneously or visiting the CMS Transmit File screen while you have a record open in another tab or window. If you get a Multiple Windows Warning message, you should locate all windows or tabs open to eRehabData, click the **HOME** button on each of those, and then close all but one. If that does not clear the Multiple Windows Warning message, you will need to click the **LOG OUT** button in the top navigation bar and then login again.

I.C. Explanation of the Organization/Facility/Site Hierarchy

The eRehabData system was designed to accommodate different kinds of rehabilitation providers. This was accomplished by including a three-tiered hierarchy of Organization/Facility/Site.

A ***facility*** is defined by a unique Medicare provider number. One ***organization*** can own or manage several facilities. If your facility belongs to a larger organization that includes other facilities under its umbrella, you can apply the Organization/Facility hierarchy to those facilities. This allows you to manage user accounts, download data, and view outcomes reports for all facilities from one (or more) Organization Administrator account, and/or manage them from Facility Administrator accounts assigned to each facility.

If your facility includes different ***sites*** that share the same Medicare provider number, you can apply the Facility/Site hierarchy to those sites and manage user accounts for all sites from one (or more) Facility Administrator account, and/or manage them from Site Administrator accounts assigned to each individual site.

If your facility belongs to a larger organization that includes other facilities under its umbrella, and your facility includes different sites, you can apply the Organization/Facility/Site hierarchy to those facilities and sites. This allows you to view reports, download data and manage user accounts for all facilities and sites from one Organization Administrator account, from Facility Administrator accounts for each facility, and/or from Site Administrator accounts for each site.

If your facility does not belong to a larger organization with other facilities (or your facility should not be managed from its parent organization), and your facility has only one site, you do not need to consider the hierarchy at all.

The structure of your facility's account with eRehabData is established when the account is created by an eRehabData representative. Please keep this hierarchy in mind when signing up your facility for the eRehabData service and when creating user accounts and assigning privileges.

I.D. eRehabData Support

If you can't see the website (http://www.eRehabData.com):

1. Confirm that your computer has a live Internet connection. The easiest way to do this is to check a few other websites. (Note: Do not use internal websites, such as your facility's home page, for this test. These sites may be visible to you from your local network and not the Internet.) If you can't see any websites on the Internet, contact your IT department for assistance.

2. If you can see other websites but can't see eRehabData.com, email assistance@eRehabData.com and describe your problem in as much detail as possible. An eRehabData support representative will respond shortly.

If you can see the website but can't log on:

1. Type your facility's Medicare provider number into the box provided on the login screen and click "Forgot your password?" The contact information for your eRehabData facility administrator(s) will appear. If you are the only eRehabData administrator for your facility, email assistance@eRehabData.com and include your name and your facility's Medicare provider number in the message. An eRehabData support representative will respond shortly.

If you have a question while using the website:

1. See if your question is answered in the User Manual. You can search for key words in the manual by holding down the Ctrl key while pressing the F key on your keyboard and typing your search word into the box that pops up. Then click **Find Next**. You can find all instances of your search word in the manual by continuing to click **Find Next**.

2. If there is a help icon () on the page you are having trouble with, click the icon and a pop-up window will appear. The pop-up window contains some basic information about the screen you are on and your question may be answered there.

3. Search the eRehabData Email Archive. After you log in, on the left side of your screen click **Info/Links**, then click **Email Archive**. This archive is a compilation of all of the emails sent to the eRehabData email list, organized by date.

4. If your question isn't answered in any of the above forums, you can use the eRehabData messaging system to send a message to eRehabData Tech Support. To send a message, please see the instructions for the eRehabData messaging system in the "User Features" section of this manual.

If you have a suggestion or request, or you have encountered an error on the site:

1. You can log your suggestion, request, or a description of the error you encountered in the Enhancement Requests section of the website. To post new items, please see the instructions concerning Enhancement Requests in the "User Features" section of this manual.

If you are having problems transmitting your files to CMS:

1. Refer to the data submission user's guide, available from the CMS website here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html. The submission instructions portion of this user's guide is available on the eRehabData site as well. You can find it by logging in to eRehabData and clicking **CMS Transmit File**, then **Transmission Instructions**.

2. If your problem isn't addressed in the user's guide, please contact the QIES Technical Support desk at: phone 1-800-339-9313; email help@qtso.com.

If you have a question about how to score a patient using the IRF-PAI:

1. Please refer to the IRF-PAI user manual available from the CMS website here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html.

If all else fails:

Call eRehabData at (202) 588-1766.

II. USER FEATURES

II.A. Logging In

To log in to eRehabData, you must use a computer that is connected to the Internet. After confirming that you have an Internet connection, open a web browser (Internet Explorer version 7.0 or higher, Firefox version 3 or higher, or something similar) and point it to www.eRehabData.com.

Your browser will be directed to a secure website and the login screen will appear. Enter your facility's Medicare provider number and the username and password that were created for you by either your facility's eRehabData administrator or an eRehabData support representative.

If you have forgotten your username and/or password, type in your facility's Medicare provider number and then click **Forgot your password?** The contact information for your facility's eRehabData administrator(s) will appear, and you can contact your facility administrator for assistance with logging in.

II.B. My Account

The My Account screen allows you to manage your personal contact information on your user account, as well as customize certain aspects of eRehabData to suit your preference. The My Account screen is available when you log onto eRehabData and click the **My Account** link that appears on the left side of your screen.

Change Password: Your password must be at least 8 characters long and must include at least 2 numbers along with letters (it must be alphanumeric). Additionally, it cannot include any part of your name or your facility's name, and it cannot contain the word "password." To change your password, click **Change Password**, type your new password into both the password and password confirmation boxes, and click **Update Password**. If your password doesn't match the password confirmation, or the password is not in the required format, you will receive an error message in red at the top of the screen. If you have entered everything correctly, you will be automatically redirected to a page confirming that your password has been updated.

Contact Data: You can edit the contact information on your account to ensure that you can receive eRehabData emails and be contacted by phone if necessary. To update your contact information, click **Contact Data**, enter (or edit) your email address and/or your phone number with extension if applicable, and click **Save**.

Font Settings: Due to variances in the way different web browsers, web browser versions, and computer hardware (monitors, video cards, etc.) display font types and sizes, and in consideration of user preference, we've added some display options to allow users to customize the look of their eRehabData home page and other screens. You can control the size and type of the font most of the text on eRehabData appears in with the display options settings. From the My Account menu, click **Font Settings**.

> ***Changing The Font:*** Setting the font is done via drop-down lists. Using the font samples displayed on the screen for reference, select the font type and the size you want from the drop-down lists, then click the **Save** button at the bottom of your screen. The screen will refresh and you will see your font selection applied. Then click **Back** or **HOME** to view your new font display.

Functional Settings: This is where you will find any additional customization options for controlling the display and functionality of eRehabData. From the My Account menu, click **Functional Settings**. All of the **Save** buttons on this screen work to save any changes you make so it doesn't matter which one you click. Current options include:

Use the FIM Log: The FIM Log allows you to record FIM scores for 3 shifts per day, for the three days of the admit and discharge assessment periods. The appropriate scores can then be copied to the FIM section of the IRFPAI. If you select Use the FIM Log, a new tab labeled FIM Log will appear on all of your assessments on eRehabData. To use the FIM Log, check the Use the FIM Log checkbox and click **Save**. For more information on the FIM Log please see the "IRF-PAI Features" section of this manual.

Use the "Combined" IRF-PAI screens: The combined screens setting allows you to configure the display of your IRF-PAI data entry screens. Originally, each section of the IRF-PAI on eRehabData appeared as a separate screen. Later, the combined screen configuration setting was added so you can display several IRF-PAI sections on one screen to reduce the number of screen changes and the amount of scrolling on each screen. These screens combine the Identification, Admission, and Payer Information sections onto one screen; the Medical Information and Needs sections onto one screen; and the Function Modifiers and FIM sections onto one screen.

The combined screens were designed for a screen resolution of 600x800 or greater and a font setting of Verdana 9 point, which is also the default font setting on eRehabData. If you have selected a different font type and/or size the screens will still display but may display slightly differently than our target setup.

To use the Combined IRF-PAI screens, check the Use the "Combined" IRF-PAI screens checkbox and click **Save**. If you are not satisfied with the new display screens within the IRFPAI, you can always return to the individual screens display by unchecking the box and clicking **SAVE**.

Tab through all FIM item scores first, then goals: This option controls in what order you complete the admission FIM items. If you are using the tab key on your keyboard to move from field to field and would like to tab through all of the FIM fields first, then all of the goals, check the "Tab through all FIM item scores first, then goals" checkbox and click **Save**. To tab from FIM score to its goal score to the next FIM score then to its goal and so on, leave this unchecked.

Use single page IRF-PAI Metrics pop-up: Two versions of the Metrics screens are available for printing. The standard Metrics screen, which looks like the Metrics screen available from an individual patient assessment, includes national and regional comparisons and offers an optional graph of patient FIM scores. When printed, the standard Metrics screen may be as long as three pages.

The alternate single page Metrics screen is a more condensed version designed for use in team conferences and for inclusion in a patient's medical record. This version excludes national and regional comparisons, reimbursement information, and graphs to give you a concise patient summary with facility comparisons that should print out on one page.

To use the single page Metrics screen, check the "Use single page IRF-PAI Metrics pop-up" checkbox and click **Save**. This setting controls the printable version of the Metrics screen on both the **MGMT** tab of individual assessments and the Multi-Metrics screen.

Disable "Appendix B" warning: eRehabData analyzes the pairing of Impairment Group codes with etiologic diagnoses that are entered on assessments and displays a warning messages if anything unusual is found. These warnings include checking whether the code pairing on an assessment appears in the list of suggested pairings in Appendix B of the IRF-PAI Training Manual. Due to the fact that the list in Appendix B is not a wholly comprehensive list, you may see warnings on legitimate or good code pairings. If you find the Appendix B warning to not be very useful because of false positives, you can check the "Disable 'Appendix B' warning" checkbox and click **Save** to turn off those warnings.

Show SSN in Patient Report: The eRehabData Outcomes Patient Report displays a patient identification number for each patient. By default the Patient ID (IRF-PAI field 5b) is shown, but if you prefer to see each patient's Social Security number instead, check the "Show SSN in Patient Report" checkbox and click **Save**.

Disable Patient Satisfaction PDF pop-up: This option offers a workaround for an extremely unusual problem caused by a unique combination of web browser version and security settings. If you are trying to print a patient satisfaction survey and are seeing a "Cannot download" error, check the "Disable Patient Satisfaction PDF pop-up" check box and click **Save** to disable the new window pop-up and display the survey PDF in the main browser window instead. This only affects facilities who have subscribed to the eRehabData Patient Satisfaction System.

Signature: To enable the use of an electronic signature, enter your signature into the "Signature" box as you would like it to appear wherever electronic signatures are allowed, then click **Save**. Currently only the physician signature field on the PAS Tool is configured to allow electronic signature.

PAS Tool PDF Margins: This setting allows you to control the size of the margins on the PAS Tool PDF to allow enough space to affix labels to printed PAS Tool assessments. The default values allow for .5" in all four margins but you can selectively modify the size of any of the margins. To change a margin, type your desired margin size in inches into the appropriate box and click **Save**.

Use the Internet Connection Monitor: The PAS Tool now includes an optional Internet connection monitor which checks the status of your Internet connection at regular intervals and pops up an alert message if your connection is disrupted, offering you an opportunity to re-establish a good connection before trying to save or leave the screen and potentially lose data. To enable the monitor, check the "Use the Internet Connection Monitor" checkbox and click **Save**.

Copy FIM scores from pre-admissions: If you are entering functional independence measures into your pre-admission assessments, you can choose whether or not those scores cross over to the admission IRF-PAI when a patient is admitted. You can also control this behavior on individual assessments when you admit a pre-admit. To copy your FIM scores forward, check the "Copy FIM scores from pre-admissions" checkbox and click **Save**.

Use the Pre-Admission Screening (PAS) Tool Offline Form: The eRehabData® Pre-Admission Screening Tool Offline Form is intended for use ONLY by eRehabData® users who are not able to work on PAS Tool assessments online in eRehabData® due to limited internet connectivity. This form stores patient pre-admission screenings, which may contain protected health information, on the user's computer in the Chrome browser database until the user is able to establish a connection to the internet and upload their screenings to eRehabData®. Follow the instructions in this section of the Functional Settings screen to download and install the Chrome web browser and the offline PAS Tool form.

> ***NOTE:*** The eRehabData® Pre-Admission Screening Tool Offline Form can only be used with Google's Chrome web browser, and only by users with the ability to create pre-admission screenings and/or IRF-PAIs.

II.C. eRehabData Messaging System (Send Message)

You can communicate with other users at your facility and/or organization through the eRehabData internal messaging system. This system works independently of Internet email and was built in to give users a convenient, centralized and secure means of communicating about eRehabData system work-related subjects.

View Messages: If you have received any messages through the internal messaging system, a list of those messages appears on your home page in a table titled Messages. The date the message was sent, the name of the sender, the subject of the message, whether it contains an attachment (an asterisk [*] indicates that the message includes an attachment, which is usually a patient assessment), and the status (read or unread) all appear in the table. To read the message, click on any one of those text fields.

If your message includes a patient assessment as an attachment, you can view and edit the assessment from the Read Message screen by clicking on either the patient name or **Edit Assessment** on the left side of your screen.

You can reply to a message by clicking **Reply** from the Read Message screen. Once you have typed your reply, click Send Message to send the message.

You can delete a message from either the Read Message screen by clicking **Delete**; or from your eRehabData home screen by checking the box next to the message(s) you wish to delete and clicking **DELETE SELECTED**.

Send Message: To send a message to another user from your organization, click **Send Message** on your eRehabData home page. A box labeled Recipients that contains the names of all eRehabData users for your organization will appear. Select the name of the person to whom you are sending the message. To select more than one person, hold down the Ctrl key while clicking on the names. Enter the message subject in the Subject box and the text of the message in the Message box. The text you type into the subject box will appear as the message subject on the recipient's home page when they log in to the system. To send the message to the selected recipients, click **Send Message** at the bottom of the screen. To cancel, click **HOME**.

You can also send a message to eRehabData tech support by clicking **Send Message** on your eRehabData home screen and selecting “eRehabData Tech Support” as the recipient. These messages are checked regularly by the eRehabData staff.

II.D. File Transfer (CMS Transmission, Downloads, Uploads)

If you have been granted permission to transfer files from your facility to eRehabData and/or vice versa, you can download your assessment data from eRehabData and/or upload assessment data to the eRehabData system in several formats. Each format is intended for a specific use. For example, the Assessment Data Download (Custom) can be used to create custom reports, while the HIPPS Data Download V2 can be imported into a billing software application, and the CMS Transmit File is designed to be submitted to CMS through the AT&T Global Dialer.

Some file formats have been superseded over time by more efficient or more comprehensive formats. Recommended and superseded formats are identified as such on the downloads and uploads screens.

To access the file transfer screens, log in to eRehabData. You will see a header on the left side of your home page labeled **File Transfer**. Below that, depending upon your user privileges you may see links for **CMS Transmit File**, **Downloads**, and/or **Uploads**.

> ***NOTE:*** If you do not see the **File Transfer** header, you will need to contact your facility's eRehabData administrator and ask them to adjust your user permissions. You can determine who your eRehabData facility administrator is on the eRehabData login screen by entering your facility’s Medicare provider number into the Provider ID box and then clicking on the **Forgot your password?** link.

Click **CMS Transmit File** to prepare a file of assessments for transmission to CMS. Click **Downloads** to access all available file download formats, or click **Uploads** to access the uploads for use in importing data into eRehabData. The uploads and downloads are grouped as follows:

1. CMS Transmit File

Downloads

2. **Assessment Data Download (Custom Template)**
3. **Assessment Data Download (Custom)**

4. **HIPPS Data Download V2**
5. **HIPPS Data Download**
6. **Assessment Data Download V4**
7. **Assessment Data Download V3**
8. **Assessment Data Download V2**
9. **Assessment Data Download**
10. **Follow Up Data Download**

Uploads

11. **IRF-PAI Import**
12. **Full Assessment Upload**
13. **Assessment ID Data Upload**
14. **Follow-Up Data Upload**
15. **PSI Scan Upload**

A brief description of each file is displayed on the Downloads and Uploads screens, along with a HELP icon. You can click the HELP icon next to each file description for online instructions. These instructions are also included here for your reference.

1. CMS Transmit File

Transmitting assessments to CMS for Medicare reimbursement requires that they be uploaded in a specific format to the CMS system. These guidelines cover how to use eRehabData to create one of these CMS Files.

Before creating any files for transmit to CMS, you must first confirm that the Facility ID information on file with eRehabData matches the facility information on file with CMS. This is a one-time-only process that must be performed by the eRehabData facility administrator for your facility. If the information in the eRehabData system does not match that on file with CMS, you will receive warnings in the transmission report returned by CMS after transmitting your file. If you make any changes to your facility information AFTER creating a CMS transmit file, you will need to re-create the file in order to apply the changes.

Preparation of the CMS file can only be performed by users that have the privilege “User can download assessments from their facility,” which is assigned by an eRehabData administrator. Administrators themselves do not automatically have this privilege; it must be specifically assigned. This was done because CMS only allows two people per facility to transmit files, while eRehabData supports an unlimited number of administrators.

> ***NOTE:*** This procedure only creates the file you will be sending. To actually transmit the files, you must use the CMSNet software to connect to the CMS private network, and then use a web browser to perform the upload. For help with the CMSNet software or for questions about your transmissions, please contact QIES Technical Support at 800-339-9313. For instructions, please refer to the data submission user's guide, available on the CMS website here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html. The submission instructions portion of this user's guide is available on the eRehabData site on the CMS Data Transmission page, under the **Transmission Instructions** link on the left side of the screen.

Creating the file in eRehabData is a multi-step process, with the first step being the selection of assessments to download and the final step being the actual download of the file containing the assessments to your computer’s hard drive.

To begin, click the **CMS Transmit File** link on the left side of the eRehabData home screen.

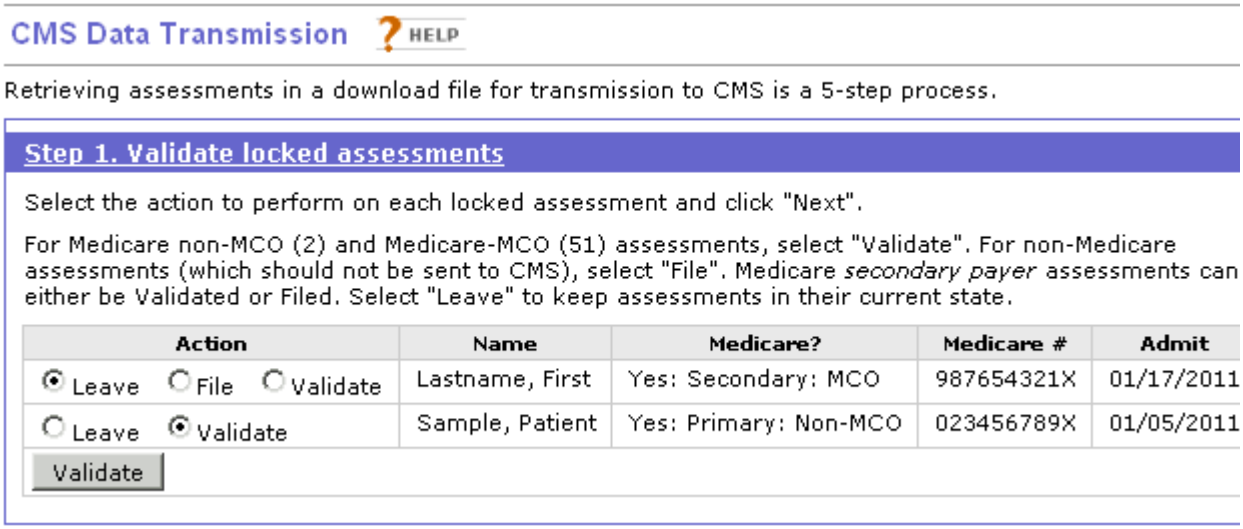
NOTE: If you do not see the **CMS Transmit File** link, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can download assessments from their facility."

After clicking on **CMS Transmit File**, you will see the following:

NOTE: The images below have been cropped. Also note that all images in this section were captured from a session using the Firefox web browser. If you are using a different browser or browser version, the appearance may be slightly different from what you see here. Functionality, however, is the same.

STEP 1: Validate Locked Assessments

This initial step allows you to choose the assessments you want to send to CMS. The following is an example of what you might see:



Only Completed and Locked Discharge assessments will appear in Step 1. If there are no assessments to choose from, you may be redirected to a later step. All assessments being transmitted to CMS must first pass an initial validation stage. To select assessments for validation, make sure that the radio buttons are set to "Validate" and click the **Validate** button. This checks the assessments to make sure that they will be acceptable by CMS standards. In most cases, if an assessment was "completed" (checked for completion from the individual assessment's management screen) then it will pass the validation stage.

All assessments with Medicare as the primary payer must be validated and transmitted to CMS. Assessments with Medicare as the secondary payer may either be validated or filed.

NOTE: While transmission of Medicare secondary payer assessments is optional, it is recommended. As of 10/1/2009, CMS requires that all Medicare-MCO (payer 51) assessments be transmitted.

Completed non-Medicare assessments can be filed either from an individual assessment's management screen or here in Step 1. For these assessments, select "File" to indicate that they need no more processing. Medicare as secondary payer assessments can be filed at this time as well. Finally, selecting "Leave" on an assessment will leave it as "Locked (Complete)" and it will remain in Step 1.

Click **Validate** to perform any actions you've marked and proceed to step 2.

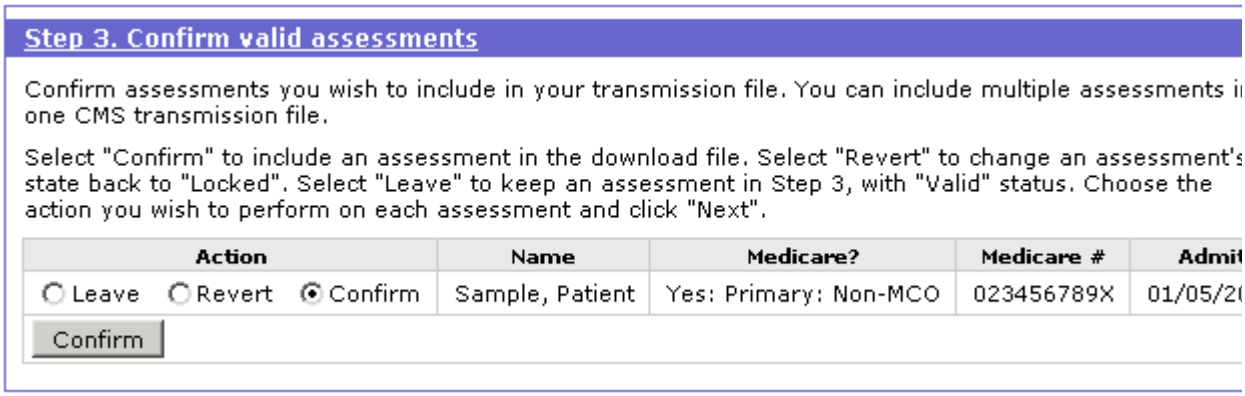
STEP 2: Review Any Problems

This step alerts you to any problems that were found during validation.
The following is an example of what you might see:

Any problems found with individual assessments will be listed on-screen, and problematic assessments will be left with the status "Locked (Complete)" so that you may fix the problem and try again. These assessments cannot be included in a CMS transmit file until the stated problems are fixed. Assessments which were validated are flagged as "Locked (xmit: Validated)" and will appear in step 3. Click **Next** to acknowledge and proceed to step 3.

STEP 3: Confirm Valid Assessments

This step shows all of the validated assessments.
The following is similar to what you might see:



Assessments marked as Valid remain in this state until you confirm or revert them. On your eRehabData home screen they will appear with status "Locked (xmit: Validated)." At this point you may:

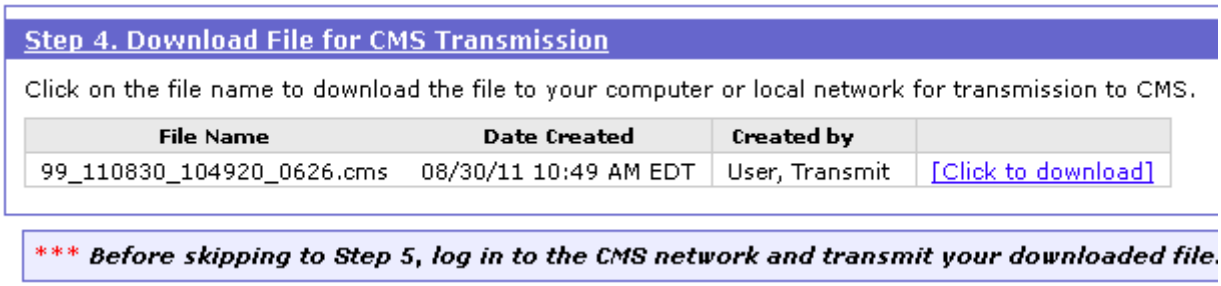
1) Return to the home screen to fix any assessments that reported problems in Step 2. When you are done, return to Step 1 and validate them. If you do not have assessment entry/edit privileges, a user with those privileges will need to make the necessary edits before the problem assessments can be transmitted.
2) Select individual assessments to revert by selecting the "Revert" option. Reverting allows you to undo a validation so that the assessment may be edited. Generally this is necessary only when an assessment was mistakenly validated.
3) Select the assessments to place into your CMS file by selecting the "Confirm" option.
4) Select individual assessments to leave in the validated state by selecting the "Leave" option.

Click the **Confirm** button to process your selected actions and create a download file on the eRehabData server.

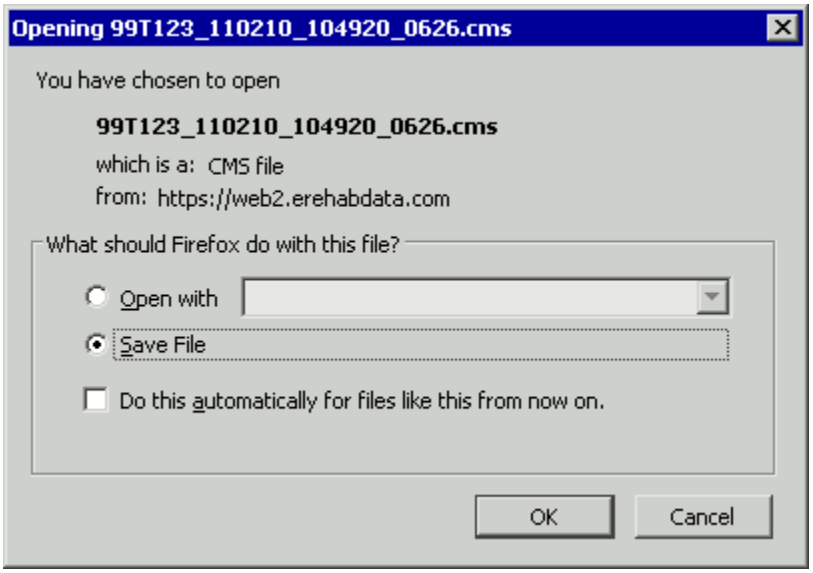
> ***NOTE:*** Once you create your CMS file, you cannot make any changes to the assessments contained in this file until you process them in Step 5.

STEP 4: Download CMS Assessments file

At this point the CMS file has been created. However, it is stored on the eRehabData server until you download it. The following is similar to what you might see:

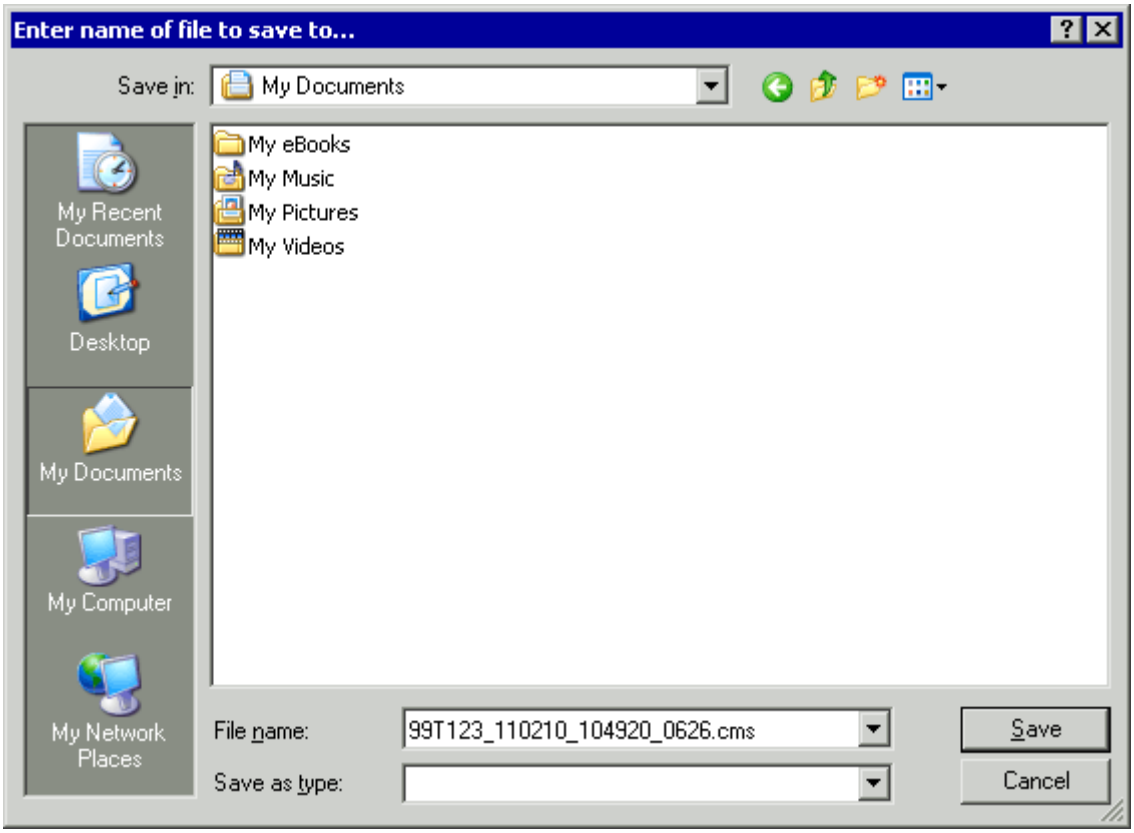


This shows that one file awaits download. By selecting the **Click to download** link, you can save the file to your computer's hard drive. The following is similar to what you might see:



Choose "Save File" and click **OK**. Next, select a destination on your computer's hard drive using the "Save in:" drop-down, change the suggested filename if you wish, and click **Save**. The default file name is comprised of your facility's Medicare provider number followed by the file creation date (yymmdd), then the file creation time (hhmmss), then the

milliseconds at which the file was created, so if you do not change the filename when you save the file you won't accidentally overwrite your other downloaded CMS files.

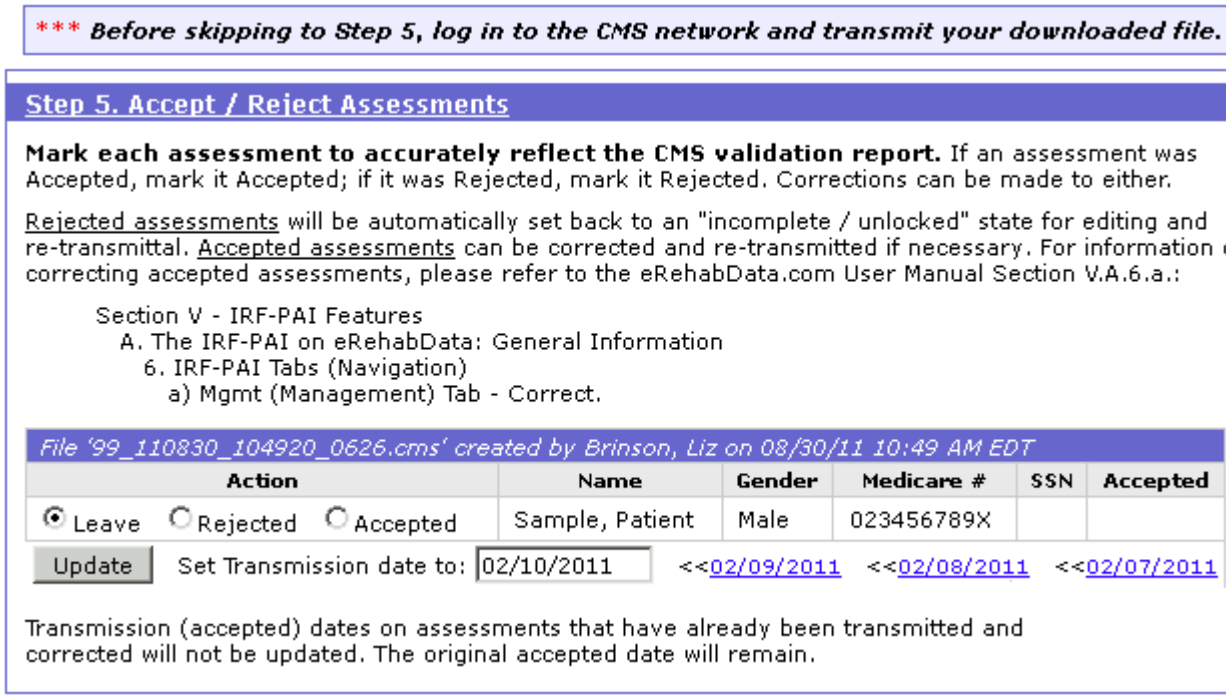


Once you have saved the file, you must access the CMS website using the CMSNet connection to perform the actual transmission. For help with CMSNet and the CMS website, refer to the data submission user's guide, available on the CMS website here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html. The submission instructions portion of this user's guide is available on the eRehabData site on the CMS Data Transmission page, under the **Transmission Instructions** link on the left side of the screen. You can also reach QIES Technical Support at 1-800-339-9313.

At this point, each assessment that has been included in your download file displays the status "Locked (xmit: Confirmed)" on the home screen. This marker identifies those assessments that have been downloaded from eRehabData and should be in transmission to CMS. Such assessments are locked and cannot be modified until they have been marked as either Accepted by CMS or Rejected by CMS in Step 5.

STEP 5: Accept/Reject Assessments

After you have transmitted your assessments file to CMS you should receive a final validation report detailing which assessments were accepted and which ones were rejected, and why. Use the CMS validation report to manually mark each assessment from the file you transmitted as Accepted or Rejected. At the top of the CMS Transmit File page, click **Skip to Step 5**. The following is similar to what you might see:



For each assessment, select the status that CMS assigned: “Accepted” or “Rejected”. If an assessment was accepted and you need to make some changes and re-transmit, you can mark it as “Accepted” and then correct and re-transmit it (for instructions on how to correct an Accepted assessment, please refer to the “IRF-PAI Features” - “Discharge Assessments” section of the eRehabData User Manual).

Marking an assessment as “Rejected” automatically reverts that assessment back to an incomplete/unlocked state so that the advised corrections can be made. Once all assessments from a particular download file have been processed, that download file will no longer appear in Step 4.

You may select “Leave” if you do not wish to mark an assessment as “Rejected” or “Accepted.” “Leave” can be used for rejected assessments that you do not wish to unlock yet.

CMS Transmission Date: When you mark assessments as accepted by CMS, you have the opportunity to modify the transmission date using the box to the right of the **Update** button to reflect when the assessments were transmitted to and accepted by CMS. If the day that you mark the assessment as “Accepted” is not the date that CMS received and accepted the assessment, you can also edit this date manually on the **ERD** tab on the assessment itself.

> ***NOTE:*** If you need to edit and re-submit any assessments, you must create a new download file containing the edited assessments after you have processed those assessments in Step 5 and corrected the errors.

Once you have selected the appropriate status for each assessment, click **Update**. Then click **HOME** to return to the launch screen.

QUICK REVIEW FOR CREATING CMS TRANSMIT FILES:

Step 1: Validate Locked Assessments

Select the "Validate" radio button only for those assessments that you are going to transmit to CMS. All others should be marked "Leave" or "File" ("File" can be used for non-Medicare or Medicare secondary payer assessments that are not being transmitted to CMS). Click **Validate**.

Step 2: Review Any Problems

Review the results and fix any problems that would prevent CMS from accepting an assessment.

Step 3: Confirm Valid Assessments

Select the "Confirm" radio button only for those assessments you are transmitting at this time. To un-validate an assessment, select "Revert". To do nothing, select "Leave." Click **Confirm**.

Step 4: Download CMS Assessments File

Download the file to your computer's hard drive in order to transmit it to CMS using the CMSNet software. Refer to the CMS documentation for how to transmit your files.

Step 5: Accept/Reject Assessments

Referring to the CMS final validation report, process your downloaded assessments by marking them either "Accepted" or "Rejected". Select "Leave" to not process an assessment. Verify the transmission date, and click **Update**.

2. Assessment Data Download (Custom Template)

The Assessment Data Download (Custom Template) allows you to select individual fields or groups of fields to include in a file you can download to your computer and control the order in which those fields are included in your file. IRF-PAI data fields are grouped by sections of the IRF-PAI and additional sections allow you to include calculations, facility custom data, notes, 60% rule compliance information, PAS Tool data, denied pre-admit information, assessment warnings, follow-up assessments, and/or patient satisfaction survey fields in your download file, giving you total control over the structure of your file. File download parameters can be saved as templates for future downloads, and these templates can be shared among users at a facility or organization.

The file downloads as a delimited text file using the delimiter you specify. Each line contains one record and each record is separated by a carriage return (ASCII 10), with each element in the record separated by your selected delimiter.

To download your custom template data file, log into eRehabData and click **Downloads**, then click **Assessment Data Download (Custom Template)**. Depending on your user permissions, you may see some or all of the following options for setting your download parameters: Load Facility Template; Choose Template; Facility Data to Download; Data Fields; Assessment Type; Primary Payer; Completion Status; Accepted; Search Date; Date Range; Include Header; Field Delimiter; Share Template; and Save Template.

Saved templates include all download parameters selected when the template was saved except for start and end dates if your date range selection is "Between the dates."

NOTE: If you do not see the **Downloads** or **Assessment Data Download (Custom Template)** options, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can download assessments from their facility."

DOWNLOAD PARAMETERS

Load Facility Template: This option allows users to view a list of all shared templates at each facility in their organization. Select a facility to display the list of shared templates for that facility.

NOTE: The "Load Facility Template" option is only available to users belonging to an organization that has more than one subscriber facility on eRehabData, and the privilege to download data from multiple facilities can only be assigned by an eRehabData organization administrator.

Choose Template: This option allows you to load a previously saved template. Users can see templates they have created, plus all templates that have been shared by other users at their facility. To load a template, select the radio button next to the template name and click **Load**. Additionally, users can delete templates they have created by selecting the radio button next to the template name and clicking **Delete**.

Facility Data to Download: This option allows you to download data for an individual facility or multiple facilities in your organization, or for all facilities in your organization combined. However, if you select more than one facility or the "All Facilities in Organization" option, your file will contain an additional data field identifying each record's facility Medicare provider number, and it will not contain facility custom fields.

NOTE: The "Facility Data to Download" option is only available to users belonging to an organization that has more than one subscriber facility on eRehabData, and the privilege to download data from multiple facilities can only be assigned by an eRehabData organization administrator.

Select Available Fields: This box displays all fields available for download, grouped by section. You can select individual fields or entire sections for download. To select an individual field, click on it. To select multiple fields, hold down the Ctrl key while you click on each field name. To select an entire section, click the section name. For example, to grab all of the IRF-PAI identification information fields, select the section header labeled "Identification Information (all fields)". Use the **>>** button to move selected fields or sections from the "Select Available Fields" box into the "Arrange Selected Fields" box.

NOTE: All records downloaded will include the eight fields listed at the beginning of the field descriptions below, beginning with "AssessUniqueID". If you select to include Follow Up Assessments in your download and you have multiple follow up assessments for any single patient discharge, you will see any downloaded IRF-PAI information duplicated for each follow up assessment. This was done to better facilitate sorting and/or grouping of the assessments.

A note about the calculations: For the most part, calculations fields are self-explanatory. Calculations are based on the final rule in effect at the time of the discharge date on any given assessment. "60% Compliant Without Comorbidity" is T if the assessment is conditionally or presumptively compliant (respectively) with the 60% rule without factoring in comorbidities. "Long Stay" is calculated as follows:

For discharges prior to 10/1/2005: T if the LOS was at least twice the PPS Mean Average Length Of Stay for the CMG.

For discharges on or after 10/1/2005: T if the LOS was at least 1.402 times the PPS Mean Average Length Of Stay for the CMG.

For discharges starting 10/1/2005 through 9/30/2006 (FY2006): T if the LOS was at least 1.402 times the PPS ALOS for the CMG.

For discharges starting 10/1/2006 through 9/30/2007 (FY2007): T if the LOS was at least 1.4263 times the PPS ALOS for the CMG.

For discharges starting 10/1/2007 through 3/31/2008 (first half FY2008): T if the LOS was at least 1.5592 times the PPS ALOS for the CMG.

For discharges starting 4/1/2008 through 9/30/2008 (second half FY2008): T if the LOS was at least 1.5648 times the PPS ALOS for the CMG.

For discharges starting 10/1/2008 through 9/30/2009 (FY2009): T if the LOS was at least 1.7910 times the PPS ALOS for the CMG.

For discharges starting 10/1/2009 through 3/31/2010 (first half FY2010): T if the LOS was at least 1.7797 times the PPS ALOS for the CMG.

For discharges starting 4/1/2010 through 9/30/2010 (second half FY2010): T if the LOS was at least 1.7867 times the PPS ALOS for the CMG.

For discharges starting 10/1/2010 through 9/30/2011 (FY2011): T if the LOS was at least 1.8232 times the PPS ALOS for the CMG.

For discharges starting 10/1/2011 through 9/30/2012 (FY2012): T if the LOS was at least 1.7611 times the PPS ALOS for the CMG.

For discharges starting 10/1/2012 through 9/30/2013 (FY2013): T if the LOS was at least 1.7297 times the PPS ALOS for the CMG.

For discharges starting 10/1/2013 through 9/30/2014 (FY2014): T if the LOS was at least 1.6245 times the PPS ALOS for the CMG.

For discharges starting 10/1/2014 through 9/30/2015 (FY2015): T if the LOS was at least 1.5822 times the PPS ALOS for the CMG.

For discharges starting 10/1/2015 through 9/30/2016 (FY2016): T if the LOS was at least 1.5594 times the PPS ALOS for the CMG.

Arrange Selected Fields: This box allows you to arrange the fields in the order in which you want them to appear in your download file. To move a field up or down in the list, click on the field name, then click the up or down arrow to the right of the box. To remove a field from the list, click on the field name and click the **X** button to the right of the box.

Assessment Type: This option refers to the assessment's current state. For example, if you select Discharge, you will retrieve all available assessment data (admit and discharge) for assessments currently in a discharge assessment state and which meet your other search criteria. If you select Admit, you will retrieve all available assessment data for current admission assessments. However, if you select only Admit and you are looking for past time periods, your search will probably not return any assessments since presumably those patients would have since been discharged and their assessments would be in a discharge state.

Primary Payer: This option controls whether your file will include "Medicare (non-MCO)" assessments, "non-Medicare" assessments, or both. You can select one or both of these options by checking the appropriate boxes.

> ***NOTE:*** When downloading Medicare assessments, only assessments with a primary payer of "2 - Medicare non-MCO" are included.

Completion Status: This option controls whether you will pull "Complete" or "Incomplete" assessments, or both. You can select one or both of these options by checking the appropriate boxes.

> ***NOTE:*** There is currently no standard group of fields defining completion of pre-admission assessments, so if you are downloading pre-admits, make sure you check "Incomplete" or you will not return any records.

Accepted: This option controls whether you will pull assessments that have been Accepted by CMS or Filed, Not Accepted by CMS or Not Filed, or both. You can select one or both of these options by checking the appropriate boxes.

Search Date: This option determines how your date filter will be applied if you specify a date range. You can filter for assessments by date Created, Last Modified, Admitted, Discharged, Denied (for denied pre-admits), Transmitted to CMS (for Medicare assessments that have been marked as Accepted by CMS), Referred, or Screened.

> ***NOTE:*** Make sure that when use the Search Date filter, you filter on a date that will be present in the records you are downloading. For example, if filtering by Discharge Date, you should not expect to download any pre-admit or admission assessments because those records do not contain discharge dates.

Date Range: This option allows you to filter assessments by the search date type you selected above. Ranges include "All", "Current Day", "Last x Days (includes today)", "Previous x Days (excludes today)", and a specified date range. Select the radio button next to your desired option before typing in any additional parameters like number of days or dates. If you do not wish to apply a date filter, select "All Assessments".

Include Header: This option controls whether your download file will contain a header record with all of the column names. If you want column names in your file, select "Yes".

Field Delimiter: This option allows you to specify what character will separate each individual data element in each record, with the recommended TAB character being the default.

Share Template: If you are saving your download options as a template and would like other users at your facility to be able to use your template, select "Yes". If you want exclusive use of your template, select "No".

> ***NOTE:*** For organization-level downloaders: If your template includes facility custom data fields from one facility and you select to use that template to download assessment data at a different facility, the facility custom data fields will be removed from the list of available fields and replaced by any facility custom fields exist for the facility whose data you are downloading. A window will pop up alerting you of this fact.

Save Template: If you wish to save your download options as a template, enter a name for the template into the "Save template as:" box and click **Save**. You can overwrite an existing template that you have created by saving a template with the same name. You cannot overwrite a template created by a different user. You do not need to save a template in order to download a file with the download options you have selected.

Make your selections and click **Download**. You will see a list of the parameters you chose, and a link that says Click here to download. Click the link, and you should be prompted to save the file to your disk (computer). You can change the filename if you wish when you save it to your computer.

FILE STRUCTURE

If you specified that your file should include a header record, the first record in the file is the header record containing column names, each separated by your selected delimiter. The fields are included in the order you specified using the "Arrange Selected Fields" box.

> ***NOTE:*** For assessments without a discharge date, the reimbursement calculator (FacilityAdjPayment) assumes the discharge date is today but does not account for short stays or transfers.

The facility custom symbolic names listed in the file header are those defined in the "Element Name" box on the facility custom data fields management screen by an eRehabData facility administrator.

While the individual records themselves generally appear in the order in which they were initially created, this is not guaranteed, so no assumptions should be made regarding order. Null values are not specified directly by any specific sequence of characters other than having no characters between two delimiters.

The first value in each record is the unique ID assigned to the assessment by eRehabData. This value is numeric and can be used by a facility as a unique assessment ID. If the system that imports these data instead assigns its own ID, this value should nonetheless be kept so that after future downloads, duplicate or updated records can be easily identified.

The second value in each record indicates the current state of the assessment:

P for Pre-Admit, A for Admit, D for Discharge, and X for Deleted.

Data Types: Char values are a single 8-bit ANSI character. Boolean values appear as T (true) or f (false), or blank. Integers and Floats are 32-bit. Date and date/time values are in YYYY-MM-DD hh:mm:ss format. Strings may be of any length. There are also many enumerated values present. In general these are integers used to represent a value selected from a set of options, for example, a FIM score, which may be from 0 to 7 or null. For descriptions and explanations of the possible values, please see the IRF-PAI specification.

In the *Notes* column below, for the IRF-PAI fields, letters from "PAD" indicate which assessment types may contain values for this field. For example, "A" indicates that a value will be present only for an admit assessment, while "AD" stands for admit and discharge assessments and "PAD" indicates that a value may be present on pre-admit, admit, and discharge assessments. In this case, "pre-admit" refers to the original eRehabData pre-admission screen which was a stripped-down version of the IRF-PAI, and not the eRehabData Pre-Admission Screening (PAS) Tool. PAS Tool fields are found further down in the list of available fields.

Here are the fields available for download:

Assessment Data Download (Custom Template) Available Fields

Column Name	Data Type	Notes	IRF-PAI Field
ProviderID	(char)	This column is only present in multi-facility downloads	N/A
AssessUniqueID	(int)	eRehabData's unique ID for this assessment	N/A

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
AssessType	(char)	P = Pre-Admit, A = Admit, D = Discharge, X = Deleted	N/A
Completed	(boolean)	AD	N/A
Locked	(boolean)	PAD	N/A
Accepted	(boolean)	AD	N/A
Filed	(boolean)	PAD	N/A
AssessCreated	(date/time)	PAD	N/A
AssessModified	(date/time)	PAD	N/A
IDENTIFICATION INFORMATION			
First Name	(string)	AD	4
Last Name	(string)	AD	5A
Medicare Num	(string)	AD	2
Medicaid Num	(string)	AD	3
Pat ID Num	(string)	AD	5B
Birth Date	(date)	AD	6
SSN	(string)	AD	7
Gender	(char)	AD (F = Female, M = Male)	8
Race AmerInd	(boolean)	AD	9
Race Asian	(boolean)	AD	9
Race AfrAmer	(boolean)	AD	9
Race HispLatino	(boolean)	AD	9
Race PacIsland	(boolean)	AD	9
Race White	(boolean)	AD	9
Marital Status	(enum)	AD	10
Pre Hospital ZIP	(string)	AD	11
ADMISSION INFORMATION			
Admit Date	(date)	AD	12
Assess Ref Date	(date)	AD	13
Admit Class	(enum)	AD	14
Admit From	(enum)	AD	15
Pre Hosp Living Setting	(enum)	AD	16
Pre Hosp Living With	(enum)	AD	17
PAYER INFORMATION			
Payer Primary	(enum)	AD	20A
Payer Secondary	(enum)	AD	20B
MEDICAL INFORMATION			
ADM IGC	(string)	AD (Impairment Group Code)	21 (Admit)
DIS IGC	(string)	D (Impairment Group Code)	21 (Disch)
Diagnosis	(string)	AD (ICDICD code)	22/22A
Diagnosis B	(string)	AD (ICDICD code)	22B
Diagnosis B	(string)	AD (ICDICD code)	22C
Onset Of Dx	(date)	AD	23
Comorb A	(string)	AD (ICD code)	24A
Comorb B	(string)	AD (ICD code)	24B
Comorb C	(string)	AD (ICD code)	24C
Comorb D	(string)	AD (ICD code)	24D
Comorb E	(string)	AD (ICD code)	24E

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Comorb F	(string)	AD (ICD code)	24F
Comorb G	(string)	AD (ICD code)	24G
Comorb H	(string)	AD (ICD code)	24H
Comorb I	(string)	AD (ICD code)	24I
Comorb J	(string)	AD (ICD code)	24J
Comorb K	(string)	AD (ICD code)	24K
Comorb L	(string)	AD (ICD code)	24L
Comorb M	(string)	AD (ICD code)	24M
Comorb N	(string)	AD (ICD code)	24N
Comorb O	(string)	AD (ICD code)	24O
Comorb P	(string)	AD (ICD code)	24P
Comorb Q	(string)	AD (ICD code)	24Q
Comorb R	(string)	AD (ICD code)	24R
Comorb S	(string)	AD (ICD code)	24S
Comorb T	(string)	AD (ICD code)	24T
Comorb U	(string)	AD (ICD code)	24U
Comorb V	(string)	AD (ICD code)	24V
Comorb W	(string)	AD (ICD code)	24W
Comorb X	(string)	AD (ICD code)	24X
Comorb Y	(string)	AD (ICD code)	24Y
Compliant Arthritis	(boolean)	AD	24A1 (Admit)
Height Inches	(integer)	AD	27 (Admit)
Weight Pounds	(integer)	AD	27 (Disch)
Admit Swallowing Stat	(enum)	AD	27 (Admit)
Disch Swallowing Stat	(enum)	D	27 (Disch)
FUNCTION MODIFIERS			
ADM Fn Mod Bladder Lvl Assist	(enum)	AD	29 (Admit)
ADM Fn Mod Bladder Freq Accidents	(enum)	AD	30 (Admit)
ADM Fn Mod Bowel Lvl Assist	(enum)	AD	31 (Admit)
ADM Fn Mod Bowel Freq Accidents	(enum)	AD	32 (Admit)
ADM Fn Mod Tub Transfer	(enum)	AD	33 (Admit)
ADM Fn Mod Shower Transfer	(enum)	AD	34 (Admit)
ADM Fn Mod Dist Walked	(enum)	AD	35 (Admit)
ADM Fn Mod Dist Wheelchair	(enum)	AD	36 (Admit)
ADM Fn Mod Walk	(enum)	AD	37 (Admit)
ADM Fn Mod Wheelchair	(enum)	AD	38 (Admit)
DIS Fn Mod Bladder Lvl Assist	(enum)	D	29 (Disch)
DIS Fn Mod Bladder Freq Accidents	(enum)	D	30 (Disch)
DIS Fn Mod Bowel Lvl Assist	(enum)	D	31 (Disch)
DIS Fn Mod Bowel Freq Accidents	(enum)	D	32 (Disch)
DIS Fn Mod Tub Transfer	(enum)	D	33 (Disch)
DIS Fn Mod Shower Transfer	(enum)	D	34 (Disch)
DIS Fn Mod Dist Walked	(enum)	D	35 (Disch)
DIS Fn Mod Dist Wheelchair	(enum)	D	36 (Disch)
DIS Fn Mod Walk	(enum)	D	37 (Disch)
DIS Fn Mod Wheelchair	(enum)	D	38 (Disch)
FIM INSTRUMENT			
ADM FIM Eating	(enum)	AD	39A (Admit)
ADM FIM Grooming	(enum)	AD	39B (Admit)
ADM FIM Bathing	(enum)	AD	39C (Admit)

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
ADM FIM Dressing Upper	(enum)	AD	39D (Admit)
ADM FIM Dressing Lower	(enum)	AD	39E (Admit)
ADM FIM Toileting	(enum)	AD	39F (Admit)
ADM FIM Bladder Ctrl	(enum)	AD	39G (Admit)
ADM FIM Bowel Ctrl	(enum)	AD	39H (Admit)
ADM FIM Bed Transfer	(enum)	AD	39I (Admit)
ADM FIM Toilet Transfer	(enum)	AD	39J (Admit)
ADM FIM Tub Transfer	(enum)	AD	39K (Admit)
ADM FIM Walk Wheelchair	(enum)	AD	39L (Admit)
ADM FIM Walk Wheelchair Measured	(char)	AD	39L (Admit)
ADM FIM Stairs	(enum)	AD	39M (Admit)
ADM FIM Comprehension	(enum)	AD	39N (Admit)
ADM FIM Comprehension Measured	(char)	AD	39N (Admit)
ADM FIM Expression	(enum)	AD	39O (Admit)
ADM FIM Expression Measured	(char)	AD	39O (Admit)
ADM FIM Social Interaction	(enum)	AD	39P (Admit)
ADM FIM Problem Solving	(enum)	AD	39Q (Admit)
ADM FIM Memory	(enum)	AD	39R (Admit)
DIS FIM Eating	(enum)	D	39A (Disch)
DIS FIM Grooming	(enum)	D	39B (Disch)
DIS FIM Bathing	(enum)	D	39C (Disch)
DIS FIM Dressing Upper	(enum)	D	39D (Disch)
DIS FIM Dressing Lower	(enum)	D	39E (Disch)
DIS FIM Toileting	(enum)	D	39F (Disch)
DIS FIM Bladder Ctrl	(enum)	D	39G (Disch)
DIS FIM Bowel Ctrl	(enum)	D	39H (Disch)
DIS FIM Bed Transfer	(enum)	D	39I (Disch)
DIS FIM Toilet Transfer	(enum)	D	39J (Disch)
DIS FIM Tub Transfer	(enum)	D	39K (Disch)
DIS FIM Walk Wheelchair	(enum)	D	39L (Disch)
DIS FIM Walk Wheelchair Measured	(char)	D	39L (Disch)
DIS FIM Stairs	(enum)	D	39M (Disch)
DIS FIM Comprehension	(enum)	D	39N (Disch)
DIS FIM Comprehension Measured	(char)	D	39N (Disch)
DIS FIM Expression	(enum)	D	39O (Disch)
DIS FIM Expression Measured	(char)	D	39O (Disch)
DIS FIM Social Interaction	(enum)	D	39P (Disch)
DIS FIM Problem Solving	(enum)	D	39Q (Disch)
DIS FIM Memory	(enum)	D	39R (Disch)
Goal FIM Eating	(enum)	AD	39A (Goal)
Goal FIM Grooming	(enum)	AD	39B (Goal)
Goal FIM Bathing	(enum)	AD	39C (Goal)
Goal FIM Dressing Upper	(enum)	AD	39D (Goal)
Goal FIM Dressing Lower	(enum)	AD	39E (Goal)
Goal FIM Toileting	(enum)	AD	39F (Goal)
Goal FIM Bladder Ctrl	(enum)	AD	39G (Goal)
Goal FIM Bowel Ctrl	(enum)	AD	39H (Goal)
Goal FIM Bed Transfer	(enum)	AD	39I (Goal)
Goal FIM Toilet Transfer	(enum)	AD	39J (Goal)
Goal FIM Tub Transfer	(enum)	AD	39K (Goal)

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Goal FIM Walk Wheelchair	(enum)	AD	39L (Goal)
Goal FIM Stairs	(enum)	AD	39M (Goal)
Goal FIM Comprehension	(enum)	AD	39N (Goal)
Goal FIM Expression	(enum)	AD	39O (Goal)
Goal FIM Social Interaction	(enum)	AD	39P (Goal)
Goal FIM Problem Solving	(enum)	AD	39Q (Goal)
Goal FIM Memory	(enum)	AD	39R (Goal)
THERAPY INFORMATION			
PT Ind Week 1	(integer)	AD	O0401A A
PT Con Week 1	(integer)	AD	O0401A B
PT Grp Week 1	(integer)	AD	O0401A C
PT Co Week 1	(integer)	AD	O0401A D
OT Ind Week 1	(integer)	AD	O0401B A
OT Con Week 1	(integer)	AD	O0401B B
OT Grp Week 1	(integer)	AD	O0401B C
OT Co Week 1	(integer)	AD	O0401B D
SLP Ind Week 1	(integer)	AD	O0401C A
SLP Con Week 1	(integer)	AD	O0401C B
SLP Grp Week 1	(integer)	AD	O0401C C
SLP Co Week 1	(integer)	AD	O0401C D
PT Ind Week 2	(integer)	AD	O0402A A
PT Con Week 2	(integer)	AD	O0402A B
PT Grp Week 2	(integer)	AD	O0402A C
PT Co Week 2	(integer)	AD	O0402A D
OT Ind Week 2	(integer)	AD	O0402B A
OT Con Week 2	(integer)	AD	O0402B B
OT Grp Week 2	(integer)	AD	O0402B C
OT Co Week 2	(integer)	AD	O0402B D
SLP Ind Week 2	(integer)	AD	O0402C A
SLP Con Week 2	(integer)	AD	O0402C B
SLP Grp Week 2	(integer)	AD	O0402C C
SLP Co Week 2	(integer)	AD	O0402C D
DISCHARGE INFORMATION			
Disch Date	(date)	D	40
Disch Against Advice	(boolean)	D	41
Program Interruptions	(boolean)	D	42
Transfer Date 1	(date)	D	43A
Return Date 1	(date)	D	43B
Transfer Date 2	(date)	D	43C
Return Date 2	(date)	D	43D
Transfer Date 3	(date)	D	43E
Return Date 3	(date)	D	43F
Disch Alive	(boolean)	D	44C
Disch Living Setting	(enum)	D	44A/44D
Disch Living With	(enum)	D	45
Transfer Dx	(string)	D (ICD code)	46
Complic A	(string)	D (ICD code)	47A
Complic B	(string)	D (ICD code)	47B
Complic C	(string)	D (ICD code)	47C
Complic D	(string)	D (ICD code)	47D

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Complic E	(string)	D (ICD code)	47E
Complic F	(string)	D (ICD code)	47F
SIGNATURES			
Signature A	(string)	AD	Z0400A A
Signature A Title	(string)	AD	Z0400A A
Signature A Date	(date)	AD	Z0400A A
Signature A Time	(time)	AD	Z0400A A
Signature B	(string)	AD	Z0400A B
Signature B Title	(string)	AD	Z0400A B
Signature B Date	(date)	AD	Z0400A B
Signature B Time	(time)	AD	Z0400A B
Signature C	(string)	AD	Z0400A C
Signature C Title	(string)	AD	Z0400A C
Signature C Date	(date)	AD	Z0400A C
Signature C Time	(time)	AD	Z0400A C
Signature D	(string)	AD	Z0400A D
Signature D Title	(string)	AD	Z0400A D
Signature D Date	(date)	AD	Z0400A D
Signature D Time	(time)	AD	Z0400A D
Signature E	(string)	AD	Z0400A E
Signature E Title	(string)	AD	Z0400A E
Signature E Date	(date)	AD	Z0400A E
Signature E Time	(time)	AD	Z0400A E
Signature F	(string)	AD	Z0400A F
Signature F Title	(string)	AD	Z0400A F
Signature F Date	(date)	AD	Z0400A F
Signature F Time	(time)	AD	Z0400A F
Signature G	(string)	AD	Z0400A G
Signature G Title	(string)	AD	Z0400A G
Signature G Date	(date)	AD	Z0400A G
Signature G Time	(time)	AD	Z0400A G
Signature H	(string)	AD	Z0400A H
Signature H Title	(string)	AD	Z0400A H
Signature H Date	(date)	AD	Z0400A H
Signature H Time	(time)	AD	Z0400A H
Signature I	(string)	AD	Z0400A I
Signature I Title	(string)	AD	Z0400A I
Signature I Date	(date)	AD	Z0400A I
Signature I Time	(time)	AD	Z0400A I
Signature J	(string)	AD	Z0400A J
Signature J Title	(string)	AD	Z0400A J
Signature J Date	(date)	AD	Z0400A J
Signature J Time	(time)	AD	Z0400A J
Signature K	(string)	AD	Z0400A K
Signature K Title	(string)	AD	Z0400A K
Signature K Date	(date)	AD	Z0400A K
Signature K Time	(time)	AD	Z0400A K
Signature L	(string)	AD	Z0400A L
Signature LTitle	(string)	AD	Z0400A L
Signature L Date	(date)	AD	Z0400A L

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Signature L Time	(time)	AD	Z0400A L
CALCULATIONS			
Age at Admit	(int)		
LOS	(int)		
ADM FIM Total Motor	(int)	does not include tub/shower transfer	
ADM FIM Total Cog	(int)		
ADM FIM Motor Weighted	(float)	does not include tub/shower transfer	
DIS FIM Total Motor	(int)	does not include tub/shower transfer	
DIS FIM Total Cog	(int)		
FIM Gain Motor	(int)	does not include tub/shower transfer	
FIM Gain Cog	(int)		
FIM Gain Total	(int)	does not include tub/shower transfer	
FIM Chg Per Day	(float)	does not include tub/shower transfer	
RIC	(int)		
CMG	(enum)		
Tier	(int)	0-3	
HIPPS Code	(string)	x####, where x = tier A, B, C, or D and #### = the CMG code	
Short Stay Expired	(boolean)	T if patient was short stay OR expired, f if neither	
Short Stay CMG	(enum)	empty if Short Stay Expired = f	
Transfer Patient	(boolean)	T or f, as defined in the Final Rule	
Long Stay	(boolean)	see explanation in "Download Parameters" above	
Base Pay Weight	(float)	from Final Rule	
Fac Adj Pay Weight	(float)	adjusted for facility	
Facility Adj Payment	(float)	adjusted for short stays and transfer patients	
CMS Transmit Date	(date)		
Final Rule ALOS	(int)		
FACILITY CUSTOM DATA			
Facility Custom	(*)	# of occurrences and types dependent upon facility definition ***Note:*** facility custom fields are not included in multi-facility downloads	
NOTES			
Notes	(memo)		
60% RULE COMPLIANCE			
Compliant 60 Pct Rule	(boolean)	Conditional compliance based on 60% Rule methodology effective on assessment discharge date	

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
No Comorb Compliant 60%	(boolean)	Conditional compliance without considering comorbidities, based on 60% Rule methodology effective on assessment discharge date	
Presumptive 60 Pct Rule Pre-2016 ICD-10	(boolean)	Presumptive compliance using **ICD-10** codes and the CMS methodology for compliance review periods beginning prior to October 1, 2015	
Presumptive 60 Pct Rule Pre-2016 No Comorb ICD-10	(boolean)	Presumptive compliance without considering comorbidities, using **ICD-10** codes and the CMS methodology for compliance review periods beginning prior to October 1, 2015	
Presumptive 60 Pct Rule 2016 ICD-10	(boolean)	Presumptive compliance using **ICD-10** codes and the CMS methodology for compliance review periods beginning on or after October 1, 2015	
Presumptive 60 Pct Rule 2016 No Comorb ICD-10	(boolean)	Presumptive compliance without considering comorbidities, using **ICD-10** codes and the CMS methodology for compliance review periods beginning on or after October 1, 2015	
Presumptive 60 Pct Rule (pre-FY2016)	(boolean)	Presumptive compliance based on the CMS **ICD-9** methodology last published in 2007	
No Comorb Presumptive 60%	(boolean)	Presumptive compliance without considering comorbidities, based on the CMS **ICD-9** methodology last published in 2007	
60% RULE QUESTIONS			
Question J	(boolean)	Does patient have active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation?	

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Question K	(boolean)	Does patient have systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation?	
Question L	(boolean)	Does patient have severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation? (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)	
Question BMI	(boolean)	Is the patient extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF?	
Question Comorb	(boolean)	Patient has a comorbidity, as defined at Section 412.602 and : (A) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2)(iii) of this section; (B) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2)(iii) of this section; and (C) The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.	
ASSESSMENT INFO			
Creating User Username	(string)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Creating User Last Name First Name	(string)		
Last Modifying User Username	(string)		
Last Modifying User Last Name First Name	(string)		
PAS To IRF-PAI	(date)	Indicates when a PAS Tool was converted to an admission IRF-PAI	
QRP Override	(boolean)	T if the QRP override checkbox was checked, indicating that fields required for the IRF Quality Reporting Program were not completed and the QRP data requirements were manually overridden	
QRP Notes	(string)		
ASSESSMENT WARNINGS			
Warnings	(string)	AppB=Appendix B, IGC=IGC/Diagnosis pairing, FIM=FIM progression	
PRE-ADMIT DEMOGRAPHICS			
First Name (PAS)	(string)		
Last Name (PAS)	(string)		
Birth Date (PAS)	(string)		
Gender (PAS)	(char)	F = Female, M = Male	
SSN (PAS)	(string)		
Patient ID Num (PAS)	(string)		
Medicare Num (PAS)	(string)		
Medicaid Num (PAS)	(string)		
Address (PAS)	(string)		
City (PAS)	(string)		
State (PAS)	(string)		
Pre Hosp ZIP (PAS)	(string)		
Marital Status (PAS)	(enum)	See IRF-PAI Item 10 for possible values	
PreHosp Living Setting (PAS)	(enum)	See IRF-PAI Item 16 for possible values	
PreHosp Living Setting Notes (PAS)	(memo)		
PreHosp Living With (PAS)	(enum)	See IRF-PAI Item 17 for possible values	
PreHosp Activity Working (PAS)	(boolean)		
PreHosp Activity Disabled (PAS)	(boolean)		
PreHosp Activity Driving (PAS)	(boolean)		
PreHosp Activity Comments (PAS)	(memo)		
Support Spouse (PAS)	(boolean)		
Support Children (PAS)	(boolean)		
Support Relatives (PAS)	(boolean)		
Support Community (PAS)	(boolean)		
Support Church (PAS	(boolean)		
Support Friends (PAS)	(boolean)		
Caregiver Contact (PAS)	(string)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Caregiver Relationship (PAS)	(string)		
Caregiver Phone Num (PAS)	(string)		
Caregiver Type of Support (PAS)	(memo)		
Caregiver Support Limitations (PAS)	(memo)		
Patient Family Rehab Goal (PAS)	(memo)		
PRE-ADMIT REFERRAL/PAYER			
Referral Date (PAS)	(date)		
Admit From (PAS)	(enum)		
Internal Referral (PAS)	(boolean)	T if internal, f if external, blank if not completed	
Referral Source (PAS)	(string)		
Facility Admit Date (PAS)	(date)		
Facility Contact Name (PAS)	(string)		
Facility Contact Num (PAS)	(string)		
Referring Physician (PAS)	(string)		
Physician Home # (PAS)	(string)		
Medicare Num (PAS)	(string)		
Medicaid Num (PAS)	(string)		
Payer Prim. (PAS)	(enum)	See IRF-PAI Item 20A for possible values	
Insurer Name Prim. (PAS)	(string)		
Insurer Contact Prim. (PAS)	(string)		
Insurer Phone Num Prim. (PAS)	(string)		
Insureds Employer Prim. (PAS)	(string)		
Insurer Policy Num Prim. (PAS)	(string)		
Insurer Auth Num Prim. (PAS)	(string)		
Payer Sec. (PAS)	(enum)	See IRF-PAI Item 20B for possible values	
Insurer Name Sec. (PAS)	(string)		
Insurer Contact Sec. (PAS)	(string)		
Insurer Phone Num Sec. (PAS)	(string)		
Insureds Employer Sec. (PAS)	(string)		
Insurer Policy Num Sec. (PAS)	(string)		
Insurer Auth Num Sec. (PAS)	(string)		
PRE-ADMIT STATUS			
IGC (PAS)	(string)		
RIC (PAS)	(enum)		
Diagnosis (PAS)	(string)	ICD code	
Diagnosis Descrip (PAS)	(string)		
Diagnosis B (PAS)	(string)	ICD code	
Diagnosis B Descrip (PAS)	(string)		
Diagnosis C (PAS)	(string)	ICD code	
Diagnosis C Descrip (PAS)	(string)		
Onset Date (PAS)	(date)		
Comorb A (PAS)	(string)	ICD code	
Comorb A Descrip (PAS)	(string)		
Comorb B (PAS)	(string)	ICD code	
Comorb B Descrip (PAS)	(string)		
Comorb C (PAS)	(string)	ICD code	
Comorb C Descrip (PAS)	(string)		
Comorb D (PAS)	(string)	ICD code	

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Comorb D Descrip (PAS)	(string)		
Comorb E (PAS)	(string)	ICD code	
Comorb E Descrip (PAS)	(string)		
Comorb F (PAS)	(string)	ICD code	
Comorb F Descrip (PAS)	(string)		
Comorb G (PAS)	(string)	ICD code	
Comorb G Descrip (PAS)	(string)		
Comorb H (PAS)	(string)	ICD code	
Comorb H Descrip (PAS)	(string)		
Comorb I (PAS)	(string)	ICD code	
Comorb I Descrip (PAS)	(string)		
Comorb J (PAS)	(string)	ICD code	
Comorb J Descrip (PAS)	(string)		
Hx Present Illness (PAS)	(memo)		
Hx Hosp/Rehab (PAS)	(memo)		
Hx Surgeries (PAS)	(memo)		
Hx Medications (PAS)	(memo)		
Vitals Taken Date (PAS)	(date)		
Vitals Height (PAS)	(int)		
Vitals Weight (PAS)	(int)		
Vitals BMI (PAS)	(float)		
Vitals BP Systolic (PAS)	(int)		
Vitals BP Diastolic (PAS)	(int)		
Vitals Temp (PAS)	(float)		
Vitals Pulse (PAS)	(int)		
Vitals Respiration (PAS)	(int)		
Vitals O2 Saturation (PAS)	(int)		
Pain (PAS)	(enum)		
Pain Notes (PAS)	(memo)		
Infection None (PAS)	(boolean)		
Infection MRSA Site (PAS)	(string)		
Infection CDiff (PAS)	(string)		
Infection VRE (PAS)	(string)		
Infection (PAS)	(string)		
Infection IV Antibiotics (PAS)	(string)		
Infection IV Antibiotics Started Date (PAS)	(date)		
Infection Notes (PAS)	(memo)		
Diet Regular (PAS)	(boolean)		
Diet Regular Notes (PAS)	(memo)		
Diet Special (PAS)	(boolean)		
Diet Special Diabetic (PAS)	(boolean)		
Diet Special Renal (PAS)	(boolean)		
Diet Special Cardiac (PAS)	(boolean)		
Diet Special Other (PAS)	(boolean)		
Diet Special Other Desc (PAS)	(string)		
Diet Special Notes (PAS)	(memo)		
Diet Modified Supervision (PAS)	(boolean)		
Diet Modified Supervision Notes (PAS)	(memo)		
Diet Tube Parenteral (PAS)	(boolean)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Diet Tube Parenteral Notes (PAS)	(memo)		
Therapy Physical (PAS)	(boolean)		
Therapy Occupational (PAS)	(boolean)		
Therapy Respiratory (PAS)	(boolean)		
Therapy Speech (PAS)	(boolean)		
Therapy Nutritional (PAS)	(boolean)		
Therapy WoundCare (PAS)	(boolean)		
Therapy Prosthetics (PAS)	(boolean)		
Therapy Orthotics (PAS)	(boolean)		
Therapy Other (PAS)	(boolean)		
Therapy Other Desc (PAS)	(string)		
Fall History (PAS)	(memo)		
Other Safety Issues (PAS)	(memo)		
PRE-ADMIT ROS			
Allergies No Known (PAS)	(boolean)		
Allergies Unspecified (PAS)	(boolean)		
Allergies Desensitization (PAS)	(boolean)		
Allergies Peanut (PAS)	(boolean)		
Allergies Milk Prod (PAS)	(boolean)		
Allergies Eggs (PAS)	(boolean)		
Allergies Seafood (PAS)	(boolean)		
Allergies Insects (PAS)	(boolean)		
Allergies Latex (PAS)	(boolean)		
Allergies Allergy NEC (PAS)	(boolean)		
Allergies Other Non Drug (PAS)	(boolean)		
Allergies Penicillin (PAS)	(boolean)		
Allergies Antibiot NEC (PAS)	(boolean)		
Allergies Sulfonamides (PAS)	(boolean)		
Allergies Anti Infect (PAS)	(boolean)		
Allergies Anesthetic (PAS)	(boolean)		
Allergies Narcotic (PAS)	(boolean)		
Allergies Analgesic (PAS)	(boolean)		
Allergies Vaccine (PAS)	(boolean)		
Allergies Drug NEC (PAS	(boolean)		
Allergies Drug NOS (PAS)	(boolean)		
Allergies Other Drug (PAS)	(boolean)		
Allergies Notes (PAS)	(memo)		
Eyes Negative (PAS)	(boolean)		
Eyes Vision Change (PAS)	(boolean)		
Eyes Glasses Contacts (PAS)	(boolean)		
Eyes Cataracts (PAS)	(boolean)		
Eyes Glaucoma (PAS)	(boolean)		
Eyes Other (PAS)	(boolean)		
Eyes Notes (PAS)	(memo)		
Hearing Notes (PAS)	(memo)		
Cardio Negative (PAS)	(boolean)		
Cardio Orthopnea (PAS)	(boolean)		
Cardio Chest Pain (PAS)	(boolean)		
Cardio Dyspnea On Exertion (PAS)	(boolean)		
Cardio Edema (PAS)	(boolean)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Cardio Palpitation (PAS)	(boolean)		
Cardio Other (PAS)	(boolean)		
Cardio Notes (PAS)	(memo)		
Pulmonary Notes (PAS)	(memo)		
GI Nausea (PAS)	(boolean)		
GI Vomiting (PAS)	(boolean)		
GI Colostomy (PAS)	(boolean)		
GI Ileostomy (PAS)	(boolean)		
GI Notes (PAS)	(memo)		
Genitourinary Notes (PAS)	(memo)		
Musculoskeletal Notes (PAS)	(memo)		
Skin Negative (PAS)	(boolean)		
Skin Wound (PAS)	(boolean)		
Skin Rash (PAS)	(boolean)		
Skin Ulcers (PAS)	(boolean)		
Skin Dry Skin (PAS)	(boolean)		
Skin Other (PAS)	(boolean)		
Skin Notes (PAS)	(memo)		
Neuro Notes (PAS)	(memo)		
Psych Negative (PAS)	(boolean)		
Psych Depression (PAS)	(boolean)		
Psych Crying (PAS)	(boolean)		
Psych Severe Anxiety (PAS)	(boolean)		
Psych Other (PAS)	(boolean)		
Psych Notes (PAS)	(memo)		
Renal Function Notes (PAS)	(memo)		
Endocrine Negative (PAS)	(boolean)		
Endocrine Diabetes (PAS)	(boolean)		
Endocrine Hypothyroid (PAS)	(boolean)		
Endocrine Hyperthyroid (PAS)	(boolean)		
Endocrine Hot Flashes (PAS)	(boolean)		
Endocrine Hair Loss (PAS)	(boolean)		
Endocrine Hirsutism (PAS)	(boolean)		
Endocrine Heat Cold Intolerance (PAS)	(boolean)		
Endocrine Other (PAS)	(boolean)		
Endocrine Notes (PAS)	(memo)		
Precaution Aspiration (PAS)	(boolean)		
Precaution Contact Isolation (PAS)	(boolean)		
Precaution Droplet Precautions (PAS)	(boolean)		
Precaution Falls (PAS)	(boolean)		
Precaution Negative Pressure (PAS)	(boolean)		
Precaution Neutropenic (PAS)	(boolean)		
Precaution Seizures (PAS)	(boolean)		
Precaution Other (PAS)	(boolean)		
Precaution Other Desc (PAS)	(string)		
Special Bariatric Needs (PAS)	(memo)		
Special Dialysis (PAS)	(memo)		
Special Isolation Precautions (PAS)	(memo)		
Special Oxygen (PAS)	(memo)		
Special Equipment (PAS)	(memo)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Special Weight Bearing Status (PAS)	(memo)		
Special Other (PAS)	(memo)		
Narrative Summary (PAS)	(memo)		
PRE-ADMIT LABS			
Labs Na (PAS)	(float)		
Labs Na Date (PAS)	(date)		
Labs K (PAS)	(float)		
Labs K Date (PAS)	(date)		
Labs Cl (PAS)	(float)		
Labs Cl Date (PAS)	(date)		
Labs CO2 (PAS)	(float)		
Labs CO2 Date (PAS)	(date)		
Labs BUN (PAS)	(float)		
Labs BUN Date (PAS)	(date)		
Labs Cr (PAS)	(float)		
Labs Cr Date (PAS)	(date)		
Labs Gluc (PAS)	(float)		
Labs Gluc Date (PAS)	(date)		
Labs Ca (PAS)	(float)		
Labs Ca Date (PAS)	(date)		
Labs WBC (PAS)	(float)		
Labs WBC Date (PAS)	(date)		
Labs RBC (PAS)	(float)		
Labs RBC Date (PAS)	(date)		
Labs Hgb (PAS)	(float)		
Labs Hgb Date (PAS)	(date)		
Labs Hct (PAS)	(float)		
Labs Hct Date (PAS)	(date)		
Labs Plat (PAS)	(float)		
Labs Plat Date (PAS)	(date)		
Labs PT (PAS)	(float)		
Labs INR (PAS)	(float)		
Labs PT Date (PAS)	(date)		
Labs PTT (PAS)	(float)		
Labs PTT Date (PAS)	(date)		
Labs CRP (PAS)	(float)		
Labs CRP Date (PAS)	(date)		
Labs Phos (PAS)	(float)		
Labs Phos Date (PAS)	(date)		
Labs Mag (PAS)	(float)		
Labs Mag Date (PAS)	(date)		
Labs Chol (PAS)	(float)		
Labs Chol Date (PAS)	(date)		
Labs LDL (PAS)	(float)		
Labs LDL Date (PAS)	(date)		
Labs HDL (PAS)	(float)		
Labs HDL Date (PAS)	(date)		
Labs Trig (PAS)	(float)		
Labs Trig Date (PAS)	(date)		
Labs Albumin (PAS)	(float)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Labs Albumin Date (PAS)	(date)		
Labs Prealbumin (PAS)	(float)		
Labs Prealbumin Date (PAS)	(date)		
Labs Ferritin (PAS)	(float)		
Labs Ferritin Date (PAS)	(date)		
Labs Fe (PAS)	(float)		
Labs Fe Date (PAS)	(date)		
Labs TIBC (PAS)	(float)		
Labs TIBC Date (PAS)	(date)		
Labs Transferrin (PAS)	(float)		
Labs Transferrin Date (PAS)	(date)		
Labs AST (PAS)	(float)		
Labs AST Date (PAS)	(date)		
Labs ALT (PAS)	(float)		
Labs ALT Date (PAS)	(date)		
Labs LDH (PAS)	(float)		
Labs LDH Date (PAS)	(date)		
Labs GGT (PAS)	(float)		
Labs GGT Date (PAS)	(date)		
Labs Tot Prot (PAS)	(float)		
Labs Tot Prot Date (PAS)	(date)		
Labs Globulin (PAS)	(float)		
Labs Globulin Date (PAS)	(date)		
Labs Alk Phos (PAS)	(float)		
Labs Alk Phos Date (PAS)	(date)		
Labs Ammonia (PAS)	(float)		
Labs Ammonia Date (PAS)	(date)		
Labs Bilirubin Dir (PAS)	(float)		
Labs Bilirubin Dir Date (PAS)	(date)		
Labs Bilirubin Indir (PAS)	(float)		
Labs Bilirubin Indir Date (PAS)	(date)		
Labs TSH (PAS)	(float)		
Labs TSH Date (PAS)	(date)		
Labs Serum T3 (PAS)	(float)		
Labs Serum T3 Date (PAS)	(date)		
Labs Serum T4 (PAS)	(float)		
Labs Serum T4 Date (PAS)	(date)		
Labs Free T3 (PAS)	(float)		
Labs Free T3 Date (PAS)	(date)		
Labs Free T4 (PAS)	(float)		
Labs Free T4 Date (PAS)	(date)		
Labs Uric Acid (PAS)	(float)		
Labs Uric Acid Date (PAS)	(date)		
Labs PSA (PAS)	(float)		
Labs PSA Date (PAS)	(date)		
Labs CPK (PAS)	(float)		
Labs CPK Date (PAS)	(date)		
Labs CKMB (PAS)	(float)		
Labs CKMB Date (PAS)	(date)		
Labs Trop I (PAS)	(float)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Labs Trop I Date (PAS)	(date)		
Labs Notes (PAS)	(memo)		
Urin SpGr (PAS)	(float)		
Urin pH (PAS)	(float)		
Urin Gluc (PAS)	(boolean)		
Urin Ket (PAS)	(boolean)		
Urin Bili (PAS)	(boolean)		
Urin Blood (PAS)	(boolean)		
Urin Nit (PAS)	(boolean)		
Urin LE (PAS)	(boolean)		
Urin Protein (PAS)	(boolean)		
Urin Urobilinogen (PAS)	(float)		
Urin Micro (PAS)	(float)		
Studies MRI (PAS)	(boolean)		
Studies MRA (PAS)	(boolean)		
Studies CT (PAS)	(boolean)		
Studies ECHO (PAS)	(boolean)		
Studies XRay (PAS)	(boolean)		
Studies Other (PAS)	(boolean)		
Studies Other Desc (PAS)	(string)		
Studies Notes (PAS)	(memo)		
PRE-ADMIT FUNCTION			
Pre Hosp Bladder Continent (PAS)	(boolean)		
Bladder Continent (PAS)	(boolean)		
Bladder Device (PAS)	(string)		
Bladder Num Accidents (PAS)	(int)		
Bladder Medication (PAS)	(boolean)		
Bladder Medication Type (PAS)	(string)		
Bowel Last BM (PAS)	(date)		
Bowel Last BM Prior To Admit (PAS)	(boolean)		
Pre Hosp Bowel Continent (PAS)	(boolean)		
Bowel Continent (PAS)	(boolean)		
Bowel Device (PAS)	(string)		
Bowel Num Accidents (PAS)	(int)		
Bowel Medication (PAS)	(boolean)		
Bowel Medication Type (PAS)	(string)		
Bladder Bowel Notes (PAS)	(memo)		
Funct Issues Balance (PAS)	(memo)		
Funct Issues Strength (PAS)	(memo)		
Funct Issues ROM (PAS)	(memo)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Pre Morbid Eating (PAS)	(enum)	The following values apply to all of the non-FIM Functional Assistance Assessment items: 7 = Independent 6 = Modified Independence 5 = Supervision 4 = Min Assist / Contact Guard Assist 3 = Moderate Assistance 2 = Maximal Assistance 1 = Total Assistance 0 = Not Evaluated	
Eating (PAS)	(enum)		
Eating Num Assist (PAS)	(int)		
Goal Eating (PAS)	(enum)		
Pre Morbid Grooming Hygiene (PAS)	(enum)		
Grooming Hygiene (PAS)	(enum)		
Grooming Hygiene Num Assist (PAS)	(int)		
Goal Grooming Hygiene (PAS)	(enum)		
Pre Morbid Upper Ext Dressing (PAS)	(enum)		
Upper Ext Dressing (PAS)	(enum)		
Upper Ext Dressing Num Assist (PAS)	(int)		
Goal Upper Ext Dressing (PAS)	(enum)		
Pre Morbid Lower Ext Dressing (PAS)	(enum)		
Lower Ext Dressing (PAS)	(enum)		
Lower Ext Dressing Num Assist (PAS)	(int)		
Goal Lower Ext Dressing (PAS)	(enum)		
Pre Morbid Bladder (PAS)	(enum)		
Bladder (PAS)	(enum)		
Bladder Num Assist (PAS)	(int)		
Goal Bladder (PAS)	(enum)		
Pre Morbid Bowel (PAS)	(enum)		
Bowel (PAS)	(enum)		
Bowel Num Assist (PAS)	(int)		
Goal Bowel (PAS)	(enum)		
Pre Morbid Bed Mobility (PAS)	(enum)		
Bed Mobility (PAS)	(enum)		
Bed Mobility Num Assist (PAS)	(int)		
Goal Bed Mobility (PAS)	(enum)		
Pre Morbid Supine Sit (PAS)	(enum)		
Supine Sit (PAS)	(enum)		
Supine Sit Num Assist (PAS)	(int)		
Goal Supine Sit (PAS)	(enum)		
Pre Morbid Sit Stand (PAS)	(enum)		
Sit Stand (PAS)	(enum)		
Sit Stand Num Assist (PAS)	(int)		
Goal Sit Stand (PAS)	(enum)		
Pre Morbid Transfer (PAS)	(enum)		
Transfer (PAS)	(enum)		
Transfer Num Assist (PAS)	(int)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Goal Transfer (PAS)	(enum)		
Pre Morbid Toilet Transfer (PAS)	(enum)		
Toilet Transfer (PAS)	(enum)		
Toilet Transfer Num Assist (PAS)	(int)		
Goal Toilet Transfer (PAS)	(enum)		
Pre Morbid Ambulation (PAS)	(enum)		
Ambulation (PAS)	(enum)		
Ambulation Num Assist (PAS)	(int)		
Goal Ambulation (PAS)	(enum)		
Pre Morbid Expression (PAS)	(enum)		
Expression (PAS)	(enum)		
Expression Num Assist (PAS)	(int)		
Goal Expression (PAS)	(enum)		
Pre Morbid Memory (PAS)	(enum)		
Memory (PAS)	(enum)		
Memory Num Assist (PAS)	(int)		
Goal Memory (PAS)	(enum)		
FIM Pre Morbid Eating (PAS)	(enum)		
FIM Eating (PAS)	(enum)		
FIM Goal Eating (PAS)	(enum)		
FIM Pre Morbid Grooming (PAS)	(enum)		
FIM Grooming (PAS)	(enum)		
FIM Goal Grooming (PAS)	(enum)		
FIM Pre Morbid Bathing (PAS)	(enum)		
FIM Bathing (PAS)	(enum)		
FIM Goal Bathing (PAS)	(enum)		
FIM Pre Morbid Dressing Upper (PAS)	(enum)		
FIM Dressing Upper (PAS)	(enum)		
FIM Goal Dressing Upper (PAS)	(enum)		
FIM Pre Morbid Dressing Lower (PAS)	(enum)		
FIM Dressing Lower (PAS)	(enum)		
FIM Goal Dressing Lower (PAS)	(enum)		
FIM Pre Morbid Toileting (PAS)	(enum)		
FIM Toileting (PAS)	(enum)		
FIM Goal Toileting (PAS)	(enum)		
FIM Pre Morbid Bladder Ctrl (PAS)	(enum)		
FIM Bladder Ctrl (PAS)	(enum)		
FIM Goal Bladder Ctrl (PAS)	(enum)		
FIM Pre Morbid Bowel Ctrl (PAS)	(enum)		
FIM Bowel Ctrl (PAS)	(enum)		
FIM Goal Bowel Ctrl (PAS)	(enum)		
FIM Pre Morbid Bed Transfer (PAS)	(enum)		
FIM Bed Transfer (PAS)	(enum)		
FIM Goal Bed Transfer (PAS)	(enum)		
FIM Pre Morbid Toilet Transfer (PAS)	(enum)		
FIM Toilet Transfer (PAS)	(enum)		
FIM Goal Toilet Transfer (PAS)	(enum)		
FIM Pre Morbid Tub Transfer (PAS)	(enum)		
FIM Tub Transfer (PAS)	(enum)		
FIM Goal Tub Transfer (PAS)	(enum)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
FIM Walk Wheelchair Measured (PAS)	(char)		
FIM Pre Morbid Walk Wheelchair (PAS)	(enum)		
FIM Walk Wheelchair (PAS)	(enum)		
FIM Goal Walk Wheelchair (PAS)	(enum)		
FIM Pre Morbid Stairs (PAS)	(enum)		
FIM Stairs (PAS)	(enum)		
FIM Goal Stairs (PAS)	(enum)		
FIM Comprehension Measured (PAS)	(char)		
FIM Pre Morbid Comprehension (PAS)	(enum)		
FIM Comprehension (PAS)	(enum)		
FIM Goal Comprehension (PAS)	(enum)		
FIM Expression Measured (PAS)	(char)		
FIM Pre Morbid Expression (PAS)	(enum)		
FIM Expression (PAS)	(enum)		
FIM Goal Expression (PAS)	(enum)		
FIM Pre Morbid Social Interaction (PAS)	(enum)		
FIM Social Interaction (PAS)	(enum)		
FIM Goal Social Interaction (PAS)	(enum)		
FIM Pre Morbid Problem Solving (PAS)	(enum)		
FIM Problem Solving (PAS)	(enum)		
FIM Goal Problem Solving (PAS)	(enum)		
FIM Pre Morbid Memory (PAS)	(enum)		
FIM Memory (PAS)	(enum)		
FIM Goal Memory (PAS)	(enum)		
FIM Other Measure Desc (PAS)	(string)		
FIM Pre Morbid Other Measure (PAS)	(enum)		
FIM Other Measure (PAS)	(enum)		
FIM Goal Other Measure (PAS)	(enum)		
FIM Notes (PAS)	(memo)		
Therapy Eval PT (PAS)	(boolean)		
Therapy Eval OT (PAS)	(boolean)		
Therapy Eval SLP (PAS)	(boolean)		
Therapy Eval Other (PAS)	(boolean)		
Therapy Eval Other Desc (PAS)	(string)		
PRE-ADMIT JUSTIFICATION			
Screening Date (PAS)	(date)		
Evaluator (PAS)	(string)		
Screen In Person (PAS)	(boolean)		
Screen Record Review (PAS)	(boolean)		
Screen Other Desc (PAS)	(string)		
Recommend Rehab Admission (PAS)	(boolean)		
Patient Tolerate Rehab (PAS	(boolean)		
Rehab Prognosis (PAS)	(string)		
Patient Willing to Participate (PAS)	(boolean)		
Est LOS 95 Pct (PAS)	(float)		
Est LOS Std Dev (PAS)	(float)		
Disch Living Setting (PAS)	(enum)		
Post Disch Treatments (PAS)	(memo)		
Accept Admission (PAS)	(boolean)		
Anticipated Admit Date (PAS)	(date)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Re Screen Patient (PAS)	(boolean)		
Re Screen Date (PAS)	(date)		
Deny Admission (PAS)	(boolean)		
Denial Referred To (PAS)	(string)		
Rehab Disposition Notes (PAS)	(memo)		
Sign 1 Title (PAS)	(string)		
Sign 1 (PAS)	(string)		
Sign 1 Date (PAS)	(date)		
Sign 2 Title (PAS)	(string)		
Sign 2 (PAS)	(string)		
Sign 2 Date (PAS)	(date)		
Sign 3 Title (PAS)	(string)		
Sign 3 (PAS)	(string)		
Sign 3 Date (PAS)	(date)		
Sufficiently Stable (PAS)	(boolean)		
Med Supervision Req (PAS	(boolean)		
Med Supervision Conditions (PAS)	(memo)		
Nursing ADLs (PAS)	(boolean)		
Nursing Bladder Mgmt (PAS)	(boolean)		
Nursing Bowel Mgmt (PAS)	(boolean)		
Nursing Cognition (PAS)	(boolean)		
Nursing Communication (PAS)	(boolean)		
Nursing Diabetes Mgmt (PAS)	(boolean)		
Nursing Disease Mgmt (PAS)	(boolean)		
Nursing Family Training Edu (PAS)	(boolean)		
Nursing Medication Admin (PAS)	(boolean)		
Nursing Nutritional Deficits (PAS)	(boolean)		
Nursing Pain Mgmt (PAS)	(boolean)		
Nursing Patient Edu (PAS)	(boolean)		
Nursing Positioning (PAS)	(boolean)		
Nursing Resp Airway Mgmt (PAS)	(boolean)		
Nursing Safety (PAS)	(boolean)		
Nursing Skin Integrity (PAS)	(boolean)		
Nursing Swallowing (PAS)	(boolean)		
Nursing Transfers (PAS)	(boolean)		
Nursing Wound Care (PAS)	(boolean)		
Therapy Needs PT (PAS)	(boolean)		
Therapy Needs OT (PAS)	(boolean)		
Therapy Needs SLP (PAS)	(boolean)		
Therapy Needs Prosthetics (PAS)	(boolean)		
Req Intensive Therapy (PAS)	(boolean)		
Therapy Min/Day (PAS)	(int)		
Therapy Days/Week (PAS)	(int)		
Team Ataxia Motor Planning (PAS)	(boolean)		
Team Balance (PAS)	(boolean)		
Team Cognition (PAS)	(boolean)		
Team Disease Mgmt (PAS)	(boolean)		
Team Elimination (PAS)	(boolean)		
Team Endurance (PAS)	(boolean)		
Team Family Train Edu (PAS)	(boolean)		

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Team Independent ADLs (PAS)	(boolean)		
Team Mod Indep (PAS)	(boolean)		
Team Pain Mgmt (PAS)	(boolean)		
Team Precautions (PAS)	(boolean)		
Team ROM (PAS)	(boolean)		
Team Safety (PAS)	(boolean)		
Team Wound Mgmt (PAS)	(boolean)		
Team Speech (PAS)	(boolean)		
Team Strength (PAS)	(boolean)		
Team Swallowing (PAS)	(boolean)		
Team Transfers (PAS)	(boolean)		
Team Vision (PAS)	(boolean)		
Team Other (PAS)	(boolean)		
Team Other Desc (PAS)	(string)		
Justification Notes (PAS)	(memo)		
Physician Signed (PAS)	(boolean)		
Physician Signature (PAS)	(string)		
Physician Signed Date (PAS)	(date)		
Physician Signed Time (PAS)	(time)		
PRE-ADMIT NOTES			
Notes (PAS)	(memo)	Multiple notes should be separated by semicolons	
PRE-ADMIT DENIAL			
Denial Date	(date)	The date on which the pre-admission assessment was marked as Denied	
Denial Reason Unique ID	(int)		
Denial Reason	(string)	See pre-admission assessment denial screen for possible values	
FOLLOW UP ASSESSMENTS			
Follow Up Date	(date)		
Information Source (FU)	(int)	1-Patient, 2-Family, 3-Other, 4-Unable to reach	
Assessment Method (FU)	(int)	1-In Person, 2-Telephone, 3-Unable to Reach	
Setting (FU)	(enum)	See IRF-PAI Item 44A for possible values	
Living With (FU)	(enum)	See IRF-PAI Item 45 for possible values	
Vocational Category (FU)	(enum)	See IRF-PAI Item 18 for possible values	
Vocational Effort (FU)	(enum)	See IRF-PAI Item 19 for possible values	
Prim. Health Maint (FU)	(int)	1-Own Care, 2-Unpaid Person or Family, 3-Paid attendant, 4-Paid skilled professional	
Sec. Health Maint (FU)	(int)	1-Own Care, 2-Unpaid Person or Family, 3-Paid attendant, 4-Paid skilled professional	

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Therapy (FU)	(int)	1-None, 2-Outpatient, 3-Home-base professional, 4-Outpatient/Home-based professional, 5-Inpatient Hospital, 6-Long Term Care, 7-Other, 8-Day Treatment	
Dx A (FU)	(string)	ICD code	
Dx B (FU)	(string)	ICD code	
Dx C (FU)	(string)	ICD code	
Dx D (FU)	(string)	ICD code	
Dx E (FU)	(string)	ICD code	
Dx F (FU)	(string)	ICD code	
FIM Eating (FU)	(enum)		
FIM Grooming (FU)	(enum)		
FIM Bathing (FU)	(enum)		
FIM Dressing Upper (FU)	(enum)		
FIM Dressing Lower (FU)	(enum)		
FIM Toileting (FU)	(enum)		
FIM Bladder Mgmt (FU)	(enum)		
FIM Bowel Mgmt (FU)	(enum)		
FIM Bed Transfer (FU)	(enum)		
FIM Toilet Transfer (FU)	(enum)		
FIM Tub Transfer (FU)	(enum)		
FIM Walk Wheelchair (FU)	(enum)		
FIM Locomotion Mode (FU)	(char)	W-Walk, C-Wheelchair, B-Both	
FIM Stairs (FU)	(enum)		
FIM Comprehension (FU)	(enum)		
FIM Comprehension Mode (FU)	(char)	A-Auditory, V-Visual, B-Both	
FIM Expression (FU)	(enum)		
FIM Expression Mode (FU)	(char)	V-Vocal, N-Non-Vocal, B-Both	
FIM Social Interaction (FU)	(enum)		
FIM Problem Solving (FU)	(enum)		
FIM Memory (FU)	(enum)		
PATIENT SATISFACTION SURVEYS			
Service Recovery Survey			
Bathroom Clean	(int)	0-5	
Equipment Working	(int)	0-5	
Rest Frequency	(int)	0-5	
Food Order CorrectF requency	(int)	0-5	
Bathroom Help Frequency	(int)	0-5	
Question Concern Promptness	(int)	0-5	
Pain Control Frequency	(int)	0-5	
Stay Info Given	(int)	0-3	
Treatment Plan Understandable	(int)	0-3	
Goal Knowledge	(int)	0-3	
Feel Safe Secure	(int)	0-3	
Considerate Of Privacy	(int)	0-3	
Respectful Treatment	(int)	0-3	

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Comfort Recommendations	memo		
Family Accomodate Recommendations	memo		
Safety Recommendations	memo		
How Service Recovery Completed	(int)	0-3	
Discharge Survey ***Note:*** this discharge survey layout includes 3 nursing shifts and separate case management and social work fields. If your facility is configured for two nursing shifts you will only download two. If your facility is configured for combined case management/social work fields you will only download one.			
Orientation After Admit	(int)	0-5	
Courtesy Of Staff	(int)	0-5	
Dignity And Respect	(int)	0-5	
Encouragement From Staff	(int)	0-5	
Your Doctor	(int)	0-5	
Nursing Day Shift	(int)	0-5	
Nursing Evening Shift	(int)	0-5	
Nursing Night Shift	(int)	0-5	
Physical Therapy	(int)	0-5	
Occupational Therapy	(int)	0-5	
Speech Therapy	(int)	0-5	
Recreation Therapy	(int)	0-5	
Social Work	(int)	0-5	
Case Management	(int)	0-5	
Social Work Case Management	(int)	0-5	
Psychology	(int)	0-5	
Spiritual Care	(int)	0-5	
Staff Promptness	(int)	0-5	
Attention To Needs	(int)	0-5	
Goal Involvement	(int)	0-5	
Answer Ability	(int)	0-5	
Coordination Of Care	(int)	0-5	
Pain Controlled	(int)	0-5	
Expectations Vs Ability	(int)	0-5	
Family Included In Care	(int)	0-5	
Room Cleanliness	(int)	0-5	
Food Temperature	(int)	0-5	
Meal Variety	(int)	0-5	
Planning Assistance	(int)	0-5	
Medications Training	(int)	0-5	
Discharge Instructions	(int)	0-5	
Privacy Consideration	(int)	0-5	
Patient Safety Security	(int)	0-5	
Extent Goals Met	(int)	0-5	
Overall Satisfaction	(int)	0-5	
Recommend Facility	memo		
How Improve Safety	memo		
Other Improvement Suggestions	memo		
How Discharge Completed	(int)	0-3	
No Followup Contact	(boolean)		
Follow Up Survey			

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
Equipment Ordered	(int)	0-1	
Equipment Satisfaction	(int)	0-5	
Home Health Received	(int)	0-1	
Home Health Satisfaction	(int)	0-5	
Outpatient Therapy Received	(int)	0-1	
Outpatient Therapy Satisfaction	(int)	0-5	
Discharge Instructions	(int)	0-5	
Functioning	(int)	0-5	
How Follow Up Completed	(int)	0-3	
HISTORIC IRF-PAI DATA (FY2013-14)			
Pre Hosp Vocation Cat	(enum)	AD	18
Pre Hosp Vocation Effort	(enum)	AD	19
Comatose at Admit	(boolean)	AD	25
Delerious at Admit	(boolean)	AD	26
Admit Dehydration	(boolean)	AD	28 (Admit)
Disch Dehydration	(boolean)	D	28 (Disch)
Disch Home Health Svc	(enum)	D	44B
Admit Stage 2 Pressure Ulcers	(int)	AD	48A (Admit)
Discharge Stage 2 Pressure Ulcers	(int)	D	48A (Disch)
Admit Stage 3 Pressure Ulcers	(int)	AD	48B (Admit)
Discharge Stage 3 Pressure Ulcers	(int)	D	48B (Disch)
Admit Stage 4 Pressure Ulcers	(int)	AD	48C (Admit)
Discharge Stage 4 Pressure Ulcers	(int)	D	48C (Disch)
Worsening Stage 2 Pressure Ulcers	(int)	D	49A
Worsening Stage 3 Pressure Ulcers	(int)	D	49B
Worsening Stage 4 Pressure Ulcers	(int)	D	49C
Pressure Ulcers Present on Admit	(boolean)	D	50A
Closed Stage 2 Pressure Ulcers	(int)	D	50B
Closed Stage 3 Pressure Ulcers	(int)	D	50C
Closed Stage 4 Pressure Ulcers	(int)	D	50D
Unable to Assess at Admit	(boolean)	A	N/A
Unable to Assess at Discharge	(boolean)	AD	N/A
HISTORIC QUALITY INDICATORS (Pre-FY2013)			
ADM Short Breath Exert	(boolean)	AD	48 (Admit)
DIS Short Breath Exert	(boolean)	D	48 (Disch)
ADM Short Breath Rest	(boolean)	AD	49 (Admit)
DIS Short Breath Rest	(boolean)	D	49 (Disch)
ADM Cough Difficulty	(boolean)	AD	50 (Admit)
DIS Cough Difficulty	(boolean)	D	50 (Disch)
ADM Highest Pain	(enum)	AD	51 (Admit)
DIS Highest Pain	(enum)	D	51 (Disch)
ADM Highest Ulcer Stage	(enum)	AD	52A (Admit)
DIS Highest Ulcer Stage	(enum)	D	52A (Disch)
ADM Number Ulcers	(int)	AD	52B (Admit)
DIS Number Ulcers	(int)	D	52B (Disch)
ADM Largest Ulcer Area	(enum)	AD	52C (Admit)
DIS Largest UlcerArea	(enum)	D	52C (Disch)
ADM Exudate Amount	(enum)	AD	52D (Admit)
DIS Exudate Amount	(enum)	D	52D (Disch)
ADM Tissue Type	(enum)	AD	52E (Admit)

Assessment Data Download (Custom Template) Available Fields (Continued)

Column Name	Data Type	Notes	IRF-PAI Field
DIS Tissue Type	(enum)	D	52E (Disch)
ADM Total PUSHScore	(int)	AD	52F (Admit)
DIS Total PUSHScore	(int)	D	52F (Disch)
ADM Balance Problem	(boolean)	AD	53 (Admit)
DIS Balance Problem	(boolean)	D	53 (Disch)
DIS Number Falls	(int)	D	54

3. HIPPS Data Download V2

Created primarily for import into hospital billing software programs, the HIPPS Data Download V2 collects various values calculated from assessments into a delimited ASCII text file, which can then be imported into any system that accepts tab, comma, or vertical bar delimited text files. Tab-delimited is recommended since the tab character cannot be embedded as data in any field.

The file downloads as a delimited text file using the delimiter you specify. Each line contains one record and each record is separated by a carriage return (ASCII 10), with each element in the record separated by your selected delimiter.

To download your HIPPS Data V2 file, log in to eRehabData and click **Downloads**, then click **HIPPS Data Download V2**. You will see a list of options that you can use to specify which assessments you will download.

> ***NOTE:*** If you do not see the **Downloads** or **HIPPS Data Download V2** options, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can download assessments from their facility."

DOWNLOAD PARAMETERS

Facility Data to Download: This option allows you to download data for either any single facility in your organization, or for all facilities in your organization combined. However, if you select "All Facilities in Organization", each record in your file will begin with an additional data field identifying the record's facility Medicare provider number.

> ***NOTE:*** The "Facility Data to Download" option is only available to users belonging to an organization that has more than one subscriber facility on eRehabData, and this privilege can only be assigned by an eRehabData organization administrator.

Search By: This option determines how your date filter will be applied if you specify a date range. You can filter for assessments by Admit Date, Discharge Date, Date Created/Last Modified, or CMS Transmission Date.

> ***NOTE:*** If filtering by Discharge Date, your file will only include assessments for which a discharge date is present and in the specified date range. This means that admission assessments and discharge assessments for which discharge dates have not yet been entered will not be included in your file. If filtering by CMS Transmission Date, your file will only include assessments that have been marked as Accepted by CMS within the specified date range.

Date Range: Date Range allows you to apply a date filter to your specified "Search By" date. Ranges include All, Today, Last x Days (including today), Previous x Days (excluding today), and a specified date range. Select the radio button next to the option you want, and then type in your desired day or date range if appropriate for your choice. If you do not wish to apply a date filter, select "All Assessments".

Include Admission assessments?: Select "Yes" to include assessments currently in an admission assessment state.

> ***NOTE:*** In order to download in-progress admission assessments, you must apply your date range to Admit Date.

Include non-Medicare assessments?: Select "Yes" to download records for all payers, "No" to download only records for primary payer 2 - Medicare non-MCO, or "No, but include Payer 51: Medicare-MCO" to download records for primary payers 2 and 51 only.

Assessment Status: If you want to download ONLY assessments that have either been Accepted by CMS or completed, locked, and filed, select "Accepted / Filed". Each successive radio button includes the options above it, so selecting "Completed and Locked" will retrieve both "Accepted / Filed" assessments and "Completed and Locked" assessments. Selecting "Completed" assessments will retrieve "Accepted / Filed" assessments, "Completed and Locked" assessments, and "Completed" assessments. You can retrieve all assessments, including Accepted / Filed, Complete, Locked, and Incomplete, by selecting "All".

> ***NOTE:*** You will only see Filed assessments included your download if in the "Assessment Status" option you select "Yes" for "Include non-Medicare Assessments".

Include headers in download file?: If you want column names in your file, select "Yes". If you are importing this file into another software application and do not require column names, select "No".

Field Delimiter: Depending upon the requirements of the software you are importing the file into, select "TAB", "Comma", or "Vertical Bar". Tab-delimited is recommended since the tab character cannot be embedded as data in any field.

Once you have selected your parameters, click **Retrieve**. You will see a list of the parameters you chose, along with a preview of the assessments that will be included in the file. However, at this point the file has not yet been created. To create and download the file, click **Create HIPPS File**. You will see a link with the name of the file. Click on the link to save your HIPPS file to your computer.

> ***NOTE:*** For assessments without a discharge date, the reimbursement calculator (Facility Adjusted Payment) assumes the discharge date is today but does not account for short stays or transfers.

FILE STRUCTURE

If you specified that your file should include a header record, the first record in the file is the header record containing column names, each separated by your selected delimiter.

The first value in each record is the unique ID assigned to the assessment by eRehabData. This value is numeric and can be used by a facility as a unique assessment ID. If the system that imports these data instead assigns its own ID, this value should nonetheless be kept so that after future downloads duplicate or updated records can be easily identified.

Char values are a single 8-bit ANSI character. Boolean values appear as true or false. Integers and Floats are 32-bit. Date values are in YYYYMMDD format. Strings may be of any length. There are also enumerated values present. These can be any datatype used to represent a value selected from a set of options; for example, a CMG code. For descriptions and explanations of the possible values, please see the IRF-PAI specification.

Here are the columns in the order in which they appear in the download:

HIPPS Data Download V2 File Format

Column Name	DataType	Notes
1. Provider ID	(char)	This column is only present in multi-facility downloads
2. eRehabData Unique ID	(int)	
3. Medicare Number	(string)	
4. First Name	(string)	
5. Last Name	(string)	
6. Pat ID Number	(string)	
7. SSN	(string)	
8. Admit Date	(date)	YYYYMMDD
9. Primary Payment Source	(enum)	See IRFPAI Item 20A for possible values
10. Secondary Payment Source	(enum)	See IRFPAI Item 20B for possible values
11. Discharge Date	(date)	YYYYMMDD
12. Discharged To	(int)	See IRFPAI Item 44A for possible values
13. Completed	(boolean)	true or false
14. Locked	(boolean)	true or false
15. Status	(string)	accepted, filed, or blank
16. Age at Admit	(int)	
17. LOS	(int)	
18. RIC	(int)	
19. CMG	(enum)	See PPS documentation for possible values
20. Tier	(int)	0-3
21. HIPPS Code	(string)	x#### (where x = tier A, B, C, or D and #### = the CMG code)
22. Short Stay	(boolean)	true if patient was short stay OR expired, false if neither
23. Short Stay CMG	(enum)	blank if Short Stay = false
24. Transfer Patient	(boolean)	true or false as defined in the Final Rule
25. Base Pay Weight	(float)	See PPS documentation for possible values
26. Adjusted Payment	(float)	adjusted for short stays and transfer patients
27. CMS Transmit Date	(date)	YYYYMMDD

4. Assessment Data Download (Custom)

This download has been superseded by the "Assessment Data Download (Custom Template)".

5. HIPPS Data Download

This download has been superseded by the "HIPPS Data Download V2".

6. Assessment Data Download V4

This download has been superseded by the "Assessment Data Download (Custom Template)".

7. Assessment Data Download V3

This download has been superseded by the "Assessment Data Download (Custom Template)".

8. Assessment Data Download V2

This download has been superseded by the "Assessment Data Download (Custom Template)".

9. Follow Up Data Download

The Follow Up Data Download allows you to download your facility's follow up assessments with some patient identifier fields (eRehabData IRFPAI ID, Patient Name, Admit Date, Discharge Date, Patient ID, and SSN).

The file downloads as a tab-delimited text file. Each line contains one record and each record is separated by a carriage return (ASCII 10), with each element in the record separated by a tab character (ASCII 9). The individual elements are not delimited by any additional characters (i.e. they are not surrounded by quotes, etc.). Furthermore no characters are escaped since users cannot enter the tab delimiter into data fields.

You may wish to link follow up data with downloaded IRFPAI data in order to do custom analysis. The AssessUniqueID field described below is the unique eRehabData integer assigned to each IRFPAI assessment and can be found in all assessment downloads.

> ***NOTE:*** The "Assessment Data Download (Custom Template)" allows you to download IRF-PAI records with their associated follow-up assessments so you may prefer to use that download for purposes of comparing IRF-PAIs to follow-ups.

To download your follow up data, log onto eRehabData and click **Downloads**, then click **Follow Up Data Download**. You will see a list of file options broken down into three sections: Search By, Date Range, and Include Headers in download file?.

> ***NOTE:*** If you do not see the **Downloads** or **Follow Up Data Download** options, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can download assessments from their facility."

DOWNLOAD PARAMETERS

Search By: This option determines how your date filter will be applied if you specify a date range. You can filter for assessments by follow up assessment date or discharge date.

Date Range: This option allows you to filter assessments by the search date type you specified above. Ranges include All, Today, Last x Days (including today), Previous x Days (excluding today), and a specified date range. Select the radio button next to your desired option before typing in any additional parameters like number of days or dates. If you do not wish to apply a date filter, select "All Assessments".

Include headers in download file?: This option controls whether your download file will contain a header record with all of the column names. If you want column names in your file, select "Yes".

Once you have selected your parameters, click **Retrieve**. You will see a list of the parameters you chose along with a list of the assessments that will be included in the file. However, at this point the file has not yet been created; this is just a preview. To create and download the file, click **Create Follow Up File**. You will see a link with the name of the file. Click on the link to save the file to your computer.

FILE STRUCTURE

If you specified that your file should include a header record, the first record in the file is the header record containing column names, each separated by a tab (ASCII 9).

The first value in each record is the unique ID assigned to the follow up assessment by eRehabData. This value is numeric and can be used by a facility as a unique follow up assessment ID. The second value in each record is the unique ID assigned to the associated

IRF-PAI by eRehabData. This value corresponds to the AssessUniqueID field found in the other assessment data downloads and can be used to link the follow-up assessment records to their respective IRF-PAIs.

Char values are a single 8-bit ANSI character. Boolean values appear as T or f. Integers and Floats are 32-bit. Date values are in YYYYMMDD format. Strings may be of any length. There are also many enumerated values present. In general these are integers used to represent a value selected from a set of options, for example, a FIM score, which may be from 0 to 7 or null. For descriptions and explanations of the possible values, please see the follow-up assessment specification.

Here are the columns in the order in which they appear in the download:

Follow Up Data Download File Format

Column Name	DataType	Notes
1. FollowUp UniqueID	(int)	
2. AssessUniqueID	(int)	eRehabData assessment ID
3. First Name	(string)	
4. Last Name	(string)	
5. Pat ID Number	(string)	
6. SSN	(string)	
7. Admit Date	(date)	YYYYMMDD
8. Discharge Date	(date)	YYYYMMDD
9. Follow Up Assessment Date	(date)	YYYYMMDD
10. InfoSource	(int)	1-Patient, 2-Family, 3-Other, 4-Unable to reach
11. AssessMethod	(int)	1-In Person, 2-Telephone, 3-Unable to Reach
12. FollowUp Setting	(enum)	See IRFPAI Item 44A for possible values
13. FollowUp Living With	(enum)	See IRFPAI Item 45 for possible values
14. FollowUp Vocational Category	(enum)	See IRFPAI Item 18 for possible values
15. FollowUp Vocational Effort	(enum)	See IRFPAI Item 19 for possible values
16. Health Maint. Primary	(int)	1-Own Care, 2-Unpaid Person or Family, 3-Paid attendant, 4-Paid skilled professional
17. Health Maint. Secondary	(int)	1-Own Care, 2-Unpaid Person or Family, 3-Paid attendant, 4-Paid skilled professional
18. FollowUp Therapy	(int)	1-None, 2-Outpatient, 3-Home-base professional, 4-Outpatient/Home-based professional, 5-Inpatient Hospital, 6-Long Term Care, 7-Other, 8-Day Treatment
19. Diagnosis Code 1	(string)	ICD Code
20. Diagnosis Code 2	(string)	ICD Code
21. Diagnosis Code 3	(string)	ICD Code
22. Diagnosis Code 4	(string)	ICD Code
23. Diagnosis Code 5	(string)	ICD Code
24. Diagnosis Code 6	(string)	ICD Code
25. FIM Eating	(enum)	
26. FIM Grooming	(enum)	
27. FIM Bathing	(enum)	
28. FIM Dressing Upper	(enum)	
29. FIM Dressing Lower	(enum)	
30. FIM Toileting	(enum)	
31. FIM Bladder Mgmt.	(enum)	
32. FIM Bowel Mgmt.	(enum)	

Follow Up Data Download File Format (Continued)

Column Name	DataType	Notes
33. FIM Transfer, Bed-Chair-Wheelchair	(enum)	
34. FIM Transfer, Toilet	(enum)	
35. FIM Transfer, Tub/Shower	(enum)	
36. FIM Walk/Wheelchair	(enum)	
37. FIM Locomotion Mode	(char)	W-Walk, C-Wheelchair, B-Both
38. FIM Stairs	(enum)	
39. FIM Comprehension	(enum)	
40. FIM Comprehension Mode	(char)	A-Auditory, V-Visual, B-Both
41. FIM Expression	(enum)	
42. FIM Expression Mode	(char)	V-Vocal, N-Non-Vocal, B-Both
43. FIM Social Interaction	(enum)	
44. FIM Problem Solving	(enum)	
45. FIM Memory	(enum)	

10. IRF-PAI Import

The IRF-PAI Import allows you to upload text files or files in one of the CMS XML formats containing partial or complete patient assessment records, including facility custom data fields, into eRehabData. This is useful for facilities that capture patient demographic and/or IRF-PAI data in another application that can export text or XML files and wish to avoid redundant data entry.

Starting 10/1/2014, the IRF-PAI Import *text file importer* will only import fields that exist across ALL versions of the IRF-PAI. See the "TEXT FILE UPLOADS" and "TEXT FILE STRUCTURE" sections below for details. You can use the applicable CMS specification XML file format to upload all IRF-PAI fields for FY2013 and later discharges.

You can upload a file to the IRF-PAI Import to create either admission or discharge IRF-PAI assessments directly from imported records. Records with no discharge information present are imported as in-progress admission assessments. If any discharge information is found (including discharge FIM scores, discharge impairment group codes, interruption dates, etc.) the imported records become in-progress discharge assessments.

The text file importer attempts to identify records that have been filed or accepted by CMS based on a flag on each record in the file. Completed assessments with this flag set to 1 are imported into the accepted/filed assessments areas. Both IRF-PAI Import file formats also allow you to update or delete existing in-progress assessments. See the specifications below for more information on the accepted/filed flag and record matching algorithms.

FILE REQUIREMENTS

XML FILE UPLOADS

The IRF-PAI Import XML file format follows the published CMS specifications for the appropriate year based on admission and/or discharge date, with a few exceptions noted below. This format can be used to upload new partial or complete IRF-PAI records and update or delete existing assessments in eRehabData for discharges on or after 10/1/2012. Only unlocked in-progress records can be updated or deleted.

The Import accepts uploads of single XML records as well as uploads of ZIP files containing multiple XML records. Any files uploaded with the extension ".XML" or ".ZIP" will be

processed according to the XML specification; all others will be processed as text files. A ZIP file must have the ".ZIP" extension or it will not be processed.

For more information on the CMS XML file formats, please see the IRF-PAI Data Specifications files available for download in the "Software" section of the CMS IRF-PPS website here:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html.

The specifications for version 1.10.1 apply to discharges between 10/1/2012 and 9/30/2014. The specifications for version 1.11.1 apply to discharges between 10/1/2014 and 9/30/2015. The specifications for version 1.12.0 apply to discharges on or after 10/1/2015.

Exceptions to the CMS XML specification:

The CMS XML specification requires a number of tags in the "Control Section" of each XML file. eRehabData requires only a few of these tags, including:

```
<ASSESSMENT>
<ASMT_SYS_CD></ASMT_SYS_CD>
<TRANS_TYPE_CD></TRANS_TYPE_CD>
<SPEC_VRSN_CD></SPEC_VRSN_CD>
</ASSESSMENT>
```

Custom Tags: The IRF-PAI XML Import recognizes the XML tag <R5B></R5B> as containing IRF-PAI item 5B Patient ID. Because this field is not transmitted to CMS, the CMS specification does not include it. Additionally, starting 10/1/2014 the XML import will accept uploads of custom data when the custom data values are surrounded by tags in this format:
<CUSTOM.FIELDNUMBER></CUSTOM.FIELDNUMBER>
where FIELDNUMBER is the unique ID for the field assigned by eRehabData. This unique ID is displayed with your existing custom data fields on the custom data field administration screen, which can be viewed by eRehabData facility administrators by logging into eRehabData and clicking **My Facility**, then **Custom Data Fields**.

Incomplete Records: the IRF-PAI Import XML format will accept incomplete records. You can upload incomplete records by either omitting the tags corresponding to the fields that have no data or by uploading blanks for those tags. However, keep in mind that unless you have checked the "Do not overwrite existing data with blanks" checkbox on the IRF-PAI Import screen, tags uploaded with blank values will overwrite any existing values in the corresponding fields in the IRF-PAI.

TEXT FILE UPLOADS

An IRF-PAI Import text file should be an ASCII text file, with each record contained on a single line and separated from the next by a carriage return/line feed. Each field in each record is separated by a delimiter of your choosing. Acceptable extensions for your uploaded text file include .txt, .csv, .dat, .tab, and any other extension commonly used to denote a text file.

During the file import the system will automatically identify the first non-alphanumeric character found on the first line of the file as the field delimiter for the entire file. Your delimiter can be anything except a letter, a digit, or an underscore, dash or space, as these characters often appear in actual data. We highly recommend the TAB character as the TAB cannot be embedded in any data fields.

If you do not have data in some of the fields, your delimiter must still be used as a placeholder for empty fields where there are gaps in the data. Referring to the file format below for an example, if you are adding a new record that has a Medicare number, no Medicaid number or patient first name, and then patient last name, your delimiter must be used to hold the place of the Medicaid number and first name or else you risk having patient last name imported into the Medicaid number or first name field. For example:

A[TAB]MedicareNum[TAB][TAB][TAB]LastName[TAB]

If you are uploading partial records, you do not need to pad the empty fields after the existing data in a record with your delimiter.

Uploading Facility Specific (custom) data: You can upload facility specific data for any assessment by appending the custom data values to the end of the assessment record, starting after record position 172. Append the fields in the same order in which they appear as elements on the **Custom Data Fields** screen in the **Manage Facility** section of eRehabData. You can upload some or all facility specific fields but be sure to use a delimiter placeholder for any blank fields. For example, if your facility uses Contact Name, Phone and Street as custom data elements and you wish to upload Contact Name and Street for a particular assessment, you would append the following to the record: [TAB]John Doe[TAB][TAB]123 Maple St.

The importer will only process as many appended fields as there are facility specific data elements for your facility. Extra fields will be ignored.

NOTE: Beginning 10/1/2014, it will no longer be possible to upload complete IRF-PAI records using the text file upload. From that day forward, only fields that exist across all versions of the IRF-PAI can be imported with a text file. The fields that will no longer be imported are highlighted in pink in the text file format below. Any data present in those fields in an uploaded text file will be ignored. The remaining fields will maintain their position in the import file so their location in each record will not change. Please refer to the IRF-PAI Import Text File Format section below for more details.

TEXT FILE IMPORT COMMANDS

The first field in each record is the Record_Type field, where you indicate with a single character what action you want to perform with that record. Valid values are:

A = Add a new assessment record. The assessment does not have to be complete. If you have any incomplete records, make sure you use your delimiter as a placeholder for any blank fields that appear between fields with data. If a duplicate assessment is found in the eRehabData system while trying to add a new assessment, the new record will not be imported. Also, if any data type violations are encountered during the import process, the new record will not be imported.

U = Update an existing unlocked, unfiled record. All fields in the existing assessment are changed to the values in the new record. This means that when updating, it is possible to overwrite existing values with blanks if there are values in fields in the existing assessment that are not present in the uploaded record.

Alternate Replacement Algorithm: Alternatively, you can choose to update data only where values are present in the import record (i.e. don't overwrite existing data with blanks) by checking the box labeled “Do not overwrite existing data with blanks” on the IRF-PAI Import screen. By selecting this option, blank values within the uploaded Update record will not overwrite data in the record in eRehabData. The only exception to this is comorbidities, which

are treated as a block. This means that if an uploaded assessment contains any comorbidities, all comorbidities in the uploaded Update record (including blanks if present) will overwrite all comorbidities in the existing assessment.

Only unlocked in-progress assessments can be modified. Also, it is not possible to update the fields used for matching, as this would prevent a match in the first place. In order to update one of the Assessment Identification "matching" fields (see "IDENTIFYING MATCHING RECORDS" below for details) a Delete record followed by an Add record will be necessary.

NOTE: The only exception to this rule is Admit Date. If a single assessment is found to have all matching fields with the exception of admit date, then the admit date will be updated to the new value.

D = Delete an existing unlocked, unfiled record. If a single assessment is matched, it will be deleted. For a delete action only the 7 matching fields listed below are used to identify an existing record, so delete records do not actually have to contain the entire assessment's data. Once again, only unlocked / unfiled assessments can be deleted.

The first non-alphanumeric character following the Record_Type character is assumed to be your delimiter.

ERROR CHECKING

The IRF-PAI Import performs data validation checks as it imports records to ensure that uploaded records conform to CMS specifications. For example, if the importer finds any zeroes in any discharge FIM scores in a record, the record will fail the data validation because zero is not a valid discharge FIM score value.

In most cases, records containing data that do not pass the validation checks will not be imported. The exception to this is facility custom data, where custom data failing a simple data type check will not be imported but the rest of the record will. Any such problems encountered during the import process will be detailed in the system message sent to you once the import has finished.

IDENTIFYING MATCHING RECORDS

In order to update or delete an existing record, it must be found. If not blank, normally the following key fields will be used to match an existing record:

Field	Name	IRF-PAI Element
1	Medicare Number	2
3	First Name	4
4	Last Name	5a
5	Patient ID Number	5b
6	Birth Date	6
7	SSN	7
18	Admit Date *	12
*see note under Update section above		

If a key field is blank in the uploaded record, that field will not be used to identify a match. If a key field other than Admit Date has a value in the uploaded record but is blank in the existing assessment, no match will be made.

If multiple matches occur (for example, searching only on Last Name = 'Smith' matching 'John Smith' and 'Jane Smith') then the record will be ignored.

Alternative Matching Algorithm: Alternatively, you can choose to match only on Admit Date and either Medicare Number, Patient ID Number, or SSN. This option is available on the IRF-PAI Import screen below the browse window. To enable this option for an individual upload, before you upload your file check the box labeled "Use single field for patient matching:" and select the field that will be used with Admit Date from the drop-down provided.

UPLOADING YOUR FILE

To upload your IRF-PAI Import file to eRehabData, log in to eRehabData and click **Uploads**, then click **IRF-PAI Import**.

> ***NOTE:*** If you do not see the **Uploads** or **IRF-PAI Import** options, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can upload assessments to eRehabData."

From the IRF-PAI Import screen, use the **Browse** button to browse to the location of the file you created for upload. In your browse window, make sure that under "Files of Type" you have selected "All files (*.*)" or you may not see your upload file. Double-click on the filename and then click **Upload**. You should see the following message appear on the screen:

> **File Upload successful.** The file "<filename>" was successfully uploaded (It has been assigned ID <number>). It now awaits processing in the upload queue. Once it has been processed, the results will be sent to you via the eRehabData messaging system (accessible from the Launch Screen).

Uploaded files are processed at regular intervals. Once the assessments in your upload file have been processed, you will receive a message via the eRehabData messaging system confirming your assessment import. The message will list the assessments imported, state the number of successfully processed assessments, and detail any problems found with specific assessments. You can access your messages from your eRehabData home page. For more information on viewing your messages, please see "View Messages" under the "eRehabData Messaging System (Send Message)" section of this manual.

You can print out the entire message so you can refer to it when reviewing your imported data. The easiest way to do this is to pull up your message and press Ctrl A to select everything on the page, then copy (Ctrl C) and paste (Ctrl V) into Notepad (if you paste into Word, you will want to delete the images before printing). Then, print out the document.

TEXT FILE STRUCTURE

Data types identified in the file format specification below are as follows:

B = Boolean [0,1]
C = Character
D = Date (YYYYMMDD)
FIM = FIM score [0-7]
I = Integer

ICD = ICD code (all ICD codes must include a '.')
S = String

If specified, valid values are listed between the brackets '[' and ']'.

Line breaks with headers in the file format correspond to the different sections of the IRF-PAI and other data groupings and are for legibility in this documentation only. They do not represent anything in the records themselves.

NOTE: **Beginning 10/1/2014, it will no longer be possible to upload complete IRF-PAI records using the text file upload.** From that day forward, only fields that exist across all versions of the IRF-PAI can be imported with a text file. The fields that will no longer be imported are highlighted in pink in the text file format below. The remaining fields will maintain their position in the import file so their location in each record does not change. Complete IRF-PAI records for discharges on or after 10/1/2012 can be uploaded using the appropriate version of the CMS XML format based on discharge date.

The text file format is as follows:

IRF-PAI Import Text File Format

Record Position	Field Name	Data Type	IRF-PAI Element
1.	Record_Type	C [A, U, D]	N/A
IDENTIFICATION INFORMATION			
2.	MEDICARE_NUM	S	2
3.	MEDICAID_NUM	S	3
4.	FIRST_NAME	S	4
5.	LAST_NAME	S	5A.
6.	PATIENT_ID	S	5B.
7.	BIRTH_DATE	D	6
8.	SSN	S (9 digits, no dashes)	7
9.	GENDER	I [1 = male, 2 = female]	8
10.	RACE_AMERIND	B	9A.
11.	RACE_ASIAN	B	9B.
12.	RACE_BLACK	B	9C.
13.	RACE_HISPANIC	B	9D.
14.	RACE_HAWAII	B	9E.
15.	RACE_WHITE	B	9F.
16.	MARITAL_STATUS	I	10
17.	ZIPCODE_PREHOSP	S	11
ADMISSION INFORMATION			
18.	ADMIT_DATE	D	12
19.	ASSESS_REF_DATE	D	13
20.	ADMIT_CLASS	I	14
21.	ADMIT_FROM	I	15
22.	PREHOSP_SETTING	I	16
23.	PREHOSP_LIVINGWITH	I	17
24.	PREHOSP_VOCCAT	I	18
25.	PREHOSP_VOCEFFORT	I	19
PAYER INFORMATION			
26.	PAYSOURCE_PRIMARY	I	20A.
27.	PAYSOURCE_SECONDARY	I	20B.
MEDICAL INFORMATION			

IRF-PAI Import Text File Format (Continued)

Record Position	Field Name	Data Type	IRF-PAI Element
28.	IMPAIR_GROUP_ADMIT	S	21 (Admit)
29.	IMPAIR_GROUP_DISCH	S	21 (Disch)
30.	DIAGNOSIS	ICD	22
31.	ONSET_DATE	D	23
32.	COMORB_A	ICD	24A.
33.	COMORB_B	ICD	24B.
34.	COMORB_C	ICD	24C.
35.	COMORB_D	ICD	24D.
36.	COMORB_E	ICD	24E.
37.	COMORB_F	ICD	24F.
38.	COMORB_G	ICD	24G.
39.	COMORB_H	ICD	24H.
40.	COMORB_I	ICD	24I.
41.	COMORB_J	ICD	24J.
MEDICAL NEEDS			
42.	COMATOSE_ADMIT	B	25
43.	DELERIOUS_ADMIT	B	26
44.	SWALLOWING_ADMIT	I	27 (Admit)
45.	SWALLOWING_DISCH	I	27 (Disch)
46.	DEHYDRATION_ADMIT	B	28 (Admit)
47.	DEHYDRATION_DISCH	B	28 (Disch)
FUNCTION MODIFIERS			
48.	FMOD_BLADDER_ASSIST_ADMIT	FIM	29 (Admit)
49.	FMOD_BLADDER_ASSIST_DISCH	FIM	29 (Disch)
50.	FMOD_BLADDER_ACCIDENT_ADMIT	FIM	30 (Admit)
51.	FMOD_BLADDER_ACCIDENT_DISCH	FIM	30 (Disch)
52.	FMOD_BOWEL_ASSIST_ADMIT	FIM	31 (Admit)
53.	FMOD_BOWEL_ASSIST_DISCH	FIM	31 (Disch)
54.	FMOD_BOWEL_ACCIDENT_ADMIT	FIM	32 (Admit)
55.	FMOD_BOWEL_ACCIDENT_DISCH	FIM	32 (Disch)
56.	FMOD_TUB_XFER_ADMIT	FIM	33 (Admit)
57.	FMOD_TUB_XFER_DISCH	FIM	33 (Disch)
58.	FMOD_SHOWER_XFER_ADMIT	FIM	34 (Admit)
59.	FMOD_SHOWER_XFER_DISCH	FIM	34 (Disch)
60.	FMOD_DIST_WALKED_ADMIT	I [0-3]	35 (Admit)
61.	FMOD_DIST_WALKED_DISCH	I [0-3]	35 (Disch)
62.	FMOD_DIST_WHEEL_ADMIT	I [0-3]	36 (Admit)
63.	FMOD_DIST_WHEEL_DISCH	I [0-3]	36 (Disch)
64.	FMOD_WALK_ADMIT	FIM	37 (Admit)
65.	FMOD_WALK_DISCH	FIM	37 (Disch)
66.	FMOD_WHEELCHAIR_ADMIT	FIM	38 (Admit)
67.	FMOD_WHEELCHAIR_DISCH	FIM	38 (Disch)
FIM INSTRUMENT			
68.	FIM_EATING_ADMIT	FIM	39A. (Admit)
69.	FIM_EATING_DISCH	FIM	39A. (Disch)
70.	FIM_EATING_GOAL	FIM	39A. (Goal)
71.	FIM_GROOMING_ADMIT	FIM	39B. (Admit)
72.	FIM_GROOMING_DISCH	FIM	39B. (Disch)
73.	FIM_GROOMING_GOAL	FIM	39B. (Goal)

IRF-PAI Import Text File Format (Continued)

Record Position	Field Name	Data Type	IRF-PAI Element
74.	FIM_BATHING_ADMIT	FIM	39C. (Admit)
75.	FIM_BATHING_DISCH	FIM	39C. (Disch)
76.	FIM_BATHING_GOAL	FIM	39C. (Goal)
77.	FIM_DRESS_UPPER_ADMIT	FIM	39D. (Admit)
78.	FIM_DRESS_UPPER_DISCH	FIM	39D. (Disch)
79.	FIM_DRESS_UPPER_GOAL	FIM	39D. (Goal)
80.	FIM_DRESS_LOWER_ADMIT	FIM	39E. (Admit)
81.	FIM_DRESS_LOWER_DISCH	FIM	39E. (Disch)
82.	FIM_DRESS_LOWER_GOAL	FIM	39E. (Goal)
83.	FIM_TOILETING_ADMIT	FIM	39F. (Admit)
84.	FIM_TOILETING_DISCH	FIM	39F. (Disch)
85.	FIM_TOILETING_GOAL	FIM	39F. (Goal)
86.	FIM_BLADDER_ADMIT	FIM	39G. (Admit)
87.	FIM_BLADDER_DISCH	FIM	39G. (Disch)
88.	FIM_BLADDER_GOAL	FIM	39G. (Goal)
89.	FIM_BOWEL_ADMIT	FIM	39H. (Admit)
90.	FIM_BOWEL_DISCH	FIM	39H. (Disch)
91.	FIM_BOWEL_GOAL	FIM	39H. (Goal)
92.	FIM_BEDCHAIRWHEEL_XFER_ADMIT	FIM	39I. (Admit)
93.	FIM_BEDCHAIRWHEEL_XFER_DISCH	FIM	39I. (Disch)
94.	FIM_BEDCHAIRWHEEL_XFER_GOAL	FIM	39I. (Goal)
95.	FIM_TOILET_XFER_ADMIT	FIM	39J. (Admit)
96.	FIM_TOILET_XFER_DISCH	FIM	39J. (Disch)
97.	FIM_TOILET_XFER_GOAL	FIM	39J. (Goal)
98.	FIM_TUBSHOWER_XFER_ADMIT	FIM	39K. (Admit)
99.	FIM_TUBSHOWER_XFER_DISCH	FIM	39K. (Disch)
100.	FIM_TUBSHOWER_XFER_GOAL	FIM	39K. (Goal)
101.	FIM_WALKWHEEL_ADMIT	FIM	39L. (Admit)
102.	FIM_WALKWHEEL_MEASURE_ADMIT	C [W, C, B]	39L. (Admit)
103.	FIM_WALKWHEEL_DISCH	FIM	39L. (Disch)
104.	FIM_WALKWHEEL_MEASURE_DISCH	C [W, C, B]	39L. (Disch)
105.	FIM_WALKWHEEL_GOAL	FIM	39L. (Goal)
106.	FIM_STAIRS_ADMIT	FIM	39M. (Admit)
107.	FIM_STAIRS_DISCH	FIM	39M. (Disch)
108.	FIM_STAIRS_GOAL	FIM	39M. (Goal)
109.	FIM_COMP_ADMIT	FIM	39N. (Admit)
110.	FIM_COMP_MEASURE_ADMIT	C [A, V, B]	39N. (Admit)
111.	FIM_COMP_DISCH	FIM	39N. (Disch)
112.	FIM_COMP_MEASURE_DISCH	C [A, V, B]	39N. (Disch)
113.	FIM_COMP_GOAL	FIM	39N. (Goal)
114.	FIM_EXPRESS_ADMIT	FIM	39O. (Admit)
115.	FIM_EXPRESS__MEASURE_ADMIT	C [V, N, B]	39O. (Admit)
116.	FIM_EXPRESS_DISCH	FIM	39O. (Disch)
117.	FIM_EXPRESS_MEASURE_DISCH	C [V, N, B]	39O. (Disch)
118.	FIM_EXPRESS_GOAL	FIM	39O. (Goal)
119.	FIM_SOCIAL_ADMIT	FIM	39P. (Admit)
120.	FIM_SOCIAL_DISCH	FIM	39P. (Disch)
121.	FIM_SOCIAL_GOAL	FIM	39P. (Goal)
122.	FIM_PROBSOLVE_ADMIT	FIM	39Q. (Admit)

IRF-PAI Import Text File Format (Continued)

Record Position	Field Name	Data Type	IRF-PAI Element
123.	FIM_PROBSOLVE_DISCH	FIM	39Q. (Disch)
124.	FIM_PROBSOLVE_GOAL	FIM	39Q. (Goal)
125.	FIM_MEMORY_ADMIT	FIM	39R. (Admit)
126.	FIM_MEMORY_DISCH	FIM	39R. (Disch)
127.	FIM_MEMORY_GOAL	FIM	39R. (Goal)
DISCHARGE INFORMATION			
128.	DISCHARGE_DATE	D	40
129.	AGAINST_ADVICE	B	41
130.	INTERRUPTIONS	B	42
131.	INT_DATE_1	D	43A.
132.	RETURN_DATE_1	D	43B.
133.	INT_DATE_2	D	43C.
134.	RETURN_DATE_2	D	43D.
135.	INT_DATE_3	D	43E.
136.	RETURN_DATE_3	D	43F.
137.	DISCH_SETTING	I	44A.
138.	DISCH_HOMEHEALTH	B	44B.
139.	DISCH_LIVE_WITH	I	45
140.	DISCH_DIAGNOSIS	ICD	46
141.	COMPLICATION_A	ICD	47A.
142.	COMPLICATION_B	ICD	47B.
143.	COMPLICATION_C	ICD	47C.
144.	COMPLICATION_D	ICD	47D.
145.	COMPLICATION_E	ICD	47E.
146.	COMPLICATION_F	ICD	47F.
QUALITY INDICATORS FOR DISCHARGES 10/1/2012-9/30/2014			
147.	NUM_STAGE2_ULCERS_ADMIT	I [0-9]	48A (Admit)
148.	NUM_STAGE2_ULCERS_DISCH	I [0-9]	48A (Disch)
149.	NUM_STAGE3_ULCERS_ADMIT	I [0-9]	48B (Admit)
150.	NUM_STAGE3_ULCERS_DISCH	I [0-9]	48B (Disch)
151.	NUM_STAGE4_ULCERS_ADMIT	I [0-9]	48C (Admit)
152.	NUM_STAGE4_ULCERS_DISCH	I [0-9]	48C (Disch)
153.	NUM_STAGE2_ULCERS_WORSENED	I [0-9]	49A
154.	NUM_STAGE3_ULCERS_WORSENED	I [0-9]	49B
155.	NUM_STAGE4_ULCERS_WORSENED	I [0-9]	49C
156.	ULCERS_PRESENT_ON_ADMISSION	B	50A
157.	NUM_STAGE2_ULCERS_HEALED	I [0-9]	50B
158.	NUM_STAGE3_ULCERS_HEALED	I [0-9]	50C
159.	NUM_STAGE4_ULCERS_HEALED	I [0-9]	50D
160.	LEAVE BLANK		
161.	LEAVE BLANK		
162.	LEAVE BLANK		
163.	LEAVE BLANK		
164.	LEAVE BLANK		
165.	LEAVE BLANK		
166.	LEAVE BLANK		
167.	LEAVE BLANK		
168.	LEAVE BLANK		
169.	LEAVE BLANK		

IRF-PAI Import Text File Format (Continued)

Record Position	Field Name	Data Type	IRF-PAI Element
QUALITY INDICATORS FOR DISCHARGES PRIOR TO 10/1/2012			
147.	SHORTBREATH_EXERTION_ADMIT	B	48 (Admit)
148.	SHORTBREATH_EXERTION_DISCH	B	48 (Disch)
149.	SHORTBREATH_REST_ADMIT	B	49 (Admit)
150.	SHORTBREATH_REST_DISCH	B	49 (Disch)
151.	WEAKCOUGH_ADMIT	B	50 (Admit)
152.	WEAKCOUGH_DISCH	B	50 (Disch)
153.	PAIN_ADMIT	I	51 (Admit)
154.	PAIN_DISCH	I	51 (Disch)
155.	HIGHEST_ULCER_STAGE_ADMIT	I	52A. (Admit)
156.	HIGHEST_ULCER_STAGE_DISCH	I	52A. (Disch)
157.	NUMBER_ULCERS_ADMIT	I	52B. (Admit)
158.	NUMBER_ULCERS_DISCH	I	52B. (Disch)
159.	ULCER_AREA_ADMIT	I	52C. (Admit)
160.	ULCER_AREA_DISCH	I	52C. (Disch)
161.	EXUDATE_AMOUNT_ADMIT	I	52D. (Admit)
162.	EXUDATE_AMOUNT_DISCH	I	52D. (Disch)
163.	TISSUE_TYPE_ADMIT	I	52E. (Admit)
164.	TISSUE_TYPE_DISCH	I	52E. (Disch)
165.	TOTAL_PUSH_SCORE_ADMIT	I	52F. (Admit)
166.	TOTAL_PUSH_SCORE_DISCH	I	52F. (Disch)
167.	BALANCE_PROB_ADMIT	B	53 (Admit)
168.	BALANCE_PROB_DISCH	B	53 (Disch)
169.	NUMBER_FALLS	I	54
MISCELLANEOUS			
170.	Correction_Num	I	N/A
171.	CMS_Transfer_OR_Filed_Status	B [0 = not sent to CMS; 1 = sent or Filed for non-Medicare]	N/A
172.	CMS_Transmit_Date	D	N/A
CUSTOM DATA FIELDS			
173. +	Facility Custom Data	varies	N/A

11. Assessment ID Data Upload

The Assessment ID Data Upload allows you to upload patient demographic data based on up to ten identification elements into a “Waiting Assessments” staging area on eRehabData, where the uploaded records can be reviewed individually before being accepted into the system as in-progress admission assessments. This is useful for facilities that capture patient demographic data in another software application that can export that data in a text file.

FILE REQUIREMENTS

Your Assessment ID Data Upload file is an ASCII text file, with each record contained on a single line and separated from the next by a carriage return/line feed. Each field in each record is separated by a TAB character.

The fields Facility Patient ID and Last Name are required. All other fields are optional but if a value is present in a field, it must be a valid value. If you do not have data in some of the fields, the TAB character must still be used as a placeholder for empty fields.

You can update records still in the "Waiting Assessments" area with subsequent uploads. However, if a duplicate admit or discharge assessment is found in the eRehabData system while trying to add a new record, the new record will not be imported. Also, if any data type violations are encountered during the import process, the new record will not be imported. See below for the record matching algorithm.

ERROR CHECKING

The Assessment ID Data Upload performs simple data type validation checks as it imports records. Records including any data that do not pass the validation checks will not be imported. Any such problems encountered during the import process will be detailed in the system message printed on-screen once the import has finished.

IDENTIFYING MATCHING RECORDS

In order to update an existing record, it must be found. Facility Patient ID is the key matching field and all matches are done based solely on this value. If an uploaded record is matched to an existing waiting assessment, all values in the waiting assessment will be overwritten with the values in the new record. If an uploaded record is matched to an existing admit or discharge assessment, the new record will not be imported.

UPLOADING YOUR FILE

To upload your IRF-PAI Import file to eRehabData, log in to eRehabData and click **Uploads**, then click **Assessment ID Data Upload**.

> ***NOTE:*** If you do not see the **Uploads** or **Assessment ID Data Upload** options, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can upload assessments to eRehabData."

From the Assessment ID Data Upload screen, use the **Browse** button to browse to the location of the file you created for upload. In your browse window, make sure that under "Files of Type" you have selected "All files (*.*)" or you may not see your upload file. Double-click on the filename and then click **Upload**. Your file will upload to eRehabData and the records will be examined and imported. Depending upon the size of the file this may take a few minutes, during which time you should not leave the screen or hit refresh on your browser. When the system has finished examining the contents of the file and importing any records found you should see the following message appear on the screen:

> **The contents of the file "<filename>" have been processed:**

The full results of the import will be displayed on screen. Any problems found in individual records will be detailed and those records will not be imported. Successfully imported new records will display this message:

> "Accepted - a new record has been added"

Successfully updated existing records will display this message:

> "Accepted - an existing record had its data updated"

You can print out the entire message so you can refer to it when reviewing your waiting assessments. The easiest way to do this is to pull up your message and press Ctrl A to select everything on the page, then copy (Ctrl C) and paste (Ctrl V) into Notepad (if you paste into Word, you will want to delete the images before printing). Then, print out the document using Landscape orientation. Because this message is only presented on-screen once directly following an upload, printing or saving it is recommended.

WAITING ASSESSMENTS

Uploaded records do not automatically become assessments; they must be "accepted" into the system. Between upload and acceptance they are locked and flagged as "waiting assessments" (i.e., waiting for acceptance). A list of any waiting assessments will appear on your eRehabData home page.

Only waiting assessments can be updated should new data arrive during an upload. Once an assessment is accepted into the system as an admit assessment, it can no longer be modified automatically with a new upload.

To accept a waiting assessment into the system, select it from your eRehabData home screen and click **Accept**. If a record is accidentally accepted, you can cancel the resulting admit assessment and perform another upload to insert the record again.

FILE STRUCTURE

Data types identified in the file format specification below are as follows:

D = Date (YYYYMMDD)
I = Integer
ICD = ICD code (all ICD codes must include a '.')
S = String

The file format is as follows:

Assessment ID Data Upload File Format

Record Position	Field Name	Data Type	IRF-PAI Element
1.	MEDICARE_NUM	S	2
2.	MEDICAID_NUM	S	3
3.	FIRST_NAME	S	4
4.	LAST_NAME	S	5a.
5.	FACILITY_PATIENT_ID	S	5b.
6.	BIRTH_DATE	D	6
7.	SSN	S (9 digits, no dashes)	7
8.	GENDER	I [1=male; 2=female]	8
9.	ADMIT_DATE	D	12
10.	DIAGNOSIS	ICD	22

11. Follow-Up Data Upload

The Follow-Up Data Upload allows you to upload follow-up assessment records to eRehabData, where they are imported and stored with their associated discharge assessments. This is especially useful for facilities who contract with an outside source for follow-up data collection in that by providing a contractor with the follow-up file format, they can assemble collected follow-up records into a text file for one easy upload into eRehabData.

FILE REQUIREMENTS

Your Follow-Up Data Upload file is an ASCII text file, with each record contained on a single line and separated from the next by a carriage return/line feed. Each field in each record is separated by a delimiter of your choosing.

During the file import the system will automatically identify the first non-alphanumeric character found on the first line of the file as the field delimiter for the entire file. Your delimiter can be anything except a letter, a digit, or an underscore, dash or space, as these characters often appear in actual data. We highly recommend the TAB character as the TAB cannot be embedded in any data fields.

The fields Operation, ADMIT_DATE and FOLLOW_UP_DATE are required. All other fields are optional but if a value is present in a field, it must be a valid value. If you do not have data in some of the fields in a record, your delimiter must still be used as a placeholder for empty fields where there are gaps in the data.

IMPORT COMMANDS

The first field in each record is the Operation field, where you indicate with a single character what action you want to perform with that record. Valid values are:

A = Add a new follow-up assessment record. The assessment does not have to be complete. If you have any incomplete records, make sure you use your delimiter as a placeholder for any blank fields that appear between fields with data. If the matched discharge assessment already has follow-up data, the new follow-up record will not be added.

U = Update an existing follow-up assessment record. All fields in the existing follow-up assessment are changed to the values in the new record. This means that when updating, it is possible to overwrite existing values with blanks if there are values in fields in the existing assessment that are not present in the uploaded record.

D = Delete an existing follow-up assessment record. If a single follow-up assessment is matched, it will be deleted.

The first non-alphanumeric character following the Operation character is assumed to be your delimiter.

ERROR CHECKING

The Follow-Up Data Upload performs data validation checks as it imports records. Records including any data that do not pass the validation checks will not be imported. Any such problems encountered during the import process will be detailed in the system message sent to you once the import has finished.

IDENTIFYING MATCHING RECORDS

In order to update or delete an existing record, it must be found. At least one of the key fields below marked with a '*' AND one of the key fields marked with a '#' are required for

matching. ADMIT_DATE is required in all cases. If not blank, the following key fields will be used to match an existing record:

Field	Name	IRF-PAI Element
1	MEDICARE_NUM#	2
2	MEDICAID_NUM	3
3+4	LAST_NAME + FIRST_NAME *	5a+4
5	PAT_ID_NUM *	5b
6	BIRTH_DATE #	6
7	SSN #	7
8	ADMIT_DATE (req)	12
9	DISCHARGE_DATE	40

If a key field is blank in the uploaded record, that field will not be used to identify a match. If a key field has a value in the uploaded record but is blank in the existing assessment, no match will be made.

If multiple matches occur (which should not be possible) then none of them will be updated.

UPLOADING YOUR FILE

To upload your Follow-Up Data file to eRehabData, log in to eRehabData and click **Uploads**, then click **Follow-Up Data Upload**.

> ***NOTE:*** If you do not see the **Uploads** or **Follow-Up Data Upload** options, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can upload assessments to eRehabData."

From the Follow-Up Data Upload screen, use the **Browse** button to browse to the location of the file you created for upload. In your browse window, make sure that under "Files of Type" you have selected "All files (*.*)" or you may not see your upload file. Double-click on the filename and then click **Upload**. You should see the following message appear on the screen:

> **File Upload successful.** The file "<filename>" was successfully uploaded (It has been assigned ID <number>). It now awaits processing in the upload queue. Once it has been processed, the results will be sent to you via the eRehabData messaging system (accessible from the Launch Screen).

Uploaded files are processed at regular intervals. Once the assessments in your upload file have been processed, you will receive a message via the eRehabData messaging system confirming your assessment import. The message will list the assessments imported, state the number of successfully processed assessments, and detail any problems found with specific assessments. You can access your messages from your eRehabData home page. For more information on viewing your messages, please see "View Messages" under the "eRehabData Messaging System (Send Message)" section of this manual.

You can print out the entire message so you can refer to it when reviewing your imported data. The easiest way to do this is to pull up your message and press Ctrl A to select everything on the page, then copy (Ctrl C) and paste (Ctrl V) into Notepad (if you paste into Word, you will want to delete the images before printing). Then, print out the document.

FILE STRUCTURE

Data types identified in the file format specification below are as follows:

C = Character
D = Date (YYYYMMDD)
FIM = FIM score [1-7]
I = Integer
ICD = ICD code (all ICD codes must include a '.')
S = String

If specified, valid values are listed between the brackets '[' and ']'.

The complete file format is as follows:

Follow-Up Data Upload File Format

Record Position	Field Name	Data Type	IRF-PAI Element
1.	Operation	C [A, U, D]	
2.	MEDICARE_NUM	S	2
3.	MEDICAID_NUM	S	3
4.	LAST_NAME	S	5a
5.	FIRST_NAME	S	4
6.	PATIENT_ID	S	5b
7.	BIRTH_DATE	D	6
8.	SSN	S (9 digits, no dashes)	7
9.	ADMIT_DATE	D	12
10.	DISCHARGE_DATE	D	40
11.	FOLLOW_UP_DATE	D	
12.	INFO_SOURCE	I [1-4]	
13.	ASSESS_METHOD	I [1-3]	
14.	LIVING_SETTING	I [1-14]	
15.	LIVING_WITH	I [1-5]	
16.	VOCATIONAL_CAT	I [1-7]	
17.	VOCATIONAL_EFFORT	I [1-3]	
18.	MAINT_PRIMARY	I [1-4]	
19.	MAINT_SECONDARY	I [1-4]	
20.	THERAPY	I [1-8]	
21.	DIAG_A	ICD	
22.	DIAG_B	ICD	
23.	DIAG_C	ICD	
24.	DIAG_D	ICD	
25.	DIAG_E	ICD	
26.	DIAG_F	ICD	
27.	FIM_EATING	FIM	
28.	FIM_GROOMING	FIM	
29.	FIM_BATHING	FIM	
30.	FIM_DRESS_UPPER	FIM	
31.	FIM_DRESS_LOWER	FIM	
32.	FIM_TOILETING	FIM	
33.	FIM_BLADDER	FIMB	
34.	FIM_BOWEL	FIM	
35.	FIM_BEDCHAIRWHEEL	FIM	

Follow-Up Data Upload File Format (Continued)

Record Position	Field Name	Data Type	IRF-PAI Element
36.	FIM_TOILET	FIM	
37.	FIM_TUBSHOWER	FIM	
38.	FIM_WALKWHEEL	FIM	
39.	FIM_WALKWHEEL_MODE	C [W, C, B]	
40.	FIM_STAIRS	FIM	
41.	FIM_COMP	FIM	
42.	FIM_COMP_MODE	C [A, V, B]	
43.	FIM_EXPRESS	FIM	
44.	FIM_EXPRESS_MODE	C [V, N, B]	
45.	FIM_SOCIAL	FIM	
46.	FIM_PROBSOLVE	FIM	
47.	FIM_MEMORY	FIM	

12. PSI Scan Upload

Facilities enrolled in the eRehabData Patient Satisfaction System have two ways to enter completed survey results into eRehabData: by typing results directly into the eRehabData interface; or by creating a text file of collected survey results, either by hand or with the use of scanning software, and uploading the file to eRehabData.

FILE REQUIREMENTS

Your PSI Scan Upload file is an ASCII text file, with each record contained on a single line and separated from the next by a carriage return/line feed. Each field in each record is separated by a delimiter of your choosing.

During the file import the system will automatically identify the first non-alphanumeric character found on the first line of the file as the field delimiter for the entire file. Your delimiter can be anything except a letter, a digit, or an underscore, dash or space, as these characters often appear in actual data. We highly recommend the TAB character as the TAB cannot be embedded in any data fields.

If you do not have data in some of the fields, your delimiter must still be used as a placeholder for empty fields where there are gaps in the data. If you are uploading partial records you do not need to pad the empty fields after the existing data in a record with your delimiter.

The first non-alphanumeric character following the SurveyVersion field is assumed to be your delimiter.

ERROR CHECKING

The PSI Scan Upload performs data validation checks as it imports records. Records including any data that do not pass the validation checks will not be imported. Any such problems encountered during the import process will be detailed in the system message sent to you once the import has finished.

IDENTIFYING MATCHING RECORDS

Patient Satisfaction Survey records are linked to assessments using the Survey ID that appears in the upper right corner of each survey page. This ID is also the eRehabData IRF-PAI UniqueID and is included in the record once for each survey page, so Discharge Survey records will include three survey IDs, Service Recovery Survey records will include two survey IDs, and Follow-Up Survey records will have one Survey ID.

The redundant Survey IDs in each Discharge and Service Recovery Survey record are based on the scannable forms and structured as such to prevent import of mismatched survey pages. If all Survey IDs in a record do not match, the record will not be imported.

If an existing survey is found in eRehabData and the record in the upload file is different, the new survey record will overwrite the existing survey. If an identical survey is found, the new survey record will not be imported.

If the facility ID in the survey record does not match the facility to which the assessment belongs, the record will not be imported.

UPLOADING YOUR FILE

To upload your PSI Scan Upload file to eRehabData, log in to eRehabData and click **Uploads**, then click **PSI Scan Upload**.

> ***NOTE:*** If you do not see the **Uploads** or **PSI Scan Upload** options, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can upload assessments to eRehabData."

From the PSI Scan Upload screen, use the **Browse** button to browse to the location of the file you created for upload. In your browse window, make sure that under "Files of Type" you have selected "All files (*.*)" or you may not see your upload file. Double-click on the filename and then click **Upload**. You should see the following message appear on the screen:

> **File Upload successful.** The file "<filename>" was successfully uploaded (It has been assigned ID <number>). It now awaits processing in the upload queue. Once it has been processed, the results will be sent to you via the eRehabData messaging system (accessible from the Launch Screen).

Uploaded files are processed at regular intervals. Once the surveys in your upload file have been processed, you will receive a message via the eRehabData messaging system confirming your survey import. The message will list the surveys imported, state the number of successfully processed surveys, and detail any problems found with specific surveys. You can access your messages from your eRehabData home page. For more information on viewing your messages, please see "View Messages" under the "eRehabData Messaging System (Send Message)" section of this manual.

You can print out the entire message so you can refer to it when reviewing your imported data. The easiest way to do this is to pull up your message and press Ctrl A to select everything on the page, then copy (Ctrl C) and paste (Ctrl V) into Notepad (if you paste into Word, you will want to delete the images before printing). Then, print out the document.

FILE STRUCTURE

The first field in each record is the SurveyVersion field, where you indicate what kind of survey the record corresponds to. Valid SurveyVersion values are:

S = Service Recovery Survey
F = Follow Up Survey
D2C = Discharge Survey with two nursing shifts and combined social work/case management questions
D2D = Discharge Survey with two nursing shifts and separate (distinct) social work and case management questions
D3C = Discharge Survey with three nursing shifts and combined social work/case management questions
D3D = Discharge Survey with three nursing shifts and separate (distinct) social work and case management questions

Your facility's discharge survey configuration will dictate which of the discharge survey file formats is right for you. To check your facility's configuration on eRehabData, log in and click **My Facility**, then click **Patient Satisfaction Instrument**. The link for the discharge survey template at the bottom of that page will indicate if you need 2C, 2D, 3C, or 3D. For more information on configuring your discharge surveys, please see the "Patient Satisfaction Instrument" section of this manual.

NOTE: If you do not see the **My Facility** or **Patient Satisfaction Instrument** option, you will need to contact your facility's eRehabData administrator and ask them to grant you either the "Facility administrator" privilege OR the "Non-admin user can manage IRF-PAI proficiency exams" privilege.

Ranges of valid values are indicated in the "Value" column below.

The survey file formats are as follows:

Service Recovery Survey File Format

Name or Survey Question Number	Value	Notes
SurveyVersion	S	S=Service Recovery Survey, as printed in bar code, lower left corner of survey page 1
FacilityID	6 digits	Facility's Medicare provider number as printed in bar code, upper left corner of survey page 1
SurveyID	6-7 digits	Survey ID as printed in bar code, upper right corner of survey
DatePrinted	MMDDYYYY	As printed in bar code, lower right corner of survey page 1
Q1	0-4	
Q2	0-4	
Q3	0-4	
Q4	0-4	
Q5	0-4	
Q6	0-4	
Q7	0-4	
Q8	0-3	
Q9	0-3	
Q10	0-3	
Q12	0-3	
Q13	0-3	
SurveyID	6-7 digits	Survey ID as printed in bar code, upper right corner of survey
ComfortableStayComments	text	
BetterAccomodateComments	text	
GeneralComments	text	
ServiceRecoveryCompleted	1-3	

Discharge Survey File Format

Name or Survey Question Number	Value	Notes
SurveyVersion	D2C or D2D or D3C or D3D	**D2C**=Discharge Survey with two nursing shifts and combined social work/case management questions; **D2D**=Discharge Survey with two nursing shifts and separate (distinct) social work/case management questions; **D3C**=Discharge Survey with three nursing shifts and combined social work/case management questions; **D3D**=Discharge Survey with three nursing shifts and separate (distinct) social work/case management questions
FacilityID	6 digits	Facility's Medicare provider number as printed in bar code, upper left corner of survey page 1
SurveyID	6-7 digits	Survey ID as printed in bar code, upper right corner of survey
DatePrinted	mmddyyyy	As printed in bar code, lower right corner of survey page 1
Q1	0-5	
Q2	0-5	
Q3	0-5	
Q4	0-5	
Q5	0-5	
Q6	0-5	
Q7	0-5	***Note:*** This field is only present on D3C or D3D surveys. When uploading D2C or D2D surveys, omit this field entirely.
Q8	0-5	
Q9	0-5	
Q10	0-5	
Q12	0-5	
Q13/Q13a	0-5	
Q13b	0-5	***Note:*** This field is only present on D2D or D3D surveys. When uploading D2C or D3C surveys, omit this field entirely.
Q14	0-5	
Q15	0-5	
Q16	0-5	
Q17	0-5	
SurveyID	6-7 digits	Survey ID as printed in bar code, upper right corner of survey
Q18	0-5	
Q19	0-5	
Q20	0-5	
Q21	0-5	
Q22	0-5	
Q23	0-5	
Q24	0-5	
Q25	0-5	
Q26	0-5	
Q27	0-5	
Q28	0-5	
Q29	0-5	

Discharge Survey File Format (Continued)

Name or Survey Question Number	Value	Notes
Q30	0-5	
Q31	0-5	
Q32	0-5	
Q33	0-5	
Q34	1-5	
SurveyID	6-7 digits	Survey ID as printed in bar code, upper right corner of survey
DischargeSurveySafetyComments	memo	
DischargeSurveySafetyComments	memo	
DischargeCompleted	1-3	
NoContact	1	

Follow Up Survey File Format

Name or Survey Question Number	Value	Notes
SurveyVersion	F	F=Follow Up Survey, as printed in bar code, lower left corner of survey
FacilityID	6 digits	Facility's Medicare provider number as printed in bar code, upper left corner of survey
SurveyID	6-7 digits	Survey ID as printed in bar code, upper right corner of survey
DatePrinted	mmddyyyy	As printed in bar code, lower right corner of survey
Q1	0-1	
Q2	0-5	
Q3	0-1	
Q4	0-5	
Q5	0-1	
Q6	0-5	
Q7	0-5	
Q8	0-5	
FollowUpCompleted	1-3	

II.E. Reports (Outcomes)

eRehabData offers a variety of different outcomes reports. If you have been granted access to view outcomes reports, Patient Satisfaction Instrument (PSI) outcomes reports, or patient assessments for your facility, you will see the a **Reports** header on the left side of your eRehabData home page. Depending on your user privileges, under this header you may see any combination of the following options:

1. Outcomes
2. Dashboard
3. PSI Outcomes
4. Referrals Outcomes

5. Multi-Metrics

The **Outcomes Reports** are generated nightly from Accepted or Filed IRF-PAI discharge assessments. The **Dashboard Report** is updated in real time and includes all assessments for which there is an admit date but no discharge date present. If your facility is subscribed to the eRehabData Patient Satisfaction System, your **PSI Outcomes** will give you an analysis of your patient satisfaction survey responses. **Multi-Metrics** gives users with IRF-PAI view privileges the ability to print assessment metrics screens for multiple in-progress assessments without opening each individual record. A more detailed description of each kind of outcomes report follows.

> ***NOTE:*** In order to access any of the reports screens you must have reports viewing privileges. If you cannot access the outcomes reports, contact your facility's eRehabData administrator and ask them to grant you either the "User can view all outcomes reports for their facility" privilege, the "User can view all outcomes reports for all facilities in their organization (includes all facilities)" privilege, OR for patient satisfaction outcomes reports only, "User can ONLY view Patient Satisfaction outcomes reports for their facility."

1. Outcomes

To get to the outcomes report menu, from your eRehabData home screen click **Outcomes**. The core eRehabData outcomes reports are delivered in a six-tiered hierarchy under the **Facility Drill-Down** header starting at the top with the overall Facility report and then drilling down into the RIC Group, RIC, CMG, IGC, and patient levels. Additional reports tools include the Time-Series Graphs and FIM Scoring Comparison Graph under the **Graphing** header, and the Percentile Report, Custom Date Report, 60% Rule Compliance Report, Top Comorbidities by RIC report, CMG Matrix, Appeals Report, and optional ORYX® Report under the **Other Views** header.

You can jump to each level of the report from any of the outcomes reports screens by using the links labeled "Facility Report", "RIC Group Report", "RIC Report", "CMG Report", "IGC Report", "Patient Report", "Time-Series Graphs", "FIM Scoring Comparison Graph", "Percentile Report", "Custom Date Report", "60% Rule Compliance Report", "Top Comorbidities by RIC", "CMG Matrix", and "Appeals Report". Users belonging to organizations with more than one facility on eRehabData may also see a "Facility Ranking" report link which allows you to compare outcomes measure-by-measure across all facilities in the organization. Organization-level reports privileges are required in order to view this report. Users from facilities subscribed to eRehabData's Joint Commission ORYX® data service will also see a link to the "ORYX® Report".

Below is a table of contents for the Outcomes section of this user manual with links to the respective subsections. This section is structured as follows:

OUTCOMES REPORTS GENERAL INFORMATION

The eRehabData drill-down outcomes reports show you many performance measures for your facility for each month and each quarter since the IRF-PPS went into effect, as well as for trailing 30, 60, 90 and 180-day, calendar year, and 60% rule review year periods. You can compare your facility to national and regional numbers for all payers, or Medicare or non-Medicare. Many of the comparisons include "weighted" and "unweighted" national and regional numbers. The weighted numbers are benchmarks which volume-adjust national or regional practice patterns to exactly match the case mix in your facility using the CMG and tier groups. For this reason the weighted numbers give you a more accurate picture of how your facility compares to other facilities in the nation and your region.

The drill-down reports are updated nightly. A time stamp at the top of the report screens indicates the last time the reports were generated. Outcomes reports only include assessments for patients 8 years of age and older that have been marked as Accepted by CMS or have been Completed, Locked and Filed, with three exceptions: 1) the 60% Rule Compliance Report, which includes all assessments regardless of completion status or age; 2) the Custom Date Report, which includes all accepted by CMS and completed/filed assessments regardless of age; and 3) the Appeals Report, which includes payment denials/appeals information entered into accepted by CMS assessments. These three reports are also updated in real time rather than overnight.

Drop-downs at the top of the drill-down reports screens allow you to select different time periods, regions and payers. The Medicare payer selection only includes assessments where the primary payer is 2 - Medicare non-MCO. The region drop-down displays your facility's region by default. Users from organizations with more than one facility on eRehabData can also select their organization as a region, so that they can compare their outcomes to only other facilities in their organization. If you select a region other than your own, your report will not display regional weighted outcomes measures. The report screens automatically refresh each time you make a change in one of the drop-downs.

If your facility is running custom (facility-specific) outcomes reports or site-level outcomes reports, your outcomes reports screens will display checkboxes below the drop-downs to control the display of those reports.

Many of the reports are available as pdf documents. On the Facility, RIC Group, RIC, CMG, IGC, Patient, Custom Date, 60% Rule, CMG Matrix, and Appeals report screens is a PRINT PDF button, appearing just above the first row of each report. Click that button to bring up a pdf version of the report you are viewing in a new window, then click the print icon in the new window to print your report.

> ***NOTE:*** This requires Adobe Reader software. If you don't already have Reader installed on your computer you can get the latest version from the Adobe website here:
> http://get.adobe.com/reader

You can also view many of the reports as Excel spreadsheets. On the Facility Ranking, Facility, RIC Group, RIC, CMG, IGC, Patient, Percentile, Custom Date, 60% Rule, CMG Matrix, and Appeals report screens is an OPEN/EXCEL button, appearing just above the first row of each report. Click that button and then select whether you want to open the comma separated (.csv) file as an Excel spreadsheet or save the .csv file to your computer.

> ***NOTE:*** The OPEN/EXCEL button on the Patient Report gives you all rows and all columns for the time period, payer, and RIC/CMG you select. For example, if you are viewing the Disch Dest, LOS, Xfer Patient Report for all patients in FY2006, on screen you will see those columns displayed for the first 50 records, and you can page through the records using the **[Next 50]** links. However, if you click OPEN/EXCEL you will get a file containing all the columns from the Patient Report sub-menu (e.g. CMG/Tier, Pay Wt., 60Pct?, Age, Disch Dest, LOS, Xfer?, FIM Totals, etc.) for all patient records for FY2006. This could potentially result in a very large file which may take additional time to open.

We suggest that national and regional benchmarks not be heavily relied upon for periods of less than 90 days regardless of the time period you select.

OUTCOMES REPORTS DRILL-DOWN LEVELS

Facility Ranking

For users belonging to organizations with more than one facility on eRehabData, the Facility Ranking Report allows you to display any individual outcomes measure for comparison across all facilities in your organization. A measures drop-down at the top of the report table lets you select which measure to display. The privilege "User can download assessments from all facilities in their organization" is required in order to view this report.

In addition to the "Facility", "Region/Org", "Time Period" and "Payer" drop-downs available on the other reports screens, the Facility Ranking Report screen also includes a "Detail Level" drop-down which lets you view the measures for all of your facilities at the facility level or at the RIC Group, RIC, CMG or IGC level. If you select anything other than "Facility" in the "Detail Level" drop-down a second drop-down appears for you to select your detail category.

For each measure except "# Discharges in Sample" you will see Organization Variance and National Variance percentages. Variances are calculated by

subtracting the organization or nation measure value from the facility number and then dividing by the organization or nation measure value.

Additionally, average measures display weighted organization and weighted national calculations. Weighted numbers are case-mix adjusted by calculating the average value for each CMG and tier category for the organization and nation. Average values are then volume-adjusted to the actual case mix volumes at each facility. For more information on weighted vs. unweighted calculations please see "Weighted vs. Unweighted Numbers" below.

If any facility in your organization has subscribed to the eRehabData site-level reports add-on, you can view a site ranking report by using the Facility drop-down to select the facility, then check the "View site-level outcomes" checkbox that appears after you have selected the facility.

To change the sort order of the report table, click on the column header for the column you want to sort the report by. Clicking on the header once will sort the report in ascending order by the values in that column. Clicking on the header a second time will sort the report in descending order. A lightly-shaded background identifies the sort column.

To jump to the complete Facility Report for any facility displayed in the Ranking Report for your selected time period and payer, click on the facility name.

Facility Report

Your Facility Report displays all available measures for all patients in your facility for your selected time period and payer against national and regional benchmarks.

RIC Group Report

Clicking on the RIC Group Report link brings you to the RIC Group Report menu. On the left side of the screen is a list of the RIC Groups along with their component RICs and IGCs. On the right side of the screen is a list of all available measures. Clicking on a RIC Group will give you a report of all available measures for the selected group. Clicking on a measure will give you a report of that measure for each RIC Group. From the individual measure for all RIC Groups screen you can click on a RIC Group to jump directly to the report of all measures for that RIC Group.

RIC Report

Clicking on the RIC Report link brings you to the RIC Report menu. On the left side of the screen is a list of the RICs. On the right side of the screen is a list of all available measures. Clicking on a RIC will give you a report of all available measures for the selected RIC. Clicking on a measure will give you a report of that measure for each RIC. From the individual measure for all RICs screen you can click on a RIC to jump directly to the report of all measures for that RIC.

CMG Report

Clicking on the CMG Report link brings you to the CMG Report menu. On the left side of the screen is a list of the CMGs. On the right side of the screen is a list of all available measures. Clicking on a CMG will give you a report of all available measures for the selected CMG. Clicking on a measure will give you a report of that measure for each CMG. From the individual measure for all CMGs screen you can click on a CMG to jump directly to the report of all measures for that CMG.

IGC Report

Clicking on the IGC Report link brings you to the IGC Report menu. On the left side of the screen is a list of the IGCs. On the right side of the screen is a list of all available measures. Clicking on an IGC will give you a report of all available measures for the selected IGC. Clicking on a measure will give you a report of that measure for each IGC. From the individual measure for all IGCs screen you can click on an IGC to jump directly to the report of all measures for that IGC.

For a crosswalk of IGCs to RICs, please see this document available on the eRehabData website:

https://web2.erehabdata.com/erehabdata/help/IGC_to_RIC.pdf

Patient Report

The Patient Report is delivered over 11 different screens to show you a variety of measures at the individual assessment level. A navigation sub-menu on the left offers links to the patient report screens for “CMG/Tier, Pay Wt., 60Pct?”, “Age”, “Disch Dest, LOS, Xfer?”, “Pressure Ulcers”, “FIM Totals”, “FIM Admit Motor”, “FIM Admit Cog.”, “FIM Discharge Motor”, “FIM Discharge Cog.”, “FIM Change Motor”, and “FIM Change Cog.” In keeping with CMS practice, wherever FIM scores are displayed scores with a value of 0 are displayed as 1, and Tub/Shower Transfer is excluded from FIM calculations.

In addition to the “Time Period” and “Payer” drop-downs available on the other reports screens, the Patient Report screen also includes “RIC” and “CMG” drop-downs so you can display patients filtered by RIC or CMG.

You can order the list of patients by patient last name, patient ID/social security number, or discharge date by clicking on the respective headers at the tops of those columns. Some reports display additional clickable headers by which you can sort the list. The header for the column controlling the sort order appears underlined in black and is not an active link.

You can also view a report comparing a selected patient to facility, regional, and national numbers for other patients falling into the same CMG by clicking on the patient name.

You can also view a comparison of a selected patient against facility, national, and regional averages for other patients with the same CMG by clicking on a patient name.

For more information about the measures and calculations specific to the Patient Report, please see the documentation available under the 

icon at the top of the Patient Report screen in eRehabData.

OUTCOMES REPORTS REGIONS

Regions are defined as the nine U.S. Census Regions, as follows:

Outcomes Reports Regions

Region	State
New England	Connecticut Maine New Hampshire Rhode Island Vermont
Middle Atlantic	New Jersey New York Pennsylvania
South Atlantic	Delaware Florida Georgia Maryland North Carolina South Carolina Virginia Washington DC West Virginia
East North Central	Illinois Indiana Michigan Ohio Wisconsin
East South Central	Alabama Kentucky Mississippi Tennessee
West North Central	Iowa Kansas Minnesota Missouri Nebraska North Dakota South Dakota
West South Central	Arkansas Louisiana Oklahoma Texas
Mountain	Arizona Colorado Idaho Montana Nevada New Mexico Utah Wyoming
Pacific	Alaska California Hawaii Oregon Washington

WEIGHTED VS. UNWEIGHTED NUMBERS

Weighted measures are presented to show what the national and regional values would be if the nation or your region had the same case mix as your facility. For comparison purposes, weighted measures should be used when you want to minimize the effect of case mix differences.

For the facility, RIC, and CMG reports, weighted numbers are created by calculating the average value for each CMG and tier category for the nation and region. Average values are then volume-adjusted to the actual case mix volumes at your facility.

For example, we calculate weighted national Average Length of Stay (ALOS) by first calculating the ALOS for each CMG and tier for all discharges in the eRehabData system. We then multiply the resulting ALOS by the number of discharges at your facility in each corresponding CMG and tier category. Then we sum the resulting "days" and divide by your total number of discharges to arrive at a weighted national ALOS.

The same methodology is used for the other weighted measures. For regional calculations, we limit the sample to all discharges for all facilities in your region.

For the RIC Group and IGC reports, weighted numbers are calculated the same except the weighting is done using CMG only, not tier.

Unweighted numbers are the raw calculations of the indicated measures.

OUTCOMES REPORTS MEASURES

Discharges in Sample

Displays the number of discharges in the selected time period and payer.

Case Mix Index (CMI)

The average Medicare payment weight for the selected population, including short stay payment weights when present. Higher numbers indicate increased average acuity. Payment weights for each CMG and tier are published in the final rule.

Average Expected Medicare Reimbursement

The average amount of expected Medicare reimbursement for the selected population. This information is displayed for all assessments regardless of payer for reference purposes only.

> ***NOTE:*** If your facility adjuster is not properly configured, this value will not accurately reflect your facility's expected reimbursement.

Co-morbidity Distribution (in tiers)

The number of patients with co-morbidity scoring that placed the patients into one of the three tiers, or no tier. Tier 1 is the most acute; Tier 3 is the least acute. Tier 0 denotes that there were no tier-assigning comorbidities scored.

Average Age

The average age at admission for the selected patient population.

Gender Split

The counts and percentages of male and female patients for the selected patient population.

Transfer Patients

The count and percentage of patients who were discharged to a qualifying institution before their length of stay (LOS) exceeded the PPS Mean Average Length of Stay (ALOS) for their CMG.

Qualifying institutions for discharges prior to 10/1/2014 include discharge destinations 5 - Skilled Nursing Facility; 6 - Acute unit of own facility; 7 - Acute unit of another facility; 8 - Chronic Hospital; 9 - Rehabilitation Facility; and 13 - Subacute Setting.

Qualifying institutions for discharges starting 10/1/2014 include discharge destinations 02—Short-term General Hospital; 03—Skilled Nursing Facility (SNF); 61—Within institution to swing bed; 62—Another Inpatient Rehabilitation Facility; 63—Long-Term Care Hospital (LTCH); and 64—Medicaid Nursing Facility. For more information on hospital transfer policies, please see MLN Matters article SE0801.

Short Stays

The count and percentage of patients who meet the requirements for the 5001 short stay CMG (length of stay <= 3 days, discharged to a setting other than one of the transfer destinations noted above).

"Long Stays"

For discharges prior to 10/1/2005: The count and percentage of patients whose LOS was at least twice the PPS Mean Average Length of Stay for their CMG.

For discharges from 10/1/2005 to 9/30/2006 (FY2006): The count and percentage of patients whose LOS was at least 1.402 times the PPS ALOS for their CMG.

The 1.402 multiplier is calculated from the Outlier Threshold and Base Payment as published in CMS-1290-CN:
[(FY2006 Outlier Threshold) / (FY2006 Base Payment)] + 1.0 or
[($5,129) / ($12,762)] + 1.0

For discharges from 10/1/2006 to 9/30/2007 (FY2007): The count and percentage of patients whose LOS was at least 1.4263 times the PPS ALOS for their CMG.

The 1.4263 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2007 Final Rule:
[(FY2007 Outlier Threshold) / (FY2007 Base Payment)] + 1.0 or
[($5,534) / ($12,981)] + 1.0

For discharges starting 10/1/2007 through 3/31/2008 (first half of FY2008): The count and percentage of patients whose LOS was at least 1.5473 times the PPS ALOS for their CMG.

The 1.5473 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2008 Final Rule:
[(FY2008 Outlier Threshold) / (FY2008 pre-April 1 Base Payment)] + 1.0 or
[($7,362) / ($13,451)] + 1.0

For discharges starting 4/1/2008 through 9/30/2008 (second half of FY2008): The count and percentage of patients whose LOS was at least 1.5648 times the PPS ALOS for their CMG.

The 1.5648 multiplier is calculated from the Outlier Threshold and Base Payment as published in the Legislative Payment Rate Change to the FY2008 Final Rule:
[(FY2008 Outlier Threshold) / (FY2008 April 1 Base Payment)] + 1.0 or
[($7,362) / ($13,034)] + 1.0

For discharges starting 10/1/2008 through 9/30/2009 (FY2009): The count and percentage of patients whose LOS was at least 1.7910 times the PPS ALOS for their CMG.

The 1.7910 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2009 Final Rule:
[(FY2009 Outlier Threshold) / (FY2009 Base Payment)] + 1.0 or
[($10,250) / ($12,958)] + 1.0

For discharges starting 10/1/2009 through 3/31/2009 (first half of FY2010): The count and percentage of patients whose LOS was at least 1.7797 times the PPS ALOS for their CMG.

The 1.7797 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2010 Final Rule:
[(FY2010 Outlier Threshold) / (FY2010 pre-April 1 Base Payment)] + 1.0 or
[($10,652) / ($13,661)] + 1.0

For discharges starting 4/1/2010 through 9/30/2010 (second half of FY2010): The count and percentage of patients whose LOS was at least 1.7867 times the PPS ALOS for their CMG.

The 1.7867 multiplier is calculated from the Outlier Threshold and Base Payment as published in the Legislative Payment Rate Change to the FY2010 Final Rule:
[(FY2010 Outlier Threshold) / (FY2010 April 1 Base Payment)] + 1.0 or
[($10,721) / ($13,627)] + 1.0

For discharges starting 10/1/2010 through 9/30/2010 (FY2011): The count and percentage of patients whose LOS was at least 1.8232 times the PPS ALOS for their CMG.

The 1.8232 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2011 Final Rule:
[(FY2011 Outlier Threshold) / (FY2011 Base Payment)] + 1.0 or
[($11,410) / ($13,860)] + 1.0

For discharges starting 10/1/2011 through 9/30/2012 (FY2012): The count and percentage of patients whose LOS was at least 1.7611 times the PPS ALOS for their CMG.

The 1.7611 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2012 Final Rule and FY2012 Correction Notice:
[(FY2012 Outlier Threshold) / (FY2012 Base Payment)] + 1.0 or
[($10,713) / ($14,076)] + 1.0

For discharges starting 10/1/2012 through 9/30/2013 (FY2013): The count and percentage of patients whose LOS was at least 1.7297 times the PPS ALOS for their CMG.

The 1.7297 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2013 Notice:
[(FY2013 Outlier Threshold) / (FY2013 Base Payment)] + 1.0 or
[($10,466) / ($14,343)] + 1.0

For discharges starting 10/1/2013 through 9/30/2014 (FY2014): The count and percentage of patients whose LOS was at least 1.6245 times the PPS ALOS for their CMG.

The 1.6245 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2014 Final Rule:
[(FY2014 Outlier Threshold) / (FY2014 Base Payment)] + 1.0 or
[($9,272) / ($14,846)] + 1.0

For discharges starting 10/1/2014 through 9/30/2015 (FY2015): The count and percentage of patients whose LOS was at least 1.5822 times the PPS ALOS for their CMG.

The 1.5822 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2015 Final Rule:
[(FY2015 Outlier Threshold) / (FY2015 Base Payment)] + 1.0 or
[($8,848) / ($15,198)] + 1.0

For discharges starting 10/1/2015 through 9/30/2016 (FY2016): The count and percentage of patients whose LOS was at least 1.5594 times the PPS ALOS for their CMG.

The 1.5594 multiplier is calculated from the Outlier Threshold and Base Payment as published in the FY2016 Final Rule:
[(FY2016 Outlier Threshold) / (FY2016 Base Payment)] + 1.0 or
[($8,658) / ($15,478)] + 1.0

Deceased Patients

For discharges prior to 10/1/2014, the count and percentage of patients whose discharge destination was 11 - Died.

For discharges starting 10/1/2014, the count and percentage of patients for whom item 44C “Was patient discharged alive?” was “No.”

Inpatient Institutional Discharges

For discharges prior to 10/1/2014, the count and percentage of patients whose discharge destination was either 5 - Skilled Nursing Facility; 6 - Acute unit of own facility; 7 - Acute unit of another facility; 8 - Chronic Hospital; 9 - Rehabilitation Facility; or 13 - Subacute Setting.

For discharges starting 10/1/2014, the count and percentage of patients whose discharge destination was either 02—Short-term General Hospital; 03—Skilled Nursing Facility (SNF); 51—Hospice (Institutional Facility); 61—Within institution to swing bed; 62—Another Inpatient Rehabilitation Facility; 63—Long-Term Care Hospital (LTCH); 64—Medicaid Nursing Facility; 65—Inpatient Psychiatric Facility; or 66—Critical Access Hospital.

Community Discharges

For discharges prior to 10/1/2014, the count and percentage of patients whose discharge destination was either 1 - Home; 2 - Board and Care; 3 - Transitional Living; 4 - Intermediate Care; or 14 - Assisted Living Residence.

For discharges starting 10/1/2014, the count and percentage of patients whose discharge destination was either 01—Home; 04—Intermediate Care; 06—Home under care of organized home health service organization; or 50—Hospice (Home).

SNF/Subacute Discharges

For discharges prior to 10/1/2014, the count and percentage of patients whose discharge destination was either 5 - Skilled Nursing Facility or 13 - Subacute Setting.

For discharges starting 10/1/2014, the count and percentage of patients whose discharge destination was either 03—Skilled Nursing Facility (SNF); 61—Within institution to swing bed; or 64—Medicaid Nursing Facility.

Acute Unit Discharges

For discharges prior to 10/1/2014, the count and percentage of patients whose discharge destination was either 6 - Acute unit of own facility or 7 - Acute unit of another facility.

For discharges starting 10/1/2014, the count and percentage of patients whose discharge destination was either 02—Short-term General Hospital or 66—Critical Access Hospital.

"60% Rule" Compliant Discharges (Conditional/Presumptive)

The counts and percentages of patients who meet the criteria for conditional or presumptive 60% rule compliance based on the latest available guidelines from CMS. For more information on how conditional and presumptive compliance values are calculated, please review these documents on the eRehabData website:

https://web2.erehabdata.com/erehabdata/help/75percentConditionalPresumptive.htm

https://web2.erehabdata.com/erehabdata/help/75percentmethodology.htm

Discharge Destination

The counts and percentages of the various discharge destinations identified on the IRF-PAI.

Average Onset Days

The average number of days between Date of Onset (IRF-PAI #23) and Admit Date. Currently excluded from the Average Onset Days calculations are onset days greater than 365 and any assessments where date of onset was omitted.

Average Length of Stay (ALOS)

The average length of stay for the selected patient population. LOS is calculated excluding the day of discharge in keeping with Medicare practice.

PRESSURE ULCER MEASURES

Data for the following pressure ulcer measures are collected in the Quality Information section of the IRF-PAI. Data collection began 10/1/2012 with the FY2013 IRF-PAI and expanded on 10/1/2014 with the FY2015 IRF-PAI.

It is recommended that you not rely on pressure ulcer data for any time periods that cross over when the ulcer data collection began or changed to avoid the potential for misinterpreting the percentages.

For example, for discharges with stage 1 pressure ulcers present at admission in Calendar Year 2014 the percent will look low because it is calculated against all discharges with complete ulcer assessments for the year, even though information on stage 1 pressure ulcers was not collected for 3 of those quarters. If you view the same measure for Q4 2014, you will see the percent calculated only from discharges where it was possible to collect that information so it will be higher.

Discharges with Complete Ulcer Assessments (was labeled Discharges with Ulcer Assessments prior to FY2015)

For discharges between 10/1/2012 and 9/30/2014, the count and percentage of discharges where NEITHER of the "Unable to Assess" checkboxes (admission or discharge) was checked.

For discharges starting 10/1/2014, the count and percentage of discharges where both questions M0210 "Does the patient have one or more unhealed pressure ulcers" (admit and discharge) were EITHER "Yes" or "No," and all of the subsequently required items were completed. This count excludes incomplete pressure ulcer assessments, i.e. any assessment for which M0210 was "Yes" but the QRP override checkbox was checked for any pressure ulcer items in order to complete the assessment.

NOTE: This count is used as the denominator for all pressure ulcer measure percentage calculations except "Discharges with Ulcer Assessments," "Discharges with Incomplete Ulcer Assessments," and "Unable to Assess/Not Assessed (Admit and Discharge)." ***Discharges with incomplete pressure ulcer assessments are excluded from all of the pressure ulcer measures except "Discharges with Incomplete Ulcer Assessments."***

Unable to Assess/Not Assessed (Admit/Discharge)

For discharges between 10/1/2012 and 9/30/2014, the count and percentage of discharges where "Unable to Assess" was checked at admission or discharge, respectively.

For discharges starting 10/1/2014, the count and percentage of discharges where M0210 "Does the patient have one or more unhealed pressure ulcers" was left "Not assessed" at admission or discharge, respectively.

Discharges with New/Worsened Ulcers Since Admission (was labeled Discharges with Ulcers Worsening in Status Since Admission prior to FY2015)

For discharges between 10/1/2012 and 9/30/2014, the count and percentage of discharges that contained values greater than 0 for IRF-PAI questions 49 A, B, or C "Not present/lesser stage at admission" for Stage 2, 3, or 4 respectively.

For discharges starting 10/1/2014, the count and percentage of discharges that contained values greater than 0 for IRF-PAI questions M0300 A3, B4, C4, or D4 "Not present at admission/worsened" for Stage 1, 2, 3, or 4 respectively.

NOTE: The sum of the individual stage counts for this measure may exceed the totals under the "All (Stages 1-4)" and "Total Stage 2, 3, 4" measures because these are counts of discharges, not pressure ulcers. For example, a patient with a worsened Stage 2 ulcer and a worsened Stage 3 ulcer will be counted only once under "All" and "Total" but twice in the individual stages: once under Stage 2, and once under Stage 3.

Discharges with Healed Pressure Ulcers

For discharges between 10/1/2012 and 9/30/2014, the count and percentage of discharges that contained values greater than 0 for IRF-PAI questions 50 B, C, or D "Healed Pressure Ulcers" for Stage 2, 3, or 4 respectively.

For discharges starting 10/1/2014, the count and percentage of discharges that contained values greater than 0 for IRF-PAI questions M0900 A, B, C, or D "Healed Pressure Ulcers" for Stage 1, 2, 3, or 4 respectively.

NOTE: The sum of the individual stage counts for this measure may exceed the totals under the "All (Stages 1-4)" and "Total Stage 2, 3, 4" measures because these are counts of discharges, not pressure ulcers. For example, a patient with a healed Stage 2 ulcer and a healed Stage 3 ulcer will be counted only once under "All" and "Total" but twice in the individual stages: once under Stage 2, and once under Stage 3.

Discharges with Pressure Ulcers Present at Admission

For discharges between 10/1/2012 and 9/30/2014, the count and percentage of discharges that contained values greater than 0 for IRF-PAI questions 48 A, B, or C at Admission "Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage" for Stage 2, 3, or 4 respectively.

For discharges starting 10/1/2014, the count and percentage of discharges that contained values greater than 0 for IRF-PAI questions M0300 A1, B1, C1, D1, E1, F1, or G1 at Admission "Current Number of Unhealed Pressure Ulcers at Each Stage" for Stage 1, 2, 3, or 4 or unstageable, respectively.

NOTE: The sum of the individual stage counts for this measure may exceed the totals under the "All (Stages 1-4)" and "Total Stage 2, 3, 4" measures because these are counts of discharges, not pressure ulcers. For example, a patient with a Stage 2 ulcer and a Stage 3 ulcer will be counted only once under "All" and "Total" but twice in the individual stages: once under Stage 2, and once under Stage 3.

Discharges with Pressure Ulcers Present at Discharge

For discharges between 10/1/2012 and 9/30/2014, the count and percentage of discharges that contained values greater than 0 for IRF-PAI questions 48 A, B, or C at Discharge "Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage" for Stage 2, 3, or 4 respectively.

For discharges starting 10/1/2014, the count and percentage of discharges that contained values greater than 0 for IRF-PAI questions M0300 A1, B1, C1, D1, E1, F1, or G1 at Discharge "Current Number of Unhealed Pressure Ulcers at Each Stage" for Stage 1, 2, 3, or 4 or unstageable, respectively.

NOTE: The sum of the individual stage counts for this measure may exceed the totals under the "All (Stages 1-4)" and "Total Stage 2, 3, 4" measures because these are counts of discharges, not pressure ulcers. For example, a patient with a Stage 2 ulcer and a Stage 3 ulcer will be counted only once under "All" and "Total" but twice in the individual stages: once under Stage 2, and once under Stage 3.

FIM MEASURES

There are two sets of FIM aggregate measures. One set does not include the Tub/Shower transfer FIM scores in the calculations; the other set does. The latter set of measures are identified in the measure name as "w/Tub Xfer." For both sets of measures, in keeping with

CMG calculation methodology, scores with a value of 0 are treated as a 1 for the purpose of these statistics.

FIM Total Admission

The combined average score of the admission FIM items. These items include: Eating, Grooming, Bathing, Dressing-Upper, Dressing-Lower, Toileting, Bladder, Bowel, Bed-Chair-Wheelchair Transfer, Toilet Transfer, Walk/Wheelchair, Stairs Comprehension, Expression, Social Interaction, Problem Solving, and Memory.

FIM Total Discharge

The combined average score of the discharge FIM items. These items include: Eating, Grooming, Bathing, Dressing-Upper, Dressing-Lower, Toileting, Bladder, Bowel, Bed-Chair-Wheelchair Transfer, Toilet Transfer, Walk/Wheelchair, Stairs, Comprehension, Expression, Social Interaction, Problem Solving, and Memory.

FIM Change Admission to Discharge

The average change in total FIM scores from admission to discharge for the selected patient population. These items include: Eating, Grooming, Bathing, Dressing-Upper, Dressing-Lower, Toileting, Bladder, Bowel, Bed-Chair-Wheelchair Transfer, Toilet Transfer, Walk/Wheelchair, Stairs, Comprehension, Expression, Social Interaction, Problem Solving, and Memory.

FIM Change per Day

The average of the change in FIM total from admission to discharge divided by the LOS. This is calculated by first subtracting total admission FIM from total discharge FIM for each individual assessment in the selected patient population. The resulting FIM change is then divided by the LOS for each assessment. The calculated FIM changes per day for each assessment are then averaged over the selected time period.

FIM Motor Subscale Admit

The combined average score of the admission FIM motor items. These items include: Eating, Grooming, Bathing, Dressing-Upper, Dressing-Lower, Toileting, Bladder, Bowel, Bed-Chair-Wheelchair Transfer, Toilet Transfer, Walk/Wheelchair, and Stairs.

FIM Motor Subscale Discharge

The combined average score of the admission FIM motor items. These items include: Eating, Grooming, Bathing, Dressing-Upper, Dressing-Lower, Toileting, Bladder, Bowel, Bed-Chair-Wheelchair Transfer, Toilet Transfer, Walk/Wheelchair, and Stairs.

Admission FIM Elements

The average admission FIM scores, item by item, for the selected patient population.

Discharge FIM Elements

The average discharge FIM scores, item by item, for the selected patient population.

FOLLOW-UP ASSESSMENT OUTCOMES REPORTS

If your facility is entering follow-up assessments into eRehabData, you will find follow-up outcomes reports at the bottom of the Facility, RIC, and CMG reports screens. To display the reports, check the box at the bottom of the reports screens labeled "Follow-Up Calculations".

Follow-up outcomes time period selections are based on the assessment's discharge date, not the date the follow-up assessment was performed, so when selecting a time period make sure to choose a meaningful time period. For example, if you select "Last 90 days" you will probably not see any follow-up outcomes data since the outcomes only include follow-up assessments performed 80-150 days post-discharge.

The follow-up outcomes reports only include one follow-up assessment per discharge. If multiple follow-up assessments are found for a discharge, the follow-up assessment occurring closest to and after 90 days post-discharge is included in the report. For example, if one follow-up is performed 85 days post-discharge and another occurs 110 days post-discharge, the 110 day follow-up assessment is used.

Because follow-up assessments are voluntary, no fields are required in order for a follow-up to be considered complete. This may result in follow-up setting breakdowns not adding up to the total number of discharges in sample. Where averages are displayed, only completed measures are included in calculating the averages.

CUSTOM (FACILITY-SPECIFIC) OUTCOMES REPORTS

Facility-specific outcomes reports are available for facilities that are tracking custom data configured as drop-downs. Facility-specific reports give you the eRehabData outcomes reports suite filtered by your facility's custom data items. Users with eRehabData facility administrator privileges can configure up to three facility custom drop-downs on which these outcomes can be based, such as referring hospital, physician, etc. After your drop-downs have been configured you can contact the eRehabData support staff directly to set up generation of your facility-specific reports.

Once they are in place, display of your facility-specific outcomes is controlled by a checkbox labeled "View Facility-Specific outcomes" at the top of each of the outcomes reports screens. Check that box to display a drop-down filter containing your facility custom data values and filter your report by those values.

For more information on configuring custom drop-downs, please see "Custom Data Fields" under the "Facility Administrator Features" section of this manual.

OUTCOMES REPORTS GRAPHS

Time-Series Graphs

The Time-Series Graphs allow users with outcomes reports privileges to graph selected measures for any or all RIC Groups, RICs, CMGs and/or IGCs over time against national or regional comparisons. Your selections will be graphed, and you have the option to view the underlying statistics, including standard deviations for some measures, numerically at the bottom of the screen.

To access the time-series graphs, click **Time-Series Graphs** from any of the Outcomes Reports screens. To create your graph, first select a measure from the "Measures" select box. You can select more than one measure at a time for comparison by holding the Ctrl key down as you click on each measure.

Next, select your time period (Quarter, Month, Year, or 60% Rule Year) from the "Period:" drop-down.

NOTE: Quarter and year refer to calendar quarter and year, not fiscal.

Then, select your start and end dates using the "Start Date:" and "End Date:" drop-downs, and indicate whether you want the comparisons to display national or regional data using the "Compare to:" and Regions drop-downs.

NOTE: The Regions drop-down only appears if you select "Region" in the "Compare to:" drop-down.

Using the "Weight FIM Calcs?" option, you can specify whether your comparison values should be volume-adjusted for your facility's case mix (weighted), or unweighted.

To display your measure(s) and time period for a particular RIC Group, RIC, CMG, or IGC, or combination thereof, select a RIC Group, RIC, CMG, or IGC from the select box. You can select multiple options for comparison by holding down the Ctrl key as you click on each option. If you do not make a selection, data for all patients will be displayed.

You can also select one or more tiers by using the "View by Tier:" select box. To select more than one tier at a time, hold down the Ctrl key while clicking on each tier. If you do not select one or more tiers, data for all tiers will be displayed.

NOTE: Tiers only apply when viewing measures by CMG.

Use the "Payer:" drop-down to display your selections for All Payers, or Medicare or Non-Medicare only. If you would like to see your data displayed numerically below your graph, check the box labeled "Display Numeric Data:".

When you have made all of your selections, click **Show** to create your graph. Your graph displays your selected measure(s) for each time increment and diagnostic group you selected, and plus and minus one standard deviation if you selected measures calculated as averages. If you selected to display the numeric data, your numeric data table appears below your graph.

To print a wide graph, either change your print layout to landscape using your printer's built-in properties or use the "Rotate Graph 90 Degrees (for printing):" checkbox to rotate the graph on-screen. You can also control the width of the lines on your graph with the "Chart Line Width:" drop-down.

To save your graph as an image, position your mouse pointer over the graph and right-click. Select "Save Picture As", browse to the location on your computer where you want to save your graph, and click **Save**. The graph should save with a .png file extension.

To import your numeric data into Excel or similar spreadsheet program, click and drag your mouse pointer over the numeric data table to highlight all of the data. Hold down the Ctrl key and press C to copy the data to your clipboard. Open Excel or a similar spreadsheet program, click in the first cell, and press Ctrl + V to paste the data into the spreadsheet.

FIM Scoring Comparison Graph

The FIM Scoring Comparison Graph allows users with outcomes reports privileges to compare FIM scoring practices in their facility to national or regional norms. It is

a tool designed to help facilities identify potential FIM scoring anomalies or problems that could affect reimbursement.

To access the FIM comparison graphs, click **FIM Scoring Comparison Graph** from any of the Outcomes Reports screens. Use the drop-downs at the top of the report screen to select your Time Period, Payer, RIC (if any), whether you want Weighted or Unweighted comparisons, and National or Regional comparisons. (For more information on weighted vs. unweighted calculations please see "Weighted vs. Unweighted Numbers" above). Each time you change a selection in a drop-down the screen will automatically refresh to display a graph and three tables of variances: Admit Variance, Discharge Variance, and Change Variance.

The FIM items have been reordered on this graph from the IRF-PAI scoring order to the order of difficulty to perform each task. In this order, "Stairs" is the first item because it is the most difficult to perform while "Eating" is the easiest of the motor items and "Expression" is the easiest item overall.

The dark red, dark green and dark blue lines represent national or regional data for average admit, discharge and change scores. The light red, light green and light blue lines show the average facility values for each item.

Because the default graphing selection is for weighted FIM comparison values, the facility lines and the comparison lines typically will be very close together. Large diversions between the facility and comparison lines indicate that the facility may have documentation, scoring or coding issues with the individual items that have the greatest variances. If the documentation, scoring and coding is accurate, large variances may indicate issues with patients or with the efficacy of the rehabilitation program.

The numerical charts under the graph show the same data but sorted in decreasing order of variance. Variance, here, is the difference between the facility FIM item average and the corresponding comparison FIM item average. In this manner the items that have the most variance and, therefore, the greatest likelihood of a scoring or documentation problem, are shown at the top of each of the different sections. Motor items are sorted separately from the cognitive items.

Numbers in red indicate items that have crossed a variance threshold. The threshold is the sum of the average and the first standard deviation of the absolute values of the variance scores for a group of FIM items (motor or cognitive, admit or discharge). When the absolute value of the variance of any single measure in a section exceeds this threshold, the variance is highlighted in red.

Consistent over-scoring of admit FIM items negatively affects Medicare reimbursement. Consistent under-scoring of admit FIM items increases Medicare reimbursement but could lead to problems with FI audits and charges of fraud.

Consistent under- or over-scoring of discharge items will affect outcomes monitoring including CARF and Joint Commission reviews.

This analysis defaults to a comparison of the last 180 days for all payers, all RICs and a comparison to weighted national data. You may select other combinations for a more detailed review. Be advised that the analysis will grow less reliable with smaller numbers of facility discharges (shown at the top of the numeric data) and that discharge counts smaller than 25 will yield unreliable results. You can increase the sample size by choosing longer time periods and/or larger groups of patients.

This analysis is descriptive of the data entered into eRehabData and it can be used to help guide and monitor an internal auditing process. It is possible that all scoring

and coding variances, even those indicated in red, are within acceptable coding and scoring guidelines.

To import your numeric data into Excel or similar spreadsheet program, click and drag your mouse pointer over the numeric data tables to highlight all of the data. Hold down the Ctrl key and press C to copy the data to your clipboard. Open Excel or a similar spreadsheet program, click in the first cell, and press Ctrl + V to paste the data into the spreadsheet.

To save your graph as an image, position your mouse pointer over the graph and right-click. Select "Save Picture As", browse to the location on your computer where you want to save your graph, and click **Save**. The graph should save with a .png file extension.

OTHER OUTCOMES REPORTS VIEWS

Percentile Report

The eRehabData Percentile Report is a sophisticated case mix adjusted report designed to give useful and accessible information related to the relative position of an IRF compared to the rest of the IRFs in eRehabData. Outcomes measures are a tool for developing strategies for improving quality and are not an end to themselves. Therefore, a facility that is in higher or lower percentiles for various measures is not definitively "good" or "bad". Variance from national norms for FIM scoring, for instance, could indicate scoring problems more than pointing to exemplary or substandard clinical outcomes. Long lengths of stay are often a "good" thing for clinical outcomes but are perceived as a "bad" thing for financial outcomes. All of these factors must be considered when using this report.

In addition to the Time Period, Region, and Payer drop-downs that appear at the top of many of the eRehabData outcomes reports, the Percentile report includes a Detail Level drop-down that allows you to view the report for your facility as a whole or by selected RIC Group, RIC, CMG, or IGC.

Percentile Report Measures

The percentile report includes a number of measures available on the eRehabData facility drill-down reports. Measures are case mix adjusted (weighted) where appropriate, and case mix adjusted measures are identified with an asterisk (*). For more information on how the measures are calculated, please refer to the Outcomes Reports Measures section of the eRehabData Outcomes Reports documentation. For information on how the percentile rankings are calculated, please see the Percentile Ranking Calculations section below.

Inverted Scale

In most cases the percentile ranking is based on a straightforward scale where a positive Facility National Variance may be perceived as a desirable trait. However, in certain cases we have inverted the percentile scale to reflect what would ordinarily be considered desirable practice.

For example, a facility has a higher than average percentage of transfer discharges that under the straightforward scale would place the facility in the 80th percentile. However, since transfer discharges are not desirable, in this case the ranking scale would be inverted to place this facility in the 20th percentile. These inverted scale measures are identified with a "^".

Percentile Reports Columns

Facility Value

The facility's actual value for the measure.

National Value

Either the case mix adjusted comparison value (identified by an *) or the unadjusted national value.

Facility National Variance

The difference between the facility value and the national value, expressed as a percentage. A zero in this column, for instance, would show that your facility's value was exactly in line with the national practice (either case mix adjusted or not). A positive value shows the percentage over the national common practice while a negative value shows the percentage below the national practice pattern. Facility National Variance is calculated using this formula:

(Facility Value - National Value) / National Value.

Facility Percentile Rank

The relative position of your facility's variance to all others. This is not the percentile rank of the overall scores, which would not yield any sort of case mix adjusting, but instead allows for a comparison of the variance of your values to case mix adjusted values.

National Percentile Values

The scores the facility would need to achieve which would result in a percentile ranking of 50, 60, 70, 80 or 90. These can also be used to demonstrate how wide the percentile spread is for a specific measure.

Percentile Ranking Calculations

The percentile report calculation methodology and formulas are specified in the Percentile Report help documentation, available under the 

icon at the top of the Percentile Report screen.

Custom Date Report

The eRehabData Custom Date Report allows users with outcomes reports privileges to generate a facility-level report of measures — some included on the nightly facility outcomes reports, some not — by user-entered admit or discharge date range and selected payer. This report selects accepted by CMS and completed/filed assessments for all patients regardless of age and is updated in real-time rather than nightly, so if you are viewing a time period that coincides with a nightly facility outcomes report time period, the values displayed may not match your outcomes report. This report also offers calculations by admit date as well as discharge date whereas other eRehabData outcomes reports include assessments by discharge date only, which may also explain any discrepancies you may see between this report and your other outcomes reports.

In addition, this report bases the calculations on the current final rule, meaning that even for historic time periods covered by an earlier final rule, for measures

such as Case Mix Index and Average Reimbursement which may change from year to year, the current PPS final rule is applied.

To access the Custom Date Report, click **Custom Date Report** from any outcomes report screen. You will see a group of filters at the top of the screen that you can use to generate your report for the date range and payer you need.

Custom Date Report Filters

Facility: This drop-down is only available to organization-level reports users from organizations that have more than one facility account on eRehabData. Use this drop-down to display a custom date report for the selected facility.

Date: To return results based on admit dates, select "Admit Date". To return results based on discharge dates, select "Discharge Date".

Start Date/End Date: Enter the start and end dates for your report. These dates will be applied to either assessment admit or discharge dates, depending upon what you selected in the Date drop-down above.

Payer: Select "All Payers" for Medicare and non-Medicare combined, or select "Medicare" or "Non-Medicare". Medicare only includes assessments for which the primary payer is 2 - Medicare non-MCO. To view the report for assessments with Medicare as either the primary or secondary payer, select "Medicare (w/ secondary)".

Custom Date Report Output

The report displays a counts and averages table and two breakdown tables. The measures are calculated the same way as on the nightly outcomes reports. For information on how the measures are calculated, please refer to the "Outcomes Reports Measures" section of this user manual.

Counts And Averages Table

This table displays number of discharges, Case Mix Index, average reimbursement, discharge destination groups, interrupted stay counts, and other averages such as length of stay, age, and FIM totals and change.

Discharge Destination Breakdown Table

This table displays counts and percentages by individual discharge destination.

Payer Breakdown Table

This table displays counts and percentages by individual payer.

60% Rule Compliance Report

60% Rule compliance information in eRehabData can be downloaded using the Assessment Data Download (Custom Template); viewed on the Metrics and eRD screens on individual assessments; and viewed in the outcomes reports. eRehabData calculates presumptive and conditional compliance on each assessment based on CMS' published methodologies; the codes present on the assessment; and the answers to any conditional questions that may appear on the eRD screen of an assessment when appropriate.

The 60% Rule Compliance Report allows users with outcomes reports privileges to generate a summary of 60% rule compliance information for their facility by user-entered admit or discharge date range. The report also offers additional filters for use in producing a patient details list based on those filters. This report includes all patients regardless of age and all assessments regardless of completion status, and is updated in real-time rather than nightly, so the summary and details lists may not match your Facility Report for the same time period. The report offers 60% rule calculations by Admit Date as well as Discharge Date, whereas other eRehabData outcomes reports include assessments by discharge date only, which may also explain any discrepancies you may see between this report and your Facility Report.

To generate a report, make your filter selections and click **Refresh**. In addition to viewing the report on-screen, you can get the report as a PDF or Excel spreadsheet by clicking the 

or 

buttons that appear below the Refresh button after you have generated the report. The IGC and ICD color coding (explained below) is not available in the PDF or Excel versions.

> ***NOTE:*** **Where "Pre-FY2016" and "FY2016" presumptive compliance is mentioned**, this refers to the CMS compliance methodology for compliance review periods that began prior to 10/1/2015, and the more restrictive methodology applied to compliance review periods starting on or after 10/1/2015, respectively. This does not refer to assessment discharge dates.

To access the 60% Rule Compliance Report, click **60% Rule Compliance Report** from any outcomes report screen.

60% Rule Compliance Report Filters

Facility: This drop-down is only available to organization-level reports users from organizations with more than one facility account on eRehabData. Use this drop-down to display a 60% rule report summary and patient list for the selected facility.

Date: To return results based on admit dates, select "Admit Date". To return results based on discharge dates, select "Discharge Date".

Start Date/End Date: Enter the start and end dates for your report. These dates will be applied to either assessment admit or discharge dates, depending upon what you selected in the Date drop-down above.

Assessment Status*: Select "All Assessments" to see 60% rule compliance information for assessments regardless of status. For assessments that haven't yet been sent to CMS or Filed, select "In-Progress Assessments". For assessments that have been accepted by CMS or Filed, select "Accepted/Filed Assessments".

> ***NOTE:*** Your report may include incomplete filed assessments if any exist at your facility.

Payer*: Select "All Payers" to view assessments regardless of payer. "Medicare" includes only assessments for which the primary payer is 2 - Medicare non-MCO. "Medicare + MCO" includes all assessments with a primary payer of either 2 - Medicare non-MCO or 51 - Medicare-MCO. "Medicare (w/secondary)" includes assessments with a primary or secondary payer of 2 - Medicare non-MCO. "Medicare + MCO (w/secondary)" includes all assessments where either the primary or secondary payer is 2 - Medicare non-MCO or 51 - Medicare-MCO. "Non-Medicare" only includes assessments where neither the primary nor secondary payer is 2 - Medicare non-MCO or 51 - Medicare-MCO.

NOTE: This definition of non-Medicare is unique to the 60% Rule Report. The other eRehabData outcomes reports define non-Medicare as any assessment where the primary payer is not 2 - Medicare non-MCO

Compliance*: Select "All Assessments" to include all assessments regardless of compliance status. You can also filter to display assessments that are presumptively compliant or conditionally compliant, or assessments that are presumptively compliant but not conditionally compliant and vice-versa. To identify assessments made compliant based on a comorbidity you can filter for "Presumptive By Comorbidity" or "Conditional By Comorbidity." You can also filter assessments for "Presumptive (FY2016)," "Presumptive By Comorbidity (FY2016)," "Presumptive (Pre-FY2016)," "Presumptive By Comorbidity (Pre-FY2016)," or "Presumptive Pre-FY2016, Not Presumptive FY2016."

Details: Select "No Details" to only display the summary. Select "Show Assessment Details" to also display the list of assessments returned by your filters.

***These filters only apply to the Details table that lists individual patients. The Details table can be viewed when the Details option is set to "Show Assessment Details."

60% Rule Compliance Report Output

Summary by Date

Your summary shows "Conditional," "Conditional Without Comorbidity," "Presumptive (FY2016)," "Presumptive Without Comorbidity (FY2016)," "Presumptive (Pre-FY2016)," "Presumptive Without Comorbidity (Pre-FY2016)," "Presumptive Not Conditional," "Conditional Not Presumptive," and "Presumptive Pre-FY2016, Not Presumptive FY2016" patient counts and percentages for All Payers, Medicare and Non-Medicare assessments, and Medicare primary plus secondary payer assessments.

NOTE: The summary is dependent *only* upon the dates you enter in the date filters. The other filter options do not apply to the summary list, so your Patient Count in the summary table may not match your patient display in the Details list.

The "Conditional Without Comorbidity" and "Presumptive Without Comorbidity" calculations exclude assessments that are counted as compliant due to a comorbidity. You can determine the effect that the exclusion of comorbidities will have on your facility by comparing the compliance rates in the "Conditional" and the "Conditional Without Comorbidity" rows for the All Payer column.

The difference between the assessment counts in these two rows represents the number of patients counted as compliant due to a comorbidity. You can review the IRF-PAIs and/or medical records for these patients to investigate the potential for improving the documentation to be able to support coding these kinds of patients in the future with a compliant IGC or diagnosis instead of a comorbidity.

Details - Displaying Assessments based on all filters

In order to display the details list you must select "Show Assessment Details" in the "Details" filter. All filters are applied to generate the details list. To

change the sort order of the details list, click on the headers for **Patient Name**, **Date**, **IGC**, **Diagnosis**, or **RIC**. Clicking on a header once will sort the list in ascending order by that value. Clicking on the header a second time will sort the list in descending order. Users with the privilege to view assessments can jump to the Metrics screen for an individual assessment by clicking on the patient name.

Details Columns

MC column: A "Y" in this column indicates that the assessment is a Medicare primary payer assessment. A "Y-S" in the **MC** column indicates an assessment where Medicare is the secondary payer.

MC MCO column: A "Y" in this column indicates that the assessment is a Medicare-MCO (Medicare Advantage) primary payer assessment. A "Y-S" in the **MC MCO** column indicates an assessment where Medicare-MCO is the secondary payer.

Presump/Cond columns: "Y"s in the **Presump** or **Cond** columns indicate the assessment is presumptively or conditionally compliant, respectively.

Pres. By Como/Cond. By Como columns: "Y"s in the **Pres. By Como** or **Cond. By Como** columns indicate the assessment is presumptively or conditionally compliant based on a comorbidity.

Checked column: A "Y" in this column indicates that at least one of the questions on the eRD tab for the assessment was answered "Yes".

Comorbidities: This column lists all comorbidities coded on each assessment.

Color Coding

The codes displayed in the IGC, Diagnosis, and Comorbidities columns are color-coded where appropriate to convey compliance information using the following key:

Compliant IGCs from the CMS published 60% Rule methodologies are outlined in **dark blue**. IGCs that are excluded from compliance because of the diagnosis are indicated by a ~~strikethrough~~. Codes removed from presumptive compliance for compliance review periods beginning on or after 10/1/2015 are outlined in **red**. IGCs that are excluded from compliance because of a diagnosis removed from compliance or a diagnosis exclusion added for compliance review periods beginning on or after 10/1/2015 are identified with a **blue outline** and ~~red strike-through~~.

Additional Compliance Resources

For additional documentation and resources regarding 60% Rule compliance, please see the links in the help document available under the HELP icon at the top of the 60% Rule Compliance Report screen in eRehabData.

Transmittal Report

The Transmittal Report is a live Medicare assessment transmission scheduling report that includes assessments with a primary payer of either 2 (Medicare non-MCO) or 51 (Medicare MCO, a.k.a. Medicare replacement/Medicare advantage). For assessments that have been marked as Accepted by CMS, the report displays information on the time elapsed between assessment discharge dates and when those assessments were placed into CMS transmission files and marked as Accepted by CMS, with color coding to identify late assessments and assessments that may qualify for late transmission penalties. For in-progress assessments, the report shows the number of days between the discharge date and today's date, with color coding to indicate approaching transmission deadlines. The report is updated in real time so as discharge dates are added and assessments are transmitted to CMS and marked as Accepted, the report is instantly updated to reflect these changes.

For more information on assessment scheduling, transmission deadlines, and late transmission penalties, please see the IRF-PAI Training Manual and the IRF-PPS Final Rules available from the CMS IRF-PPS website.

Transmittal Report Filters

Facility: This drop-down is only available to organization-level reports users from organizations that have more than one facility account on eRehabData. Use this drop-down to view transmission scheduling information for the selected facility.

Time Period: The report includes assessments based on discharge dates. Enter start and end dates for the discharge date range you wish to see. Fiscal year links to the right of the Refresh button offer a shortcut to view the report based on Federal Fiscal Year date ranges (October 1 - September 30 for the selected year). If you use one of these links, the report will refresh automatically and you will not need to click the **Refresh** button.

Assessment Status: Select “Accepted by CMS Assessments only” to view transmittal information for assessments that have been marked as accepted by CMS. Select “In-Progress Assessments only” to view scheduling information for in-progress discharge assessments. Select “Both” to include both in-progress and accepted by CMS assessments.

> ***NOTE:*** In-progress discharge assessments must have discharge dates in order to be included in the report.

Transmittal Report Output

The report columns are clickable links that allow you to sort the output by a selected column. Click a column header once to re-order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to display the report in descending order. The header for the column determining the order of the report is surrounded by brackets. For example, if the report is ordered by discharge date, the discharge date column header will be displayed like this: [Discharged].

You may see more than one record per discharge. Usually this is because a correction to a previously transmitted assessment was sent to CMS. For this reason, the record count displayed at the bottom of the report screen may not match the number of Medicare discharges for your facility for the same time period.

For your selected discharge date range and assessment group, the report displays the following information:

Last Name/First Name: The patient's last and first names from the IRF-PAI (IRF-PAI item numbers 5A and 4).

Birth Date: The patient's birth date from the IRF-PAI (IRF-PAI item number 6).

Pat ID #: The patient ID number from the IRF-PAI (IRF-PAI item number 5B).

Medicare #: The Medicare number from the IRF-PAI (IRF-PAI item number 2).

Payer: The primary payer from the IRF-PAI (IRF-PAI item number 20A).

Admitted: The patient's admission date from the IRF-PAI (IRF-PAI item number 12).

Discharged: The patient's discharge date from the IRF-PAI (IRF-PAI item number 40).

Correction #: If a correction was made to an assessment and transmitted to CMS, you may see more than one record for the same discharge. This column displays the correction number found in the CMS transmit file containing the correction record. If an inactivation record was transmitted, "Inactivation" is displayed. Inactivation records may be sent as part of corrections to key IRF-PAI fields or to retract completely assessments that were transmitted to CMS accidentally.

File Created: This column displays the creation date for each CMS transmit file. Blank values in this column indicate that the CMS transmit files for those records were not created using eRehabData.

Transmit Date: The date that the assessment was marked in eRehabData as having been accepted by CMS. This value is set when an assessment is marked as Accepted by CMS on the CMS Transmit File screen, and it can be viewed and edited on individual accepted by CMS assessments on the eRD tab on those assessments. In cases where this date is before the file creation date (for example, on corrected and re-transmitted assessments where the original transmission date was retained), it is italicized.

> ***NOTE:*** This does not necessarily represent the exact date an assessment was received by CMS. It is up to each facility to accurately record these dates in eRehabData based on the CMS Final Validation report received through the CMS website after each successful transmission to CMS.

Day Sent: This column displays the difference between the Discharge Date and either the File Created or the Transmit Date, whichever is greater. If neither of these two dates has been entered (for example, on in-progress assessments), the difference is calculated using today's date. If the Transmit Date is before the File Created Date (usually an indication that a correction was sent), the difference between Transmit Date and Discharge Date is shown in parentheses after the value representing the difference between the File Created and Discharge dates.

Values for in-progress assessments are shown in *italics*. Additionally, for in-progress assessments with Day Sent values less than 17, the background is shown in blue. A yellow background identifies all assessments with Day Sent values between 17 and 27 days. A red background identifies all assessments with Day Sent values of 28 days or greater.

> ***NOTE:*** Assessments transmitted to CMS more than 27 days after discharge may be subject to a 25% reduction in reimbursement penalty.

Top Comorbidities by RIC

The data for the Top Comorbidity reports is drawn from the same assessments used in the nightly Outcomes Reports calculations; i.e. Complete Transmitted or Filed discharge assessments for patients whose age at admit is greater than or equal to 8 years. Unlike other outcomes reports, top comorbidity data is presented for all payers.

Determination of tier is based on the current Final Rule. For example, a comorbidity that places an assessment in Tier 2 using the current rule but placed the assessment in Tier 1 in the past will show as Tier 2. An asterisk next to the tier indicates that the tier for that comorbidity changed during or after the time period selected in the Time Period drop-down.

To access the Top Comorbidities report, click **Top Comorbidities by RIC** from any outcomes report screen. The main Top Comorbidities by RIC screen displays a list of RICs on the left side and a link to view tiered comorbidities for all RICs on the right. Select any RIC from the list of RICs to view a report of the most common comorbidities found on assessments at your facility and in the nation belonging to that RIC.

You can view the most common comorbidities for a selected RIC for all tiers, or select a tier using the Tier drop-down to view only comorbidities for tiered assessments where the comorbidity assigned the selected tier for the selected time period and RIC. When viewing Top Comorbidities by RIC and choosing 'Show All Tiers' for the tier, only those comorbidities appearing in 3% or more of the assessments for the selected RIC are displayed.

For the tier reports, only comorbidities which determine the tier for any individual assessment are included. For example, if an assessment includes both a Tier 3 comorbidity and a Tier 1 comorbidity, because the assessment would be assigned Tier 1, only the Tier 1 comorbidity will be included in the report.

You can also see a list of all tier-assigning comorbidities in the eRehabData database regardless of RIC by clicking on **View Top ICD Codes for Selected Tier and All RICs** on the main Top Comorbidities by RIC screen. Then select a tier from the View Tier drop-down.

CMG Matrix

The CMG Matrix report is a grid displaying PPS payment weights, PPS average lengths of stay, and facility-adjusted reimbursement for all CMGs and tiers for the 2006 and 2007 Final Rules. The reimbursement values use the applicable standard payment conversion factor from each rule and your facility's pricer adjusters as configured on eRehabData to calculate your facility's reimbursement for each CMG and tier, assuming discharge to community.

NOTE: The reimbursement values are only as accurate as your facility's pricer adjusters. For more information on configuring your facility pricer adjusters, please refer to the "Facility Pricer Adjuster" section of this user manual.

Appeals Report

The eRehabData Appeals Tracking Report allows users with outcomes reports privileges to generate a summary of Medicare payment denials and appeals for their facility, and view a list of appeals at their facility and de-identified appeals in the nation. This report is intended to help ensure that your facility's Medicare claims are being processed in a fair and consistent manner. The data for the report comes from information entered into the **APPEALS** screen on assessments that have been marked as Accepted by CMS on eRehabData.

The report includes a number of filters which you can use to view reports for different discharge date ranges for your facility or the nation, or by individual FI, RAC, ALJ, QIC, or Federal District Court. Viewing the report by a selected FI, RAC, ALJ, QIC, or Federal District Court will give you appeals records for your selection for the nation, not just your facility. The report outputs a general summary table, an active appeals summary table, a closed appeals summary table, and an optional details table listing each appeal based on your filters. The filters and output tables are detailed below.

The appeals report also includes an anonymous cross-facility messaging feature, which allows you to get in touch with the contact person for appeals at other facilities. This feature was added in order to give facilities a means by which to share information about aspects of the appeals process, including how appeals specific to a particular FI or IGC can be handled successfully. This feature ties into the eRehabData internal messaging system and is available when viewing the appeals details table. For more information on this feature, see Cross Facility Messaging in the Details section under Appeals Report Output below.

CMS offers a downloadable brochure explaining the Medicare appeals process which you can find on the CMS website here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf.

Appeals Report Filters

Data Set: This drop-down lets you select whether you will view the report information for your Facility, for your Organization as a whole (if your organization has more than one facility and you have the org-level reports privilege), for the Nation, or by selected FI, RAC, ALJ, QIC, or Federal District Court. If you select FI, RAC, ALJ, QIC, or Federal District Court, an additional drop-down will appear below the Data Set drop-down to allow you to select an FI, RAC, ALJ, QIC, or Federal District Court. By default, the last FI, RAC, ALJ, QIC, or Federal District Court option saved for your facility on the Appeals screen of an assessment will be selected but you can choose a different option.

> ***NOTE:*** When selecting the data set Facility, users with organization-level reports privileges will see an additional drop-down appear which will allow them to select an individual facility from their organization.

Search Type: To return results based on a discharge date range of your choosing, select "Discharge Date". To find all appeals by discharge date starting with the earliest appeal that is still active, select "Make Start Date Earliest Active". To find all appeals by discharge date starting with the earliest appeal recorded in eRehabData, select "Make Start Date Earliest Appeal".

NOTE: If you select an option other than Discharge Date, you will not be able to enter the start date. The system will instead find the discharge date on the earliest active appeal or the earliest appeal for the data set you are viewing and use that as the start date.

Start Date / End Date: Enter the start and end discharge dates for your report. If you select a search type other than discharge date in the Search Type drop-down above, you will not be able to enter the start date.

Compliance: Select "All Assessments" to include all assessments regardless of compliance status. You can also filter to display assessments that are presumptively compliant or conditionally compliant, or assessments that are presumptively compliant but not conditionally compliant and vice-versa.

Details: Select "Hide Details" to only display the summary tables. Select "Show Details" to also display the list of assessments returned by your filters.

Appeals Report Output

General Summary

The general summary table displays the following measures for the filters you selected:

Total Discharges: The total number of discharges.

NOTE: When viewing the report by selected FI, RAC, ALJ, QIC, or District Court using one of the dynamic search types (Make Start Date Earliest Active or Earliest Appeal), you will see N/A values for Total Discharges and Medicare Discharges.

Medicare Discharges: This displays the number of Medicare discharges and the percentage of Medicare Discharges to Total Discharges.

Medicare Discharges Denied: This displays the total number of denied Medicare discharges, the percentage of denied Medicare discharges to total Medicare discharges, and the total claim amount for all appealed claims.

NOTE: Total Claim Amount is the sum of the claim amounts entered into the Appeals screen on all assessments returned by your report filters. It is not adjusted for payments or partial payments made on any appeals included in the data sample.

Active Appeals

An active appeal is an appeal with either some fields not completed on a level of the appeal; an appeal that has not been marked as a Technical Denial; an appeal that has not been electively terminated with the "elect to end the appeals process" checkbox; or an appeal that has reached the Federal District Court level but where all fields have not been completed for that level.

The Active Appeals table displays the following information for ongoing appeals at each level of appeal for the filters you selected:

 # Discharges: For each level of appeal, this displays the number of discharges currently at that level of appeal.

Percentage of Active Appeals: For each level of appeal, this displays the percentage of the active appeals at that level to the total of active appeals.

Total Claim Amount: For each level of appeal, this displays the total claim amount for all appeals at that level.

Total Under Dispute: For each level of appeal, this displays the total amount under dispute for all appeals at that level.

> ***NOTE:*** Total Under Dispute is carried forward from the previous level of appeal until the Amount Paid and Amount Denied have been entered for the current level.

The table also includes a line for Medicare Discharges Under Appeal. This line displays totals for all the Active Appeals table columns except for Percentage of Active Appeals. The percentage displayed on this line is the percentage of Medicare discharges under active appeal.

Closed Appeals

The Closed Appeals table displays the following information for appeals that have terminated at each level of appeal for the filters you selected:

 # Discharges: For each level of appeal, this displays the number of discharges with appeals terminated at that level of appeal.

Appeals Upheld: For each level of appeal, this displays the number of appeals marked as Favorable and terminated at that level of appeal, and the percentage of such appeals to the number of appeals closed at that level.

Appeals Denied: For each level of appeal, this displays the number of appeals marked as Unfavorable or Partially Favorable and terminated at that level of appeal, and the percentage of such appeals to the total number of closed appeals.

Total Claim Amount: For each level of appeal, this displays the total claim amount for all appeals terminated at that level.

Total Amount Denied: For each level of appeal, this displays the total amount denied for all appeals terminated at that level.

Total Amount Paid: For each level of appeal, this displays the total amount paid for all appeals terminated at that level.

Details

In order to display the details list you must select “Show Details” in the “Details” filter. To change the sort order of the details list, click on the headers for Patient Name, ADR/MR Date, IGC, Diagnosis, CMG, Tier, or Admit FIM Total. Clicking on a header once will sort the list in ascending order by that value. Clicking on the header a second time will sort the list in descending order. Users with the privilege to view assessments can jump to the Appeals screen for an individual assessment by clicking on the patient name.

Along with the line number, Patient Name (where appropriate), ADR/MR Date, IGC, Etiologic Diagnosis Code, CMG, Tier, Admit FIM Total, Level of Appeal, Response Date, Hearing Date (where applicable), Decision Date, and

Outcome for the indicated level of appeal, the Details table also includes the following columns:

Active: This column displays a "Y" on the ADR/MR line to indicate a currently active appeal.

Presump/Cond columns: "Y"s in the Presump or Cond columns indicate the assessment is presumptively or conditionally compliant, respectively.

Cross-Facility Messaging: When viewing details for data sets other than your facility, the patient name column for appeals from other facilities will have a **request details** link. Click on that link to tap into the eRehabData internal messaging system and send a message to the contact person for the selected appeal. Your message, along with your name and the name of your facility, will be sent to the contact person who can reply anonymously or choose to reveal their name and facility name. This system was added to facilitate information sharing among facilities seeking to resolve issues with their appeals and is completely voluntary. No PHI is shared unless specifically typed into the messages exchanged by the contact people.

ORYX® Report

If your facility has designated eRehabData as your ORYX® data service provider, you will be able to access your ORYX® report from the Outcomes Reports screens. These reports are updated every month. All accepted by CMS and filed discharge assessments for patients over the age of seven are included in the ORYX® analysis regardless of payer. The analysis requires a monthly population greater than one in order to make valid comparisons.

To view your ORYX® Report, click **ORYX® Report** from any of the Outcomes Reports screens. To display the report, select a measure, start date and end date. To view the report statistics, in the "Display:" drop-down select "Data". To view a graph instead, in the "Display:" drop-down select "Chart", then select a chart size using the "Chart Size:" drop-down. The chart size option controls the size of the graph images so you can tailor the page display to suit your download speed. When you have made your selections, click Show and scroll down to view your report.

To view the list of ORYX® measures that eRehabData is submitting to The Joint Commission on behalf of your facility, from your ORYX® report screen click **HCO Measures**.

For information on the ORYX® measures and how they are calculated, please review this document available under the ? HELP icon on the ORYX® Report screen:

https://web2.erehabdata.com/erehabdata/help/jcahohelp.htm

2. Dashboard Report

The Dashboard Report includes all assessments with an admit date but no discharge date. Unlike the eRehabData Outcomes Reports which are generated each night, your facility's Dashboard Report works in real time and refreshes each time you visit the dashboard report screen. As you admit and discharge patients over the course of the day the dashboard report instantaneously incorporates fluctuations in occupancy, patient case mix and other data.

To get to the Dashboard Report, from your eRehabData home screen click **Dashboard Report**.

At the top of your dashboard report screen you will see a table displaying a snapshot of your facility's occupancy, patient case mix, and other information for today's date, which is the default selection for the Dashboard Report. In order to calculate your occupancy rate, an eRehabData facility administrator must first configure your facility's Bed Count. For more information on configuring your Bed Count, please refer to the "Bed Count" section of this User Manual.

The snapshot table and graphs display the following measures for your facility:

SNAPSHOT TABLE DATA

Occupancy Rate: The percentage of total facility beds occupied on the selected day.

Total Patients: The number of patients in the facility on the selected day.

Bed Count: The total number of patient beds at your facility on the selected day as indicated by an eRehabData facility administrator for your facility.

Medicare Utilization: The percentage of total patients in the facility on the selected day who are Medicare patients.

All Patients CMI: The case mix index for all of your facility's patients on the selected day (Medicare, non-Medicare, and unknown case mix combined).

Medicare CMI: The case mix index for your facility's Medicare patients on the selected day.

Non-Medicare CMI: The case mix index for your facility's non-Medicare patients on the selected day.

Unknown Payer CMI: The case mix index for any patients whose payers have not been indicated.

Average Estimated Medicare Per Diem: This uses ALOS values to calculate the average daily payment per patient for all Medicare patients on the selected day.

> ***NOTE:*** Average Length of Stay (ALOS) values used for this calculation are not those specified in the Final Rule. The ALOS used is as follows: your facility's ALOS for the last 180 days for each CMG represented in your census is used as the basis for the average. If your facility had fewer than 5 patients for any particular CMG in the last 180 days then the National ALOS as found in the eRehabData database is used for that CMG for the average.

Total Estimated Medicare Per Diem: The estimated total Medicare reimbursement for the selected day based on Medicare patient count and the average per diem.

60% Rule (Conditional/Presumptive) Compliance Rate: The percentage of patients who meet 60% rule compliance guidelines.

> ***NOTE:*** This calculation excludes assessments for which 60% rule compliance cannot be calculated, i.e. assessments with insufficient data. For information on how presumptive and conditional compliance values are calculated, please review these documents on the eRehabData website:

https://web2.erehabdata.com/erehabdata/help/75percentConditionalPresumptive.htm

https://web2.erehabdata.com/erehabdata/help/75percentmethodology.htm

60% Rule (Conditional/Presumptive) Compliant Patients: The number of patients who meet 60% rule compliance guidelines.

60% Rule (Conditional/Presumptive) Non-Compliant Patients: The number of patients who are not 60% rule compliant.

60% Rule Unknown Compliance: The number of patients for whom 60% rule compliance has not yet been determined due to insufficient data.

GRAPHS

Patient Count for 30-day period ending <selected day>: The first graph below the snapshot table is a bar graph displaying your facility's occupancy for the trailing 30 days prior to your selected day. This graph displays Medicare, non-Medicare, unknown payer, and empty bed values.

Estimated Patient Count for 14 days following <selected day>: This graph uses national historical discharge data by CMG for patients in-house on the selected day to project the daily patient count at your facility as those patients are discharged. The percent probability that any given patient will still be present on a given day is calculated based on the frequency curve of historical discharges. The percent probability that a patient will still be present is equal to the sum of the discharge frequencies for lengths of stay longer than the day for which we want a projection, divided by the sum of the discharge frequencies for lengths of stay longer than the patient has currently stayed. All of the percentages for each day are added together, rounded up, and displayed as a patient count. Patients for which no CMG has been calculated will assume the national frequency curve of historical discharges for the projection.

CMI for month ending <selected day>: This graph shows Case Mix Index for the month ending on the selected day for Medicare, non-Medicare, unknown, and all in-house patients combined.

60% Rule Compliance for 30-day period ending <selected day>: This graph shows 60% rule compliance distribution as percentages. Unlike the value displayed in the snapshot table, these percentages are calculated against the total patient count, not just the patients for whom compliance could be determined.

> ***NOTE:*** This graph should not be relied upon for indicators of the overall compliance level at your facility since it does not take into account the number of discharges over time. For a more accurate calculation of 60% rule compliance, please refer to the 60% Rule Compliance Report or your Facility Report.

RIC Distribution: The RIC pie chart shows RIC distribution among all patients in-house on the selected day.

Payer Distribution: The Payers pie chart shows payer distribution among all patients in-house on the selected day.

To save your graphs or pie chart images to your computer, position your mouse pointer over the graph and right-click. Select “Save Picture As”, browse to the location on your computer where you want to save your graph, and click **Save**. The graph should save with a .png file extension.

To import your numeric data into Excel or similar spreadsheet program, click and drag your mouse pointer over the snapshot table to highlight all of the data. Hold down the Ctrl key and press C to copy the data to your clipboard. Open Excel or a similar spreadsheet program, click in the first cell, and press Ctrl + V to paste the data into the spreadsheet.

To select a different date to display the dashboard report for, scroll to the bottom of the screen and use the month, day, and year drop downs to indicate your desired date. Then click **Update**

to update the report. If you select a date for which there is no data, the graphs will not be displayed and an error message will appear at the top of the screen explaining the problem.

3. PSI Outcomes

If your facility has subscribed to the eRehabData® Patient Satisfaction System, your eRehabData® Patient Satisfaction Instrument Outcomes Reports are available to eRehabData users who have been granted the privilege to view outcomes reports or PSI outcomes reports for their facility or for their organization. To get to the PSI Outcomes Reports menu, from your eRehabData home screen click **PSI Outcomes**.

The information in this documentation is presented as outlined in this table of contents:

PSI OUTCOMES REPORTS GENERAL INFORMATION

The core eRehabData PSI Outcomes Reports are delivered in a six-tiered hierarchy under the **Facility Drill-Down** header starting at the top with the overall Facility Report, and then drilling down into the RIC Group, RIC, CMG, IGC, and Patient levels. Additional reporting tools include the Service Recovery, Discharge, Follow-Up, and Historical View Graphs under the **Dashboard Graphs** header, and the Comments and Time-Series Graphs under the **Other Views** header.

The Facility Drill-Down reports show you aggregate patient satisfaction survey results for your facility for each calendar month and quarter since the eRehabData Patient Satisfaction Survey System was introduced in October 2004, as well as for trailing 30, 60, 90, 180, and 365 days, year to date, calendar year, and fiscal year periods. Surveys are included in drill-

down time periods based on discharge date. All patient satisfaction surveys where at least one survey response has been completed are included in the PSI outcomes. Because the completion of patient satisfaction surveys is optional, your individual measures totals may not match your total number of completed surveys. Where averages are displayed, only measures that were completed are included in calculating the averages.

Drop-downs at the top of the drill-down reports screens allow you to select different surveys, time periods, and payers. The Medicare payer selection only includes assessments where the primary payer is 2 - Medicare non-MCO. The report screens automatically refresh each time you make a change to one of the drop-downs. If your facility has custom outcomes reports, you can view survey outcomes for those custom data values by checking the "View Facility-Specific outcomes" checkbox. If your facility has site-level reports, you can view survey outcomes for each site by checking the "View site-level outcomes" checkbox.

Your facility is shown compared to your geographic region and the nation as a whole.

The Facility Drill-Down reports only include surveys attached to assessments that have been marked as Accepted by CMS or have been Completed, Locked and Filed. The drill-down reports and Time-Series Graphs are updated nightly. A time stamp at the top of the report screens indicates the last time the reports were generated.

The Dashboard Graphs and Comments reports are updated in real time as surveys and comments are entered into the system, regardless of assessment status.

You can jump to each report screen from any of the outcomes reports screens by using the links labeled **Facility Report**, **RIC Group Report**, **RIC Report**, **CMG Report**, **IGC Report**, **Patient Report**, **Service Recovery**, **Discharge**, **Follow-Up**, **Historical View**, **Comments**, and **Time-Series Graphs**.

Some reports are available as PDF documents. On reports where this is available, near the top of the report screen is a 

button that you can click to open a new window displaying a PDF version of the report. You can then click the print icon in the new window to print your report.

> ***NOTE:*** This requires Adobe Reader software. If you don't already have Reader installed on your computer you can get the latest version from the Adobe website here: http://get.adobe.com/reader.

Some reports are also available as an Excel spreadsheet. On reports where this is available, near the top of the report screen is an 

button that you can click to either open the comma separated (.csv) file as an Excel spreadsheet or save the .csv file to your computer.

PSI OUTCOMES REPORTS DRILL-DOWN LEVELS

PSI Facility Report

Your Facility Report displays all available measures and survey questions for all patients in your facility for your selected survey, time period, and payer compared to national and regional benchmarks.

PSI RIC Group Report

Clicking on the **RIC Group Report** link brings you to the RIC Group Report menu. On the left side of the screen is a list of the RIC Groups along with their component RICs and IGCs. On the right side of the screen is a list of all available measures and

survey questions for the survey type you last selected. Clicking on a RIC Group will give you a report of all available measures and survey questions for the selected group. Clicking on a measure or question will give you a report of that measure or question for each RIC Group. From the individual measure or question for all RIC Groups screen you can click on a RIC Group to jump directly to the report of all measures and questions for that RIC Group.

PSI RIC Report

Clicking on the **RIC Report** link brings you to the RIC Report menu. On the left side of the screen is a list of the RICs. On the right side of the screen is a list of all available measures and survey questions for the survey type you last selected. Clicking on a RIC will give you a report of all available measures and survey questions for the selected RIC. Clicking on a measure or question will give you a report of that measure or question for each RIC. From the individual measure or question for all RICs screen you can click on a RIC to jump directly to the report of all measures and questions for that RIC.

PSI CMG Report

Clicking on the **CMG Report** link brings you to the CMG Report menu. On the left side of the screen is a list of the CMGs. On the right side of the screen is a list of all available measures and survey questions for the survey type you last selected. Clicking on a CMG will give you a report of all available measures and survey questions for the selected CMG. Clicking on a measure or question will give you a report of that measure or question for each CMG. From the individual measure or question for all CMGs screen you can click on a CMG to jump directly to the report of all measures and questions for that CMG.

PSI IGC Report

Clicking on the **IGC Report** link brings you to the IGC Report menu. On the left side of the screen is a list of the IGCs. On the right side of the screen is a list of all available measures and survey questions for the survey type you last selected. Clicking on an IGC will give you a report of all available measures and survey questions for the selected IGC. Clicking on a measure or question will give you a report of that measure or question for each IGC. From the individual measure or question for all IGCs screen you can click on a IGC to jump directly to the report of all measures and questions for that IGC.

PSI Patient Report

The Patient Report lists all patients with the selected survey type included in the selected report time period and payer. You can order the list of patients by patient last name, Medicare number, admit date, discharge date, length of stay (LOS), etiologic diagnosis code, impairment group code, RIC, or CMG by clicking on the respective headers at the tops of those columns. The active selection appears surrounded by black brackets. Click on a header once to sort the report by that column in ascending order. Click on the header again to sort in descending order.

PSI DASHBOARD GRAPHS

The PSI Dashboard Graphs for each survey type include all surveys for which there is at least one survey response present. Unlike the eRehabData PSI Outcomes Reports which are generated each night, your facility's PSI Dashboard Graphs refresh each time you visit the dashboard graphs screen. As you enter survey responses the dashboard graphs instantly incorporate those new responses. Graphs are available for all survey types. Select any graph using the **Service Recovery**, **Discharge**, **Follow-Up**, and **Historical View** links on the left.

To save your graph as an image, position your mouse pointer over the graph and right-click. Select “Save Picture As”, browse to the location on your computer where you want to save your graph, and click **Save**. The graph should save with a .png file extension.

To import your numeric data into Excel or similar spreadsheet program, click and drag your mouse pointer over the numeric data table to highlight all of the data. Hold down the Ctrl key and press C to copy the data to your clipboard. Open Excel or a similar spreadsheet program, click in the first cell, and press Ctrl + V to paste the data into the spreadsheet.

Service Recovery

The Service Recovery Survey Dashboard Graph report displays graphs and numeric data for all patients in-house on the selected day. Month, day and year drop-downs at the top of the report screen allow you to select any day, and radio buttons below the drop-downs allow you to indicate whether you want to view your numeric data as counts or percentages.

Below the numeric data table, a checkbox labeled “Display Patient List” enables you to view the list of patients included in the reporting period. The patient list includes patient name, patient ID, admit date, age, discharge date (where present), motor and cognitive FIM gain values (where all FIM scores have been entered), RIC, CMG, Tier, and length of stay (LOS). The screen will automatically refresh to display the patient names when you check the box.

Discharge

The Discharge Survey Dashboard Graph report displays graphs and numeric data for all patients discharged during the selected time period. A time period drop-down at the top of the report screen allow you to select one of the standard outcomes reports time periods, and radio buttons below the drop-down allow you to indicate whether you want to view your numeric data as counts or percentages.

Below the numeric data table, a checkbox labeled “Display Patient List” enables you to view the list of patients included in the reporting period. The patient list includes patient name, patient ID, admit date, age, discharge date (where present), motor and cognitive FIM gain values (where all FIM scores have been entered), RIC, CMG, Tier, and length of stay (LOS). The screen will automatically refresh to display the patient names when you check the box.

Follow-Up

The Follow-Up Survey Dashboard Graph report displays graphs and numeric data for all patients discharged during the selected time period. A time period drop-down at the top of the report screen allow you to select one of the standard outcomes reports time periods, and radio buttons below the drop-down allow you to indicate whether you want to view your numeric data as counts or percentages.

Below the numeric data table, a checkbox labeled “Display Patient List” enables you to view the list of patients included in the reporting period. The patient list includes patient name, patient ID, admit date, age, discharge date (where present), motor and cognitive FIM gain values (where all FIM scores have been entered), RIC, CMG, Tier, and length of stay (LOS). The screen will automatically refresh to display the patient names when you check the box.

Historical View

The Historical View Dashboard Graph report displays graphs for all patients in-house at any time during the 30-day trailing period ending on the selected day. Month, day and year drop-downs at the top of the report screen allow you to select any day.

OTHER VIEWS

Comments

The PSI Comments report allows you to view and search through patient comments that have been entered into the free text areas on the Service Recovery and Discharge Surveys. The search filters include subject drop-downs for each of the free-text entry questions available on the surveys. If your eRehabData facility administrator has configured subject drop-downs for any of the comments fields on the surveys you can filter your search results by those subjects; otherwise, "All" will be the only option displayed in the subject filter drop-downs.

You can also use the "Search Comments" box to search the comments. All comments returned by your search filters will be displayed below the search filters. If you don't use any search filters, all comments from all surveys will be displayed.

Users with IRF-PAI view privileges can jump directly to the patient satisfaction survey section of each assessment returned by the search filters by clicking on the patient name in the search results.

PSI Time Series Graphs

The PSI Time-Series Graphs allow you to graph selected measures for any or all RIC Groups, RICs, CMGs and/or IGCs over time against national or regional comparisons. Your selections will be graphed and you have the option to view the underlying statistics, including standard deviations for some measures, in a numeric data table at the bottom of the screen.

To create your graph, first select survey type from the "Survey Type" drop-down above the clinical groupings. The "Choose Measures" box will display the survey questions from your selected survey. Next, select a measure from the "Choose Measures" select box. You can select more than one measure at a time for comparison by holding the Ctrl key down as you click on each measure.

Next, select your time period (Quarter, Month, or Year) from the "Period:" drop-down. Then, select your start and end dates using the "Start Date:" and "End Date:" drop-downs, and indicate whether you want the comparisons to display national or regional data using the "Compare to:" and Regions drop-downs.

To display your measure(s) and time period for a particular RIC Group, RIC, CMG, or IGC, or combination thereof, select a RIC Group, RIC, CMG, or IGC from the select box. You can select multiple options for comparison by holding down the Ctrl key as you click on each option. If you do not make a selection, data for all patients will be displayed.

You can also select one or more tiers by using the "View by Tier:" select box. To select more than one tier at a time, hold down the Ctrl key while clicking on each tier. If you do not select one or more tiers, data for all tiers will be displayed.

NOTE: Tiers only apply when viewing measures by CMG.

Use the "Payer:" drop-down to display your selections for All Payers, or Medicare or Non-Medicare only. If you would like to see your data displayed numerically below your graph, check the box labeled "Display Numeric Data."

When you have made all of your selections, click **Show** to create your graph. Your graph displays your selected measure(s) for each time increment and diagnostic group you selected, and plus and minus one standard deviation if you selected

measures calculated as averages. If you selected to display the numeric data, your numeric data table appears below your graph.

To print a wide graph, either change your print layout to landscape using your printer's built-in properties or use the "Rotate Graph 90 Degrees (for printing)" checkbox to rotate the graph on-screen. You can also control the width of the lines on your graph with the "Chart Line Width" drop-down.

To save your graph as an image, position your mouse pointer over the graph and right-click. Select "Save Picture As", browse to the location on your computer where you want to save your graph, and click **Save**. The graph should save with a .png file extension.

To import your numeric data into Excel or similar spreadsheet program, click and drag your mouse pointer over the numeric data table to highlight all of the data. Hold down the Ctrl key and press C to copy the data to your clipboard. Open Excel or a similar spreadsheet program, click in the first cell, and press Ctrl + V to paste the data into the spreadsheet.

PSI OUTCOMES REPORTS REGIONS

Regions are defined as the nine U.S. Census Regions, as follows:

PSI Outcomes Reports Regions

Region	State
New England	Connecticut Maine New Hampshire Rhode Island Vermont
Middle Atlantic	New Jersey New York Pennsylvania
South Atlantic	Delaware Florida Georgia Maryland North Carolina South Carolina Virginia Washington DC West Virginia
East North Central	Illinois Indiana Michigan Ohio Wisconsin
East South Central	Alabama Kentucky Mississippi Tennessee
West North Central	Iowa Kansas Minnesota Missouri Nebraska North Dakota South Dakota

PSI Outcomes Reports Regions (Continued)

Region	State
West South Central	Arkansas Louisiana Oklahoma Texas
Mountain	Arizona Colorado Idaho Montana Nevada New Mexico Utah Wyoming
Pacific	Alaska California Hawaii Oregon Washington

PSI OUTCOMES REPORTS MEASURES

TOP SUMMARY TABLE

Completed Surveys

This displays the number of surveys of the selected survey type that had at least one response.

Case Mix Index (CMI)

The average Medicare payment weight for the selected survey population, including short stay payment weights when present. Higher numbers indicate increased average acuity. Payment weights for each CMG and tier are published in the final rule.

Transfer Patients

The count and percentage of surveyed patients who were discharged to a qualifying institution before their length of stay (LOS) exceeded the PPS Mean Average Length of Stay (ALOS) for their CMG. Qualifying institutions include discharge destinations 5 - Skilled Nursing Facility; 6 - Acute unit of own facility; 7 - Acute unit of another facility; 8 - Chronic Hospital; 9 - Rehabilitation Facility; and 13 - Subacute Setting.

Short Stay Patients

The count and percentage of surveyed patients who meet the requirements for the 5001 short stay CMG.

Deceased Patients

The count and percentage of surveyed patients whose discharge destination was 11 - Died.

Inpatient Institutional Discharges

The count and percentage of surveyed patients whose discharge destination was either 5 - Skilled Nursing Facility; 6 - Acute unit of own facility; 7 - Acute unit of

another facility; 8 - Chronic Hospital; 9 - Rehabilitation Facility; or 13 - Subacute Setting.

Community Discharges

The count and percentage of surveyed patients whose discharge destination was either 1 - Home; 2 - Board and Care; 3 - Transitional Living; 4 - Intermediate Care; or 14 - Assisted Living Residence.

AVERAGES TABLE

The Averages table displays facility, national, and regional average values for each question on the selected survey. In order to normalize the averages displayed and make the information in the report more useful, the responses for each question are assigned a value ranging from 0 to 100 or, in two cases, -100 to 100. Each assigned value is then multiplied by the frequency of the corresponding response and the results are summed and then divided by the number of total responses to that question to give the average value.

For example, the first question on the Discharge Survey asks about the patient's orientation to rehab. The survey responses have values ranging from 5 (Excellent) to 1 (Poor). In order to calculate an average based on a 100 point scale, the values are converted as follows:

5) Excellent = 100
4) Very Good = 75
3) Good = 50
2) Fair = 25
1) Poor = 0

For a selected survey sample, let's say that there were 10 responses to the Orientation to Rehab question. Of those, there were 5 Excellent responses, 2 Very Good responses, and 3 Good responses. After converting to the 100 point scale and multiplying by the frequency, the responses would look like this:

Excellent (100 x 5) = 500
Very Good (75 x 2) = 150
Good (50 x 3) = 150

The converted values are then added together, giving a total of 800, and then divided by the number of responses to the question (10) resulting in an average value for this question of 80. The facility, national and regional columns display the average and one standard deviation.

The response values for all survey responses are converted as follows:

4) Always = 100
3) Usually = 66.67
2) Sometimes = 33.33
1) Never = 0

3) Yes = 100
2) Somewhat = 0
1) No = -100

5) Excellent = 100
4) Very Good = 75
3) Good = 50
2) Fair = 25
1) Poor = 0

5) Definitely Yes = 100
4) Probably Yes = 75
3) Not Sure = 50
2) Probably No = 25
1) Definitely No = 0

5) Much Better = 100
4) Somewhat Better = 50
3) About the Same = 0
2) Somewhat Worse = -50
1) Much Worse = -100

COUNTS

The Counts table shows the total number of responses to each question on the selected survey and the count and percentage of each response compared to your region and the nation.

PSI CUSTOM (FACILITY-SPECIFIC) OUTCOMES REPORTS

Facility-specific outcomes reports are available for facilities that are tracking custom data configured as drop-downs. Facility-specific reports give you the eRehabData outcomes reports filtered by your facility's custom data items. Users with eRehabData facility administrator privileges can configure up to three facility-specific drop-downs on which these outcomes can be based, such as referring hospital, attending physician, etc. After your drop-downs have been configured, you will need to contact the eRehabData support staff directly to set up generation of your facility-specific reports.

Once custom outcomes are being calculated, the custom report display is controlled by a checkbox labeled "View Facility-Specific outcomes" at the top of each of the outcomes reports drill-down screens. Check that box to display a drop-down containing your facility-specific data values and make a selection to filter your report by that value.

For more information on configuring custom drop-downs, please see "Custom Data Fields" under the "Facility Administrator Features" section of this User Manual.

4. Referrals Outcomes

The eRehabData Referrals Outcomes reports allow users with outcomes reports privileges to view outcomes on their patient referrals and admission denials. The data for the reports come from denied pre-admission assessments and IRF-PAI assessments that began as pre-admission assessments. The reports are generated from live data, meaning that as pre-admits are converted to admission assessments or denied, this information is immediately reflected in the reports. To get to the reports, from your eRehabData home screen click **Referrals Outcomes**.

The reports include a number of filters which you can apply to view the data for your date range by selected referral source, referring physician, internal or external source, and/or denial reason. Because none of the fields on a pre-admission assessment are required, for each calculation the reports only include assessments where a value is present.

The reports output tables of numeric data with associated pie charts and are available at the Facility, RIC, CMG, and Patient levels. The filters and output are detailed below.

REPORT FILTERS

Referral Source: This drop-down lets you select from your facility custom list of referral sources. If your facility has not configured a custom data field drop-down called Referral Source, this filter will not be available on your reports. Custom data fields are configured by an eRehabData facility administrator for your facility.

NOTE: In order for this filter to be available on the reports, the custom data field must be called "Referral Source", must be spelled correctly, and must be configured as a drop-down.

Referring Physician: This drop-down lets you select from your facility custom list of referring physicians. If your facility has not configured a custom data field drop-down called Referring Physician, this filter will not be available on your reports. Custom data fields are configured by an eRehabData facility administrator for your facility.

NOTE: In order for this filter to be available on the reports, the custom data field must be called "Referring Physician", must be spelled correctly, and must be configured as a drop-down.

Internal or External Source: This drop-down separates referrals from an acute unit at your own facility (i.e. internal source) from all external sources, based on what is selected on IRF-PAI Item #15. Admit From on the pre-admit assessment.

Denial Reason: This drop-down lets you filter the report by denial reason, which can be selected from a list on the pre-admit assessment at the time of denial.

Primary Payer: This drop-down lets you filter the report based on the primary payer categories of either "All," "Medicare" (primary payer 2 only), or "Non-Medicare" (all payers other than 2).

Between: These boxes let you enter start and end dates for a date range to view the report by. The date range for denied assessments uses the date a pre-admit was marked as denied, while admissions are included based on the admit date entered on an admission assessment that began as a pre-admit.

RIC: The RIC drop-down is only available on the Patient Report, and lets you filter the list of denials by a selected RIC.

CMG: The CMG drop-down is only available on the Patient Report, and lets you filter the list of denials by a selected CMG.

REPORT OUTPUT

Facility Report

Referrals by Referring Physician

If your facility has configured the Referring Physician custom field, this table displays a list of all of the referring physicians, with counts and percentages of denials, admissions, and referrals for each physician. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the total number of referrals from each physician. The accompanying pie chart shows referrals by referring physician percentages calculated against the total number of referrals. You can click on a physician's name to filter the report by the selected physician along with your other filters.

Referrals by Referral Source

If your facility has configured the Referral Source custom field, this table displays a list of all of the referral sources, with counts and percentages of denials, admissions, and referrals for each source. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the total number of referrals from each source. The accompanying pie chart shows

referrals by referral source percentages calculated against the total number of referrals. You can click on a referral source to filter the report by the selected source along with your other filters.

Distribution by Denial Reason

This table displays counts and percentages by denial reason for your facility, your region, and the nation. Percentages are calculated against the total number of denials for each geographic category. The accompanying pie chart shows facility denials. You can click on a denial reason to filter the report by the selected reason along with your other filters.

Referrals by Zip Code

This table displays counts and percentages of denials, admissions, and referrals by zip code, specified in IRF-PAI Item #11. Zip Code of Patient's Pre-Hospital Residence on the pre-admit assessment. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the total number of referrals from each zip code. The accompanying pie chart shows referrals by zip code percentages calculated against the total number of referrals.

Referrals by Primary Payer

This table displays counts and percentages of denials, admissions, and referrals by primary payer, specified in IRF-PAI Item #20. Payment Source A. Primary Source on the pre-admit assessment. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the total number of referrals from each payer. The accompanying pie chart shows referrals by payer percentages calculated against the total number of referrals.

RIC Group Report

Denied pre-admit assessments with an Impairment Group Code will be included in the RIC Group Report. Clicking on RIC Group Report will give you a list of the eRehabData RIC groups and the number of denials your facility has logged for each group. To collapse the list of RIC groups to only display groups with denials at your facility, check the box labeled “Hide codes with zero denied pre-admission assessments.” Clicking on an individual RIC group will give you a report structured like the Facility Report, but only for the selected RIC group. The same filters available on the Facility Report are available on the RIC Group Report.

RIC Report

Denied pre-admit assessments with an Impairment Group Code will be included in the RIC Report. Clicking on RIC Report will give you a list of all RICs and the number of denials your facility has logged for each RIC. To collapse the list of RICs to only display RICs with denials at your facility, check the box labeled “Hide codes with zero denied pre-admission assessments.” Clicking on an individual RIC will give you a report structured like the Facility Report, but only for the selected RIC. The same filters available on the Facility Report are available on the RIC Report.

CMG Report

Denied pre-admit assessments with an Impairment Group Code, patient birth date, and all FIM scores and modes will be included in the CMG Report. Clicking on CMG Report will give you a list of all CMGs and the number of denials your facility has logged for each CMG. To collapse the list of RICs to only display CMGs with denials at your facility, check the box labeled “Hide codes with zero denied pre-admission

assessments." Clicking on an individual CMG will give you a report structured like the Facility Report, but only for the selected CMG. The same filters available on the Facility Report are available on the CMG Report.

Patient Report

The patient report lists denied pre-admission assessments returned by your search filters. In addition to the filters available on the other reports, the patient report includes a RIC drop-down and a CMG drop-down so you can filter your report by selected RIC or CMG. For each denial the report will display (where present): the date the pre-admit was marked denied; patient last and first names; patient ID; IGC; RIC; CMG; admit from source; primary payer; FIM motor total; and FIM cognitive total.

5. Multi-Metrics

The Multi-Metrics screen allows users with IRF-PAI view privileges to print Metrics screens for multiple in-progress assessments from one screen. To get to the Multi-Metrics screen, from your eRehabData home screen click **Multi-Metrics**.

The screen displays a list of all in-progress assessments at your facility (i.e. assessments that haven't been marked as Accepted by CMS or Filed). To view Metrics screens for up to 10 assessments, check the checkboxes next to the assessments and then click **Display** at the bottom of the screen. A pop-up window will appear displaying the metrics information for your selected assessments. To print the information, in the window menu bar select "File", then select "Print".

Two versions of the Metrics screens are available for printing. The standard Metrics screen, which looks like the Metrics screen available from an individual patient assessment, includes national and regional comparisons and offers an optional graph of patient FIM scores. When printed, the standard Metrics screen may be as long as three pages.

The alternate single page Metrics screen is a more condensed version designed for use in team conferences and for inclusion in a patient's medical record. This version excludes national and regional comparisons, reimbursement information, and graphs to give you a concise patient summary with facility comparisons that should print out on one page.

You can control the printable Metrics version by either checking the "Use the alternate single page Metrics format" checkbox at the top of the Multi-Metrics screen, or by editing your user account settings. To edit your user account settings, from your eRehabData home screen click **My Account**, then click **Functional Settings**. Check the box labeled "Use single page IRF-PAI Metrics pop-up" and click **Save**. Settings configured using either of these methods will also be applied to the **Print Metrics** feature on the **MGMT** screen of individual assessments.

The standard Metrics screen can display a graph of patient FIM scores compared to national and/or facility averages. You can use the **Graph Display Options** link at the bottom of the Multi-Metrics screen to configure, enable, or disable the graph. Settings configured using the **Graph Display Options** link on the Multi-Metrics screen will also be applied to individual assessment Metrics screens.

II.F. Enhancement Requests

eRehabData is continually enhanced and refined in response to user input to better serve the needs of all users. If you have a suggestion or recommendation for how you think the system might be improved, or if you find a problem (a "bug") in the system, you can log your suggestions or problems in Enhancement Requests. The Enhancement Requests screen is available to all users through the **Enhancement Requests** link on the eRehabData home page.

VIEW BUG REPORTS:

To access the Bug Reports screen, log in to eRehabData and click **Enhancement Requests** on your home page. You'll see a list of all reports on file, including when each request was posted, the severity of any bugs, the name of the screen in question, the subject (which is a brief description of the request or bug), and its current status (fixed, in progress, etc.). You can read a detailed description of each report by clicking on the subject line. We recommend perusing the existing list before logging a report so the list doesn't grow unnecessarily long with duplicates.

You can sort the list by "Date Created", "Date Modified", "Severity", "Status", or "Screen Name" using the "Sort By:" drop-down at the top of the screen. You can also filter the list to view only new reports, only reports that you have posted, or all reports not marked as Fixed, Closed, or Not a Bug.

POST NEW REPORT:

If the bug or suggestion you want to log isn't already in the bug reports, click **Post New Request**. You'll see a drop-down list at the top of the screen with five options for severity of problem:

Enhancement Request
Low: Doesn't interfere with work
Medium: Mildly interferes
High: Bad/incorrect functioning
Critical: Major problem of system/prevents work/data loss

Choose the severity option that best describes your report. If you are making a suggestion or request, use "Enhancement Request". Type in a short description of the bug and select the screen on which it appears. In the full description box, enter a detailed description of the bug. Be as specific as possible; the more information you give, the better the chance we can find a solution or incorporate your suggestion.

When you have entered in all of the information on the bug, click **Post Report**. Your bug will appear in the list of bugs with a status of New.

NOTE: If you encounter a problem that requires immediate attention, please send a message to the Support account through the **Send Message** link on your eRehabData home screen or call eRehabData at 202-588-1766 rather than posting a bug report.

II.G. eRehabData User Forums

In response to requests from many of our users who have asked for a way to communicate with eRehabData users at other facilities, and in order to provide an easy way to gather feedback on planned eRehabData improvements and reports, we created the eRehabData Forums Bulletin Board, the Internet version of a message corkboard. It works much the same as a community message board. Any eRehabData user can browse through all the messages in the forums, post a new message, or reply to another user's message so that eRehabData users can share thoughts, tips, questions and experiences with other eRehabData users. Since the eRehabData forums are only available from within the eRehabData application, only active eRehabData users can access the forums.

To access the forums, log in to eRehabData and click **User Forums**. The forums home page displays links to each forum, representing the following main topics: **General**, **eRehabData Software**, **IRF PAI Coding**, and **Outcomes**. Under each forum, or main topic, are individual "threads" or sub-topics which may correspond to a particular aspect of the main topic. Users can

create their own new threads under a forum, read and/or reply to other users' messages, and edit or delete messages they have posted previously.

To browse the forums, click one of the four forum names on the Forums home page. You'll then see a list of all threads posted under that forum organized in chronological order with the thread containing the latest posted message appearing at the top. You can choose to start a new thread by clicking **Start New Thread** on the left side of the screen or at the bottom of the threads index page.

To browse the messages posted under a thread, click on the name of the thread. You can reply to a message in a thread by clicking **Reply** on the left side of the screen or **Reply to this thread** at the bottom of the messages page.

You can send a private message to a user who has posted a message on the forums by clicking on their username. You can also edit or delete messages you have posted by selecting the thread the message is posted under and clicking the **Edit** or **Delete** link in your message.

Above the threads list you'll see what are called “breadcrumbs”. These links represent your location in the forums. For instance, if from the forums index you clicked on the “**IRF-PAI**” forum, the breadcrumbs at the top of the screen would look like this: **eRehabData Forums** > **IRF-PAI**. Each time you click to a deeper level in the forums the breadcrumbs will expand to illustrate where you are, and offer you links to climb back up the hierarchy so you're never more than a click or two away from any of the other forums or threads.

You can also use the links on the left side of the screen to jump to the forums index, the threads index (if you have selected a thread), or your eRehabData home screen.

III. FACILITY ADMINISTRATOR FEATURES

III.A. Facility Administrator General Information

Users with eRehabData facility administrator privileges are responsible for managing their facility's information, settings, and user accounts on eRehabData. This includes creating and updating user account profiles and privileges; configuring CMS transmit file information; setting password expiration requirements for all eRehabData user accounts at the facility; creating and updating optional custom data fields; configuring facility adjusters for reimbursement calculations; configuring facility bed count data for the Dashboard Report; and signing the facility up for optional services such as ORYX® data submission to The Joint Commission, the IRF-PAI Proficiency Exam system, or the Patient Satisfaction Instrument system.

Once a facility has at least one facility administrator account configured on eRehabData, that user is encouraged to set up any other required user accounts and manage them directly. This includes re-setting user passwords when lost or forgotten. In order to avoid conflicts in case an eRehabData facility administrator is unavailable to adjust user account or other information, we recommend that each facility have at least two users with eRehabData facility administrator privileges.

There is no limit to the number of facility administrator accounts a facility can have.

III.B. Manage Facility Screen

The Manage Facility screen is the starting point for all administrator functions, including managing user accounts, facility custom data, and the information that is included in your facility's CMS transmission files.

To access the administration screen, log in to eRehabData and click **My Facility** under the **Manage** header on the left side of your home page. You will see a table displaying the names of all eRehabData users for your facility, including your own. If your facility has more than one site, you can toggle between the sites to display the users for each site by selecting the site name from the Sites box at the bottom of the screen and clicking Switch Site.

EDITING USER ACCOUNTS

You can edit an existing user account from the Manage Facility screen by clicking on a username. The screen will refresh with the selected user's account information displayed at the top. Click **Edit User** to make any changes to the user's account. See the "Add User" instructions below for an explanation of user account requirements and privileges.

You will also see the option **Delete User.** If the user has ever logged on to eRehabData, even once, you will not be able to delete them from the system. This option is included only to allow you to correct mistakes in account assignments. If you need to deactivate a user's account, you can remove all of their privileges and then select "No" under "Active?" on the edit screen. See the "Add User" instructions below for more information.

MANAGE FACILITY SCREEN OPTIONS

On the left side of your Manage Facility screen you will see the following links, grouped under the headers **Facility Admin**, **Recent Activity**, and **Systems**:

1) **Add User**
2) **Bed Count**

3) **Custom Data Fields**
4) **Facility Settings**
5) **Digital Signatures**
6) **Facility Pricer Adjuster**
7) **View Logins**
8) **Recently Modified Assessments**
9) **Manage Proficiency Exams**
10) **Patient Satisfaction Instrument**
11) **ORYX® Signup**

An explanation of the functions of each link follows. If you have a **My Facility** link on your home page and you do not see all of these links on your Manage Facility screen, you are either a Site Administrator or an Organization Administrator, not a Facility Administrator.

1. Add User

Facility administrators are responsible for managing all user accounts for their facility. This includes multiple sites if your facility has more than one location operating under a single Medicare provider number. Each user should be given their own user account with a unique username and password but all users from your facility will use the facility's Medicare provider number as part of their login.

Each user should also be given a set of user privileges that corresponds to their duties on the eRehabData system. Privileges can be combined to ensure that each user has the unique combination of user privileges they require in order to perform their job. There is no limit to the number of user accounts a facility can have.

To add a new user, from your Manage Facility screen click **Add User**. You will see the following fields:

Site: If your facility has more than one site, select the site this user will be associated with from the drop-down list.

User Name: This is the name the user will log in with. A standard format username is first initial of the first name followed by the entire last name with no spaces (for example, jdoe for John Doe), but you may choose whatever format you wish. The username is not case-sensitive. **required*

Password: An eRehabData password must be at least 8 characters long and must include at least 2 numbers, along with letters (it must be alphanumeric). Additionally, it cannot include any part of your name or your facility's name, and it cannot include the word "password." If an administrator sets a password for a user, the user will be required to set a new password on their first login. **required*

Confirm Password: Type in the password again, exactly as you entered it the first time. **required*

First Name: The user's first name. **required*

Last Name: The user's last name. **required*

MI: The user's middle initial.

Suffix: The user's suffix (Ph.D., Esq., II, etc.).

Email Address: The user's email address. This is not required but it is recommended. Users can edit their own email address.

Phone Number: The user's phone number. This is not required but it is recommended, in case eRehabData staff needs to contact a user. Users can edit their own phone number.

Extension: Any applicable extension to the user's phone number.

Active?: This is the on/off switch for a user account. The default setting is "Yes". A user with an "Active" setting of "Yes" will be able to log on to their account on eRehabData. To de-activate a user account and prevent that user from logging on, select "No".

Privileges: When creating a user account, consider the user's requirements. Will the user need to be able to create other user accounts? Will they be creating IRF-PAI assessments? Will they be uploading data to or downloading data from eRehabData? Will they be transmitting assessments to CMS?

The answers to these questions will determine what combination of privileges the user needs. You can refer to the "Privileges Reference Guide" below for help in determining which privileges to assign each user account. We offer Roles you can select from in order to assign a user a pre-determined group of privileges, or you can customize a user's privileges using the list of available privileges. For more information on which privileges are assigned using the Roles, please refer to the link in the Roles section on the Add User screen. The individual privileges are grouped by general tasks as follows:

Administrator Privileges

Facility administrator (user can create / manage all user accounts for their facility and configure facility information - includes all sites): This privilege allows the user to create and manage all user accounts for the facility, including multiple sites associated with that facility (*site administrator privileges inclusive*). The facility administrator can also create facility custom data fields, edit facility settings such as password expirations, access assessment tracking information, configure facility pricer adjusters, perform advanced IRF-PAI functions on individual assessments, sign the facility up for additional services such as IRF-PAI proficiency exams or the Patient Satisfaction System, and monitor user access of eRehabData. Facilities can have more than one facility administrator. In fact, this is recommended as it distributes responsibility in case an administrator is ill, on vacation, or otherwise unavailable.

Site administrator (user can create / manage user accounts only for their site): This privilege restricts a user's administrative capacity to their site only. *This is only applicable if a facility has more than one site and the site administrator should not have access to user accounts at other sites.* A site administrator creates and manages user accounts for their site only and does not have the ability to grant user privileges associated with a facility (for instance, a site administrator cannot authorize a user to upload data to CMS or to view reports). Site administrators also cannot create custom data fields or sign the facility up for additional services such as IRF-PAI proficiency exams or the Patient Satisfaction System.

> ***NOTE:*** If you are designating the user as a facility administrator, this privilege is unnecessary and redundant.

Sub-Administrator Privileges

Non-admin user can perform IRF-PAI advanced maintenance functions: This privilege allows a user who is not an eRehabData facility administrator to manually change an assessment's status (Accepted by CMS to In-Progress and

vice-versa) and correction number in cases where a mistake was made while processing the assessment in Step 5 on the CMS file transfer screen.

NOTE: This privilege is not necessary if the user has facility administrator privileges.

Non-admin user can manage IRF-PAI proficiency exams: This privilege allows a user who is not an eRehabData facility administrator to purchase, assign, and correct proficiency exams for their facility, and view the exam outcomes reports.

NOTE: This privilege is not necessary if the user has facility administrator privileges.

Non-admin user can manage IRF-PAI proficiency exams: This privilege allows a user who is not an eRehabData facility administrator to purchase, assign, and correct proficiency exams for their facility, and view the exam outcomes reports.

NOTE: This privilege is not necessary if the user has facility administrator privileges.

IRF-PAI Privileges

User can view all assessments for their facility (includes all sites): This privilege gives the user the ability to see all patient assessments at their facility, including assessments from multiple sites if your facility has more than one site. This does not include the ability to create or edit assessments.

User can view only assessments for their site: This limits the user to seeing only assessments at their site. This does not include the ability to create or edit assessments.

NOTE: This privilege is not necessary if the user has the privilege "User can view all assessments for their facility (includes all sites)". It is also unnecessary if your facility has only one site.

User can create / edit IRF-PAI assessments: This gives a user the ability to create pre-admit, admit, and discharge assessments and edit existing assessments, including patient satisfaction surveys where enabled.

User can add follow-up data to accepted / filed discharge assessments: This allows the user to append follow-up information to assessments that have either been accepted by CMS or filed. Users do not require any other IRF-PAI privileges in order to add follow-up data to assessments.

User can lock assessments (in preparation for transmission to CMS): This gives the user the ability to lock assessments against any edits, either in preparation for transmission to CMS or to prevent any changes.

NOTE: If the user will be transmitting assessments to CMS, they should be given this privilege.

User can unlock assessments: This gives the user the ability to re-open locked assessments for further edits.

NOTE: If the user will be transmitting assessments to CMS, they should be given this privilege.

User can receive late transmission warning messages: This designates a user to receive warnings issued by the eRehabData system alerting the user about discharge assessments that are approaching their CMS transmission due date. Messages are issued to all users with this privilege for assessments that haven't been marked as Accepted by CMS as of 16 days past the discharge date entered. If any assessments have still not been marked as Accepted by CMS as of 18 days past discharge, all facility and organization administrators are automatically alerted as well.

Data Upload/Download Privileges

User can download assessments from their facility: This gives the user the ability to download any or all of their facility's patient assessment data from the eRehabData system to their local computer. This privilege is necessary if the user will be creating files to transmit to CMS or if they will be downloading assessment data to keep as a local back up or for import into another software application.

User can upload assessments to eRehabData: This gives the user the ability to upload patient identification data, full assessments, follow-up assessments and patient satisfaction surveys to the eRehabData system for use in creating or updating assessments on eRehabData without manually keying in assessment information.

Outcomes Reports Privileges

User can view all outcomes reports for their facility: This privilege allows a user to view eRehabData outcomes reports for their facility including patient satisfaction outcomes reports where enabled.

User can ONLY view Patient Satisfaction outcomes reports for their facility: This privilege allows users without outcomes reports privileges to view their facility's patient satisfaction survey outcomes.

> ***NOTE:*** This privilege is not necessary if the user has the privilege "User can view all outcomes reports for their facility".

Notification Privileges

User can receive physician notification emails: This privilege allows a user to receive email notifications when Pre-Admission Screening (PAS) Tool assessments are ready for their review and signature. When users with this privilege are notified about a pending referral, the email they receive will contain a special link which, when clicked, directs them to a the Simple PAS, a simplified version of the PAS Tool. The Simple PAS displays all of the information entered into the PAS Tool as read-only, and allows the user to indicate a rehabilitation disposition (Accepted, Re-screen, or Denied); type in notes; and sign the PAS Tool. The Simple PAS was designed specifically for use on small mobile devices.

User can receive admissions office notification emails: This privilege allows a user to receive email notifications when Pre-Admission Screening (PAS) Tool assessments require their input or review. When users with this privilege are notified about a pending referral, the email they receive will contain a special link which, when clicked, directs them to the fully functional PAS Tool.

> ***NOTE:*** No patient data is sent in the emails. Instead, a special link is provided which directs the user to the correct record in eRehabData when clicked. A valid email address AND either facility-level IRF-PAI view/create/edit privileges OR create/edit pre-admission assessments only privileges are required in order for a notification privilege to be assigned.

Special Limited Privileges

User can create / edit pre-admission assessments only: This allows users who do not have the privilege "User can create/edit IRF-PAI assessments" to create pre-admission assessments.

> ***NOTE:*** This privilege is not necessary if the user has the privilege "User can create/edit IRF-PAI assessments", and cannot be combined with other special IRF-PAI privileges such as "User can create/edit patient satisfaction surveys only".

User can create / edit patient satisfaction surveys only: This allows users who do not have the privilege "User can create/edit IRF-PAI assessments" to enter patient satisfaction survey results. Such users will be able to view assessment data only for the surveys they are entering but they will not be able to change any assessment data other than the patient satisfaction survey responses. If the user needs to print surveys for distribution to patients, they will also need the privilege "User can view all assessments for their facility (includes all sites)."

> ***NOTE:*** This privilege is not necessary if the user has the privilege "User can create/edit IRF-PAI assessments", and cannot be combined with other special IRF-PAI privileges such as "User can create/edit pre-admission assessments only".

Once you have entered all of the user account information and made your privilege selections, click **Save** to create the account and return to the Manage Facility screen.

PRIVILEGES REFERENCE GUIDE

Almost everything a user can do on eRehabData is controlled by a separate user privilege. The purpose of this guide is to help you determine which privileges are appropriate for each user account based on the tasks each user has to perform. These privileges should be combined as necessary to allow each user only the access they require.

Administrative Tasks

Does the user need to:

- Create other user accounts and manage user privileges?
- Re-set passwords for users who have forgotten them?
- Configure a password expiration for all facility passwords?
- Create custom data fields for the IRF-PAI?
- Configure facility pricer adjusters so eRehabData can calculate Medicare reimbursement?
- Configure your facility bed count for the Dashboard Report?
- Purchase, assign, and manage IRF-PAI proficiency exams and view proficiency exam outcomes reports?
- Manually override an assessment's status (Incomplete/Accepted by CMS) and/or correction number after a mistake was made during processing of the assessment on the CMS file transfer screen?
- Revert a discharge assessment back into an admit assessment, for example on interrupted stay assessments?
- View assessment tracking and user login history?

If the user needs to do any combination of the above tasks, they will need the privilege "Facility administrator (user can create/manage all user accounts for their facility and configure facility information - includes all sites)."

Does the user need to:

- Manually override an assessment's status (Incomplete/Accepted by CMS) and/or correction number after a mistake was made during processing of the assessment on the CMS file transfer screen?
- Revert a discharge assessment back into an admit assessment, for example on interrupted stay assessments?

If the user needs to do these two tasks WITHOUT the rest of the administrator tasks listed above, they will need the privilege "Non-admin user can perform IRF-PAI advanced maintenance functions."

Does the user need to:

- Purchase, assign, and manage IRF-PAI proficiency exams and view proficiency exam outcomes reports WITHOUT all of the other facility administrator privileges?

If yes, they will need the privilege "Non-admin user can manage IRF-PAI proficiency exams."

Assessment Tasks

Does the user need to:

- Create patient assessments (including pre-admit, admit, and discharge)?
- Transmit assessments to CMS?

If yes, they will need the privileges:

- "User can view all assessments for their facility (includes all sites)"
- "User can create/edit IRF-PAI assessments"
- "User can lock assessments (in preparation for transmittal to CMS)"
- "User can unlock assessments", AND
- "User can download assessments from their facility."

Does the user need to:

- Receive notification emails when a Pre-Admission Screening (PAS) Tool requires their review, input or signature?

If yes, their eRehabData account will need a valid email address and ONE of these privileges:

- "User can receive physician notification emails" (appropriate if the user is a physician who will only need to review the screening, indicate a rehabilitation disposition [Accepted, Denied, Re-screen], and sign the screening)
- "User can receive admissions office notification emails" (appropriate if the user works in the admissions office and collects information relevant to the potential admission)

AND also one of the following options:

- "User can view all assessments for their facility (includes all sites)" plus "User can create/edit IRF-PAI assessments",
  OR
- "User can create/edit pre-admission assessments only".

Does the user need to:

- Create follow-up assessments?

If yes, they will need the privilege "User can add follow-up data to accepted / filed discharge assessments."

Does the user need to:

- Enter pre-admission assessments only?

If the user only enters pre-admission assessments without entering any IRF-PAI assessments, they will only need the special limited privilege "User can create/edit pre-admission assessments only."

Does the user need to:

- Complete IRF-PAI proficiency exams?

If yes, the user will only need an eRehabData user account (username and password). No privileges are necessary in order for a user to complete IRF-PAI proficiency exams.

Patient Satisfaction Surveys

Does the user need to:

- Print and/or enter Patient Satisfaction Instrument surveys only?

If the user only enters patient satisfaction survey data without editing any IRF-PAI assessments, they will only need the special limited privilege "User can create/edit patient satisfaction surveys only."

Data Uploading/Downloading

Does the user need to:

- Download data from eRehabData to their computer or local network for local storage, import into another software system, generating custom reports, or transmission to CMS?

If yes, the user will need the privilege "User can download assessments from their facility."

Does the user need to:

- Upload files to eRehabData for import into the eRehabData system, such as follow-up assessments, full or partial assessments, patient demographics files, or patient satisfaction surveys?

If yes, the user will need the privilege "User can upload assessments to eRehabData."

Outcomes Reports

Does the user need to:

•View facility reports, RIC reports, CMG reports, IGC reports, patient reports, top comorbidities reports, ORYX® reports, time-series graphs, FIM scoring comparison graphs, dashboard reports, 60% rule compliance reports, or Patient Satisfaction Instrument outcomes reports?

If yes, the user will need the privilege "User can view all outcomes reports for their facility."

2. Bed Count

Your facility bed count is used to calculate occupancy data on your facility's "Dashboard Report". If your facility maintains the same number of patient beds over time you only need to configure one bed count value. If your facility gains or loses patient beds you will need to create new bed count values to reflect those changes and ensure accurate occupancy rate calculations over time on the dashboard report.

CONFIGURING YOUR BED COUNT

To set your bed count value, from your Manage Facility screen click **Bed Count**, then click **Add New**. You will see the following input boxes:

Description of effective date range (e.g. "FY2003"): Enter a description of the time period covered (for instance, "Current", or "2002 - 2004").

Effective Date Start: Enter the date when your facility acquired this number of beds (MM/DD/YYYY). If your bed count has remained the same since the start of the IRF-PPS, you can use 01/01/2002 as your start date.

Effective Date End: Enter the last date your facility had or will have this number of beds (MM/DD/YYYY). If this bed count is current and is not expected to change, use a date far in the future.

Facility Beds: Enter the number of patient beds covered by this date range.

When you have entered in all of your bed count data, click **Save**. You will see your new bed count value appear on the Bed Count screen.

NOTE: Completion of all fields is required for configuration of your bed count.

EDITING A BED COUNT

To edit a bed count, from your Manage Facility screen click **Bed Count**. From your list of bed counts, select the radio button to the left of the bed count you wish to edit and then click **Edit**. Make your changes on the edit screen and click **Save Changes**.

NOTE: If your facility's bed count changes, do not edit the existing bed count value, or you will affect the accuracy of your occupancy calculations on your dashboard report for assessments within its effective date range. Instead, edit the current bed count's end date and create a new bed count to appropriately reflect the date that the change takes effect.

To delete a bed count, from your Manage Facility screen click **Bed Count**. From your list of bed counts, select the radio button to the left of the bed count you wish to delete and click **Delete**, then click "OK" to confirm deletion.

3. Custom Data Fields

Custom data fields provide a way for facilities to expand the information collected during the assessment process through custom data fields included on the IRF-PAI screens. These fields can be used to store patient or other information that is not part of the IRF-PAI itself, such as patient contact information or physician name. All custom data elements appear in assessments on a tab labeled **CUSTOM**. If you have no custom data elements then the **CUSTOM** tab will not be shown.

Creation of these items is optional and the data stored in them are available only to your facility or organization. They are not transmitted to CMS. You can access your custom data in the following ways:

- On the **CUSTOM** tab on an individual assessment
- Via the Assessment Data Download (Custom) and the Assessment Data Download V4
- Via Facility-Specific Outcomes (see below)

ADDING CUSTOM FIELDS

To add a custom data field, from your Manage Facility screen click **Custom Data Fields**, then click **Add Element**. Then, complete the following input fields:

Element Name: Type in a simple name which will be used to identify the field during download or on the outcomes reports.

Description of element: Type in a more user-friendly description which will be displayed on the **CUSTOM** tab on assessments. This can include instructions to the user, examples of acceptable input ranges, etc.

DataType of element: This is used to error-check data entry. “TEXT” allows any characters to be entered, while “DATE”, “INTEGER” and “DECIMAL NUMBER” all require that values entered conform to a specific definition. INTEGER refers to whole numbers with no decimal points and DECIMAL NUMBER means “real” or “floating point” values (for example, 98.6). If you specify a datatype other than TEXT, eRehabData will apply the appropriate validation check to that element. For example, if you specify a DATE data type and a user tries to enter anything other than a proper date value, a warning will be displayed and the invalid value will not be saved.

Entry method: This refers to the means by which the user will enter the data into this field on the **CUSTOM** tab. Two methods are available: Text Box (hand entry) and Drop-Down (select list). Text Box allows the user to type in values. Drop-Down allows the element to be configured with a list of values from which the user can choose. This method is useful in preventing data-entry errors due to typos. It is also necessary if outcomes analysis will be performed on the field. See “Configuring Drop-Downs” below for more information on drop-down fields.

The next set of options refers to the list of checkboxes that control when during the assessment process the element can or must be completed. You can select more than one of the following options:

Required?: Check this box to require that the field be filled out before an assessment can be marked Complete. As with the other tabs, the **CUSTOM** tab uses the green / yellow / red color coding to indicate completeness state.

Allow entry after CMS acceptance?: Check this box to allow the field to be edited on an assessment that has either been Accepted by CMS or Filed. Normally

such assessments are locked and read-only, but this setting allows the facility custom value to be edited directly without requiring the assessment to be unlocked.

Pre-Admit / Admit / Discharge / Follow-Up: Use these checkboxes to specify during which stages of the assessment process the field can be edited. Items not allowed before a given stage will not appear on the **CUSTOM** tab until that stage is reached. For example, a field flagged for entry only at Discharge will not appear during Pre-Admit or Admit, but will appear on Discharge and Follow-Up assessments. Data entered early is shown at later assessment stages, either as editable or as read-only depending on how the field was configured (in the previous example, the field edited at Discharge would be readable during Follow-Up).

> ***NOTE:*** There is a difference between "Allow entry after CMS acceptance?" and "Follow-Up?". In the former case a field can be modified for any Accepted discharge assessment, but the latter is only available when a Follow-Up assessment has been created.

EDITING CUSTOM FIELDS

To edit a custom data field, from your Manage Facility screen click **Custom Data Fields**. From your list of existing facility custom data elements, select the radio button to the left of the element you wish to edit and then click **Edit Element**. Make your changes on the edit screen and click **Save Changes**.

REORDERING CUSTOM FIELDS

By default, your facility custom fields appear on the **CUSTOM** tab in the order in which they are created. You can reorder the fields using the "Order" input boxes on your Custom Data Fields admin screen. To change the order of your facility custom elements, from your Manage Facility screen click **Custom Data Fields**. Use the input boxes in the "Order" column next to your existing elements to type in numbers representing the order you want those fields to appear in. Then click **Reorder Elements** and review the new order.

> ***NOTE:*** If your facility uploads facility custom data to eRehabData using the IRF-PAI Import, you will need to verify that the order of elements in your upload file matches the new order before you do another upload.

CONFIGURING CUSTOM DROP-DOWNS

Drop-downs are intended as a means to help avoid data-entry errors, make facility custom data entry faster and easier and also standardize data values for accuracy. Custom data fields configured as drop-downs will appear on your eRehabData home screen as drop-downs that you can filter your assessments lists by, in addition to the other filters available. You can also have your eRehabData Outcomes Reports generated based on your custom drop-downs.

To configure a drop-down field, first set the "Entry Method" to "Drop-down (select list)" as specified above. An input box labeled "Allowable Values:" will appear. You will use this box to specify both the values that will appear in the drop-down itself and the corresponding values that are saved to the database when a selection is made using the drop-down.

Enter the valid values in the edit box by typing only one item per line in the form **Value : Description**, where Value is what is stored in the database and Description is what is displayed in the drop-down on the **CUSTOM** tab during assessment data-entry, with the two separated by a colon. If a line only contains only a value then that will also be used in the description. Values and Descriptions may not contain the characters " (double quotes), < or >. If there are multiple colons on one line, the first colon is treated as the Value / Description separator and the rest are kept as part of the Description. The values are also type-checked against the DataType specified, so for example, if an element is configured as a Date then each choice configured must be a valid date.

For example: An element called “Attending Physician” is configured as a text drop-down with the following allowable values:

X : Dr. Xavier
N : Dr. Nelson
Other

Line 1: “Dr. Xavier” is what the user selects in the drop-down on the **CUSTOM** tab and “X” is what is actually stored to the database and downloaded in your facility custom data files.
Line 2: “Dr. Nelson” appears in the drop-down, “N” is stored in the database.
Line 3: “Other” is displayed in the drop-down *and* stored in the database.

Values automatically appear in the drop-downs in the order in which you enter them in the Allowable Values box.

EDITING CUSTOM DROP-DOWNS

Editing the list of options available for a drop-down will not automatically alter any data in existing assessments. For instance, in the above example if “Dr. Xavier” is removed from the list, any assessments that already have that value will retain that value. HOWEVER, in this example, if an assessment containing “Dr. Xavier” is selected from the eRehabData home screen and the user goes to the **CUSTOM** tab on that assessment, “Dr. Xavier” will appear as a temporary value in the drop-down and a message displayed on screen will alert the user to the fact that the value no longer exists as a valid option. If the user doesn't then select a different option from the drop-down then the data will not be updated to reflect one of the available values. This means that if your facility is running outcomes reports based on facility custom fields, the assessments with values that don't match anything from the list of configured valid options will not be included in your facility-specific outcomes.

It is important to recognize that a selection made in the drop-down is identified in the database by the Value, not the Description. Here is another example: Patient Smith's assessment had its “Attending Physician” value set to “Other”. The next day the administrator edited the facility custom element and changed that option from “Other” to “Other : Other Attending”. If Smith's assessment is loaded and the user clicks on the **CUSTOM** tab, it will appear as if the choice was changed from “Other” to “Other Attending”. In this case, because only the *Description* changed, the database entry stays the same (“Other”).

However, if instead the line were changed to “Other Attending” (no colon) then both the *Value* and *Description* would change. If the assessment were then loaded and the **CUSTOM** tab clicked, the drop-down would display a *temporary* value of “Other” because the value of “Other” is no longer a valid drop-down option and the assessment is in edit mode. This assessment would then be excluded entirely from any facility-specific outcomes reports generated on eRehabData. This same scenario would be true if the choice were just completely removed. It is therefore recommended that great care be taken when editing facility custom items once assessments have been saved using those options.

Values are not case-sensitive, meaning that if you change “x : Dr. Xavier” to “X : Dr. Xavier” on the admin screen and then load an assessment where “x : Dr. Xavier” had been selected, the drop-down will identify that as “X : Dr. Xavier” and will save the uppercase “X” to the database if the Attending Physician field is in edit mode.

CONVERTING FREE-TEXT ENTRY FIELDS TO DROP-DOWN FIELDS

An existing free-text entry field can be switched to a drop-down simply by making the choice on the admin screen. For more information, see the Configuring Custom Drop-Downs section of this user manual.

NOTE: There is a high probability that typographic errors have been made within previous free-text data entries. If you convert a free-text entry field to a drop-down, contact the eRehabData support staff to perform an audit on your existing data so you can correct existing typos and standardize data to ensure that your facility-specific outcomes reports include all applicable assessments.

FACILITY-SPECIFIC OUTCOMES REPORTS

The standardization of data entry offered by custom drop-downs gives facilities the opportunity to generate outcomes reports based on drop-down values. For example, if you are recording primary caregiver information in patient assessments, it is possible to generate outcomes at the Facility, RIC Group, RIC, CMG, IGC, and patient levels based on primary caregiver.

eRehabData can generate facility-specific outcomes based on up to three facility custom fields, which must be configured as drop-downs.

To set up facility-specific outcomes reports, please contact eRehabData support staff directly at 202-588-1766. As with the other outcomes reports, the reports will be recalculated nightly.

NOTE: Once your custom outcomes reports have been set-up, if you make any edits to the available options in a drop-down custom data field you will need to contact the eRehabData support staff to make sure your custom outcomes reports are updated to match.

4. Facility Settings

CMS TRANSMIT FILE INFORMATION

Before creating any files for transmit to CMS, you must confirm that your facility information in the eRehabData system matches the information on file with CMS. Unless your facility information on file with CMS changes, this is a one-time-only requirement. CMS requires your Medicare Provider ID, CMS Facility ID, Address (one line), City, State, Zip Code, and Phone.

NOTE: Your CMS Facility ID is not the same as your Medicare Provider ID.

The Medicare Provider ID that you submit to CMS uniquely identifies your facility to CMS. Some facility's provider numbers include a "T"; others do not. Because the provider number used for eRehabData logins is numeric only, eRehabData facility administrators can edit the provider ID that is included with the data transmission to CMS.

Changing this value will not affect your login or the provider ID as it is referenced or displayed anywhere else in the eRehabData system. This change simply allows you to match the provider ID submitted with your assessments to the number on file with CMS. You'll receive warnings or rejections on your transmission status report if the provider ID on file doesn't match what was submitted with your assessments.

To verify your information, from your Manage Facility screen click **Facility Settings**. If you need to edit anything on this screen, type in your changes, click **Save**, and then log out of eRehabData by clicking **LOG OUT** in the green toolbar. Then log back in. Logging out and logging back in allows you to apply the changes to your current user session.

Any CMS assessment files created *before* the changes were made will still include the old values, so be sure to create new files to apply any changes before transmitting them to CMS.

BILLING CONTACT INFORMATION

The billing contact information section of the Facility Settings screen is used to indicate to whom any communication regarding eRehabData invoices should be directed.

PASSWORD EXPIRATION SETTINGS

Facility administrators can specify how often all users at their facility will need to change their eRehabData user passwords. Enter a value between 0 and 365 to represent the number of days the facility's passwords will be valid for. If you enter 0, your facility's passwords will never expire; however, this is not recommended for reasons of security and HIPAA compliance. You should check with the person in charge of HIPAA compliance at your facility before setting your password expiration to 0.

After you have entered your values, click **Save** at the bottom of the screen.

5. Digital Signatures

The Digital Signatures screen allows eRehabData® facility administrators to configure electronic signature requirements for their users. Electronic signature functionality is available for the Physician Signature field in the Justification section of the Pre-Admission Screening (PAS) Tool and Simple PAS, and the signatures on the Signatures tab of the IRF-PAI. For more information on the PAS Tool, please see the "Pre-Admission Screening (PAS) Tool Assessments" section of this manual.

Electronic signature functionality on eRehabData® provides facilities with a way to reasonably authenticate that the person whose signature appears in an electronically signed field is, in fact, that person. However, this is dependent upon each user maintaining their own unique signature and their own login information, and it is the responsibility of the facility administrator(s) to verify the accuracy of each user's electronic signature information. Users can configure their signature from the eRehabData® home screen by clicking **My Account**, then **Functional Settings**. Facility administrators can view, but not edit, each user's configured signature from the eRehabData® home screen by clicking **My Facility**, then clicking on a username, then clicking **Edit User**.

When a user has configured their signature, a **SIGN** button will be displayed next to the physician signature fields which, when clicked, will populate the signature, date, and time fields based on their configured signature, plus the date and time settings on their computer. The user must then click **CONFIRM** to save the signature or **CANCEL** to cancel it. If necessary, the date and time can be adjusted before clicking **CONFIRM**. Printed copies of PAS Tool assessments that were signed using the **SIGN** button (i.e. digitally signed) are identified as such with a notation that appears below the physician signature line on the PDF. Additionally, whenever the **SIGN** button is used, a "SIGN" event is saved to the user tracking for that assessment.

Electronic signature enforcement is not retroactive, meaning that each signed PAS Tool maintains whatever level of enforcement was in effect at the time it was signed by the physician. There are four different levels of enforcement, as detailed below.

> ***NOTE:*** Requiring electronic signatures only controls the way the physician signature boxes can be filled out on the PAS Tool. It does not affect the ability to admit or deny pre-admission screenings and does not require that a signature be present before a screening can be admitted. It also does not affect signatures on the IRF-PAI.

Electronic Signature Enforcement Levels

No Restrictions: This option allows users to type freely into the physician signature, date, and time fields on the PAS Tool. Users have the option of configuring a signature in their

user account to effectively use as a shortcut for signing PAS Tool assessments, but this is not required.

Signature Required: This option requires that a user have a signature configured in their account in order to be able to complete the physician signature fields on the PAS Tool. When this level of enforcement is selected, the PAS Tool may still be modified after it is signed.

Signature Locking: This option requires that a user have a signature configured in their account in order to be able to complete the physician signature fields on the PAS Tool, and locks the PAS Tool against any edits after it is signed. Signed and locked PAS Tools can be unlocked if necessary by anyone with the ability to edit PAS Tool assessments, using the **Unlock** button on the **MGMT** tab, but doing so will clear the physician signature fields and the assessment will need to be signed again.

Strong Signature Locking: This option requires that a user have a signature configured in their account in order to be able to complete the physician signature fields on the PAS Tool, and locks the PAS Tool against any edits after it is signed. Signed and locked PAS Tools can *only* be unlocked for further edits by either the user who signed the document or by a facility administrator, using the **Unlock** button on the **MGMT** tab, but doing so will clear the physician signature fields and the assessment will need to be signed again.

6. Facility Pricer Adjuster

Your facility's pricer adjusters allow eRehabData to calculate Medicare reimbursement values for all of your facility's assessments in the eRehabData database. These reimbursement values are displayed on the Metrics screens for all assessments, averaged in the eRehabData outcomes reports, displayed for each assessment on the outcomes patient report, and available for download in the HIPPS Data Download V2 and the Assessment Data Download (Custom).

Each facility adjuster is valid for a limited period of time, such as calendar year, facility fiscal year, or even partial year periods if any of your facility's data elements which make up the facility adjuster change during the year. In order to ensure that all reimbursement values calculated on eRehabData are correct and accurate you will need to configure a facility adjuster for each time period and/or set of data elements for which you have assessments on eRehabData. If your facility's assessments on eRehabData date back to the beginning of the IRF-PPS (January 1, 2002), you will want to configure facility adjusters for your facility's time periods (fiscal or other) for 2002, 2003, 2004, 2005, 2006, and so on.

For example, if your fiscal year begins January 1, 2006 and ends December 31, 2006, and your SSI Ratio, Wage Index, Rural Adjuster, Medicaid Days Ratio, and Teaching Status Adjuster remain unchanged during your fiscal year period, you can configure a facility adjuster for fiscal year 2006 using your fiscal year 2006 information. However, if your fiscal year begins January 1, 2006 and ends December 31, 2006, but your Wage Index changed on October 1, 2006, you would need to configure two adjusters for your 2006 fiscal year: the first, beginning January 1 and ending September 30; and the second beginning October 1 and ending December 31. Alternately, if your SSI Ratio, Wage Index, etc. remain unchanged from one year to the next, you can configure an adjuster that spans more than one fiscal year. Just make sure you enter the correct effective start and end dates for the various elements of each adjuster.

> ***NOTE:*** eRehabData automatically adjusts for general reimbursement changes such as changes to the Base Payment Rate, Labor Share and LIP Exponent so you do not need to configure a new adjuster based on those kinds of updates or changes that are not specific to your facility.

CONFIGURING FACILITY ADJUSTERS

Your facility's billing department or Fiscal Intermediary (FI) should be able to provide you with the information required in order to configure your facility adjusters. To configure a

Facility Pricer Adjuster, from your Manage Facility screen click **Facility Pricer Adjuster**. To add a new facility adjuster, click **Add New**. You will see the following input boxes:

Description of time period (e.g. "FY 2003"): Enter a meaningful description of the time period this adjuster represents.

Effective Date Start: Enter the start date of your facility's fiscal year or applicable date (MM/DD/YYYY).

Effective Date End: Enter the end date of your facility's fiscal year or applicable date (MM/DD/YYYY).

SSI Ratio: Enter your facility's SSI Ratio.

Wage Index: Enter your facility's Wage Index.

Rural Adjuster: Enter your facility's Rural Adjuster (for example, 1.0).

Medicaid Days Ratio: Enter your facility's Medicaid Days Ratio.

Teaching Status Adjuster: Enter your facility's Teaching Status Adjuster. The Teaching Status Adjuster only applies to time periods starting on or including October 1, 2005 and later.

NOTE: Your teaching status adjuster should be calculated according to this formula:

Teaching Status Adjuster = 1plus the ratio of the number of FTE residents to the average daily census (ADC) all raised to the 0.9012 power, or $(1 + FTE/ADC)^{0.9012}$.

The FTE/ADC ratio is also known as the Teaching Status and is shown in the IME (indirect medical education) field in the PC PRICER software you can download from CMS here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/IRF.html.

You should confirm all pricer values with your reimbursement department or Fiscal Intermediary as the PC PRICER may not reflect current values. If your facility does not have a medical education program, please enter 1.0 as the Teaching Status Adjuster.

When you have entered in all of your facility adjuster data, click **Save**. Your new facility adjuster will appear on the Facility Adjusters screen.

NOTE: Completion of all fields is required for calculation of your facility adjuster.

EDITING FACILITY ADJUSTERS

To edit a facility adjuster, from your Manage Facility screen click **Facility Pricer Adjuster**. From your list of facility adjusters, select the radio button to the left of the adjuster you wish to edit and click **Edit**. Make your changes on the edit screen and click **Save Changes**.

NOTE: If any of your facility's data elements change during an effective time period, do not edit a facility adjuster to include new values or you will force a recalculation of prior assessments within its effective date range, which may impact the accuracy of your reimbursement calculations. Instead, edit the current facility adjuster's end date and create a new facility adjuster to appropriately reflect the date that the changes take effect.

To delete an adjuster, from your Manage Facility screen click **Facility Pricer Adjuster**. From your list of facility adjusters, select the radio button to the left of the adjuster you wish to delete and click **Delete**, then click "OK" to confirm deletion.

FACILITY ADJUSTER CALCULATIONS

Reimbursement calculations based on your facility adjusters are displayed in the Medicare Pricer table on the Metrics screen for all Pre-Admit, Admission, and Discharge assessments.

For Pre-Admit and Admission assessments the Medicare Pricer table includes:

- The applicable Facility Adjuster
- The Federal Rate for the CMG and Tier (highlighted)
- The Federal Rate for the other Tiers within that CMG
- The Facility Adjusted Payment (Federal Rate x Facility Adjuster)
- Transfer per Diem (used for calculating transfer payments)
- High Cost Outlier Threshold – This is the amount that would need to be exceeded in cost before additional reimbursement would be granted to the facility.

For Discharge assessments the Medicare Pricer section includes:

- The applicable Facility Adjuster
- The Federal Rate for the CMG and Tier (highlighted)
- The Federal Rate for the other Tiers within that CMG
- The Facility Adjusted Payment (Federal Rate x Facility Adjuster)
- Transfer per Diem or Transfer Payment (if the patient is a transfer patient)
- High Cost Outlier Threshold – This is the amount that would need to be exceeded in cost before additional reimbursement would flow to the facility.

The reimbursement calculations are available for download in the "HIPPS Data Download V2" and the "HIPPS Data Download V2". You can also view reimbursement information on your eRehabData outcomes reports.

7. View Logins

View Logins allows eRehabData facility administrators to view user login history and activity for their facilities. From your Manage Facility screen click **View Logins** to see a list of your facility's users who have logged in within the last specified number of days. The default time period is the last 3 days: you can see all logins for up to the last 99 days. Clicking on the Browser Session ID link for a user will display a list of all pages the user visited during that session, and when.

8. Recently Modified Assessments

Recently Modified Assessments allows eRehabData facility administrators to track assessment activity for their facilities. From your Manage Facility screen click **Recently Modified Assessments** to view a list of your facility's assessments that have been modified within the last specified number of days. Click on a patient name to list all the users who have accessed that patient's assessment, and when. Click on a Session ID : Username link to list all of the screens that user visited during that particular session, and when.

9. Manage Proficiency Exams

The eRehabData Proficiency Exam system is an optional add-on to the standard eRehabData subscription. The system consists of IRF-PAI proficiency exams and proficiency exam outcomes reports and is managed entirely by your facility's eRehabData facility administrators or non-admin users who have been granted the privilege to manage proficiency exams for their facility. Through the admin screen, users with those privileges can purchase proficiency exams, assign them to users at the facility, correct completed exams, review the corrected exams, and view outcomes reports which include comparisons between users at the facility, and national comparisons.

> ***NOTE:*** Non-facility administrators with the privilege "Non-admin user can manage IRF-PAI proficiency exams" will enter this area through a **Proficiency Exams** link under the **Manage** header on the left side of their home screen.

Each proficiency exam includes two patient scenarios for which patient assessments must be completed. By default all IRF-PAI fields are required for each scenario but the exam requirements can be tailored to focus on specific areas of the IRF-PAI, such as the FIM, or to exclude certain areas like Medical Needs or Quality Indicators.

The exams are designed to be distributed and completed online through the eRehabData system.

PURCHASING EXAMS

Exams are available for purchase in blocks and priced on a sliding scale. The pricing structure is displayed on the Manage Proficiency Exams screen. To purchase a block of proficiency exams, from your Manage Facility screen click **Manage Proficiency Exams**, then click **Purchase Exams**. This screen displays exam blocks your facility has already purchased. Click the **Purchase** button, then use the radio buttons to select the number of exams you wish to purchase. Enter billing instructions, pertinent notes or other information into the Notes box. Then click **Purchase** again and click "OK" to confirm. You will be redirected to the purchase display screen, updated with your new purchase, and your exams will be immediately available for assignment.

To delete an exam block purchase, from your Manage Facility screen click **Manage Proficiency Exams**, then click **Purchase Exams**, then click **Delete**. Select the radio button next to the purchase you wish to delete, click **Delete**, then click "OK" to confirm.

> ***NOTE:*** If you see an "X" instead of a radio button, you cannot delete the associated purchase as the number of exams you would be deleting exceeds the number of exams assigned to users.

ASSIGNING EXAMS

In order to take proficiency exams, a user needs only a username and password on eRehabData. No user privileges are required. To assign a proficiency exam to a user, from your Manage Facility screen click **Manage Proficiency Exams**, then click **Assign Exam**.

Select a user by clicking in the radio button to the left of the user's name and then click **Next**. A confirmation box will appear with the user's name and brief descriptions of the test scenarios to be assigned. Scenarios are selected at random by the eRehabData system from a pool of 25 possible scenarios.

> ***NOTE:*** A user cannot be assigned the same scenario more than once.

By default all IRF-PAI fields are required on an exam. It is possible to complete an exam with empty fields but skipped answers will be counted against the overall exam score.

Rather than requiring users to complete the entire IRF-PAI for each scenario, you can modify the exam requirements to focus on specific areas of the IRF-PAI using the following exam options:

- **No ICDs:** Check this to exempt the user from entering any ICD-9 codes, including Diagnosis, Comorbidities and Complications.
- **No optional fields:** Check this to exempt the user from entering any information on the Medical Needs and Quality Indicators sections, as well as any other fields not normally required for assessment completion.

  NOTE: This includes comorbidities, so if you select this option the user will not be able to score comorbidities.

- **No Patient Information:** Check this to exempt the user from entering any information on the Identification Information section of the IRF-PAI.
- **No Medical Needs:** Check this to exempt the user from entering any information on the Medical Needs section of the IRF-PAI.
- **No Function Modifiers or FIM scores:** Check this to exempt the user from entering any information on the Function Modifiers and FIM sections of the IRF-PAI.
- **No Quality Indicators:** Check this to exempt the user from entering any information on the Quality Indicators section of the IRF-PAI.
- **Function Modifiers and FIM only:** Check this to exempt the user from entering anything other than Function Modifier and FIM scores.

  NOTE: This option cannot be combined with any other options.

- **ICD Coding only (Diagnosis, Comorbidities, Complications):** Check this to exempt the user from entering anything other than ICD-9 codes on the Medical Information and Discharge screens.

  NOTE: This option cannot be combined with any other options.

Once you have made your selections, click **Next** to review your scenarios and assigned options. To confirm the exam assignment, click **Save**. The next time the selected user logs in to eRehabData, a link to their assigned proficiency exam will appear on their home screen.

MANAGING EXAMS

Your Proficiency Exam Manager screen displays a list of all of the exams you have assigned. Depending upon the state the exams are in, you will be able to cancel or correct them, or view the corrected scenarios. The Proficiency Exam Management screen is available from your Manage Facility screen by clicking on **Manage Proficiency Exams**. In your list of assigned exams, under the "Action" column you will see some or all of the following options:

View Scenario: You can view and/or print the patient scenarios for each assigned exam by clicking **View Scenario**.

Cancel: You can cancel an exam at any time until the user has finished at least one of the exam scenarios and submitted it for review. Canceling an exam cancels both scenarios.

Correct Scenario: After a user has finished a scenario and submitted it for review and submitted it for review by clicking the **Finish** button, click **Correct Scenario** to score the scenario. Click "OK" to confirm. The screen will refresh and display a summary of the scenario results (# correct, # incorrect, # skipped) below the

scenario name, with links to **Scoresheet** and **Review Answers** in the Action column. Once a scenario has been corrected, no further changes can be made to it.

Unlock Scenario: Once a user has finished a scenario and submitted it for review by clicking the **Finish** button, that scenario is locked and they can no longer make changes to it. However, if they discover they need to make a change before you have corrected the scenario you can unlock the scenario to let the user edit their answers. Click **Unlock Scenario**, then click "OK" to confirm.

Review Answers: Once a scenario has been corrected, you can view the corrected assessment by clicking **Review Answers**. This lets you into the scenario assessment itself and you can see which answers the user scored correctly, which answers they missed alongside the correct answers, and which measures they skipped, if any.

To view the correct answers, click on the tabs for the sections the user completed to go to each section. Questions answered correctly are marked "Correct". Questions answered incorrectly are marked with a red 'X' followed by the correct score in parentheses. Questions that could have been answered but weren't are marked "Skipped". Questions that were not part of the test are marked "[*skip*]".

To return to the proficiency exam management screen, from inside the corrected scenario click on the **MGMT** tab on the assessment, then click **Menu**.

Scoresheet: The scoresheet is a summary of the corrected scenario. It lists which measures were scored correctly, which ones were missed, and which ones were skipped, if any. It does not display the actual answers from the scenario or the answer key.

EXAM OUTCOMES REPORTS

Proficiency exam outcomes reports are generated nightly and offer analysis of your facility as a whole compared to the nation, as well as a comparison of individual users to each other and to users nationwide.

To view your exam outcomes, from your Manage Facility screen click **Manage Proficiency Exams**, then click **Exam Scoring**.

Facility/Nation Comparison

The first Proficiency Exam Scores screen displays the number of users tested, exams assigned and exams left to be assigned, as well as a comparison of your facility's average scoring to national averages plus and minus one standard deviation. All completed exam scenarios from your facility and in the nation are used to calculate the averages.

The values displayed are calculated as follows:

Average "Absolute" Score: The percentage of correct answers out of the total required answers in the exam, including skipped answers.

Average "Completed" Score: The percentage of correct answers out of questions answered. It excludes skipped answers from the total.

Average Skipped: The percentage of total skipped answers out of the total required answers. This does not include measures excluded from the test requirements. For example, if a user was assigned an exam with "Skip Identification Info" selected, the missing patient information will not be included in the total skipped.

Individual User Scoring

To view your exam outcomes by user, from the facility/nation comparison screen click **Individual Exams**. Each user from your facility who has completed at least one exam scenario will be listed. The user's most recent exam scores are shown as either averages of two completed scenarios or scores from one completed scenario if both scenarios haven't yet been completed.

For the national comparison numbers, each component scenario's national average is calculated and then the two scenario averages are averaged together to create the exam national averages. For example, if an assigned exam has two completed scenarios, "A" and "B", then the average national scores for "A" and "B" are averaged and displayed. If the user only completed one scenario then only that scenario's national average scores are shown for the comparison.

The column headers in the report table are clickable links which you can use to sort the report by the selected column. The values displayed are calculated as follows:

% Correct Absolute: The percentage of correct answers out of the total required answers in the exam, including skipped answers.

% Correct Answered Only: The percentage of correct answers out of questions answered. It excludes skipped answers from the total.

% Skipped: The percentage of total skipped answers out of the total required answers. This does not include measures excluded from the test requirements. For example, if a user was assigned an exam with "Skip Identification Info" selected, the missing patient information will not be included in the total skipped.

% Variance (User scores): This calculation shows how much an exam differs from the national average. This is done by taking the difference between the exam score (which is first averaged between the exam's component scenarios) and the national average for those two scenarios, and then dividing by the national average ((e - n) / n). The idea is to show the magnitude of the difference between a user's score and the national average as a percentage of the national score. For example, if an exam score was 80% and the national average was 70% then the variance would be +14.29, because the difference (10) is 14.29% of the national average.

Percentile Rank (User - Unweighted): This calculation shows the percent of exams facility-wide that had a lower score (for both absolute and answered-only scores) than the user's most recent exam. It is calculated by dividing the number of exams that had a lower score by the total number of exams taken. The higher an exam's score is, the higher the percentile will be. This is calculated as an overall percentage regardless of the individual scenarios that make up the exam.

Percentile Rank (Nation - Weighted): This calculation shows the percent of exams nationwide that had a lower score (for both absolute and answered-only scores) than the user's most recent exam. It is calculated first at the scenario level by dividing the number of the same scenarios that had a lower score by the total number of those scenarios completed. The two scenario results are then averaged to come up with the national weighted number.

Individual Exam Scoring

From the Individual Exams screen, click on a user's name to view outcomes for each exam completed by the user. This screen displays all exams (or individual

scenarios) the user has completed compared to national averages for those same scenarios. The calculations are performed as described in the Individual User Scoring section above.

Individual Scenario Scoring

To view a user's exam outcomes at the individual scenario level, from the Individual Exam Scoring screen click on the scenario names on an exam. The national averages displayed on this screen only take into account the individual scenario, as does the percentile rank so you can see how each user compares to the national average on an individual scenario level.

10. Patient Satisfaction Instrument

PATIENT SATISFACTION SYSTEM GENERAL INFORMATION

The eRehabData Patient Satisfaction System integrates patient satisfaction surveys into eRehabData's existing assessments and outcomes reports structure. The Patient Satisfaction Instrument (PSI) includes three patient satisfaction surveys for each patient stay: the Service Recovery Survey, completed during the first few days of the rehabilitation stay; the Discharge Survey, given to the patient the day before or day of discharge; and the Follow-Up Survey, which can be completed in conjunction with a follow-up assessment or separately. Facilities can elect to use all three surveys or concentrate on one or two. PSI Outcomes Reports for each type of survey are generated nightly. The annual subscription fee for the Patient Satisfaction System is $4500.

The design document on which the Patient Satisfaction System is based is available on the eRehabData website here:

https://web2.erehabdata.com/erehabdata/help/IRFPatientSatisfaction.pdf

PATIENT SATISFACTION SYSTEM SIGNUP

To subscribe your facility to the eRehabData Patient Satisfaction System, from your Manage Facility screen click **Patient Satisfaction Instrument**, then check the checkbox labeled “I request the subscription to eRehabData’s PSI service on behalf of my facility, and also acknowledge the $4500.00 fee.”

PATIENT SATISFACTION SURVEY CONFIGURATION

The patient satisfaction surveys themselves can be configured to match your facility's structure regarding number of daily nursing shifts (2 or 3) and whether your facility's case management and social work duties are combined or separate. The patient satisfaction discharge survey forms and screens will change to adjust to the configuration.

To configure the surveys for your facility, on the PSI Signup screen under Survey Options, select the number of daily nursing shifts (2 or 3) at your facility.

Next, if your facility has separate social work and case management duties, set “Distinct Social Work and Case Management Questions?” to “Yes”. If social work and case management are combined, select “No”.

Additionally, your facility also has the option of using scannable patient satisfaction forms so that the completed forms can be scanned in and then uploaded in a data file rather than hand-entered by an eRehabData user at your facility. If your facility will be scanning and uploading the responses, set “Use scannable versions of the Survey PDFs?” to “Yes”.

Click **Save** to save your selections.

NOTE: Scanning of the patient satisfaction forms requires third-party hardware and software. Please review this document available under the HELP icon on the PSI Signup screen for more information on scanning and uploading PSI forms:

https://web2.erehabdata.com/erehabdata/help/PSI/PSIAdminHelp.htm

ADMIN PSI SUBJECTS

Configurable subject drop-downs on the eRehabData Patient Satisfaction Service Recovery and Discharge Surveys facilitate more efficient patient comment field browsing and searching. Subjects configured by an eRehabData facility administrator appear in drop-downs above the associated comment fields on the survey entry screens, and users entering survey results can select from the drop-downs a general subject or topic that may describe or apply to the comments written on the survey. These same drop-downs appear on the PSI Outcomes Reports Comments screen for use in searching or grouping patients' comments.

To configure PSI subject drop-downs, from the PSI Signup screen click **PSI Subjects**. A drop-down at the top of the screen lists all of the comments survey questions.

Creating a new subject:

1) Select the survey question using the drop-down.
2) Type your subject or topic into the "Subject" box and click **Add New Subject**.
3) Your new subject will appear below the survey question drop-down.

Editing an existing subject:

1) Select the survey question using the drop-down.
2) Click the **Edit Subject** button next to the subject you are editing.
3) Your subject text will appear in the "Subject" box. Type in your changes and then click the **Edit Subject** button below the "Subject" box.
4) Your edited subject will appear below the survey question drop-down.

Deleting an existing subject:

1) Select the survey question using the drop-down.
2) Click the **Delete Subject** button next to the subject you are editing.
3) Click "OK" to confirm delete.

NOTE: Any subject which has been selected on existing surveys cannot be deleted.

Viewing PSI Subjects:

Once you have configured PSI comment field subjects you will see your configured subjects appear in the drop-downs above the comments fields on the Patient Satisfaction Discharge and Follow-Up Survey screens.

Browsing PSI Subjects:

Users with Outcomes Reports privileges or PSI outcomes reports privileges can browse patient comments by logging in to eRehabData and clicking on **PSI Outcomes**, then **Comments**. Your configured subjects will appear in drop-downs next to their respective survey questions. You can use the drop-downs individually

or combine them with other drop-downs or free-text search strings to return your desired results.

11. ORYX® Signup

If you would like eRehabData to submit ORYX® data to The Joint Commission for your facility, from your Manage Facility screen click **ORYX® Signup** and check the box on the ORYX® Signup screen requesting that eRehabData transmit ORYX® data to The Joint Commission for your facility and acknowledging the ORYX® data service fee.

You will also need to inform The Joint Commission that eRehabData will be submitting data on behalf of your facility. Click **ORYX® FAQ** on the ORYX® Signup screen for the link to the form you must fill out and fax to The Joint Commission. Once The Joint Commission receives the form, they will send us your facility's Joint Commission HCO ID so that we can send them your facility data.

> ***NOTE:*** For discharges beginning January 1, 2013, The Joint Commission will no longer require or accept data submissions of non-core measures. For more information, see the article on The Joint Commission website here: http://www.jointcommission.org/issues/article.aspx?Article=iHfF8qSm%2BRbZYQZJn6KRjr20x33F3yWvPHxpTwEEgCk%3D.

IV. ORGANIZATION ADMINISTRATOR FEATURES

IV.A. Organization Administrator General Information

Users with eRehabData organization administrator privileges are responsible for managing user accounts for all eRehabData subscribed facilities belonging to their organization. This type of account is only necessary if an organization has more than one facility, facility being defined by a unique Medicare provider number.

This level of access has been included for convenience, to allow one user to manage user accounts for different facilities without needing to log out and log back in under each provider number. An organization administrator has access to assign the organization-level privileges for data downloading or outcomes reports viewing to any user under their organization. All other access to data on eRehabData is done at the facility level. For example, an organization administrator with the privilege to view patient assessments can only see assessments belonging to the provider number the organization admin logged in with.

There is no limit to the number of organization and facility administrator accounts an organization can have.

IV.B. Manage Facility Screen

The administration screen is the starting point for all administrator functions including managing user accounts.

To access the administration screen, log in to eRehabData and click **My Facility** under the **Manage** header on the left side of your home page. You will see a table displaying the names of all eRehabData users for your facility. You can toggle between the facilities under your organization to display the users for each facility by selecting the facility name from the Facilities box at the bottom of the screen and clicking **Switch Fac**. If you do not see the Facilities box, you do not have organization administrator privileges.

Likewise, if a facility has more than one site, you can toggle between sites by selecting the site name and clicking **Switch Site**.

EDITING USER ACCOUNTS

You can edit an existing user account from the Manage Facility screen by clicking on a username. The screen will refresh with the selected user's account information displayed at the top. Click **Edit User** to make any changes to the user's account. See the "Add User" instructions below for an explanation of user account requirements and privileges.

You will also see the option **Delete User.** If the user has ever logged on to eRehabData, even once, you will not be able to delete them from the system. This option is included only to allow you to correct mistakes in account assignments. If you need to deactivate a user's account, you can remove all of their privileges and then select "No" under "Active?" on the edit screen. See the "Add User" instructions below for more information.

MANAGE FACILITY SCREEN OPTIONS

On the left side of your Manage Facility screen you will see the following link:

1) **Add User**
2) **Custom Data Fields**

If you see links for **Bed Count**, **Facility Settings**, **Facility Pricer Adjuster**, **Logins**, **Recently Modified Assessments**, **Manage Proficiency Exams**, **Patient Satisfaction Instrument**, and **ORYX® Signup**, you are either solely a facility administrator or a facility administrator in addition to an organization administrator. Please refer to the "Facility Administrator Features" section for how to manage the facility-level information. If you are an organization administrator with facility administrator privileges, you will be able to manage facility information for only the *one* facility at a time, corresponding to the Medicare provider number you log on with. To edit facility information for other facilities in your organization, you will need to create a facility administrator user account for yourself under each of those facilities.

1. Add User

Organization administrators are responsible for managing all user accounts for all facilities under their organization. Each user should be given their own user account with a unique username and password and each user from a particular facility will use their facility's Medicare provider number as part of their login.

Each user should also be given a set of user privileges that corresponds to their duties on the eRehabData system. Privileges can be combined to ensure that each user has the unique combination of user privileges they require in order to perform their job. There is no limit to the number of user accounts a facility or organization can have.

To add a new user, from your Manage Facility screen click **Add User**. You will see the following fields:

Facility / Site: Select the facility/site this user will be associated with from the drop-down list.

User Name: This is the name the user will login with. A standard format username is first initial of the first name followed by the entire last name with no spaces (for example, jdoe for John Doe), but you may choose whatever format you wish. The username is not case-sensitive. **required*

Password: An eRehabData password must be at least 8 characters long and must include at least 2 numbers, along with letters (it must be alphanumeric). Additionally, it cannot include any part of your name or your facility's name, and it cannot include the word "password." When an administrator sets a password for a user, the user will be required to set a new password on their first login. **required*

Confirm Password: Type in the password again, exactly as you entered it the first time. **required*

First Name: The user's first name. **required*

Last Name: The user's last name. **required*

MI: The user's middle initial.

Suffix: The user's suffix (Ph.D., Esq., II, etc.).

Email Address: The user's email address. This is not required but it is recommended. Users can edit their own email address.

Phone Number: The user's phone number. This is not required, but it is recommended, in case eRehabData staff needs to contact a user. Users can edit their own phone number.

Extension: Any applicable extension to the user's phone number.

Active?: This is the on/off switch for a user account. The default setting is "Yes". A user with an "Active" setting of "Yes" will be able to log on to their account on eRehabData. To de-activate a user account and prevent that user from logging on, select "No".

Privileges: When creating a user account, consider the user's requirements. Will the user need to be able to create other user accounts? Will they be creating IRF-PAI assessments? Will they be uploading data to or downloading data from eRehabData? Will they be transmitting assessments to CMS?

The answers to these questions will determine what combination of privileges the user needs. You can refer to the "Privileges Reference Guide" in the facility administrator features section for help in determining what privileges to assign each user account. We offer Roles you can select from in order to assign a user a pre-determined group of privileges, or you can customize a user's privileges using the list of available privileges. For more information on which privileges are assigned using the Roles, please refer to the link in the Roles section on the Add User screen. The individual privileges are grouped by general tasks as follows:

Administrator Privileges

Organization administrator (user can create / manage all user accounts for their organization): This privilege allows the user to create and manage all user accounts for all facilities and sites in their organization, and enables the user to grant organization-level access to data downloads and reports to any user. This level of privileges is only applicable to users belonging to an organization that has more than one subscriber facility on eRehabData.

> ***NOTE:*** Organization administrator privileges do not give a user full control over each facility in their organization. To access facility-level settings and functionality such as custom data fields, pricer information, etc., an organization administrator also requires facility administrator accounts at each facility.

Facility administrator (user can create / manage all user accounts for their facility and configure facility information - includes all sites): This privilege allows the user to create and manage all user accounts for the facility, including multiple sites associated with that facility (*site administrator privileges inclusive*). The facility administrator can also create facility custom data fields, edit facility settings such as password expirations, access assessment tracking information, configure facility pricer adjusters, perform advanced IRF-PAI functions on individual assessments, sign the facility up for additional services such as IRF-PAI proficiency exams or the Patient Satisfaction System, and monitor user access of eRehabData. Facilities can have more than one facility administrator. In fact, this is recommended as it distributes responsibility in case an administrator is ill, on vacation, or otherwise unavailable.

Site administrator (user can create / manage user accounts only for their site): This privilege restricts a user's administrative capacity to their site only. *This is only applicable if a facility has more than one site and the site administrator should not have access to user accounts at other sites.* A site administrator creates and manages user accounts for their site only and does not have the ability to grant user privileges associated with a facility (for instance, a site administrator cannot authorize a user to upload data to CMS or to view reports). Site administrators also cannot create custom data fields or sign the facility up for additional services such as IRF-PAI proficiency exams or the Patient Satisfaction System.

> ***NOTE:*** If you are designating the user as a facility administrator, this privilege is unnecessary and redundant.

Sub-Administrator Privileges

Non-admin user can perform IRF-PAI advanced maintenance functions: This privilege allows a user who is not an eRehabData facility administrator to manually change an assessment's status (Accepted by CMS to In-Progress and vice-versa) and correction number in cases where a mistake was made while processing the assessment in Step 5 on the CMS file transfer screen.

> ***NOTE:*** This privilege is not necessary if the user has facility administrator privileges.

Non-admin user can manage IRF-PAI proficiency exams: This privilege allows a user who is not an eRehabData facility administrator to purchase, assign, and correct proficiency exams for their facility, and view the exam outcomes reports.

> ***NOTE:*** This privilege is not necessary if the user has facility administrator privileges.

Non-admin user can copy assessments from their facility to other facilities in their organization: This privilege allows a user who is not an eRehabData organization administrator to copy PAS Tool assessments from one facility to another in their organization. This is intended for use by sister facilities sharing liaisons who may not know to which facility a patient will be admitted when they begin the pre-admission screening.

> ***NOTE:*** This privilege can only be assigned by an eRehabData organization administrator, but is not necessary if the user already has organization administrator privileges.

IRF-PAI Privileges

User can view assessments belonging to ANY facility in their organization: This privilege gives the user the ability to see patient assessments at any facility in their organization. This does not include the ability to create or edit assessments. Users with this privilege will be able to select from a drop-down list of their organization's facilities at the bottom of the eRehabData home screen in order to display that facility's assessments.

User can view all assessments for their facility (includes all sites): This privilege gives the user the ability to see all patient assessments at their facility, including assessments from multiple sites if your facility has more than one site. This does not include the ability to create or edit assessments.

User can view only assessments for their site: This limits the user to seeing only assessments at their site. This does not include the ability to create or edit assessments.

> ***NOTE:*** This privilege is not necessary if the user has the privilege "User can view all assessments for their facility (includes all sites)". It is also unnecessary if your facility has only one site.

User can create / edit IRF-PAI assessments: This gives a user the ability to create pre-admit, admit, and discharge assessments and edit existing assessments, including patient satisfaction surveys where enabled.

User can add follow-up data to accepted / filed discharge assessments: This allows the user to append follow-up information to assessments that have

either been accepted by CMS or filed. Users do not require any other IRF-PAI privileges in order to add follow-up data to assessments.

User can lock assessments (in preparation for transmission to CMS): This gives the user the ability to lock assessments against any edits, either in preparation for transmission to CMS or to prevent any changes.

> ***NOTE:*** If the user will be transmitting assessments to CMS, they should be given this privilege.

User can unlock assessments: This gives the user the ability to re-open locked assessments for further edits.

> ***NOTE:*** If the user will be transmitting assessments to CMS, they should be given this privilege.

User can receive late transmission warning messages: This designates a user to receive warnings issued by the eRehabData system alerting the user about discharge assessments that are approaching their CMS transmission due date. Messages are issued to all users with this privilege for assessments that haven't been marked as Accepted by CMS as of 16 days past the discharge date entered. If any assessments have still not been marked as Accepted by CMS as of 18 days past discharge, all facility and organization administrators are automatically alerted as well.

Data Upload/Download Privileges

User can download assessments from all facilities in their organization: This gives the user the ability to download patient assessment data for any facility in their organization from the eRehabData system to their local computer. This privilege is only applicable to users belonging to an organization that has more than one subscriber facility on eRehabData, and can only be assigned by an eRehabData organization administrator.

User can download assessments from their facility: This gives the user the ability to download any or all of their facility's patient assessment data from the eRehabData system to their local computer. This privilege is necessary if the user will be creating files to transmit to CMS or if they will be downloading assessment data to keep as a local back up or for import into another software application.

User can upload assessments to eRehabData: This gives the user the ability to upload patient identification data, full assessments, follow-up assessments and patient satisfaction surveys to the eRehabData system for use in creating or updating assessments on eRehabData without manually keying in assessment information.

Outcomes Reports Privileges

User can view all outcomes reports for all facilities in their organization (includes all facilities): This privilege allows a user to view eRehabData outcomes reports for all facilities under their organization. This privilege is only applicable to users belonging to an organization that has more than one subscriber facility on eRehabData, and can only be assigned by an eRehabData organization administrator.

User can view all outcomes reports for their facility: This privilege allows a user to view eRehabData outcomes reports for their facility including patient satisfaction outcomes reports where enabled.

User can ONLY view Patient Satisfaction outcomes reports for their facility: This privilege allows users without outcomes reports privileges to view their facility's patient satisfaction survey outcomes.

> ***NOTE:*** This privilege is not necessary if the user has the privilege "User can view all outcomes reports for their facility".

Notification Privileges

User can receive physician notification emails: This privilege allows a user to receive email notifications when Pre-Admission Screening (PAS) Tool assessments are ready for their review and signature. When users with this privilege are notified about a pending referral, the email they receive will contain a special link which, when clicked, directs them to the Simple PAS, a simplified version of the PAS Tool. The Simple PAS displays all of the information entered into the PAS Tool as read-only, and allows the user to indicate a rehabilitation disposition (Accepted, Re-screen, or Denied); type in notes; and sign the PAS Tool. The Simple PAS was designed specifically for use on small mobile devices.

User can receive admissions office notification emails: This privilege allows a user to receive email notifications when Pre-Admission Screening (PAS) Tool assessments require their input or review. When users with this privilege are notified about a pending referral, the email they receive will contain a special link which, when clicked, directs them to the fully functional PAS Tool.

> ***NOTE:*** No patient data is sent in the emails. Instead, a special link is provided which directs the user to the correct record in eRehabData when clicked. A valid email address AND either facility-level IRF-PAI view/create/edit privileges OR create/edit pre-admission assessments only privileges are required in order for a notification privilege to be assigned.

Special Limited Privileges

User can create / edit pre-admission assessments only: This allows users who do not have the privilege "User can create/edit IRF-PAI assessments" to create pre-admission assessments.

> ***NOTE:*** This privilege is not necessary if the user has the privilege "User can create/edit IRF-PAI assessments", and cannot be combined with other special IRF-PAI privileges such as "User can create/edit patient satisfaction surveys only".

User can create / edit patient satisfaction surveys only: This allows users who do not have the privilege "User can create/edit IRF-PAI assessments" to enter patient satisfaction survey results. Such users will be able to view assessment data only for the surveys they are entering but they will not be able to change any assessment data other than the patient satisfaction survey responses. If the user needs to print surveys for distribution to patients, they will also need the privilege "User can view all assessments for their facility (includes all sites)."

> ***NOTE:*** This privilege is not necessary if the user has the privilege "User can create/edit IRF-PAI assessments", and cannot be combined with other special IRF-PAI privileges such as "User can create/edit pre-admission assessments only".

Once you have entered all of the user account information and made your privilege selections, click **Save** to create the account and return to the Manage Facility screen.

2. Custom Data Fields

Organization administrators can create and manage custom data fields for all of the facilities in their organization. These fields can be used to store patient or other information that is not part of the IRF-PAI itself, such as patient contact information or physician name. For instructions on creating and managing custom data fields, please refer to the "Custom Data Fields" section of this manual under "Facility Administrator Features".

V. IRF-PAI FEATURES

V.A. The IRF-PAI on eRehabData: General Information

Following is some general information about the IRF-PAI on eRehabData. If you will be working on patient assessments on eRehabData it is recommended that you review both this section and the sections on individual assessment types that follow.

Below is a table of contents for the IRF-PAI Features section of this user manual with links to the respective subsections. This section is structured as follows:

ACCESSING PATIENT ASSESSMENTS

Access to the IRF-PAI screens on eRehabData is controlled by a combination of user privileges. All information about the IRF-PAI screens in this section is provided assuming the highest level

of privileges. If you don't see all of the buttons, screens, or functions described in the following text, you most likely do not have the privileges necessary to view or do what is described. If you believe you do not have the privileges you require in order to perform your assessment duties, contact one of your eRehabData facility administrators and ask them to adjust your user permissions.

CREATING NEW ASSESSMENTS

PRE-ADMISSION ASSESSMENTS

You can create pre-admission assessments by clicking **Pre-Admit** on your eRehabData home page or by uploading an Offline PAS Tool record.

ADMISSION ASSESSMENTS

You can create admission assessments four ways: by clicking **New Admission** on your eRehabData home page; by clicking the **Admit** button on pre-admit assessments; by clicking **Accept** on waiting assessments uploaded to eRehabData using the "Assessment ID Data Upload"; or by uploading partial or complete admission assessment records to eRehabData using the "IRF-PAI Import".

DISCHARGE ASSESSMENTS

You can create discharge assessments two ways: by clicking the **Discharge** button on the **MGMT** screen of an admission assessment; or by uploading partial or complete discharge assessment records to eRehabData using the "IRF-PAI Import".

EDITING EXISTING ASSESSMENTS

To view or edit existing assessments, click on the patient name in your in-progress assessments lists on your eRehabData home screen. For more information on locating assessments on your home screen please see the "Displaying Patient Assessments on the eRehabData Home Screen" section of this manual.

WORKING IN MULTIPLE BROWSER WINDOWS OR TABS

Your web browser can only track one patient record at a time. If you attempt to open multiple patient records in separate browser windows or tabs, you will see a **Multiple Windows Warning** message that will prevent you from opening more than one record simultaneously or visiting the CMS Transmit File screen while you have a record open in another tab or window. If you get a Multiple Windows Warning message, you should locate all windows or tabs open to eRehabData, click the **HOME** button on each of those, and then close all but one. If that does not clear the Multiple Windows Warning message, you will need to click the **LOG OUT** button in the top navigation bar and then login again. To avoid these problems, **only work in one browser window or tab at a time.**

AN IMPORTANT NOTE ABOUT SAVING ASSESSMENT DATA

The data you enter into your assessment screens is saved only when you go to another screen or refresh the current screen by clicking the tab corresponding to the IRF-PAI or PAS Tool section you are on. For example, if you are on the FIM screen entering FIM scores, you can save your entries by clicking the **FIM** tab to refresh that screen, or by clicking another tab, the **NEXT** button at the bottom of the screen, **HOME** or even **LOG OUT** to leave the screen.

> ***NOTE:*** It is important to remember that the information isn't saved as you type into each field, but only once you click a tab or button on eRehabData. To illustrate, let's say you are entering FIM scores onto the FIM screen and you are called away from

your desk. You leave without logging out of eRehabData. You are gone long enough (approximately 2 hours) that the system automatically logs you out, ending your user session.

In this case, if before you left your desk, you clicked the **FIM** tab to save your data to the FIM screen, your scores will be saved even though your user session timed out. If you didn't click the **FIM** tab (or another tab or button) to save your data, when you return you will still see the scores you entered displayed on the FIM screen but because your session timed out, when you next click your mouse you will be redirected to the login screen and the scores you entered will be lost.

IRF-PAI SECTION LAYOUT AND COLOR CODING

Each user can configure the IRF-PAI screen display to either show each section of the IRF-PAI on a separate screen or use the combined screens setting to display multiple sections at a glance. The combined screen setting combines the Identification, Admission, and Payer Information sections onto one screen; the Medical Information and Needs sections onto one screen; and the Function Modifiers and FIM sections onto one screen. For more information on configuring this setting please see "Functional Settings" under the "User Features" section of this user manual.

The colored flags next to the tabs for each section indicate the completion status of each section, with green indicating that nothing more is required for that section and yellow indicating that some required information is missing. Red flags are displayed after you click the **Complete** button on the **MGMT** screen to highlight sections that still need attention.

IRF-PAI TABS (NAVIGATION)

The IRF-PAI screens on eRehabData have a unique navigation scheme as compared to the rest of the eRehabData site. While in an IRF-PAI record you'll see a list of tabs on the left side of the screen, displayed next to colored flags. Each tab corresponds to a section or sections of the IRF-PAI, with the exception of the Mgmt, FIM Log, Facility, eRD, Flw-Up, Appeals, Files, RPF and Metrics tabs. Click on a tab for an IRF-PAI screen to go directly to that section of the IRF-PAI.

The non-IRF-PAI section screens allow you to collect additional information and perform various functions on the assessment records. These tabs and their functions are as follows:

Mgmt (Management) Tab

The assessment management screen is the starting point for all functions you can perform on an assessment. Clicking on an existing assessment from your eRehabData home screen brings up the management screen for that assessment, or you can use the **MGMT** tab from within an assessment to get to the management screen.

The top of the management screen displays some general information about the record you are viewing, including Medicare #, Birth Date, and the record Status (e.g. Incomplete, Complete, etc.). Below that is a list of buttons you can use to do such things as print the assessment or check for errors among other things. The list of function buttons changes depending on the kind of assessment, the assessment status, and your user permissions. The complete list of all possible buttons on the management screen and their functions is as follows:

Print: *On the PAS Tool*, click **Print** to pop up a window from which you can print a PDF version of all of the PAS Tool data entered. *On an IRF-PAI*, click **Print** to pop up a window from which you can print a text version of the IRF-PAI on two pages.

Print PDF: Click **Print PDF** to pop up a window from which you can print a pdf version of the IRF-PAI on three pages. This format follows the layout in the final rule and requires Adobe Reader software in order to view and print.

Print Metrics: Click **Print Metrics** to pop up a window from which you can print the Metrics screen. Two versions of the Metrics screen are available for printing: 1) the standard Metrics screen, which includes national and regional comparisons and an optional FIM score graph and prints out on up to three pages, and; 2) the alternate Metrics screen, which excludes national and regional comparisons, reimbursement information and the graph, and is designed print out on one page. For information on configuring which version is printed using **Print Metrics** please see **Functional Settings** under the "My Account " section of this user manual.

Accept (for Waiting Assessment): On waiting assessments, use the **Accept** button to accept the record into the system and create an admission assessment record from the waiting assessment.

Complete: Click **Complete** to run a completion check on the assessment. If the assessment is complete (i.e. for the type of assessment, no required information is missing), the complete button disappears and the assessment status changes to complete. If the assessment is NOT complete, flags next to the tabs representing the sections with missing or incomplete data turn red and a list of all missing information is displayed.

Lock: Click **Lock** to prevent users from making any changes to the record. All assessments being transmitted to CMS must be completed and locked.

Unlock: On a locked assessment, click **Unlock** to open the record up for edits again.

File: On completed and locked assessments that are either non-Medicare or Medicare secondary payer assessments that are not being transmitted to CMS, click **File** to file the record and remove it from your In-Progress assessments list.

Unfile: On filed assessments, click **Unfile** to bring the record back into your In-Progress assessments list.

Re-Screen: On PAS Tool assessments, click **ReScreen** to create another PAS Tool assessment attached to the originating PAS Tool assessment, to be used to capture updates or changes in the patient's condition in subsequent screenings prior to admission.

Duplicate PAS Tool Assessment: On PAS Tool assessments or IRF-PAIs that began as PAS Tool assessments, click **Duplicate PAS** to create a completely separate PAS Tool assessment for a new admission. This is especially useful in cases where a patient is initially denied but then rescreened later for admission, or when a patient leaves the facility and doesn't return within the 3-day interrupted stay window. When you click **Duplicate PAS**, a list of checkboxes appears which allows you to control which sections from the previous screening will copy forward to the new one. Users with organization-level administrator privileges can also use this functionality to copy a PAS Tool assessment from one facility to another. Note that in these cases, the original PAS Tool assessment will need to be manually deleted from the originating facility.

Admit: *On a pre-admit assessment*, click **Admit** to create an admission assessment from the pre-admit record. *On a discharge assessment*, click **Admit** to edit information entered on the admission assessment.

Discharge: *On an admission assessment*, click **Discharge** to create the discharge record, move the assessment from the Admission Assessments table to the Discharge Assessments table, and begin entering discharge data. *On a discharge assessment*, click **Discharge** to return to entering discharge data after you have been editing previously-entered admit data (see **Admit** below for more information).

Forward: The **Forward** button allows you to forward the assessment as an attachment to another eRehabData user at your facility through the secure eRehabData internal messaging system. This is a HIPAA-compliant means by which you can draw someone's attention to the record, as opposed to regular email which is not secure and could potentially be intercepted in transit. For more information on the eRehabData messaging system please see the "eRehabData Messaging System (Send Message)" section of this manual.

Attach Files: Click **Attach Files** to access a screen that will allow you to upload files to eRehabData for storage with an assessment record. The eRehabData document repository allows you to store files such as Word documents, .pdfs, scanned images of other documents, or any other file or document in electronic format that you want to store with the assessment record on eRehabData. Uploaded files are not subject to any processing or importing like the other eRehabData uploads.

Deny: On pre-admit assessments, click **Deny** to access the reason for denial screen. This screen checks the pre-admit assessment for values present in the fields included in the eRehabData referrals outcomes reports. Any missing or incorrectly configured fields will be listed. You can either input data into those fields or select a reason for denial and click **Deny**, or you can delete the pre-admit by clicking **Delete**.

Edit Denial: On denied pre-admission assessments, click **Edit Denial** to modify the denial date and/or reason for denial, then click **Update** to save your changes.

Undeny: To revert a denied pre-admission assessment back into an active pre-admission assessment, first click **Edit Denial**, then click **Undeny**.

Correct: On an assessment that has been sent to CMS and marked as Accepted by CMS, click **Correct** to open up the record for edits that you will re-transmit to CMS. Clicking **Correct** automatically increments the correction number on an assessment. eRehabData automatically generates an invalidation record to accompany a correction when one is required.

> ***NOTE:*** **Correct** is intended for use only on assessments Accepted by CMS but requiring correction and retransmission to CMS. If an assessment was accidentally marked as Accepted but was in fact Rejected by CMS, you will need to use the **Advanced** button to change the assessment status from Accepted to Incomplete (In-Progress). See **Incomplete** under **Advanced** below for more information. Do not use **Correct** to edit facility custom information or 60% rule compliance questions.

Activate Appeals: On an assessment that has been sent to CMS and marked as Accepted by CMS, click **Activate Appeals** to log an Additional Documentation Request and create a record of payment denials and appeals on an individual assessment.

Delete Appeal: On an assessment with an existing appeal record, click **Delete Appeal** to delete all denial/appeal information entered.

Follow Up: On either Completed and Filed or Accepted by CMS assessments, click **Follow Up** to create a follow-up assessment.

Delete: Click **Delete** to delete an unlocked assessment. **Delete** deletes all information entered for an assessment and should not be used to try to delete just a discharge record, for example in cases where a discharge becomes an interrupted stay. See **Revert** under **Advanced** below for more information.

Tracking: Click **Tracking** to display a list of all of the eRehabData users who have accessed the assessment, along with the screens they visited, when the screens were visited, and whether any data were saved to a screen. **Tracking** is only available to users with facility administrator privileges.

Advanced: The **Advanced** button gives you access to four specific functions and is generally only used when a mistake was made in processing an assessment using normal workflow channels. **Advanced** is only available to users with either facility administrator privileges or non-fac admin users who have been specifically granted permission to perform advanced maintenance functions. The advanced functions are as follows:

Include/Exclude: On admission or discharge assessments that did not begin as pre-admission assessments in eRehabData, click **Include** to include them in the Referrals Outcomes reports. To exclude individual assessments from the Referrals Outcomes, click **Exclude**.

Incomplete: On assessments that have been marked as Accepted by CMS, click **Incomplete** to move the assessment back into the In-Progress assessments list and change the assessment's status back to Incomplete. This button should only be used when an assessment was marked as Accepted by CMS in error on the CMS File Transfer screen.

Accept: On Medicare assessments that have been marked Completed and Locked, click **Accept** to manually mark the assessment as Accepted by CMS. This button should only be used when an assessment was marked as Rejected in error on the CMS File Transfer screen, or when the **Correct** button was clicked in error.

Decrement/Increment: If the **Correct** button was clicked in error on an Accepted by CMS assessment, click the **Decrement** button to subtract one from the correction number. If you need to increase the correction number, click **Increment**.

Revert: On a discharge that became an interrupted stay, use the **Revert** button to move the assessment record from the discharge assessments table back into the admit assessments table.

> ***NOTE:*** When you revert a discharge assessment back into an admission assessment, any discharge information entered into the assessment will be lost.

Pre Adm Tab

On a pre-admission assessment, the **PRE ADM** tab allows you to access the pre-admission data entry screen. When present on an IRF-PAI, the **PRE ADM** tab allows you to view the information that was entered on the pre-admission screening.

FIM Log Tab

For information on the FIM Log screen please see the "FIM Log" section of this user manual.

Custom Tab

If your eRehabData facility administrator has created any custom data fields to track information not entered as part of the IRF-PAI itself, your assessments will include a **CUSTOM** tab, which you can click on to enter your custom data.

eRD Tab

The eRD (eRehabData) screen tracks 60% rule compliance information, and also displays the CMS Transmission Date on assessments that have been marked Accepted by CMS. For more information on the eRD screen please see the "60% Rule Calculations (eRD Tab)" section below.

Flw-Up Tab

If you have added a follow-up assessment to an assessment using the **Follow Up** button on the **MGMT** tab, click the **FLW-UP** tab to view or edit the follow-up assessment information. To create multiple follow-up assessments, click the **FLW-UP** tab and then click **New Follow-Up Report** in the "Available follow-up reports" table at the top of the screen. To delete an existing follow-up assessment, click the **FLW-UP** tab, click the Assess. Date for the record you want to delete in the "Available follow-up reports" table at the top of the screen, click **Delete Current Follow-Up**, then click **OK**.

Appeals Tab

If you have created a payment denials/appeals record on an assessment using the **Activate Appeals** button on the **MGMT** tab, click the **APPEALS** tab to view or edit the information entered. For more information on creating and editing payment denials and appeals records please see the "Appeals Tracking" section of this user manual.

Files Tab

If you have uploaded any files to an assessment using the **Attach Files** button on the **MGMT** tab, click the **FILES** tab to review your uploaded files or upload new files.

P.S.I. Tab.

If your facility has subscribed to the eRehabData Patient Satisfaction System, your assessments will include a **P.S.I.** (Patient Satisfaction Instrument) tab. Click **P.S.I.** to access the patient satisfaction survey screens. For more information on the Patient Satisfaction System and instructions on entering patient satisfaction survey data please see the "eRehabData Patient Satisfaction System" section of this manual.

Metrics Tab

Once you have entered enough information into an assessment for a CMG calculation, the Metrics screen displays clinical and reimbursement information as well as clinical comparisons for the assessment in a series of tables. In general order, those tables are described as follows:

RIC/CMG Table: This table lists the assessment's IGC, RIC, CMG, tier, HIPPS code, 60% rule conditional and presumptive compliance status, and FIM totals.

Assessment Dates Table: This table displays DOB, admit and discharge dates, and patient age at admit.

Length Of Stay Table: The patient's LOS is displayed in the highlighted tier row of the Patient column. If no discharge date has been entered the LOS is followed by an asterisk indicating that the number displayed is a running LOS. Facility, Region and Nation columns display average LOS for each tier calculated from the eRehabData database. The Final Rule column displays the average LOS for each CMG and tier from the final rule.

Medicare Pricer Table: Federal Rate, Facility Adjusted Payment, Transfer per Diem (on admit assessments), Transfer Payment (on discharge transfers) and Payment Weight are displayed for each tier. Your facility adjuster for the assessment time period is displayed on the left side of the table and the assessment's High Cost Outlier Threshold amount is displayed at the bottom.

> ***NOTE:*** If no facility adjuster is configured for this assessment time period, the facility adjuster column will display an adjuster of 1.000 (not configured) and no facility adjusted payment will be displayed. For more information on configuring facility adjusters please see "Configuring Facility Adjusters" in the "Facility Administrator Features" section of this manual.

Comorbidities Table: This table displays all comorbidities entered along with their tier assignments and RIC exclusion status.

CMG Tiers Table: This table displays the tier distribution percentages for the patient's CMG in your facility, your region, and the nation.

Discharge Setting % Table: This table displays discharge destination distribution percentages by tier for your facility and region, and for the nation.

% Transfer Patients Table: This table displays transfer patient percentages by tier for your facility and region, and for the nation.

Current Assessment FIM Scores Table: This table displays FIM subtotals, FIM Totals, Admit and Discharge FIM scores, FIM Goals, and FIM Gain for the assessment record alongside FIM averages for your facility and the nation.

FIM Graph: At the bottom of the Metrics screen, the FIM Graph displays a line graph of FIM scores. The graph can be configured to include any combination of patient admit, discharge, goal, and gain measures, facility average admit, discharge, and gain measures, and national average admit, discharge, and gain measures. Use the **Graphs Options** link below the graph to configure the display. You can also disable the graph display using the "Disable Graph" checkbox under the **Graph Options** link.

You can display and print metrics screens for multiple in-progress assessments using the Multi-Metrics screen. More information on multi-metrics is available in the "Multi-Metrics" section of this user manual.

ASSESSMENT WARNINGS, ERRORS, AND COMPLETION CHECKING

The IRF-PAI data entry screens on eRehabData include a variety of built-in checks which look for data entry problems ranging from simple typos such as invalid dates or IGCs, to logic routines such as verifying that a FIM score entered matches the lowest corresponding Function Modifier score. Some problems trigger a warning message alerting the user to review the

suspect data. Other problems trigger errors that will not allow data to be saved at all. In both cases, a message is displayed at the top of the screen detailing the problem encountered.

Error messages are displayed at the top of the assessment screens with a red header when either an invalid value has been entered or the **Complete** button has been clicked on the **MGMT** tab. Errors will prevent an assessment from being marked as complete.

Warning messages are displayed at the top of the assessment screens with a gray header when any information triggering a warning has been entered. Warning messages do not prevent the completion of an assessment and the display of these messages can be hidden by clicking the **Hide** link at the top of the assessment screens. Hiding the warning messages on one assessment will hide them for all assessments until you click the **here** link at the top of the assessment screens to display the warnings again.

CMS has two sets of requirements for data: the minimum data set that must be present in order for a record to be accepted into the QIES ASAP database; and the data set required under the IRF Quality Reporting Program. If any items belonging to the CMS minimum data set are missing from a record in eRehabData, you will not be able to complete and send the record to CMS until the missing information has been entered.

eRehabData's requirements for completion of the IRF-PAI follow the CMS submission specifications for IRF-PAI data, with these exceptions:

> **Discharge to Living Setting (Item 44d):** CMS does not require that this field be completed. However, since this value can affect reimbursement, eRehabData requires it in order for an assessment to be considered complete.
>
> **Facility Custom Data Fields (optional):** Your eRehabData facility administrator can create custom fields to track information that is not collected as part of the IRF-PAI itself. These fields appear under the **CUSTOM** tab on each assessment and can be made required so an assessment won't be considered complete until the required custom fields have been filled out.

CMS has two sets of requirements for data: the minimum data set that must be present in order for a record to be accepted into the QIES ASAP database; and the data set required under the IRF Quality Reporting Program. If any items belonging to the CMS minimum data set are missing from a record in eRehabData, you will not be able to complete and send the record to CMS until the missing information has been entered.

Items belonging to the QRP dataset can be omitted. However, failure to submit QRP items may result in a 2% across the board reimbursement penalty for your facility for the applicable QRP year. For records that must be transmitted with incomplete QRP items, eRehabData offers an override checkbox that appears on the **MGMT** tab when you click **Complete**. If any QRP items have not been completed, you will see a warning message like this:

> **CMS IRF Quality Reporting Program data are missing. Warning:**
> This may result in Medicare payment reductions for your facility:
>
> •(missing QRP items listed here)

☐ Check this box to override eRehabData completion checking for incomplete fields that CMS has identified as required to preserve full Medicare reimbursement in the CMS IRF Quality Reporting Program. This may result in Medicare payment reductions for your facility.

Notes:

To complete an assessment with missing QRP data, check the override box in the warning message and use the "Notes" field to record the reason the QRP data are missing. The notes entered here will be available for review on the upcoming QRP Override Report.

An additional set of checks compares the combination of etiologic diagnosis and impairment group code entered on an assessment to combinations appearing in Appendix B of the IRF-PAI training manual and combinations in the eRehabData assessments database, looking for inconsistencies or anomalies. These checks are explained in detail in the help documentation available on the eRehabData website here: https://web2.erehabdata.com/erehabdata/help/IGC_diagnosis_warning.htm.

eRehabData also performs an analysis of admission FIM scores entered to help identify potential FIM data entry errors or unusual groups of FIM scores. This analysis is explained in detail in the help documentation available on the eRehabData website here: https://web2.erehabdata.com/erehabdata/help/FIMProgressionHelp.htm.

DATA ENTRY TIPS

Here are some tips for entering data into the IRF-PAI screens on eRehabData:

•While entering data on assessment screens, you can use the Tab key on your keyboard to tab to each input field.

•In numeric drop-down lists such as FIM scores, you can use the number keypad on your keyboard to select the number, or use the up and down arrows to scroll up and down through the drop-down list. When you arrive at your desired selection, hit Tab to move on to the next field.

•If you tab to radio buttons or check boxes you can use the Space bar on your keyboard to select the radio button or check the checkbox.

•When you tab to a button, for example the **Next** button at the bottom of an IRF-PAI screen, you can hit Enter on your keyboard to effectively click the button.

IRF-PAI TOOLS

The IRF-PAI screens on eRehabData have a variety of built-in tools to assist you with data entry. These tools include:

IGC list: Under IRF-PAI item #21 Impairment Group on the Medical Information screen is the **Valid Codes** link, which when clicked pops up a window that lists all Impairment Group Codes. You can then click on a code to move that code into your IGC box and close the pop-up window.

IGCs by RIC: Under the Valid Codes link on the Medical Information screen is the **IGCs by RIC** link, which when clicked pops up a pdf document that lists all Impairment Group Codes grouped by the RICs they belong to.

ICD Search: Under IRF-PAI Items #22 Etiologic Diagnosis and #24 Comorbid Conditions is the **ICD Search** link, which when clicked pops up a window that allows you to search for

ICD codes by either part of the code or by description. A ? HELP icon on the search window includes some instructions for various ways you can search for codes or descriptions.

BMI Calculator: Under IRF-PAI item #24 Comorbid Conditions is the BMI Calculator link, which when clicked pops up a window where you can enter a patient's height and weight and calculate their BMI. This is useful for determining whether a patient qualifies as morbidly obese or, in certain cases, conditionally compliant with the 60% rule.

Disable ICD Checking: Under IRF-PAI item #24 Comorbid Conditions is the Disable ICD Checking checkbox. The list of ICD codes that eRehabData refers to when checking for valid codes may not be a fully comprehensive list. If you believe a code you have entered is valid but the eRehabData system disagrees with you, you can disable the ICD code validation for an individual assessment by checking the Disable ICD Checking checkbox. This will allow you to enter codes that eRehabData does not recognize.

Top Comorbidities by RIC: Once you have saved an IGC to the Medical Information screen, two lists labeled "Top Comorbidities by RIC" appear at the bottom of the screen. The first list displays the most commonly-scored comorbidities at your facility for patients belonging to the same RIC as the assessment being viewed. Below that is a list that displays the same information for RICs in the nation.

Diagnosis Distribution by Admit IGC: Once you have saved an admission IGC to the Medical Information screen, a list labeled "Diagnosis Distribution by Admit IGC" appears at the bottom of the screen. This list offers a breakdown of the frequency that an etiologic diagnosis code is selected given the Impairment Group Code you entered, in decreasing order of frequency. The list is drawn from all completed and filed or accepted by CMS assessments discharged on or after January 1, 2005, regardless of payer and where patient age at admit is 8 or greater.

IGC Distribution by Diagnosis: Once you have saved an etiologic diagnosis to the Medical Information screen, a list labeled "IGC Distribution by Diagnosis" appears at the bottom of the screen. This list offers a breakdown of the frequency that an Impairment Group Code is selected given the etiologic diagnosis code you entered, in decreasing order of frequency. The list is drawn from all completed and filed or accepted by CMS assessments discharged on or after January 1, 2005, regardless of payer and where patient age at admit is 8 or greater.

Scoring Guidelines: When using the combined IRF-PAI screens, at the bottom of each IRF-PAI section you'll see a **Scoring Guidelines** link. Clicking on that brings up a window which displays the definitions for the various measures and scores for the section you are working on.

IRF-PAI Training Manual: At the bottom of each of the IRF-PAI screens are links to the IRF-PAI training manual which take you directly to the section of the manual corresponding to the section you are on.

Tiered Comorbidities List: On the Medical Information screen below the link to the IRF-PAI training manual is the **List of Comorbidities** link, which when clicked pops up a pdf document that lists all of the tiered comorbidities from the current Final Rule.

60% RULE CALCULATIONS (ERD TAB)

eRehabData calculates two kinds of 60% Rule compliance: Presumptive and Conditional.

Presumptive compliance just looks at the IGCs, Diagnoses and comorbidities entered on the Medical Information screen to determine compliance.

Conditional compliance uses a more strict interpretation of the Final Rule that relies upon both the codes entered in Medical Information and collection of additional information for certain codes that is not part of the IRF-PAI itself.

The eRD screen on each assessment displays information about that assessment's 60% rule compliance status. When additional information is required in order to determine conditional compliance status for an assessment, the flag next to the eRD tab will turn yellow and questions for collecting the relevant additional information will appear on the eRD screen.

More information on the methodology used to determine compliance on eRehabData can be found in this help document:
https://web2.erehabdata.com/erehabdata/help/75percentmethodology.htm

More information on the differences between presumptive and conditional compliance can be found in this help document:
https://web2.erehabdata.com/erehabdata/help/75percentConditionalPresumptive.htm

Links to both of these documents also appear on the eRD screen on each assessment.

FIM LOG

The eRehabData FIM Log allows you to record multiple FIM assessments for any or all FIM measures for up to 3 shifts per day for the 3 days during the admission and discharge FIM assessment periods. The FIM Log automatically identifies the appropriate lowest score for each FIM measure on admit and discharge and allows you to copy over those scores to the FIM section with the click of a button. When you enable the FIM Log a **Copy FIM Log** button will appear on your FIM screen, and you can use that button to transfer the appropriate scores from the FIM Log to the FIM screen.

Use of the FIM Log is optional and is specific to each user, meaning that if one user chooses to use the FIM Log that won't automatically make the FIM Log appear for all other users at a facility. None of the fields on the FIM Log is required. However, if all scores for all shifts are not filled in, the flag next to the FIM Log tab will remain yellow. This will not prevent you from completing the assessment.

For instructions on enabling the FIM Log please see "Functional Settings" under the "User Features" section of this user manual.

How the FIM Log selects which scores to copy over:

Admit Assessment: The most dependent (lowest) score for each measure across all shifts scored will be highlighted in blue. When you click the **Copy FIM Log** button on the FIM screen, the highlighted scores are transferred to the FIM screen.

Discharge Assessment: The most dependent (lowest) score for each measure for each day scored will be highlighted in blue. When you click the **Copy FIM Log** button on the FIM screen, the highlighted score for each measure from the day with the highest score total* is transferred to the FIM screen.

Locomotion mode: When comparing the Walk/Wheelchair FIMs, only the scores recorded for the most frequent mode are considered.

> ***NOTE:*** If all 9 shifts have not been recorded or there are an equal number of measurements made between the 2 most common modes, then the mode of locomotion is ignored and the user will need to check that the Walk/Wheelchair values copied to the FIM tab are correct.

Bladder/bowel frequency of accidents: These measures incorporate a 7-day assessment period and the FIM Log does not account for that, so you may have to manually adjust these scores on the FIM screen.

> ***NOTE:*** If there are FIM scores already on the FIM screen, *clicking* **Copy FIM Log** *will overwrite those scores*. The FIM Log will not copy blank scores over to the FIM screen. No data validation is performed between the FIM Log scores and the Function Modifier scores so you may see warnings about mismatching scores once you copy your scores over and save them to the FIM screen.

Score totals are calculated as follows:

Admit total*: The most dependent (lowest) score for each measure across all shifts is used to calculate the daily total. These scores are highlighted in blue. When admit scores are copied to the FIM screen, these are the ones copied.

Discharge total*: The most dependent (lowest) score for each measure recorded for each day is factored into the daily total and then shown. The highest daily total score is shown in bold. When discharge scores are copied to the FIM screen, the lowest scores from the day with the highest total are copied even if another day has a lower score for an individual measure.

> *****Totals are calculated by treating all 0 scores as 1 and ignoring the Tub/Shower Transfer score in keeping with CMS practice.

V.B. Displaying Patient Assessments on the eRehabData Home Screen

The first screen that you come to when you log in to eRehabData is the eRehabData home screen, also referred to as the launch screen. Users with the privilege to view patient assessments will see assessments lists displayed on this screen. You may see rows of patient names displayed in different tables labeled **Waiting Assessments**, **Pre-Admit Assessments**, **Admit Assessments**, and **Discharge Assessments**. The display of each table is controlled by a checkbox. If you see one of the table labels displayed with no assessments appearing below it, check the box to display the assessments. The screen will automatically refresh if you check or uncheck a checkbox to show or hide a table.

> ***NOTE:*** You may not see all of the assessments tables if you do not have at least one of each type of assessment.

In addition to the checkboxes, a number of other user-selectable options control which assessments are displayed, how many assessments are displayed per list, and what information is displayed for each assessment. These options appear as drop-downs, input boxes, and a **List Options** link in the box below all displayed assessments. The options you select are applied to all available assessments tables and can be used in any combination. The options are also “sticky”, meaning that the eRehabData system will remember which options you selected the last time you logged out and apply those selections the next time you log in.

> ***NOTE:*** The options you select will not be permanently saved for future eRehabData sessions until you log out, so if your session expires before you click **LOG OUT**, you will need to repeat your selections the next time you login.

If you have trouble finding the assessments you expect to see on the home screen, review your display options to make sure the selections are correct for what you intend to display. The options are as follows:

DISPLAY OPTIONS

Show: The "Show" option includes two drop-downs which are used together.

The first "Show" drop-down controls the assessments displayed by status. Assessment status options include:

- *In-Progress (Incomplete only):* Select this to display only assessments that haven't passed the eRehabData completion check.
- *In-Progress (Complete only):* Select this to display only assessments that have passed the eRehabData completion check.
- *In-Progress:* Select this to display Incomplete AND Complete In-Progress assessments.
- *Accepted by CMS (Medicare):* Select this to display assessments that have been transmitted to CMS and marked as Accepted.
- *Filed (non-Medicare):* Select this to display non-Medicare assessments that have been filed.
- *Either Accepted or Filed:* Select this to display both Accepted by CMS Medicare assessments and Filed non-Medicare assessments.
- *Denied Pre-Admission:* Select this to display Pre-Admission assessments that have been denied admission.

The second "Show" drop-down controls the assessments displayed by owner. These options include:

- *Only assessments I have created:* Select this to display only the assessments that you began.
- *All assessments for my site:* Select this to display assessments created by any eRehabData user at your site. This is only applicable if your facility has more than one site sharing the same Medicare provider number. Site assignment at this level is controlled by user login, not any custom data fields.
- *All assessments for my facility:* Select this to display assessments created by any eRehabData user at your facility. This option is only available to users who have the privilege "User can view all assessments for their facility (includes all sites)."

Sort assessments by: This option also includes two drop-downs which are used together.

The first "Sort" drop-down specifies what value the assessments lists should be sorted by. Sort options include:

- *CMG:* Sorts the assessments by CMG.
- *Date Admitted:* Sorts the assessments lists by admission date, IRF-PAI field #12.
- *Date Created:* Sorts the assessments by the date the record was first created in eRehabData.
- *Date Denied:* Sorts the assessment by the date the pre-admission screening was marked as denied. Only applicable to pre-admission assessments.
- *Date Discharged :* Sorts the assessments by discharge date, IRF-PAI field #40.

- *Date Transmitted:* Sorts the assessments by the date they were marked as Accepted by CMS.
- *Impairment Group:* Sorts the assessments by IGC, IRF-PAI field #21.
- *Medicare Number:* Sorts the assessments by Patient Medicare Number, IRF-PAI field #2.
- *Patient ID Number:* Sorts the assessments by Patient ID Number, IRF-PAI field #5b.
- *Patient Name:* Sorts the assessments by patient last name, IRF-PAI field #5a.
- *Payer:* Sorts the assessments by primary payer, IRF-PAI field # 20A.
- *RIC:* Sorts the assessments by RIC.
- *SSN:* Sorts the assessments by Social Security Number, IRF-PAI field #7.
- *Warnings:* Sorts the assessments by the presence of eRehabData FIM progression or IGC/Etiologic Diagnosis combination warnings.

The second "Sort" drop-down controls whether your sort value is listed in ascending or descending order.

- *Ascending:* Select this to sort your assessments in ascending order. For example, if you are sorting your assessments by CMG, the assessments with no CMG will appear first, followed by CMG 0101, then all the way up to CMG 2101.
- *Descending:* Select this to sort your assessments in descending order. For example, if you are sorting your assessments by Discharge Date, the most recent discharges will appear first.

NOTE: The sort options above work as a master sort control over all of your assessments lists. Alternatively, you can click on a column header at the top of an assessments list to sort that list of assessments by the selected column. Click the header once to sort the list based on the selected column in ascending order; click the header a second time to sort the list in descending order.

Restrict to: Depending upon your selections in this section, this option includes three drop-downs and up to three input boxes.

The first "Restrict to" drop-down allows you to display assessments from a date range by selected assessment date. Assessment date options include:

- *Admitted:* Select this to apply your date range to assessments admitted during the date range.
- *Discharged:* Select this to apply your date range to assessments discharged during the date range.
- *Created:* Select this to apply your date range to assessments created during the date range.
- *Transmitted:* Select this to apply your date range to assessments marked as Accepted by CMS during the date range.
- *Denied:* Select this to apply your date range to pre-admission assessments marked as Denied during the date range.

The second "Restrict to" drop-down controls the date range filter applied to your selected assessment date. Date ranges include:

- *None (blank):* Select this if you do not want to restrict your assessments lists to any date type (e.g. admit date) or range.
- *Custom:* Select this to enter your own date range. If you select this option, two additional input boxes will appear for you to enter your start and end dates. Enter your start and end dates and then click **Enter**.

The remaining options allow you to list assessments that have either been admitted, discharged, created, or transmitted (marked as Accepted by CMS) within a specified time period. Those periods include:

- *Last 90 days*
- *Last 365 days*
- *Cal Yr 2002 - Present*

The third "Restrict to" drop-down lets you search for assessments by hand-entered values applied to one of four IRF-PAI fields, and is used in conjunction with the "starting with" input box to its right. Searchable IRF-PAI fields include:

- *Last Name:* Select this to search for records by Patient Last Name, IRF-PAI field #5a.
- *Patient ID:* Select this to search for records by Patient ID Number, IRF-PAI field #5b.
- *Medicare #:* Select this to search for records by Patient Medicare #, IRF-PAI field #2.
- *SSN:* Select this to search for records by Social Security Number, IRF-PAI field #7.

Once you have selected your IRF-PAI field, type your search string into the "starting with:" input box and click **Enter**.

Facility-Specific: If your facility has any facility-specific (custom) fields that have been configured as drop-downs, you can display assessments based on the facility custom values. Using the "Facility-Specific:" drop-down, select your facility custom field. Another drop-down containing all of the possible values for that field will appear, and you can use that to filter by your custom data field.

Max. # assessments displayed per table: Use this option to control the number of assessments displayed in each assessment list at any one time. Enter a large number to display a lot of information or a smaller number to shrink the vertical size of your home screen. This doesn't limit the number of assessments returned by your search filters and if the total number of records returned exceeds the number you enter in this box, your assessments lists will display links that you can use to page through the records. The default value is 50. To change that, type in your desired maximum number and click **Enter**.

CONFIGURING LIST OPTIONS

The **List Options** feature allows you to specify which IRF-PAI values or calculations are displayed in your assessments tables on the home screen and on the Multi-Metrics screen, and allows you to customize three additional home screen display settings. To access the list options settings, from the bottom of the eRehabData home screen click **List Options**.

On the left side of the List Options screen is a table listing all available display columns. The right side of the list options screen offers several options that control how the home screen assessments tables display and how the home screen refreshes when a change is made to any of the display options.

DISPLAY COLUMNS CONFIGURATION

The column selection and ordering section includes two controls for each column you want to display in your assessments lists. The first is a simple checkbox that determines whether or not the column will appear on your eRehabData home page. If the box next to a column is not checked, that column will not appear on your home page. The second is an input box to the right of the column name that allows you to specify in what order the columns are displayed.

- If a column is added but no order number is entered, it will be appended to the list when the **Save** button is clicked.
- If a column is changed so that its order number is the same as another column, the changed column will be inserted before the unchanged columns.
- If more than one column is added without specifying an order, the new columns will be added at the end of the list in alphabetical order.

> ***NOTE:*** Depending on the type of assessment, some selected display columns will not appear in some assessment tables. For example, the Discharge Date column will not appear in the admit assessments table. Admit and Discharge Dates, Gender, LOS, Payer, and assessment Status (complete, incomplete, etc.) will not appear in the Pre-Admit table.

Individual column information:

Patient Name: This is the default for the link you use to actually select an assessment. If you do not choose to display the patient name, the selection link will default to whatever data is in the first column. If there is no value in that column for an assessment you will not be able to click on that assessment, so make sure that the first column is one that will always have a value, such as Creation Date, if you are not displaying the patient name.

Length Of Stay: If LOS is specified as a display column but there is no discharge date for an assessment, the running LOS will be displayed *in italics* in the LOS column. This means that the value displayed shows how many days have passed since the patient was admitted, not the final LOS.

Final Rule ALOS: The CMG and tier average length of stay as published in the applicable IRF-PPS Final Rule.

Expected Reimb. (Facility Adjusted): Once a CMG has been calculated, this displays the facility-adjusted reimbursement. If no facility adjuster has been configured for the time period covering a particular assessment, the reimbursement will be calculated using an adjuster of 1.

Assessment Status: This displays the status of the record itself. Possible assessment status values are:

Incomplete: This indicates that the **Complete** button was clicked on the assessment, but there is information missing.

Complete: This indicates that the **Complete** button was clicked on the assessment and all required fields have been completed.

Notified: On Pre-Admission Screening (PAS) Tool assessments, this indicates that a physician notification has been sent alerting users with the physician notification privilege that the record awaits physician review.

Signed: On PAS Tool assessments, this indicates that a physician signature is present on the Justification tab.

Locked: The record has been locked. It is available for viewing but no changes can be made unless it is first unlocked.

Locked (xmit: Validated): The record has been validated in Step 1 on the CMS Data Transmission screen. It is locked and cannot be edited without first being processed on the CMS File Transfer screen.

Locked (Xmit: Confirmed): The record has been confirmed in Step 3 on the CMS Data Transmission screen and has been placed into a file for transmission to CMS. It is locked and cannot be edited without first being processed on the CMS File Transfer screen.

Accepted by CMS: The record has been marked as Accepted by CMS.

Filed: The non-Medicare, Medicare-MCO, or Medicare secondary payer record has been Filed.

Denied: On PAS Tool assessments, the record has been denied.

PAS Decision: This displays the result of the PAS review as indicated by the Rehabilitation Disposition field on the Justification tab, and indicates what action should be taken with the record. Possible values are:

Accept: When the Rehabilitation Disposition is “Accepted,” this indicates that the PAS awaits conversion to an admission IRF-PAI record.

Re-screen: When the Rehabilitation Disposition is “Re-screen,” this indicates that a re-screening needs to be performed.

Deny: When the Rehabilitation Disposition is “Denied,” this indicates that the PAS should be denied.

60% Rule Compliant: This displays a “Y” for assessments that are *conditionally* compliant and an “N” for assessments that are not conditionally compliant.

Line Number: If you choose to display line number, each row in your assessments lists will begin with a number representing the row number.

FIM and IGC vs. Diagnosis warnings: This option allows you to display coding and scoring warnings. If an assessment has a warning associated with it, depending upon the warning or warnings you will see any combination of the following codes:

FIM: This indicates that some of the Admit FIM scores entered may be questionable.

IGC: This indicates that the combination of Admit IGC and Etiologic Diagnosis entered is either uncommon or extremely rare.

AppB: This indicates that the pairing of Admit IGC and Etiologic Diagnosis does not appear in the IRF-PAI Training Manual Appendix B.

Assessments can be sorted by the warnings using the “Sort assessments by:” drop-down at the bottom of the eRehabData home screen. If you order assessments by the warnings in ascending order, the warnings will be sorted primarily by FIM, then IGC, then AppB. Within that sorting, assessments will be sorted secondarily by

assessments with three warnings, followed by assessments with two warnings, then one warning.

For more information on the warnings, please refer to these help documents available from the warnings messages on your assessments on eRehabData:

https://web2.erehabdata.com/erehabdata/help/IGC_diagnosis_warning.htm

https://web2.erehabdata.com/erehabdata/help/FIMProgressionHelp.htm

Final Rule ALOS: This displays the average length of stay for the assessment's CMG and tier from the Final Rule.

CMG Base Pay Weight: This displays the payment weight for the assessment's CMG and tier from the Final Rule. This value is used to calculate Case Mix Index for a selected patient population.

ASSESSMENT LISTS SETTINGS

Screen Refresh: To require a **Refresh** button click to refresh the home screen after you've made changes to the display options, select the first radio button. To have the screen automatically refresh each time you change a drop-down selection, select the second radio button.

Codes: To display the numeric code with a text description of the code for IGC, Payer, RIC, and Discharge Setting in your assessments lists, select the first radio button. To display just the numeric code, select the second radio button. This is useful for minimizing the width of your home screen, especially if you are displaying a large number of columns.

Line Separator: To display a distinct line in between each column that visually separates one column from the next in each row, select the first radio button. To display the rows with no lines demarcating the columns, select the second radio button.

When you have made all of your selections on the List Options screen, click **Save** to save your settings. The screen will refresh with a "Changes saved" message at the top. Then click **HOME** to return to the home screen and review your settings.

NOTE: The options you select will not be permanently saved for future eRehabData logins until you log out, so if you allow your session to expire without logging out your changes will be lost.

V.C. Waiting Assessments

Waiting assessments are records created from a patient data file uploaded to the eRehabData system using either the Full Assessment Upload or Assessment ID Data Upload. These records are not yet assessments; they are staged after upload awaiting final acceptance into the system. By clicking on the tabs on the left side of a waiting assessment you can view the information uploaded for an assessment, but waiting assessments cannot be edited other than with subsequent uploads.

To create an admit assessment from a waiting assessment, click the **MGMT** tab on the waiting assessment and then click the **Accept** button. This will move the record from the Waiting Assessments table into one of the assessments tables and open it up for edits. If the record was uploaded using the Assessment ID Data Upload it becomes an admission assessment when it is accepted. If the Full Assessment Upload was used, the record becomes a discharge assessment when it is accepted.

If the record was uploaded in error you can delete it from the **MGMT** tab by clicking on the **Cancel** button.

V.D. Pre-Admission Screening (PAS) Tool Assessments

With the 2010 IRF-PPS Final Rule, CMS mandated that rehabilitation facilities complete a pre-admission screening on all of their patients. The Rule requires that specific information be collected on each patient prior to admission in order to fully establish the medical necessity and appropriateness of the rehab admission. The eRehabData® Pre-Admission Screening (PAS) Tool satisfies those requirements while offering Referrals Outcomes reports which allow you to track referrals, admissions, and denials. It also includes all of the information captured on the original eRehabData pre-admit assessment. For more information about the PAS Tool, please see the documentation located under the 

icon on the PAS Tool screens.

To create a pre-admission assessment, on the left side of your eRehabData home screen click **Pre-Admit**, or upload an Offline PAS Tool. You can use the tabs across the top of the screen that are shown when you're on the **PRE ADM** tab, or the **Next** buttons at the bottom of each screen, to navigate to the different sections of the assessment.

Saving PAS Tool Data/Data Entry Tips

Saving data to the PAS Tool screens works the same as it does for the IRF-PAI. For more information on how to save data, and for some data entry tips, please see "An Important Note About Saving Assessment Data" and "Data Entry Tips" in the IRF-PAI section above.

Physician/Admissions Office Notification System

The PAS Tool on eRehabData includes a notification feature that enables users to notify each other via email when a pre-admission screening requires their attention. The ability to receive notifications is controlled by specific user privileges which identify a user as either a physician responsible for reviewing and/or signing PAS Tools, or an admissions office user responsible for collecting and/or reviewing patient information relevant to a potential admission. No patient data is sent in the email. Instead, a special link is provided which directs the user to the correct record in eRehabData when clicked.

My Notifications

If you have been notified on a PAS Tool, a checkbox labeled "My Notifications" appears on your eRehabData home screen. To display the list of PAS Tools for which you received a notification, check the checkbox. To hide your notifications, uncheck the box.

Users identified as receiving physician notifications are directed to the Simple PAS when they click on a patient name in their "My Notifications" list.

Users identified as receiving admissions office notifications are directed to the fully functional PAS Tool when they click on a patient name in their "My Notifications" list.

After you have been notified on a PAS Tool, the screening remains in your "My Notifications" list until the record has been converted to an admission record, re-screened, or denied.

Simple PAS

The Simple PAS allows users to view an existing PAS Tool assessment in a simplified form that was designed specifically for easy reading on a mobile device. It is viewable by users who have received a physician notification regarding a PAS Tool that is ready for physician review.

The Simple PAS displays all of the information entered into the PAS Tool as read-only and allows a user with the physician notification privilege to indicate a rehabilitation disposition (Accepted, Re-screen, or Denied); type in notes; and sign the PAS Tool.

You can then click the **NOTIFY** button at the top or bottom of the Simple PAS to save your input; generate an automatic email containing the rehabilitation disposition decision to all users who have been notified regarding the PAS Tool; and return to your My Notifications list for mobile devices.

Offline PAS

An offline version of the PAS Tool is available for users with chronic Internet connectivity problems. The offline PAS Tool enables users to create PAS Tool records on a computer that is not connected to the Internet and upload those records to eRehabData when a reliable Internet connection can be established. After an offline PAS Tool has been uploaded to eRehabData, it is immediately available online for any required additional data collection, physician/admissions office notification, review, and/or signatures.

For more information about the offline PAS Tool, please see "Functional Settings" under the "User Features" section of this user manual.

> ***NOTE:*** Use of the eRehabData PAS Tool Offline Form requires the Safari web browser.

Patient Referrals/Denials Tracking

The pre-admission assessments also include a patient referrals/denials tracking feature which is used to generate the eRehabData Referrals Outcomes. This feature is voluntary but it allows you to run reports on admission referrals and denials at your facility.

This feature incorporates the standard IRF-PAI fields Admit From, Primary Payment Source, Zip Code of Patient's Pre-Hospital Residence, and Impairment Group Code, plus two facility custom fields you can configure: Referral Source and Referring Physician. In order for these custom fields to be incorporated into the referrals outcomes, they must be configured for drop-down data entry and must be named exactly as stated. For more information on configuring facility custom fields, please see the "Custom Data Fields" section of this user manual under "Facility Administrator Features". For more information on referrals outcomes reports, please see the "Referrals Outcomes" section of this user manual.

For more information about the screens and functions on pre-admission assessments, please see the "IRF-PAI Tabs (Navigation)" section of this user manual.

To create an admission assessment from a pre-admission assessment, from the **MGMT** tab on the pre-admission assessment click the **Admit** button.

V.E. Admission Assessments

You can create admission assessments four ways: by clicking **New Admission** on your eRehabData home page; by clicking the **Admit** button on pre-admit assessments; by clicking **Accept** on waiting assessments uploaded to eRehabData using the "Assessment ID Data Upload"; or by uploading partial or complete admission assessment records to eRehabData using the "IRF-PAI Import".

The admission assessment allows you to enter all admission IRF-PAI measures. Using the tabs on the left side of the screen or the **Next** buttons at the bottom of each screen you can navigate to different sections of the assessment.

For more information about the screens and functions on admission assessments, please see the "IRF-PAI Tabs (Navigation)" section of this user manual.

For instructions on to how to complete the IRF-PAI, please refer to the CMS IRF-PAI training manual, which can be downloaded from the CMS website here:

For discharges on or after October 1, 2004 and before October 1, 2012:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/irfpai-manual040104.pdf

For discharges on or after October 1, 2012:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/IRFPAI-manual-2012.pdf

To create a discharge assessment from an admission assessment, from the **MGMT** tab on the admission assessment click the **Discharge** button (not the **DISCH** tab).

V.F. Discharge Assessments

You can create discharge assessments two ways: by clicking the **Discharge** button (not the **DISCH** tab) on an admission assessment; or by uploading assessments to eRehabData using the IRF-PAI Import or Full Assessment Upload.

The discharge assessment allows you to enter all discharge IRF-PAI measures. Using the tabs on the left side of the screen or the **Next** buttons at the bottom of each screen you can navigate to different sections of the assessment.

For more information about the screens and functions on discharge assessments, please see the "IRF-PAI Tabs (Navigation)" section of this user manual.

For instructions on to how to complete the IRF-PAI, please refer to the CMS IRF-PAI training manual, which can be downloaded from the CMS website here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html.

In order to prepare a discharge assessment for transmission to CMS, you must first check completion on the file by clicking **Complete** on the **MGMT** screen, fix any errors that are displayed, and then lock the assessment by clicking **Lock** on the **MGMT** screen. As long as the assessment has Medicare or Medicare-MCO listed as primary or secondary payer, it will appear on the CMS Transmit File page for validation and transmission.

V.G. Follow-Up Assessments

Follow-up assessments may be entered for patients who have been discharged. These records are stored with their associated Completed and Filed or Accepted by CMS discharge assessments.

To create a follow-up assessment, from your eRehabData home screen select a discharge assessment that has either been Filed or Accepted by CMS. From the **MGMT** tab, click the **Follow Up** button to create a new follow-up assessment.

> ***NOTE:*** If you do not see the **Follow Up** button on the **MGMT** tab, you will need to contact your facility's eRehabData administrator and ask them to grant you the privilege "User can add follow-up data to accepted / filed discharge assessments."

You can also create follow-up assessments by uploading a file of follow-up assessment records to eRehabData using the "Follow-Up Data Upload". Follow-up assessments are voluntary but eRehabData does generate outcomes reports based on them.

> ***NOTE:*** Only follow-up assessments performed 80-150 days post-discharge are included in the follow-up outcomes reports. For more information on follow-up outcomes reports, please see the "Follow-Up Assessment Outcomes Reports" section of this user manual.

You can add follow-up information to an existing follow-up assessment by clicking on the **FLW-UP** tab of any accepted or filed assessment for which follow-up information has already been entered. You can also create multiple follow-up assessments directly from the Follow-Up Assessment screen by clicking **New Follow-Up Report** on an existing follow-up assessment, then use the assessment date links in the "Available follow-up reports" table at the top of the follow-up screen to view each individual follow-up assessment. You can delete a follow-up assessment by clicking **Delete Current Follow-Up** on an existing follow-up assessment.

If you will be performing a follow-up assessment away from Internet access, you can download a blank follow-up form to fill out here: https://web2.erehabdata.com/erehabdata/help/irfpai_followup_blank.pdf.

V.H. Appeals Tracking

On the Management (**MGMT**) screen on all of your assessments marked as Accepted by CMS in eRehabData is a button labeled **Activate Appeals**, which you can click to log an Additional Documentation Request and create a trail of payment denials and appeals for the assessment. Once created, your denials/appeals tracking screens will be available under a new tab labeled **APPEALS**.

The appeals screen allows you to track claim denials and appeals on individual assessments throughout the entire appeal process, starting with the Additional Documentation/Medical Records Request and going all the way to where your appeal terminates, up to the Federal District Court level. The information entered into this screen is used to generate reports that can be referred to for future claim denials to help ensure that your facility's claims are being processed in a fair and consistent manner.

All fields on the appeals screens are required in order to proceed to the next appeal level. Once you have completed and saved all the fields for one level of an appeal, if another level is indicated the next level will appear in the "Level" drop-down at the top of the screen and you can proceed. You can save your data by clicking on the Appeals tab or any of the IRF-PAI tabs, the **Next:** button at the bottom of the screen, or even the **HOME** or **LOGOUT** buttons.

Appeals created accidentally can be deleted from the Management (**MGMT**) screen of an assessment by clicking the **Delete Appeal** button.

> ***NOTE:*** Deleting an appeal using the **Delete Appeal** button deletes all appeal information entered for all levels. To delete information entered at an individual level of an appeal, erase the information from the input boxes, uncheck any checkboxes, and set drop-downs back to "--select one--" instead.

Following is a level-by-level description of how to step through the appeals process on eRehabData. CMS offers a downloadable brochure explaining the Medicare appeals process which you can find on the CMS website here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf.

LEVEL 1: ADDITIONAL DOCUMENTATION REQUEST (ADR)

The ADR is a correspondence from an FI or RAC after the facility submits a claim. Prior to or after paying a claim, the FI or RAC will review the patient's record to make a decision of whether or not to pay the claim. Each item requested by the FI or RAC as noted in their letter should be copied and sent. It is recommended that a cover letter be included with each packet to explain the case details. The record must be sent within 45 days from the date on the request or other time frame as stated in the FI's or RAC's correspondence or the claim is denied with no further appeal rights - a technical denial.

The fields filled out for this level are as follows:

Date of Additional Document / Medical Records Request Letter: Enter the date on the letter of Additional Documentation Request.

FI or RAC Request: Indicate whether the request was issued by an FI or a RAC.

Which FI / RAC?: Select the FI or RAC that issued the request. Once you indicate whether this is an FI or RAC request, this drop-down will default to the last FI or RAC selected on an ADR for your facility.

Type of Audit: Use this drop-down to indicate whether the audit is an LCD Audit Review, a Probe Audit Review, a Pre-Payment Audit Review, or a Post-Payment Audit Review. If none of these options applies, select "Other". This information may be found on the correspondence from the FI or RAC.

Facility Contact: Select the name of the person managing the denial at your facility who may be available to answer questions.

Days to Respond: Enter the number of days your facility has to respond to the request for documentation as indicated the correspondence from the FI or RAC.

Date Response Submitted: Enter the date that the facility sent the record to the FI or RAC. It is recommended that you send the record via certified mail so the package can be tracked for confirmed delivery.

RAC Notification Date: If your ADR was issued by a RAC, the RAC may notify you of a denial before notifying the FI and allow you 15 days to submit a rebuttal. Enter the notification date into this field. If your ADR was issued by your FI and you selected "FI" under "FI or RAC Request" you will not be able to enter anything into this field.

RAC Rebuttal Date: If you received notification of denial from a RAC, they may allow you 15 days to respond before they notify the FI of the denial. Enter the date you submitted your rebuttal into this field. If your ADR was issued by your FI and you selected "FI" under "FI or RAC Request" you will not be able to enter anything into this field.

Decision Letter Date: Enter the date on the decision letter you received from the FI. The FI should make a determination within 60 days of receiving the record.

Outcome: From the correspondence you received from the FI or RAC, indicate whether the claim was paid in full (Favorable), denied in full (Unfavorable), or partially denied (Partially Favorable).

Reason(s) for Decision: From the correspondence you received from the FI or RAC, select the option(s) that most closely matches the reason(s) for their decision. You can select more than one option. Technical denials are not appealable so if you select that option you will not be able to navigate to the other levels of appeal, but the other reasons for denial are appealable.

Claim Amount: This value defaults to the eRehabData estimated reimbursement for the claim. If the default value does not match the amount calculated by your FI, enter your FI's calculation. Amount Paid plus Amount Denied must equal the Claim Amount.

Amount Paid: Enter the amount paid on the claim. If no payment was received, enter 0. For partially favorable claims, there are no monetary restrictions as to what can be further appealed.

Amount Denied: Enter the amount denied on the claim. If no payment was denied, enter 0.

Elect to end the appeals process checkbox: Check this box if your facility will not appeal an unfavorable or partially favorable decision.

LEVEL 2: REDETERMINATION REQUEST (APPEAL)

This is also known as the appeal. The appeal must be sent within 120 days of the date that the determination letter was written or as per any directions provided in the decision letter. Each item requested by the FI as noted in their letter should be copied and sent. The record is sent again with a letter explaining the patient's circumstances and events of the stay. Many FIs have a standard form that they wish to have included with the redetermination request. It will likely be included or referenced in the correspondence from the FI. Be sure to check your FI's website for this. It is recommended that you send the record via certified mail so the package may be tracked for confirmed delivery. For partially favorable claims, there are no monetary restrictions as to what can be further appealed.

The fields filled out for this level are as follows:

Days to Appeal: Enter the number of days your facility has to appeal the determination as indicated by the FI.

Date Appeal Submitted: Enter the date that the facility sent the record to the FI. It is recommended that you send the record via certified mail so the package can be tracked for confirmed delivery.

Decision Letter Date: Enter the date on the redetermination letter you received from the FI. The FI should make a redetermination within 60 days of receiving the record.

Outcome: From the correspondence you received from the FI, indicate whether the claim was paid in full (Favorable), denied in full (Unfavorable), or partially denied (Partially Favorable).

Reason(s) for Decision: From the correspondence you received from the FI, select the option(s) that most closely matches the reason(s) for their decision. You can select more than one option. Technical denials are not appealable so if you select that option you will not be able to navigate to the other levels of appeal, but the other reasons for denial are appealable.

Claim Amount: This is carried over from the ADR level and displayed on-screen for your information. Amount Paid plus Amount Denied must equal the Claim Amount.

Amount Paid: Enter the amount paid on the claim. If no payment was received, enter 0.

Amount Denied: Enter the amount denied on the claim. If no payment was denied, enter 0.

Elect to end the appeals process checkbox: Check this box if your facility will not appeal an unfavorable or partially favorable decision.

LEVEL 3: RECONSIDERATION REQUEST TO QUALIFIED INDEPENDENT CONTRACTOR (QIC)

If the claim is not paid at the redetermination level, the next step in the appeals process is to appeal to the QIC. This is done through Maximus or First Coast regardless of who your FI is. The FI will forward your case file to the QIC. You should request a copy of what the FI forwards to the QIC from your FI. If you have additional information that will help explain the situation, you should include that as well. This may be a statement from a physician or caseworker that details or explains the medical necessity for the case.

Many FIs have a standard form that they wish to have included with the reconsideration request. It will likely be included or referenced in the correspondence from the FI. Be sure to check your FI's website for this. Reconsideration must be requested within 180 days of the date that the redetermination letter was written by the FI, or as otherwise indicated in the redetermination letter.

The fields filled out for this level are as follows:

Which QIC?: Select First Coast or Maximus.

Days to Appeal: Enter the number of days your facility has to appeal the redetermination as indicated by the FI.

Date Appeal Submitted: Enter the date that the facility sent the record. It is recommended that you send the record via certified mail so the package can be tracked for confirmed delivery.

Decision Letter Date: Enter the date on the decision letter you received from the QIC. The QIC should make a determination within 60 days of receiving the record.

Outcome: From the correspondence you received from the QIC, indicate whether the claim was paid in full (Favorable), denied in full (Unfavorable), or partially denied (Partially Favorable).

Reason(s) for Decision: From the correspondence you received from the QIC, select the option(s) that most closely matches the reason(s) for their decision. You can select more than one option. Technical denials are not appealable so if you select that option you will not be able to navigate to the other levels of appeal, but the other reasons for denial are appealable.

Claim Amount: This is carried over from the ADR level and displayed on-screen for your information. Amount Paid plus Amount Denied must equal the Claim Amount.

Amount Paid: Enter the amount paid on the claim. If no payment was received, enter 0.

Amount Denied: Enter the amount denied on the claim. If no payment was denied, enter 0.

Elect to end the appeals process checkbox: Check this box if your facility will not appeal an unfavorable or partially favorable decision.

LEVEL 4: ADMINISTRATIVE LAW JUDGE (ALJ) HEARING REQUEST

If the QIC denies payment, the next level of appeal available is the ALJ. This is a hearing with a judge who will hear your case to determine whether payment should be made. The hearing may take place via phone/video conference or in person. If you have a preference for an in-person hearing, this should be stated in the ALJ Hearing Request that you submit. There must be at least $110 left in dispute in order to appeal a claim at this level. The request must be sent in within 60 days of the date on which the reconsideration decision was written.

The fields filled out for this level are as follows:

Which ALJ?: Select the ALJ from the drop-down.

Days to Appeal: Enter the number of days your facility has to appeal the reconsideration decision.

Date Appeal Submitted: Enter the date that the facility sent the hearing request to the ALJ.

Hearing Date: Enter the date of the hearing scheduled with the ALJ.

Decision Letter Date: Enter the date on the decision letter received from the ALJ. The ALJ should forward their determination to the FI within 90 days of the hearing.

Outcome: From the correspondence you received from the FI, indicate whether the claim was paid in full (Favorable), denied in full (Unfavorable), or partially denied (Partially Favorable).

Reason(s) for Decision: From the correspondence you received from the FI, select the option(s) that most closely matches the reason(s) for the decision. You can select more than one option. Technical denials are not appealable so if you select that option you will not be able to navigate to the other levels of appeal, but the other reasons for denial are appealable.

Claim Amount: This is carried over from the ADR level and displayed on-screen for your information. Amount Paid plus Amount Denied must equal the Claim Amount.

Amount Paid: Enter the amount paid on the claim. If no payment was received, enter 0. For partially favorable claims, there are restrictions as to what can be further appealed and what has no further appeal rights.

Amount Denied: Enter the amount denied on the claim. If no payment was denied, enter 0.

Elect to end the appeals process checkbox: Check this box if your facility will not appeal an unfavorable or partially favorable decision.

LEVEL 5: MEDICARE APPEALS COUNCIL (MAC) REQUEST

This is a rarely used step in the appeals process that is used if a large number of claims are unpaid. You can submit all claims together or you can submit them individually, but all are argued and decided as individual claims. No additional information may be submitted at this level of appeal. This must be requested within 60 days of the date on the ALJ decision.

The fields filled out for this level are as follows:

Days to Appeal: Enter the number of days your facility has to appeal the ALJ decision.

Date Appeal Submitted: Enter the date that the facility sent the claim to the MAC.

Hearing Date: Enter the date of the hearing scheduled with the MAC.

Case Number: Enter the case number representing the bundled claims.

Decision Letter Date: Enter the date on the decision letter you received from the MAC. The MAC should forward their determination to the FI within 90 days of receiving the record.

Outcome: From the correspondence you received from the FI, indicate whether the claim was paid in full (Favorable), denied in full (Unfavorable), or partially denied (Partially Favorable).

Reason(s) for Decision: From the correspondence you received from the FI, select the option(s) that most closely matches the reason(s) for the decision. You can select more

than one option. Technical denials are not appealable so if you select that option you will not be able to navigate to the other levels of appeal, but the other reasons for denial are appealable.

Claim Amount: This is carried over from the ADR level and displayed on-screen for your information. Amount Paid plus Amount Denied must equal the Claim Amount.

Amount Paid: Enter the amount paid on the claim. If no payment was received, enter 0. For partially favorable claims, there are restrictions as to what can be further appealed and what has no further appeal rights.

Amount Denied: Enter the amount denied on the claim. If no payment was denied, enter 0.

Elect to end the appeals process checkbox: Check this box if your facility will not appeal an unfavorable or partially favorable decision.

LEVEL 6: FEDERAL DISTRICT COURT

The last level of appeal that is available to providers is the Federal District Court appeal. This request would be made with the court with notification made to the FI. An attorney would likely lead this process and represent the facility in court. Staff members, former patients, and other facility representatives may be encouraged to be witnesses. There must be at least $1,130 left in dispute in order to appeal a claim at this level.

The fields filled out for this level are as follows:

Which Court?: Select the Federal District Court hearing your case.

Days to Appeal: 60 days to appeal.

Date Appeal Submitted: Enter the date that the facility sent the request for a hearing to the Federal District Court.

Hearing Date: Enter the date of the Federal District Court appearance.

Case Number: Enter the case number representing the claim.

Decision Letter Date: Enter the date on the decision letter you received from the Federal District Court.

Outcome: From the correspondence you received from the court, indicate whether the claim was paid in full (Favorable), denied in full (Unfavorable), or partially denied (Partially Favorable).

Reason(s) for Decision: From the correspondence you received from the court, select the option(s) that most closely matches the reason(s) for their decision. You can select more than one option.

Claim Amount: This is carried over from the ADR level and displayed on-screen for your information. Amount Paid plus Amount Denied must equal the Claim Amount.

Amount Paid: Enter the amount paid on the claim. If no payment was received, enter 0.

Amount Denied: Enter the amount denied on the claim. If no payment was denied, enter 0.

VI. OPTIONAL ADD-ONS

VI.A. eRehabData Patient Satisfaction System

The eRehabData Patient Satisfaction System integrates patient satisfaction surveys into eRehabData's existing assessments and outcomes reports structure. The Patient Satisfaction Instrument (PSI) includes three patient satisfaction surveys for each patient stay: the Service Recovery Survey, completed during the first few days of the rehabilitation stay; the Discharge Survey, given to the patient the day before or day of discharge; and the Follow-Up Survey, which can be completed in conjunction with a follow-up assessment or separately. Facilities can elect to use all three surveys or concentrate on one or two. PSI Outcomes Reports for each type of survey are generated nightly. The annual subscription fee for the Patient Satisfaction System is $4,500.

The design document on which the surveys are based is available here: https://web2.erehabdata.com/erehabdata/help/IRFPatientSatisfaction.pdf.

Surveys are available on all admission and discharge assessments under the **PSI** tab. If you do not see the **PSI** tab when you pull up a patient assessment, your facility is not subscribed to the system.

> ***NOTE:*** Because patient satisfaction surveys were available on an evaluation basis for all facilities until December 31, 2004, you will still have access to surveys completed then even if your facility has not subscribed to the system.

PATIENT SATISFACTION SYSTEM SIGNUP

Any eRehabData facility administrator can sign up your facility for the Patient Satisfaction System. To sign up, from your eRehabData home screen click **My Facility**, then click **Patient Satisfaction Instrument** and check the checkbox labeled "I request the subscription to eRehabData's PSI service on behalf of my facility, and also acknowledge the $4500.00 fee."

For information on the other configuration options available on the PSI Signup screen, please refer to the "Patient Satisfaction Instrument" section of this manual.

PATIENT SATISFACTION SYSTEM SURVEYS

Service Recovery Survey

The purpose of the Service Recovery Survey is to gather information about a patient's experience in the rehab facility while they are still in your facility, in order to give you an opportunity to address areas of improvement early in the patient's stay.

The survey should be completed by the patient and/or family on the third, fourth, or fifth day of the rehabilitation stay. A designated person at your facility will give the patient and/or their family a printed copy of the survey to complete. Once completed, the survey should be returned in a sealed envelope or by other discreet means to the person or department responsible for data entry. Physicians, staff, and other administrative employees should not be allowed to see the completed survey.

You can find a sample cover letter that you can customize and include when you give patients their Service Recovery Surveys here: https://web2.erehabdata.com/erehabdata/help/ServiceRecoverySampleLetter.doc

Discharge Survey

The purpose of the discharge survey is to gather information about a patient's total experience in the rehab facility.

The survey should be distributed to the patient the day before or the day of discharge. A designated person at your facility will give the patient and/or their family a printed copy of the survey to complete. Once completed, the survey should be returned in a sealed envelope or by other such discreet means to the person or department responsible for data entry. Physicians, staff, and other administrative employees should not be allowed to see the completed survey.

You can find a sample cover letter that you can customize and include when you give patients their Discharge Surveys here:
https://web2.erehabdata.com/erehabdata/help/DischargeSurveySampleLetter.doc

Follow Up Survey

The purpose of the follow up survey is to gather information about a patient's level of satisfaction with any services and equipment that were ordered at discharge, and to compare functioning at follow-up as compared to discharge.

The survey can be administered in conjunction with the follow up FIM survey, typically 3-4 months after discharge, or separately especially if your facility either does not collect perform follow-up assessments or contracts with an outside resource for follow-up assessments. The survey can be conducted either by phone or mail; whichever is the preferred method for your facility. If mailed, the completed survey should be returned in a sealed envelope or by other such discreet means to the person or department responsible for data entry. Physicians, staff, and other administrative employees should not be allowed to see the completed survey.

PRINTING SURVEYS

In order to print patient satisfaction surveys you will need the privilege “User can view all assessments for their facility (includes all sites).” If you do not have this privilege, contact your eRehabData facility administrator and ask them to adjust your user privileges.

The survey forms print out as pdf documents, which requires Adobe Reader software. If you don’t already have Reader installed on your computer you can get the latest version from the Adobe website here: http://get.adobe.com/reader

To print out a patient satisfaction survey, from your eRehabData home screen select the patient’s assessment from the list of admit or discharge assessments and then click the **P.S.I.** tab on the left side of your screen.

Near the top of the screen under the “Patient Satisfaction Instrument” header is the title of the survey you are viewing. It will say either “Service Recovery Survey”, “Discharge Survey”, or “Follow-Up Survey”. If you are not on the survey screen you want, use the links to the right or left of the survey title to open the survey you wish to print.

Click the **Print** link below the survey header to pop up a window with the pdf survey document. In the pop-up window menubar click **File**, then **Print** to print out your survey.

> ***NOTE:*** Each printed survey form displays a unique ID number in the upper right corner which is used to identify the assessment record that the survey is associated with. If you are printing multiple surveys and the number doesn't change from survey to survey, stop printing and go to the Adobe website to download and install the latest version of Adobe Reader:

http://get.adobe.com/reader. Then reprint the surveys and check the numbers again.

Foreign Language Surveys

eRehabData also offers patient satisfaction surveys in Simple Chinese, Traditional Chinese, French, Korean, Spanish, and Vietnamese. To print out your survey in one of these languages, click the button to the right of the **Print** link on the survey screen and select the language. Then print your survey as normal.

ENTERING COMPLETED SURVEYS

In order to enter completed patient satisfaction surveys you will need either the privilege "User can create/edit IRF-PAI assessments" OR "User can create/edit patient satisfaction surveys only." If you do not have one of these privileges, contact your eRehabData facility administrator and ask them to adjust your user privileges.

To enter a patient's survey responses into eRehabData, scroll to the bottom of your eRehabData home page. Below your assessments display options is a box labeled "Patient Satisfaction Survey ID". Enter the number from the upper right corner of the survey form into the box and click **Load**.

Near the top of the screen under the "Patient Satisfaction Instrument" header is the title of the survey you are viewing. It will say either "Service Recovery Survey", "Discharge Survey", or "Follow-Up Survey". If you are not on the survey screen you want, use the links to the right or left of the survey title to open the survey you wish to complete.

Referring to the patient's answers on the completed survey printout, fill out the patient's survey on eRehabData. If the patient skipped any questions on the survey, select "Not Answered". On the Service Recovery Survey, for number 7 if the patient answered "Not applicable/No pain", select "I have no pain."

If your eRehabData facility administrator has configured any subjects or topics for the free text comments fields (questions 14, 15 and 16 on the Service Recovery Survey; questions 35 and 36 on the Discharge Survey), they will be displayed in drop-downs above each comments field. Select the subject or topic that best describes the comments entered or select "None" if no subject applies to the comments.

When you are finished entering all of the patient's answers, click either the button at the bottom of the screen labeled **Next: Metrics**, any one of the tabs on the left side of your screen, or the **HOME** button under the eRehabData logo at the top of your screen to save the information.

If there is no activity on eRehabData for 2 hours or so (e.g. if you don't move to another screen or refresh the current screen for 2 hours), the system will assume you are no longer working on eRehabData and will automatically end your session. If you think you may stay on one P.S.I. screen for over 2 hours, save your data at regular intervals by clicking on the P.S.I. tab to refresh the screen. When you are finished entering survey results, click the **LOG OUT** button in the green toolbar in the upper right corner of your screen.

SCANNABLE SURVEYS

Your facility has the option of using scannable patient satisfaction survey forms so that completed forms can be scanned in and then uploaded in a data file rather than hand-entered. If your facility has configured this option, your printed surveys will display bar codes for use by a scanner and third-party software. Scanning these surveys requires use of third-party hardware and software which will require extensive set-up and testing by someone at your

facility. Completed scannable surveys can also still be hand-entered. Foreign language surveys are not available in scannable form at this time.

> ***NOTE:*** Scanning of the patient satisfaction forms requires third-party hardware and software. Please review this document available under the HELP icon on the Admin PSI Signup screen for more information on scanning and uploading PSI forms:
>
> https://web2.erehabdata.com/erehabdata/help/PSI/PSIAdminHelp.htm

VI.B. IRF-PAI Proficiency Exams

Your eRehabData IRF-PAI Proficiency Exam is assigned to you by an eRehabData facility administrator for your facility. The exam consists of two patient scenarios for which you will complete two patient assessments. To access your exam you will need to log in to eRehabData using the login information provided to you by your eRehabData Facility Administrator.

LOGGING IN TO eREHABDATA

To log in to eRehabData, open a web browser and go to http://www.eRehabData.com.

Next, type your facility's 6-digit Medicare provider number, your username, and your user password into the appropriate boxes, and then click **Enter**. Once logged in you will see a link to your exam near the top of your eRehabData home screen, in a table labeled “Proficiency Exams”. If you see a checkbox labeled “Proficiency Exams” but the box is not checked, check the box to display the link to your exam.

AN IMPORTANT NOTE ABOUT SAVING YOUR EXAM ANSWERS

The answers you enter into your scenario assessment screens are saved only when you go to another screen or refresh the current screen by clicking the tab corresponding to the IRF-PAI section you are on. For example, if you are on the FIM screen entering FIM scores, you can save your entries by clicking the **FIM** tab to refresh that screen, or by clicking another tab, the **Next** button at the bottom of the screen, **HOME** or even **LOG OUT** to leave the screen.

> ***NOTE:*** It is important to remember that the information isn’t saved as you type into each field, but only once you click a tab or button on eRehabData. To illustrate, let’s say you are entering FIM scores onto the FIM screen and you are called away from your desk. You leave without logging out of eRehabData. You are gone long enough (approximately 2hours) that the system automatically logs you out, ending your user session.
>
> In this case, if before you left your desk you clicked the **FIM** tab to save your data to the FIM screen, your scores will be saved even though your user session timed out. If you didn't click the **FIM** tab (or another tab or button) to save your data, when you return you will still see the scores you entered displayed on the FIM screen but because your session timed out, when you next click your mouse you will be redirected to the login screen and the scores you entered will be lost.

STARTING YOUR EXAM

To start your exam, click on the exam link in the Proficiency Exams table on your eRehabData home screen. Two patient scenarios will be listed. To start a scenario, click the **Start** link to the right of a scenario name. The management (**MGMT**) screen for that scenario will appear, and a

pop-up window will display the patient scenario. To print the scenario, in the menubar of the pop-up window click **File**, then **Print**.

SCENARIO SCREENS

While in a scenario assessment you'll see a list of tabs on the left side of the screen, displayed next to colored flags. Each tab corresponds to a section or sections of the IRF-PAI, with the exception of the **MGMT** tab.

The colored flags next to the tabs for each section indicate the completion status of each section, with green indicating that nothing more is required for that section and yellow indicating that some required information is missing. Red flags are displayed after you click the **Complete** button on the **MGMT** screen to highlight sections that still need attention.

Click on a tab for an IRF-PAI screen to go directly to that section of the IRF-PAI. A description of each tab follows:

Mgmt Tab: The scenario management screen is the starting point for the functions you can perform on the scenario.

The top of the management screen displays some general information about the scenario, including any exam options that have been set for your exam. The complete list of all possible buttons on the management screen and their functions is as follows:

Menu: Clicking the **Menu** button brings you back to your list of both scenarios.

Scenario: Clicking the **Scenario** button brings up the pop-up window with the scenario text.

Check: Clicking the **Check** button scans your scenario for missing information. If any required information is missing, a complete list of the missing fields is displayed and the colored flags next to the tabs for those sections turn red.

Discharge: *After completing the admission assessment portion of a scenario*, click **Discharge** to create the discharge record and begin entering discharge data. *On a discharge scenario*, click **Discharge** to return to entering discharge data after you have been editing previously-entered admit data (see **Admit** below for more information).

***Admit*:** On a discharge scenario, click **Admit** to edit information entered on the admission assessment portion of the scenario.

Finish: Clicking the **Finish** button signals that you are done entering all information into the scenario and it is ready to be corrected by your eRehabData facility administrator. After you click **Finish** you will need to click **OK** to confirm. If your scenario is not complete (i.e. if you have skipped any possible answers) a second confirmation window will appear alerting you that your scenario is missing some answers and is not complete. You can click **Cancel** to enter the missing answers or click **OK** to confirm that you are finished. *This will lock the scenario against any further edits and you will not be able to add or change any answers. It is possible to finish an exam with empty fields but skipped answers will be counted against the overall exam score.*

NOTE: Until your scenario is corrected by your eRehabData facility administrator, it can be unlocked by an administrator if you need to get back in to edit your scenario. However, once the scenario has been corrected by an administrator it cannot be edited.

Screens corresponding to the following tabs will include editable fields only if your exam options require you to complete them:

Ident Tab: Click **IDENT** to enter Identification Information.

Admit Tab: Click **ADMIT** to enter Admission Information.

Payer Tab: Click **PAYER** to enter Identification Information.

Med Inf Tab: Click **MED INF** to enter Medical Information.

Med Nds Tab: Click **MED NDS** to enter Medical Needs answers.

Fnc Mod Tab: Click **FNC MOD** to enter Function Modifiers answers.

FIM Tab: Click **FIM** to enter FIM scores.

Qlty Ind Tab: Click **QLTY IND** to enter Quality Indicators answers.

Disch Tab: Click **DISCH** to enter Discharge Information.

HOW TO COMPLETE YOUR EXAM SCENARIO

ADMISSION ASSESSMENT

Once you have clicked the **Start** link (see **Starting Your Exam** above) and opened a scenario, click any yellow-flagged tab on the left to begin entering required exam answers on the admission portion of the exam. As you complete each yellow-flagged screen, the flag will turn green indicating that you have entered all the information required for that section. Questions that are not required are marked "[skip]".

Once you have completed the admission assessment portion of the scenario, check that no required answers are missing. To do this, click the **MGMT** tab, then click the **Check** button to list any missing answers on screen. You can click on the tab for any section missing data to enter the missing information. If the admission assessment is complete, the **Check** button will disappear and the assessment status displayed on screen will change to Complete.

DISCHARGE ASSESSMENT

To create the discharge assessment, from the management (**MGMT**) screen on your admission assessment scenario click the **Discharge** button. Click any yellow-flagged tab on the left to begin entering required exam answers on the discharge portion of the exam. As you complete each yellow-flagged screen, the flag will turn green indicating that you have entered all the information required for that section. Questions that are not required are marked "[skip]".

Once you have completed the discharge assessment portion of the scenario, check that no required answers are missing. To do this, click the **MGMT** tab, then click the **Check** button to list any missing answers on screen. You can click on the tab for any section missing data to enter the missing information. If the discharge assessment is complete, the **Check** button will disappear and the assessment status displayed on screen will change to Complete.

If at any time during the discharge assessment you realize you need to make a change to any information you entered on admit, go to the **MGMT** screen and click the **Admit** button. This will allow you to modify your admission assessment answers. Once you have made your corrections, return to the **MGMT** screen and click **Discharge** so you can complete your discharge assessment.

When the assessment scenario is complete, on the **MGMT** screen click **Finish**, then click **OK** to confirm. If your scenario is not complete (i.e. if you have skipped any possible answers) a second confirmation window will appear alerting you that your scenario is missing some answers and is not complete. You can click **Cancel** to enter the missing answers or click **OK** to confirm that you are finished.

> ***NOTE:*** This will lock the scenario against any further edits and you will not be able to add or change any answers. It is possible to finish an exam with empty fields but skipped answers will be counted against the overall exam score.

You can then click the **Menu** button to return to your Proficiency Exams menu so you can start your second scenario.

If you are unable to finish the exam in one sitting, you can continue it later but be sure to click the **LOG OUT** button first on eRehabData before leaving your computer or closing your browser.

If You Are Interrupted During An Exam

If you cannot complete an exam scenario at one time you can return to it later. To continue an interrupted exam, from your eRehabData home screen click on the exam names link in the proficiency exams table. Then click the **Continue** link on the scenario you were working on. You must complete and finish one exam scenario before you can start the second scenario. After you have finished a scenario you can review your answers by clicking the **Review** link.

Reviewing Your Corrected Exam

When you have marked a scenario Finished, let your eRehabData facility administrator know it is available for correction. To review your corrected exam scenarios, from your eRehabData home screen click on the exam names link in the Proficiency Exams table. Then click **Review** to the right of one of the scenario names.

On a corrected scenario, the status on the **MGMT** screen will say “Corrected” and will list your number of correct, incorrect, and skipped answers. You can view a list of the questions you answered correctly, answered incorrectly, or skipped by clicking the **Score Sheet** button on the **MGMT** screen.

To view the correct answers, click on the tabs for the sections you completed to go to each section.

- Questions answered correctly are marked “Correct”.
- Questions answered incorrectly are marked with a red ‘X’ followed by the correct score in parentheses.
- Questions that required answers but were left blank are marked “Skipped”.
- Questions that were not part of the test are marked “[skip]”, as they were during the exam.

For information on managing proficiency exams, please review the “Manage Proficiency Exams” section of this user manual.