IRF-PAI PRA Package
(OCN 0938-0842)
Public Comments & Responses

Comment #1: The additional burden of data collection (that is, seeking information about a patient's influenza immunization status directly from the patient or by searching through the paper medical record) must not take away from limited resources in these facilities which are needed to provide direct care.

Response #1: We agree that there will be some additional burden added because IRFs will be required to check to see if the patient received the influenza vaccination prior to admission to the IRF. However, we believe that the burden will be minimal. Most patients are transferred to IRFs from an acute care facility. If the patient received the influenza vaccination while in the acute care facility, there should be several places where the information about the administration of this vaccination can be quickly and easily located. The influenza vaccination is a medication, so the Medication Administration Record would be one place that this information could be located. Also, if this vaccination was ordered by a physician or the acute care facility had standing orders for the administration of the vaccination, then the Physicians Order section of the chart is another place that is likely to contain the influenza vaccination information.

Comment #2: One commenter suggested that CMS' estimates of the burden caused by the implementation of the two vaccination measures (Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) and Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF#0680) are inaccurate because they do not encompass changes that must be made to its billing software, electronic medical records, or administrative processes.

Response #2: When making a burden estimate, we estimate only those activities and costs that are common to a majority of providers and which can be fairly and accurately estimated across all IRFs. Unfortunately, costs related to changes to billing and electronic medical record

software, or administrative processes are costs that are so variable among different IRFs we are not able to make an accurate estimate of these costs that can be applied across all providers. Costs for updates to electronic medical records are extremely variable and will depend on many factors such as the manufacturer of the electronic medical records software; whether there is a warranty that covers updates; whether the IRF has a service contract which covers updates; who the IRF hires to perform upgrades to its system; where the IRF is geographically located; or whether the cost is incurred by a large corporation that owns many IRFs or the IRF is a solely owned and operated facility. In regard to costs for changes to administrative processes, these costs are also difficult to define or quantify as they are equally variable, if not more so than costs related to changes to electronic record systems.

Even though it was not reflected in the burden estimate, CMS does recognize that many IRFs will incur costs for changes that will be required to billing software, electronic medical records, or administrative processes. Some of these changes are required as a result of the IRF QRP proposals that we are finalizing in this rule. However, we believe that some of these costs are also attributable to non-quality related proposals that are being finalized in this rule. These costs are considered to fall into the category of business overhead expenses, which is a category of expense that we are not required to include in a burden estimate.

Comment #3: Several commenters indicated that the IRF-PAI is now too long and causes undue burden. Another commenter suggested that CMS should carefully consider the burden associated with reporting on the voluntary items of the IRF PAI.

Response #3: CMS obtained feedback from providers on the October 2012 Quality Reporting Program during the Provider Trainings, Open Door Forums, and via the Quality Reporting Program Helpdesk. Based on the feedback received, providers wanted the ability to provide as much information as possible to truly track the evolution of pressure ulcers. Since the goal of the IRF Quality Reporting Program was to obtain complete, accurate information about the quality of care being provided in rehab facilities, CMS is adding these additional items. However, only those pressure ulcer items required to calculate the quality measure Percentage of Patients or Residents with New or Worsening Pressure Ulcers are required in order to receive the 2% annual payment update. Therefore, if a facility finds completing the additional

questions burdensome, they are under no obligation to do so. Please refer to the 2014 IRF-PAI training manual for the voluntary/mandatory status of each item.

In addition, a PRA burden estimates typically account for the additional time required to perform work that is over and above normal work duties and patient care activities. We believes that clinicians in the IRF setting perform pressure ulcer assessments and document their findings in the medical records in the normal course of patient care. Therefore, our burden estimate related to completion of the pressure ulcer data item set does not include these tasks. Our burden estimate includes only that work that is not part of the providers normal work duties.

We have estimated that it will take 15 minutes to complete the admission pressure ulcer data item set and that this involves a review of the clinician's admission pressure ulcer assessment and documentation of the findings on the IRF-PAI. We have further estimated that it will take approximately 10 minutes to complete the discharge pressure ulcer data item set and that this will involve a review of the medical documentation from the IRF stay to determine if any new or worsened pressure ulcers that have occurred during the IRF stay. In addition, we have included 3 minutes in the burden estimate to account for the time required to enter the data and transmit the IRF-PAI record to CMS.