Centers for Medicare & Medicaid Services

INPATIENT REHABILITATION FACILITY-PATIENT ASSESSMENT INSTRUMENT (IRF-PAI)

CHANGE TABLE SUMMARIZING REVISIONS TO THE IRF-PAI MANUAL VERSION 4.2

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Contents

IRF-PAI 4.2 Item Set 1
All Sections 2
Chapter 1 4
Chapter 2 7
Chapter 2, Section A 8
Chapter 2, Section B 13
Chapter 2, Section D 22
Chapter 2, Section GG 23
Chapter 2, Section J 30
Chapter 2, Section K 33
Chapter 2, Section M 35
Chapter 2, Section N 36
Chapter 2, Section O 40
Chapter 2, BIMS Supplement 46
Chapter 3 47
Chapter 4 61

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IRF-PAI 4.2 Item Set

Below is a list of changes to the IRF-PAI 4.2.

Section	Item #	Added/Removed	Item Description
Section A	A1400	Added	Payer Source
Section GG	Discharge Goals	Removed	N/A
Section O	O0350	Added	COVID-19 Vaccination Up To Date

Note: Guidance has been added to the Manual pages for all the new items listed above.

All Sections

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 4.0 – Effective October 1, 2022	IRF-PAI Manual Version 4.2 – Effective October 1, 2024	Description of Change
0.1	All sections	--	Where applicable the manual is edited for the following: formatting, grammar, stylistic edits, improved clarity, updated dates, updated references, updated resources, reorganized information, updated version number from 4.0 to 4.2.	--
0.2	All sections	Revised Version 4.0, Effective October 1, 2022	Version 4.2, Effective October 1, 2024	Updated version number and effective date in the footer.
0.3	Appendix A	Revised Version 4.0, Effective October 1, 2022	Version 4.2, Effective October 1, 2024	Updated version number and effective date in the footer. No other substantive edits.
0.4	Appendix D	Revised Version 4.0, Effective October 1, 2022	Version 4.2, Effective October 1, 2024	Updated version number and effective date in the footer. No other substantive edits.
0.5	Appendix E	Revised Version 4.0, Effective October 1, 2022	Version 4.2, Effective October 1, 2024	Updated version number and effective date in the footer. No other substantive edits.

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 4.0 – Effective October 1, 2022	IRF-PAI Manual Version 4.2 – Effective October 1, 2024	Description of Change
0.6	Chapter 5	--	New chapter added	Added a new chapter to the manual to explain the iQIES submission and modification processes.

Chapter 1

Chapter 1				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
1.1	Chapter 1, Page 1-1	The completion of the IRF-PAI is required for every Medicare Part A fee-for-service patient discharged on or after the IRF PPS implementation day of January 2, 2002.	**Removed**	Removed language due to the introduction of the All Payer item, A1400.
1.2	Chapter 1, Page 1-1	The FY 2023 IRF PPS final rule (87 FR 47073) finalized the collection of IRF-PAI assessment data on each patient receiving care in an IRF, regardless of payer. IRFs would be required to report these data with respect to admission and discharge of all patients, regardless of payer, discharged on and after October 1, 2024. The completion of the IRF-PAI is also required for every Medicare Part C (Medicare Advantage) patient discharged on or after October 1, 2009 (see the fiscal year 2010 2023 IRF PPS final rule [87 FR 4707374 FR 39762] for more information).	The IRF-PAI is also the assessment instrument IRF providers use to collect patient assessment data for quality measure calculation in accordance with the IRF QRP. IRFs are required to report these data with respect to admission and discharge of all patients, regardless of payer, discharged on and after October 1, 2024.[1] [*Footnote*][1] The FY 2023 IRF PPS final rule (87 FR 47073) finalized the collection of IRF-PAI assessment data on each patient receiving care in an IRF, regardless of payer.	Updated language.

Chapter 1				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
1.3.	1-1	• In October 2017, CMS launched the Meaningful Measures Initiative, which is one component of the agency-wide Patients Over Paperwork Initiative, aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful Measures Initiative is aimed at identifying the highest-priority areas for quality measurement and quality improvement in order to assess the core quality-of-care issues that are most vital to advancing our work to improve patient outcomes. • CMS will evaluate each program according to six overarching quality priorities: • Making Care Safer by Reducing Harm Caused in the Delivery of Care. • Strengthen Person and Family Engagement as Partners in Their Care. • Promote Effective Communication and Coordination of Care. • Promote Effective Prevention and Treatment of Chronic Disease. • Work with Communities to Promote Best Practices of Healthy Living. • Make Care Affordable.	• In October 2017, CMS launched the Meaningful Measures Initiative, which is one component of the agency-wide Patients Over Paperwork Initiative, aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. When first introduced, the objective was to reduce the number of Medicare quality measures and ease the burden on measured entities. The launch of the Meaningful Measures Initiative made considerable progress in reducing the number of Medicare quality measures by 18 percent. • The initiative has evolved into a new phase referred to as Meaningful Measures 2.0 and the Cascade of Meaningful Measures framework in the context of the CMS National Quality Strategy. o The CMS National Quality Strategy provides an overarching, strategic plan that brings together initiatives and frameworks across the agency to ensure harmony and alignment across CMS quality efforts. o Meaningful Measures 2.0 is a key initiative that addresses several of the Strategy's priority areas and goals, including: ▪ Person-centered care	Updated language.

Chapter 1				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
1.3. (cont.)	1-1	For more information, please see: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html	▪ Safety ▪ Chronic conditions ▪ Seamless care coordination ▪ Equity ▪ Affordability and efficiency ▪ Wellness and prevention ▪ Behavioral health ○ The Cascade of Meaningful Measures describes, in increased detail of the components of the health care system that are being measured. It moves from the eight Meaningful Measures health care priorities to goals and objectives. • For more information, please see: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html	Updated language.

Chapter 2
Chapter 2, Overview

Chapter 2, Overview				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.0.1	Chapter 2, Table 2-1, Special Treatments, Procedures, and Programs Page 2-2	**Table 2-1; Section O** This section includes Special Treatments, Procedures, and Programs. The intent of the item in this section is to identify any special treatments, procedures, and programs that the patient received during the stay.	**Table 2-1; Section O** This section includes Special Treatments, Procedures, and Programs. The intent of the items in this section is to identify any special treatments, procedures, and programs that the patient received during the stay, as well as information regarding patient vaccinations.	Updated language including new items.
2.0.2	Chapter 2, Section 2.2 Page 2-3	**2.2 IRF-PAI Completion** **Did not exist**	**2.2 IRF-PAI Completion** The IRF-PAI is applicable to all patients receiving inpatient services in a facility certified as an IRF and designated as an IRF under the Medicare program. It is not applicable to patients receiving services in IRF units that are not designated as IRFs under the Medicare program. Data collection using the IRF-PAI is applicable regardless of patient's age, diagnosis, length of stay, or payment/payer source. Data collected must be submitted in the time frame, manner, and form established by CMS for the IRF QRP. The applicable IRF-PAI Version 4.2 must be completed for eligible patients who have been admitted or discharged on or after 12:00 a.m. on October 1, 2024. The applicable IRF-PAI Version 4.2 must also be completed for eligible	Added new guidance.
2.0.2 (cont.)	Chapter 2, Section 2.2 Page 2-3		patients who have been admitted prior to 12:00 a.m. on October 1, 2024 and are discharged (or who die) on or after 12:00 a.m. on October 1, 2024.	Added new guidance.

Chapter 2, Section A

Chapter 2, Section A				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.A.1	Chapter 2, Section A, Page A-1	**2. Patient Medicare Number:** Enter the patient's Medicare Number (Part A). Verify the number through the business office. **NOTE:** For those patients with a Medicare Advantage (Medicare Part C) Plan, a Medicare number is still needed to complete this section of the IRF-PAI. For additional information regarding how to obtain this number, reference the IRF PPS FY 2010 final rule (74 FR 39799).	**2. Patient Medicare Number:** Enter the patient's Medicare Number (if known) whether or not Medicare is the primary payment source for this episode of care. Verify the number through the business office. If the patient does not have Medicare, leave the item blank. **NOTE:** For those patients with a Medicare Advantage (MA) (Medicare Part C) Plan, a Medicare number is still needed to complete this section of the IRF-PAI. Do not enter the MA/HMO identification number. Currently, all IRFs are required to submit abbreviated Medicare claims on their MA patients, and MA plans provide IRFs with the Medicare beneficiary identification numbers anytime a MA patient is admitted to the IRF.	Revised to reflect updates to guidance.
2.A.2	Chapter 2, Section A, Page A-1	**3. Patient Medicaid Number:** Enter the patient's Medicaid Number. Verify the number through the business office. **NOTE:** This item is mandatory if the patient is a Medicaid recipient.	**3. Patient Medicaid Number:** Enter the patient's Medicaid Number. Verify the number through the business office. **NOTE:** This item is mandatory if the patient is a Medicaid recipient. If the patient does not have Medicaid, leave the item blank. If the patient is Medicaid pending, enter "+".	Revised to reflect updates to guidance.
2.A.3	Chapter 2, Section A, Page A-3	**14. Admission Class:** 2- THIS CODE IS NO LONGER VALID	**14. Admission Class:** **Removed**	Removed response option.

Chapter 2, Section A				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.A. 4	Chapter 2, Section A, Page A-6	**Payer Information**	**Removed**	Removed section.
2.A.5	Chapter 2, Section A, Page A-11	**Coding Instructions** • If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code ("-") and document the rationale on the patient's medical record.	**Coding Instructions** • If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, enter a dash ("-") and document the rationale on the patient's medical record.	Revised for clarity.
2.A.6	Chapter 2, Section A, Page A-12	**42. Program Interruptions:** A program interruption is defined as the situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days.	**42. Program Interruptions:** A program interruption is defined as the situation where a patient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. CMS acknowledges that private insurers may not recognize interrupted stays. However, IRFs should follow this same guidance for interrupted stays, regardless of the patient's payer.	Revised to reflect updates to guidance.
2.A.7	Chapter 2, Section A, Page A-14	**44D. Patient's discharge destination/living setting, using codes below:** 62- Another Inpatient Rehabilitation Facility	**44D. Patient's discharge destination/living setting, using codes below:** 62- Another Inpatient Rehabilitation Facility or remained a patient of the same IRF under a new payer	Revised to reflect updates to guidance.
2.A.8	Chapter 2, Section A, Page A-21	**Coding Instructions** Complete as close to the time of admission as possible. *Check all that apply.*	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period. *Check all that apply.*	Revised to reflect updates to guidance.

Chapter 2, Section A				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.A.9	Chapter 2, Section A, Page A-21	**Coding Tips** **Did not exist**	**Coding Tips** • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.	Added coding tip to reflect updates to guidance.
2.A.10	Chapter 2, Section A, Page A-24	**Coding Instructions** Complete as close to the time of admission as possible. *Check all that apply.*	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period. *Check all that apply.*	Revised to reflect updates to guidance.
2.A.11	Chapter 2, Section A, Page A-24	**Coding Tips** **Did not exist**	**Coding Tips** • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.	Added coding tip to reflect updates to guidance.
2.A.12	Chapter 2, Section A, Page A-27	**Coding Tips and Special Populations** Complete as close to the time of admission as possible.	**Coding Tips and Special Populations** Complete based on an assessment that occurs within the 3-day admission assessment time period.	Revised to reflect updates to guidance.
2.A.13	Chapter 2, Section A, Page A-27	**Coding Tips and Special Populations** **Did not exist**	**Coding Tips and Special Populations** • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.	Added coding tip to reflect updates to guidance.

Chapter 2, Section A				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.A.14	Chapter 2, Section A, Page A-28	**Coding Instructions** Complete as close to the time of admission as possible and within 3 days of discharge.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
2.A.15	Chapter 2, Section A, Page A-29	**Coding Tips** **Did not exist**	**Coding Tips** • Considering a patient's unique circumstances, use facility policy to determine who is an appropriate proxy. A proxy can include, but is not limited to family, caregiver, friend, Power of Attorney (POA), or health care representative.	Added coding tip to reflect updates to guidance.
2.A.16	Chapter 2, Section A, Page A-	**A1400. Payer Information** **Did not exist**	**A1400. Payer Information** **New Section guidance added**	Added section
2.A.17	Chapter 2, Section A, Page A-37	**Coding Instructions** • **Code 0, No,** if at discharge to a subsequent provider, your facility did not provide the patient's current reconciled medication list to the subsequent provider, or the patient was not discharged to a subsequent provider.	**Coding Instructions** • **Code 0, No,** if at discharge to a subsequent provider, your facility did not provide the patient's current reconciled medication list to the subsequent provider o For planned discharges, skip to B1300, Health Literacy o For unplanned discharges, skip to C1310, Signs and Symptoms of Delirium	Revised to reflect updates to guidance.

Chapter 2, Section A				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.A.18	Chapter 2, Section A, Page A-41	**Coding Instructions** • **Code 0, No,** if at discharge to a home setting (44D=01), or a not listed location (44D=99), your facility did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver. Or the patient was discharged to a subsequent provider.	**Coding Instructions** • **Code 0, No,** if at discharge to a home setting (44D=01), or a not listed location (44D=99), your facility did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver. o For planned discharges, skip to B1300, Health Literacy o For unplanned discharges, skip to C1310, Signs and Symptoms of Delirium	Revised to reflect updates to guidance.
2.A.19	Chapter 2, Section A, Page A-43	**DEFINITIONS** **Did not exist**	**DEFINITIONS** **Health Information Exchange (HIE)** An organization used by provider facilities to electronically exchange patients' health information, including medical records, current reconciled medication lists, etc.	Added definition for clarity.
2.A.20	Chapter 2, Section A, Page A-46	**Coding Tips for A2122 and A2124** • The route of transmission usually is established with each subsequent provider, depending on how they are able to receive information from your facility. The route(s) may not always be documented in the patient's record. It will be helpful to understand and document how your facility typically transmits information to each subsequent provider at discharge to prepare for coding this item.	**Coding Tips for A2122 and A2124** • The route of transmission usually is established with each subsequent provider, depending on how they are able to receive information from your facility. The route(s) may not always be documented in the patient's record.	Revised coding tip for clarity.

Chapter 2, Section B

Chapter 2, Section B				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.B.1	Chapter 2, Section B, Page B-2	**Section B: HEARING, SPEECH, AND VISION** The intent of these items is to document the patient's ability to hear (with assistive devices, if they are used), understand and communicate with others, and see objects nearby in their environment.	**Section B: HEARING, SPEECH, AND VISION** The intent of these items is to document the patient's ability to hear (with assistive devices, if they are used), understand and communicate with others, process health information, and see objects nearby in their environment.	Updated intent for accuracy.
2.B.1	Chapter 2, Section B, Page B-2	**Coding Instructions** Complete as close to the time of admission as possible.	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period.	Revised to reflect updates to guidance.
2.B.2	Chapter 2, Section B, Page B-5	**Coding Instructions** Complete as close to the time of admission as possible.	**Coding Instructions** Complete based on an assessment that occurs within the 3-day admission assessment time period.	Revised to reflect updates to guidance.
2.B.3	Chapter 2, Section B, Page B-7	**Coding Instructions** Complete as close to the time of admission as possible and within 3 days of discharge.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.

Chapter 2, Section C

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.C.1	Chapter 2 Section C Page C-1	**Steps for Assessment** Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip items C0200-C0500, Brief Interview for Mental Status (BIMS).	**Steps for Assessment** Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip items C0200-C0500, Brief Interview for Mental Status (BIMS) and C0600, Should the Staff Assessment for Mental Status (C0900) be Conducted?	Revised for clarity.
2.C.2	Chapter 2 Section C Page C-2	**Coding Instructions** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
2.C.3	Chapter 2 Section C Page C-2	**Coding Instructions** **Code 0, No**, if the interview should not be conducted because the patient is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip items C0200-C0500, Brief Interview for Mental Status (BIMS)	**Coding Instructions** **Code 0, No**, if the interview should not be conducted because the patient is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip items C0200-C0500, Brief Interview for Mental Status (BIMS) and C0600, Should the Staff Assessment for Mental Status (C0900) be Conducted?.	Revised to reflect updates to guidance.
2.C.4	Chapter 2 Section C Page C-4	**Coding Instructions** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.C.5	Chapter 2 Section C Page C-5	**Examples of Incorrect Answers, Refusals, and Nonsensical Responses** Code 0 is used to represent three types of responses: incorrect answers (unless the item itself provides an alternative response code), nonsensical responses, and questions the patient chooses not to answer (or "refusals"). Since zeros resulting from these three situations are treated differently when coding the summary score in C0500, the interviewer may find it valuable to track the reason for the zero reponse to aid in accurately calculating the summary score.	**Examples of Incorrect Answers, Refusals, and Nonsensical Responses** Code 0 is used to represent three types of responses: incorrect answers (unless the item itself provides an alternative response code), nonsensical responses, and questions the patient chooses not to answer (or "refusals"). Since zeros resulting from these three situations are treated differently when coding the summary score in C0500, the interviewer may find it valuable to track the reason for the zero response to aid in accurately calculating the summary score.	Typographical error corrected.
2.C.6	Chapter 2 Section C Page C-11	**Coding Tips** • In most instances, it will be immediately obvious which code to select. In some cases, you may need to write the patient's response in your notes and go back later to count days if you are unsure whether the date given is within 5 days.	**Coding Tips** • In most instances, it will be immediately obvious which code to select. In some cases, you may need to write the patient's response in your notes and go back later to count days if you are unsure whether the month given is within 5 days.	Updated guidance for clarity.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.C.7	Chapter 2 Section C Page C-16	**Item Rationale** **Did not exist**	**Item Rationale** • The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where patients can hear all questions and the patient is not delirious suggest the following distributions: o 13-15: cognitively intact o 8-12: moderately impaired o 0-7: severe impairment	Added item rationale.
2.C.8	Chapter 2 Section C Page C-16	**Coding Instructions** • Code 99, Unable to complete interview, if (a) the patient chooses not to participate in the BIMS, (b) four or more items were coded 0 because the patient chose not to answer or gave a nonsensical response, or (c) any of the BIMS items is coded with a "-" (dash).	**Coding Instructions** • Code 99, Unable to complete interview, if a) the patient chooses not to participate in the BIMS, b) four or more items were coded 0 because the patient chose not to answer or gave a nonsensical response, or c) any but not all of the BIMS items are coded with a "-" (dash).	Revised to reflect updates to guidance.
2.C.9	Chapter 2 Section C Page C-18	**Coding Tips** **Did not exist**	**Coding Tips** • If all of the BIMS items are coded with a "-" (dash), then C0500 - BIMS Summary Score must also be coded with a "-" (dash).	Adding coding tip to reflect updates to guidance.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.C.10	Chapter 2 Section C Page C-18	**Example #3** 3. STOP the interview after C0300C if each of items C0200-C0300C are coded as 0, because a patient chose not to participate in the BIMS and/or has provided nonsensical answers and/or does not provide verbal or written responses.	**Example #3** 3. STOP the interview after C0300C if C0200-C0300C are all coded as 0, because a patient chose not to participate in the BIMS and/or has provided nonsensical answers and/or does not provide verbal or written responses.	Revised to reflect updates to guidance.
2.C.11	Chapter 2 Section C Page C-20	**Coding Tips** If a patient is scored 00 on C0500, BIMS Summary Score, C0900, Memory/Recall Ability, should not be completed. 00 is a legitimate value for C0500 and indicates that the interview was complete. To have an incomplete interview, a patient had to choose not to answer or had to give completely unrelated, nonsensical responses to four or more BIMS items resulting in the interview being stopped.	**Coding Tips** If a patient is scored 00 on C0500, BIMS Summary Score, C0900, Memory/Recall Ability, should not be completed. 00 is a legitimate value for C0500 and indicates that the interview was complete. To have an incomplete interview, a patient had to choose not to answer and/or had to give completely unrelated, nonsensical responses to four or more BIMS items resulting in the interview being stopped.	Revised to reflect updates to guidance.
2.C.12	Chapter 2 Section C Page C-22	**Guidance for Completing the BIMS Using Alternative Methods** If the patient's primary method of communication is in written format, the BIMS can be administered in writing. The administration of the BIMS in writing should be limited to this circumstance.	**Section Removed**	Removed section due to redundancy.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.C.13	Chapter 2 , Section C Page C-22 through Page C-23	**Instructions for BIMS When Administered in Writing** 1. Interview any patient not screened out by C0100, Should Brief Interview for Mental Status Be Conducted? item. 2. Conduct the interview in a private setting. 3. Patients with visual impairment should be tested using their usual visual aids. 4. Minimize glare by directing light sources away from the patient's face and from written materials. 5. Provide a written introduction before starting the interview. 6. Suggested language: "I would like to ask you some questions, which I will show you in a moment. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult. We ask these questions of everyone so we can make sure that our care will meet your needs". • C0300C: "What day of the week is today?" • For C0400 items, instructions should be written as: o Let's go back to an earlier question. What were those three words that I asked you to repeat?	**Section Removed**	Removed section due to redundancy.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.C.13 (cont.)	Chapter 2 Section C Page C-22 through Page C-23	○ If the patient is unable to remember a word, provide category cues again, but without using the actual word. Therefore, category cues for: • C0400A should be written as "something to wear"; • C0400B should be written as "a color"; and • C0500C should be written as "a piece of furniture". 7. If the patient chooses not to answer a particular item, accept their refusal and move on to the next question. For C0200 through C0400C, code refusals as incorrect. 8. Rules for stopping the interview are the same as if for administering the BIMS verbally. See page C-4. The facility may develop its own signs for this process. If the facility develops its own, it must • use the exact language as that used in the item set.form clearly written in a large enough font to be easily seen. • The patient may respond to any of the BIMS questions in writing. • Show separate sheets or cards for each question or statement.	**Section Removed**	Removed section due to redundancy.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.C.13 (cont.)	Chapter 2 Section C Page C-22 through Page C-23	• For C0200 items, instructions should be written as: o I have written 3 words for you to remember. Please read them. Then I will remove the card and ask you repeat or write down the words as you remember them. o Category cues should be provided to the patient in writing after the patient's first attempt to answer. Written category cues should state: "sock, something to wear; blue, a color; bed, a piece of furniture". • For C0300 items, instructions should be written as: o C0300A: "Please tell me what year it is right now". 9. C0300B: "What month are we in right now?" Directly provide the written questions for each item in C0200 through C0400 at one sitting and in the order provided. o For each BIMS question, show the patient a sheet of paper or card with the instruction for that question.	**Section Removed**	Removed section due to redundancy.

Chapter 2, Section C				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.C.14	Chapter 2 Section C Page C-24	**Steps for Assessment** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible. 1. Observe patient behavior during the cognitive assessment (BIMS items (C0200-C0400), Staff Assessment for Mental Status (C0900) or other cognitive assessment for the signs and symptoms of delirium).	**Steps for Assessment** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period. 1. Observe patient behavior during the cognitive assessment [BIMS items (C0200-C0400), Staff Assessment for Mental Status (C0900), if completed, or other cognitive assessment for the signs and symptoms of delirium].	Revised to reflect updates to guidance.
2.C.15	Chapter 2 Section C Page C-25	**Coding Tips** **Did not exist**	**Coding Tips** • At discharge, compare the patient's current mental status to their baseline mental status (prior to the discharge assessment time period).	Adding coding tip to reflect updates to guidance.

Chapter 2, Section D

Chapter 2, Section D				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.D.1	Chapter 2 Section D Page D-2	**Steps for Assessment** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.	**Steps for Assessment** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
2.D.2	Chapter 2 Section D Page D-10	**Coding Instructions** • If the PHQ-9 was completed (that is, D0150C through D0150I were not skipped blank due to the responses in D0150A and B), **and** if the patient answered the frequency responses of at least 7 of the 9 items on the PHQ-9; add the numeric scores from D0150A2-D0150I2 following the instructions found in Supplement D, and enter in D0160.	**Coding Instructions** • If the PHQ-9 was completed (that is, D0150C through D0150I were not blank due to the responses in D0150A and D0150B), **and** if the patient answered the frequency responses of at least 7 of the 9 items on the PHQ-9; add the numeric scores from D0150A2-D0150I2 following the instructions found in Supplement D, and enter in D0160.	Revised for clarity.
2.D.3	Chapter 2 Section D Page D-11	**Coding Instructions** Complete as close to the time of admission as possible and within 3 days of discharge.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.

Chapter 2, Section GG

Chapter 2, Section GG				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.GG.1	Chapter 2, Section GG, Page GG-1	**SECTION GG: FUNCTIONAL ABILITIES AND GOALS**	**SECTION GG: FUNCTIONAL ABILITIES**	Revised to reflect removal of discharge goals.
2.GG.2	Chapter 2, Section GG, Page GG-1	**Intent:** This section includes items about functional abilities and goals. It includes items focused on prior functioning, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.	**Intent:** This section includes items about functional abilities. It includes items focused on prior functioning, admission performance, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.	Revised to reflect removal of discharge goals.
2.GG.3	Chapter 2, Section GG, Page GG-13	**Coding Tips** • When coding the patient's usual performance and patient's discharge goal(s), use the 6-point scale or one of the four "activity not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted.	**Coding Tips** • When coding the patient's usual performance use the 6-point scale or one of the four "activity not attempted" codes (07, 09, 10, and 88) to specify the reason why an activity was not attempted.	Revised to reflect removal of discharge goals.
2.GG.4	Chapter 2, Section GG, Page GG-14	**Discharge Goal(s): Coding Tips**	**Removed section**	Removed section.
2.GG.5	Chapter 2, Section GG, Page GG-18	**GG0130A Coding Tips** **Did not exist**	**GG0130A Coding Tips** • The adequacy of the patient's nutrition or hydration is not considered for GG0130A, Eating.	Adding coding tip to reflect updates to guidance.

Chapter 2, Section GG				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.GG.6	Chapter 2, Section GG, Page GG-18	**GG0130A Coding Tips** ○ If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, exacerbation, or injury, code GG0130A, Eating as 09, Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.	**GG0130A Coding Tips** ○ If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, exacerbation, or injury, code GG0130A, Eating as 09, Not applicable.	Revised for accuracy.
2.GG.7	Chapter 2, Section GG, Page GG-23	**GG0130C Coding Tips** **Did not exist**	**GG0130C Coding Tips** • For some patients, this may include assessing the type and amount of assistance needed to complete clothing management and hygiene tasks after episodes of incontinence.	Adding coding tip to reflect updates to guidance.
2.GG.8	Chapter 2, Section GG, Page GG-25 through GG-26	**GG0130F, GG0130G, GG0130H Coding Tips** • Upper body dressing items used for coding include: • Lower body dressing items used for coding include: • Footwear dressing items used for coding include:	**GG0130F, GG0130G, GG0130H Coding Tips** • Upper body dressing items used for coding include but are not limited to: • Lower body dressing items used for coding include but are not limited to: • Footwear dressing items used for coding include but are not limited to:	Revised for clarity.

Chapter 2, Section GG				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.GG.9	Chapter 2, Section GG, Page GG-48	**GG0170I, Example #2** **Walk 10 feet:** The patient had bilateral amputations 3 years ago, and prior to the current admission used a wheelchair and did not walk. Currently the patient does not use prosthetic devices and uses only a wheelchair for mobility. The patient's care plan includes fitting and use of bilateral lower extremity prostheses. **Coding:** GG0170I, Walk 10 feet would be **coded 09, Not applicable** - not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. **Rationale:** When assessing a patient for GG0170I, Walk 10 feet, consider the patient's status prior to the current episode of care and current 3-day assessment status. Use code 09, Not applicable, because the patient did not walk prior to the current episode of care and did not walk during the 3-day assessment period. Because GG0170I, Walk 10 feet is coded 09, follow the skip pattern to GG0170M, 1 step (curb). The patient's care plan includes fitting and use of bilateral prostheses and walking as a goal. A discharge goal for any admission performance item skipped may be entered if a discharge goal is determined as part of the patient's care plan.	**GG0170I, Example #2** **Walk 10 feet:** The patient had bilateral amputations 3 years ago, and prior to the current admission used a wheelchair and did not walk. Currently the patient does not use prosthetic devices and uses only a wheelchair for mobility. **Coding:** GG0170I, Walk 10 feet would be **coded 09, Not applicable** - not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. **Rationale:** When assessing a patient for GG0170I, Walk 10 feet, consider the patient's status prior to the current episode of care and current 3-day assessment status. Use code 09, Not applicable, because the patient did not walk prior to the current episode of care and did not walk during the 3-day assessment period. Because GG0170I, Walk 10 feet is coded 09, follow the skip pattern to GG0170M, 1 step (curb).	Example revised to reflect removal discharge goals.

Chapter 2, Section GG				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.GG.10	Chapter 2, Section GG, Page GG-49	**GG0170J, Coding Tips** The turns included in the items GG0170J, Walk 50 feet with two turns are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).	**GG0170J, Coding Tips** • The turns included in the items GG0170J, Walk 50 feet with two turns are 90 degree turns. The turns may occur at any time during the 50-foot distance. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).	Revised to reflect updates to guidance.
2.GG.11	Chapter 2, Section GG, Page GG-51	**GG0170K, Example #2** **Walk 150 feet:** The patient has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. The patient has not walked 150 feet or more during the assessment period, including with the physical therapist, who has been working with the patient. The therapist knows that the patient walked long distances prior to their exacerbation and speculates that the patient could walk this distance in the future with additional assistance. **Coding:** GG0170K, Walk 150 feet would be coded 88, Not attempted due to medical or safety concerns. **Rationale:** The activity was not attempted. The patient did not complete the activity,	**GG0170K, Example #2** **Walk 150 feet:** The patient has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. The patient has not walked 150 feet or more during the assessment period, including with the physical therapist, who has been working with the patient. The therapist knows that the patient walked long distances prior to their exacerbation. **Coding:** GG0170K, Walk 150 feet would be **coded 88, Not attempted due to medical or safety concerns**. **Rationale:** The activity was not attempted. The patient did not complete the activity, and a helper cannot complete the activity for	Example revised to reflect removal discharge goals.

Chapter 2, Section GG				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.GG.11 (cont.)	Chapter 2, Section GG, Page GG-51	and a helper cannot complete the activity for the patient. The patient performed the activity prior to their exacerbation. A patient who walks less than 50 feet would be coded in item GG0170I, Walk 10 feet.	the patient. The patient performed the activity prior to their exacerbation. A patient who walks less than 50 feet would be coded in item GG0170I, Walk 10 feet.	Example revised to reflect removal discharge goals.
2.GG.12	Chapter 2, Section GG, Pages GG-51, GG-52	**GG170M, GG0170N, GG0170O Coding Tips Did not exist**	**GG170M, GG0170N, GG0170O Coding Tips** • While a patient may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means without taking more than a brief rest break in order to consider the stair activity completed. • Do not consider the stand-to-sit or sit-to-stand transfer when coding any of the step activities.	Adding coding tips to reflect updates to guidance.
2.GG.13	Chapter 2, Section GG, Page GG-52	**GG170M, GG0170N, GG0170O Coding Tips** If, at the time of the assessment, the patient is unable to complete the activity due to a physician prescribed restriction (for instance, no stair climbing for 2 weeks), but could perform this activity prior to the current illness, exacerbation, or injury, code 88, Not attempted due to medical condition or safety concern.	**GG170M, GG0170N, GG0170O Coding Tips** If, at the time of the assessment, the patient is unable to complete the activity due to a physician-prescribed restriction of no stair climbing, they may be able to complete the stair activities safely by some other means (e.g., stair lift, bumping/scooting on their buttocks). If so, code based on the type and amount of assistance required to complete the activity. If, at the time of assessment, a patient is unable to complete the stair activities because of physician-prescribed bed rest, code the stair activity using the appropriate "activity not attempted" code.	Revised for clarity.

Chapter 2, Section GG				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.GG.14	Chapter 2, Section GG, Pages GG-54, GG-55	**GG0170Q, Example #1** **Does the patient use a wheelchair and/or scooter?** On admission, the patient wheels themself using a manual wheelchair but with difficulty due to their severe osteoarthritis and COPD. **Coding:** GG0170Q1, Does the patient use a wheelchair and/or scooter? would be **coded 1, Yes**. The admission performance codes for wheelchair items GG0170R, Wheel 50 feet with two turns and GG0170S, Wheel 150 feet are coded; in addition, the type of wheelchair the patient uses for GG0170RR1 and RR3 is indicated as **code 1, Manual**. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded. **Rationale:** The patient currently uses a wheelchair. Coding both items and coding the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.	**GG0170Q, Example #1** **Does the patient use a wheelchair and/or scooter?** On admission, the patient wheels themself using a manual wheelchair but with difficulty due to their severe osteoarthritis and COPD. **Coding:** GG0170Q1, Does the patient use a wheelchair and/or scooter? would be **coded 1, Yes**. The admission performance codes for wheelchair items GG0170R, Wheel 50 feet with two turns and GG0170S, Wheel 150 feet are coded; in addition, the type of wheelchair the patient uses for GG0170RR1 and RR3 is indicated as **code 1, Manual**. **Rationale:** The patient currently uses a wheelchair. Coding both items and coding the type of wheelchair (manual) is indicated.	Example revised to reflect removal discharge goals.

Chapter 2, Section GG				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.GG.15	Chapter 2, Section GG, Page GG-55	**GG0170R, GG0170RR Coding Tips** • The turns included in the items GG0170R, Wheel 50 feet with two turns are 90 degree turns. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level.	**GG0170R, GG0170RR Coding Tips** • The turns included in the items GG0170R, Wheel 50 feet with two turns are 90 degree turns. The turns may occur at any time during the 50-foot distance. The turns may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90 degree turn should occur at the person's ability level.	Revised to reflect updates to guidance.

Chapter 2, Section J

Chapter 2, Section J				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.J.1	Chapter 2 Section J Page J-3	**Coding Instructions** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
2.J.2	Chapter 2 Section J Page J-5	**Coding Instructions** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
2.J.3	Chapter 2 Section J Page J-5	**Definition** **Rehabilitation Therapy** Special healthcare service or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.	**Definition** **Rehabilitation Therapy** Includes, but is not limited to, special healthcare services or programs that help a person regain physical, mental, and or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Can include, for example, any services provided by physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP) therapy, and cardiac and pulmonary therapies.	Revised to reflect updates to guidance.

Chapter 2, Section J				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.J.4	Chapter 2 Section J Page J-6	**Coding Tips** • Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient carrying out a prescribed therapy program without staff present.	**Coding Tips** • Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present, regardless of the rehab focus or goal(s).	Revised to reflect updates to guidance.
2.J.5	Chapter 2 Section J Page J-7	**Coding Instructions** If admission assessment, complete as close to the time of admission as possible. If discharge assessment, complete as close to the time of discharge as possible.	**Coding Instructions** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.	Revised to reflect updates to guidance.
2.J.6	Chapter 2 Section J Page J-11	**Coding Tips** **Did not exist**	**Coding Tips** • Include all falls that occurred since the time of admission. This would include any falls that occurred outside of the IRF facility during a program interruption.	Added coding tip to reflect updates to guidance.
2.J.7	Chapter 2 Section J Page J-14	**Coding Tips** • For item J1900, include all falls that occurred since the time of admission. This would include any falls that occurred during a program interruption.	**Coding Tips** • Include all falls that occurred since the time of admission. This would include any falls that occurred outside of the IRF facility during a program interruption.	Revised coding tip for clarity.

Chapter 2, Section J				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.J.8	Chapter 2 Section J Page J-14	**Coding Tips** **Did not exist**	**Coding Tips** • Facilities are encouraged to utilize accurate and/or new information regarding fall-related injuries as information becomes known. For example, injuries can present themselves later than the time of the fall. The facility may not learn of the level of injury until after the IRF-PAI assessment is completed or the patient has left the facility (e.g., because the patient was transported to an emergency room and admitted to an inpatient facility post-fall). Errors should be corrected following the facility's correction policy. Additional information can be found in Chapter 5 of this manual.	Added coding tip to reflect updates to guidance.

Chapter 2, Section K

Chapter 2, Section K				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.K.1	Chapter 2 Section K Page K-2	**Coding Instructions for Admission** Check all that apply on admission. If none apply, check K0520Z, None of the above.	**Coding Instructions for Admission** Check all that are part of the patient's current care/treatment plan during the 3-day admission assessment time period, even if not used during the 3-day admission assessment time period. If none apply, check K0520Z, None of the above.	Revised to reflect updates to guidance.
2.K.2	Chapter 2 Section K Page K-2	**Steps for Assessment for Discharge** 1. Review the medical record to determine if any of the listed nutritional approaches were received in the last 7 days (Column 1) and at discharge (Column 2).	**Steps for Assessment for Discharge** 1. Review the medical record to determine if any of the listed nutritional approaches were part of the current care/treatment plan in the last 7 days (Column 4) and at discharge (Column 5).	Revised to reflect updates to guidance.
2.K.3	Chapter 2 Section K Page K-2	**Definitions Box** **Feeding Tube** Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.	**Definitions Box** **Feeding Tube** Presence of any type of tube that can deliver food/nutritional substances/fluids directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.	Revised to reflect updates to guidance.

Chapter 2, Section K				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.K.4	Chapter 2 Section K Page K-2	**Coding Instructions for Discharge** Check all nutritional approaches that were received in the last 7 days and at discharge. If none apply, check K0520Z, None of the above.	**Coding Instructions for Discharge** Check all nutritional approaches that were part of the patient's current care/treatment plan during the last 7 days, even if not used in the last 7 days and check all of the nutritional approaches that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period, even if not used during the 3-day discharge assessment time period. If none apply, check K0520Z, None of the above.	Revised to reflect updates to guidance.
2.K.5	Chapter 2 Section K Page K-3	**Coding Tips for Discharge** **Did not exist**	**Coding Tips for Discharge** • At discharge, K0520 does not report on nutritional approaches that are expected to occur after discharge.	Added coding tips to reflect updates to guidance
2.K.6	Chapter 2 Section K Page K-3	**Coding Tips for K0520A** • IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration.	**Coding Tips for K0520A** • IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and/or hydration.	Revised to reflect updates to guidance.
2.K.7	Chapter 2 Section K Page K-4	**Coding Tips for K0520B** **Did not exist**	**Coding Tips for K0520B** • If a feeding tube is in place but there are no scheduled or PRN orders to provide nutrition or hydration via the feeding tube on the current care/treatment plan, do not code K0520B, Feeding Tube.	Added coding tip to reflect updates to guidance

Chapter 2, Section M

Chapter 2, Section M				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.M.1	Chapter 2, Section M, Page M-3	**Coding Instructions** • **Code 0**, No, if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day assessment period (or the last skin assessment in the 3-day assessment period at discharge). • **Code 1,** Yes, if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) on the first skin assessment in the 3-day assessment period (or the last skin assessment in the 3-day assessment period at discharge).	**Coding Instructions** • **Code 0**, No, if the patient did not have a pressure ulcer/injury on the first skin assessment in the 3-day assessment period at admission (or the last skin assessment in the 3-day assessment period at discharge). • **Code 1,** Yes, if the patient had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) on the first skin assessment in the 3-day assessment period at admission (or the last skin assessment in the 3-day assessment period at discharge).	Revised for clarity.

Chapter 2, Section N

Chapter 2, Section N				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.N.1	Chapter 2 Section N Page N-1	**Section N: Medications** **Intent:** The intent of the High-Risk Drug Classes items in this section is to record whether the patient is taking any medications in specified drug classes and whether the indication was noted for taking the prescribed medications.	**Section N: Medications** **Removed**	Removed Section intent.
2.N.2	Chapter 2 Section N Page N-1	**N0415. High-Risk Drug Classes: Use and Indication** **Intent** **Did not exist**	**N0415. High-Risk Drug Classes: Use and Indication** **Intent**: The intent of the High-Risk Drug Classes items in this section is to record whether the patient is taking any medications in specified drug classes and whether the patient-specific indication was noted for the prescribed medications.	Added Item intent.
2.N.3	Chapter 2 Section N Page N-1	**Definition Box** **Did not exist**	**Definition Box** **INDICATIONS** The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the patient's condition and therapeutic goals.	Added new definition for clarity in guidance.

Chapter 2, Section N				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.N.4	Chapter 2 Section N Page N-1 through Page N-2	**Steps for Assessment** Complete on admission and discharge. 1. Determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). 2. If Column 1 is checked (patient is taking medication in drug classification), review patient documentation to determine if there is a documented indication noted for all medications in the drug class (Column 2).	**Steps for Assessment** Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period. 1. Determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). Include all medications that are part of a patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment time period. 2. If Column 1 is checked (patient is taking medication in drug classification), review patient documentation to determine if there is a documented patient-specific indication noted for all medications in the drug class (Column 2).	Revised to reflect updates to guidance.
2.N.5	Chapter 2 Section N Page N-2 through Page N-3	**Coding Tips** • Code medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication. • Include any of these medications used by any route (e.g., PO, IM, transdermal, or IV) in any setting (e.g., at IRF, in a hospital emergency room, at physician office or	**Coding Tips** • Code medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it. • Include any of these medications used by any route in any setting (e.g., at IRF, in a hospital emergency room, at physician office or clinic) while a patient of the setting that is also part of a patient's current reconciled drug regimen, even if it was not taken during the 3-day assessment time period. • Count long-acting medications, such as fluphenazine decanoate or haloperidol	Revised to reflect updates to guidance.

Chapter 2, Section N				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.N.5 (cont.)	Chapter 2 Section N Page N-2 through Page N-3	clinic) while a patient of the setting. • Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly **only** if they are taken at admission/discharge. • A transdermal patch is designed to release medication over a period of time (typically 3– 5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the IRF-PAI, and are only counted if the patch is attached to the skin during admission or discharge assessment period. • Combination medications should be coded in all categories/drug classes that constitute the combination. For example, if the patient receives a single tablet that combines an antipsychotic and an antidepressant, then both antipsychotic and antidepressant categories should be coded.	decanoate, that are given every few weeks or monthly **only** if they are part of the patient's current reconciled drug regimen during the 3-day assessment time period, even if it was not taken during the 3-day assessment time period. • A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the IRF-PAI, and are counted if they are part of the patient's current reconciled drug regimen during the 3-day assessment time period, even if was not used during the 3-day assessment time period. • Combination medications should be coded in all categories/drug classes that constitute the combination. For example, if the patient receives a single tablet that combines an opioid and an antiplatelet, then both opioid and antiplatelet categories should be coded, regardless of why the medication is being used.	Revised to reflect updates to guidance.
2.N.6	Chapter 2 Section N Page N-2	**Coding Tips** • Code a medication even if it was taken only once during the assessment period.	**Coding Tips** **Removed**	Removed coding tip.

Chapter 2, Section N				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.N.7	Chapter 2 Section N Page N-3	**Coding Tips** **Did not exist**	**Coding Tips** Some facilities utilize standing orders or a standing order set, providing a specific PRN order for all patients. If a medication is included on the patient's prescribed drug regimen due to facility policy (and not due to patient-specific need), it would only be considered for N0415 - High-Risk Drug Classes: Use and Indication if the patient received it during the 3-day assessment time period. Do not include flushes to keep an IV access patent in N0415E, Anticoagulant. CMS does not specify a source for identifying the therapeutic category and/or pharmacological classification. CMS does not provide an exhaustive list of examples for determining the source for the documented patient-specific indication. At Discharge, N0415 considers medications included in the patient's prescribed drug regimen at discharge, and not what is expected to occur after discharge.	Added new coding tips to reflect updates to guidance.
2.N.8	Chapter 2 Section N Page N-5	**Steps for Assessment** Complete at the time of admission.	**Steps for Assessment** Complete based on an assessment that occurs within the 3-day admission assessment time period.	Revised to reflect updates to guidance.
2.N.9	Chapter 2 Section N Page N-11	**Coding Instructions** Complete at the time of admission; and if N2001 Drug Regimen Review was coded 1. Yes – Issues found during review.	**Coding Instructions** **Removed**	Removed coding instruction due to redundancy.

Chapter 2, Section O

Chapter 2, Section O				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.O.1	Chapter 2 Section O Page O-1	**SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS** Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient.	**SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS** **Removed**	Removed Section intent.
2.O.2	Chapter 2 Section O Page O-1	**O0110. Special Treatments, Procedures, and Programs** **Did not exist**	**O0110. Special Treatments, Procedures, and Programs** Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that apply to the patient.	Added item intent.
2.O.3	Chapter 2 Section O Page O-4	**Steps for Assessment for Admission** 1. Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs apply on admission.	**Steps for Assessment for Admission** 1. Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs are part of the patient's current care/treatment plan during the 3-day admission assessment time period.	Revised to reflect updates to guidance.
2.O.4	Chapter 2 Section O Page O-4	**Coding Instructions for Admission** Check all treatments, procedures, and programs that apply on admission. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply on admission, **check Z1, None of the above**.	**Coding Instructions for Admission** Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day admission assessment time period. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply on admission, **check Z1, None of the above.**	Revised to reflect updates to guidance.

Chapter 2, Section O				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.O.5	Chapter 2 Section O Page O-4	**Steps for Assessment for Discharge** 1. Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs apply at discharge.	**Steps for Assessment for Discharge** 1. Review the patient's medical record and consult with the patient, family, caregiver(s), and/or staff to determine whether or not any of the treatments, procedures, or programs are part of the patient's current care/treatment plan during 3-day discharge assessment time period. Do not consider what is expected to occur after discharge.	Revised to reflect updates to guidance.
2.O.6	Chapter 2 Section O Page O-4	**Coding Instructions for Discharge** Check all treatments, procedures, and programs that apply at discharge. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply at discharge, check Z1, None of the above.	**Coding Instructions for Discharge** Check all treatments, procedures, and programs that are part of the patient's current care/treatment plan during the 3-day discharge assessment time period. For O0110A1 (Chemotherapy), O0110B1 (Radiation), and O0110J1 (Dialysis), check if the patient is undergoing treatment. If no items apply on discharge, **check Z1, None of the above.**	Revised to reflect updates to guidance.
2.O.7	Chapter 2 Section O Page O-5	**Coding Tips** **Did not exist**	**Coding Tips** • Some facilities utilize standing orders or a standing order set, providing a specific PRN order for their patients. If a standing order for treatment is included on the patient's current care/treatment plan due to facility policy (and not due to patient-specific need), it would only be considered for O0110 - Special Treatments, Procedures, and Programs, if the patient received it during the 3-day assessment time period.	Added new coding tip to reflect updates to guidance.

Chapter 2, Section O				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.O.8	Chapter 2 Section O Page O-5	**O0100A3, Oral** **O0100A10, Other**	**O0110A3, Oral** **O0110A10, Other**	Correction
2.O.9	Chapter 2 Section O Page O-6	**O0110C1, Oxygen Therapy** Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a patient to relieve hypoxia	**O0110C1, Oxygen Therapy** Code continuous or intermittent oxygen administered via mask, cannula, etc., that is part of the patient's current care/treatment plan regardless of reason for its use.	Revised to reflect updates to guidance.
2.O.10	Chapter 2 Section O Page O-7	**O0110G1, Non-Invasive Mechanical Ventilator** Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support their own spontaneous respiration** by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that "breathe" for the individual. If a ventilator is being used as a substitute for BiPAP/CPAP, code here (and do not check O0110G2 or O0110G3). This item may be checked if the patient places or removes their own BiPAP/CPAP mask/device or if the staff applies it for the patient.	**O0110G1, Non-Invasive Mechanical Ventilator** Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support their own spontaneous respiration by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that "breathe" for the individual. If a ventilator is being used as a substitute for BiPAP/CPAP, code here. This item may be checked if the patient places or removes their own BiPAP/CPAP mask/device or if the staff applies it for the patient.	Revised to reflect updates to guidance.

Chapter 2, Section O				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.O.11	Chapter 2 Section O Page O-7	**O0110H1, IV Medications** Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** include flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be checked here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** included in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.	**O0110H1, IV Medications** Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Include IV fluids with medications added, unless otherwise excluded in guidance. Do **not** include flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be checked here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** included in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.	Revised to reflect updates to guidance.
2.O.12	Chapter 2 Section O Page O-8	**O0110H1, IV Medications** Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be included here. To determine what products are considered medications or for more information consult the FDA website: The Orange Book, http://www.accessdata.fda.gov/scripts/cder/ob/ The National Drug Code Directory, http://www.fda.gov/drugs/informationondrugs/ucm142438.htm	**O110H1, IV Medications** **Removed**	Removed coding tip to reflect updated guidance.

Chapter 2, Section O				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.O.13	Chapter 2 Section O Page O-8 through Page O-9	**O0110O1, IV Access** Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication	**O0110O1, IV Access** Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication	Revised to reflect updates to guidance.
2.O.13 (cont.)	Chapter 2 Section O Page O-8 through Page O-9	administration, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure.	administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure. An AV fistula does not meet the definition of IV Access for O0110O1. If there is not a current IV access in place at the time of assessment do not code IV access for O0110O1, even if a treatment which would require an IV access is part of the patient's current care/treatment plan.	Revised to reflect updates to guidance.

Chapter 2, Section O				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.O.14	Chapter 2 Section O Page O-9	**Example #1** 1. The patient's referral information indicates that they were discharged from an acute care facility following inpatient stay for bacterial pneumonia that required placement of a tracheostomy. On admission, the patient requires intermittent oxygen. Their suctioning needs vary but are decreasing. The patient has, however, had intermittent desaturations due to mucus plugging that have required use of a tracheostomy mask at an FiO2 of greater than 40% intermittently. The patient has orders for 1 more week of IV antibiotics, which are being delivered via a PICC line.	**Example #1** 1. The patient's referral information indicates that they were discharged from an acute care facility following inpatient stay for bacterial pneumonia that required placement of a tracheostomy. On admission, the patient requires intermittent oxygen. The patient's admission orders also include an order for PRN suctioning. The patient has, however, had intermittent desaturations due to mucus plugging that have required use of a tracheostomy mask at an FiO2 of greater than 40% intermittently. The patient has orders for 1 more week of IV antibiotics, which are being delivered via a PICC line.	Revised for clarity.

Chapter 2, BIMS Supplement

Chapter 2, Supplement				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
2.S.1	Chapter 2 Supplement Page S-2	C0500C, Able to recall "bed" should be written as "a piece of furniture".	C0400C, Able to recall "bed" should be written as "a piece of furniture."	Corrected item number.
2.S.2	Chapter 2 Supplement Page S-3	There are several BIMS sections that require direct interview of the patient as the primary source of information (e.g., mood, pain).	**Removed**	Removed language.

Chapter 3

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.1	Chapter 3, Page 3-1	CHAPTER 3: CLARIFICATION OF TERMINOLOGY	CHAPTER 3: GLOSSARY AND COMMON ACRONYMS	Updated chapter title.
3.2	Chapter 3, Page 3-1	**Did not exist**	**Term: Active Diagnoses** **Definition:** Diagnoses (conditions or diseases) that have a direct relationship to the patient's current functional, cognitive, mood, or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.	Added new term and definition.
3.3	Chapter 3, Page 3-1	**Did not exist**	**Term: Admission Date** **Definition:** The date a person enters the IRF and is admitted as a patient. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the first day of admission.	Added new term and definition.
3.4	Chapter 3, Page 3-1	**Did not exist**	**Term: Ambulation** **Definition:** Self-mobilization along a surface on foot, step by step so that one foot is always in contact with the ground. Ambulation may include walking short or long distances and walking on different surfaces as specified in the assessment item. Movement from place to place, which usually includes walking.	Added new term and definition.
3.5	Chapter 3, Page 3-1	**Term: Ancillary Services** **Definition:** Health services other than room and board. These may include x-ray, laboratory, and therapy services.	**Removed**	Removed item and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.6	Chapter 3, Page 3-1	**Term: Another Inpatient Rehabilitation Facility** **Definition:** For the purposes of coding items 15A, 16A, and 44D, this code should be used when a patient is admitted from/transferred to another IRF.	**Term: Another Inpatient Rehabilitation Facility** **Definition:** For the purposes of coding items 15A, 16A, and 44D, this code should be used when a patient is admitted from/transferred to another IRF or remained a patient of the same IRF under a new payer.	Revised definition to reflect updates to guidance.
3.7	Chapter 3, Page 3-1	**Term: Assessment Reference Date (ARD)** **Definition:** (…) For the discharge assessment, the Assessment Reference Date is the date that the patient is discharged from the IRF, or the date that the patient ceases to receive Medicare Part A fee-for-service inpatient rehabilitation services.	**Term: Assessment Reference Date (ARD)** **Definition: (…)** For the discharge assessment, the Assessment Reference Date is the date that the patient is discharged from the IRF, or the date that the patient ceases to receive Medicare inpatient rehabilitation services.	Updated definition.
3.8	Chapter 3, Page 3-1	**Term: Assessment Schedule** **Did not exist**	**Term: Assessment Schedule** **Definition:** Refers to when assessments must be coded and transmitted. The assessment and discharge assessment schedules are illustrated in Charts 1, 2 and 3 in Chapter 2.	Added new term and definition.
3.9	Chapter 3, Page 3-2	**Term: Board and care, assisted living, group home** **Definition:** A non-institutional community residential setting that includes home health services, homemaker/personal care services, or meal services.	**Term: Board and care, assisted living, group home** **Definition:** A non-institutional community residential setting that includes homemaker/personal care services, or meal services.	Updated definition.
3.10	Chapter 3, Page 3-2	**Term: Body Mass Index (BMI)** **Did not exist**	**Term: Body Mass Index (BMI)** **Definition:** Number calculated from a person's weight and height. BMI is a reliable indicator of body fat and is used as an indicator to identify possible weight problems for adults.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.11	Chapter 3, Page 3-2	**Term: CMS** **Definition:** Centers for Medicare & Medicaid Services	**Removed**	Removed item and definition.
3.12	Chapter 3, Page 3-2	**Term: CMS Certification Number (CCN)** **Did not exist**	**Term: CMS Certification Number (CCN)** **Definition:** Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities.	Added new term and definition.
3.13	Chapter 3, Page 3-2	**Term: Confusion Assessment Method (CAM)** **Did not exist**	**Term: Confusion Assessment Method (CAM)** **Definition:** An instrument that screens for overall cognitive impairment as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments.	Added new term and definition.
3.14	Chapter 3, Page 3-2	**Term: Contact with Physician (or Physician-Designee)** **Did not exist**	**Term: Contact with Physician (or Physician-Designee)** **Definition:** Communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue, AND a response from the physician (or physician-designee) to convey prescribed/ recommended actions in response to the medication issue. Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status. Communication can be directly to/from the physician (or physician-designee), or indirectly through physician's office staff on behalf of the physician (or physician-designee), in accordance with the legal scope of practice.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.15	Chapter 3, Page 3-3	**Term: Delirium** **Did not exist**	**Term: Delirium** **Definition:** A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations.	Added new term and definition.
3.16	Chapter 3, Page 3-3	**Term: Discharge Date** **Did not exist**	**Term: Discharge Date** **Definition:** The date a patient leaves the IRF. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual Discharge Date for Item 40. If a discharge is delayed, the Discharge Date is the day the patient actually leaves the IRF.	Added new term and definition.
3.17	Chapter 3, Page 3-4	**Term: Disorganized Thinking**	**Term: Disorganized Thinking** **Definition:** The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using, and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.18	Chapter 3, Page 3-4	**Term: Fatal File Error** **Did not exist**	**Term: Fatal File Error** **Definition:** An error in the IRF submission file format that causes the entire file to be rejected; therefore, the individual assessment records in the submission file are not validated or stored in the iQIES. The Submitter Final Validation Report identifies Fatal File Error(s). The IRF must contact its software support to resolve the problem with the submission file. Once the submission file problem is resolved, the submission file and associated IRF-PAI assessment records must be resubmitted.	Added new term and definition.
3.19	Chapter 3, Page 3-4	**Term: Fatal Record Error** **Did not exist**	**Term: Fatal Record Error** **Definition:** An error in an IRF-PAI assessment record that results in the assessment record being rejected. The Final Validation Report lists the assessment records that were rejected. The IRF-PAI must correct error(s) on each assessment record that was rejected, and resubmit.	Added new term and definition.
3.20	Chapter 3, Page 3-4	**Term: Federal Register** **Did not exist**	**Term: Federal Register** **Definition:** The official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents. It is a publication of the National Archives and Records Administration, and is available by subscription and online.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.21	Chapter 3, Page 3-5	**Term: Final Validation Report (FVR)** **Did not exist**	**Term: Final Validation Report (FVR)** **Definition:** A report generated after the successful submission of IRF-PAI assessment record files. This report lists all of the patients for whom assessments have been submitted in a particular submission batch and displays all errors and/or warnings that occurred during the validation process. Each individual record is listed on the FVR as "accepted" or "rejected". Accepted records are added to the iQIES database. Rejected records are not added to the iQIES database and must be corrected and resubmitted.	Added new term and definition.
3.22	Chapter 3, Page 3-6	**Term: Health Information Exchange (HIE)** **Did not exist**	**Term: Health Information Exchange (HIE)** **Definition:** Health Information Exchange (HIE) allows health care professionals and patients to appropriately access and securely share a patient's medical information electronically. There are many health care delivery scenarios driving the technology behind the different forms of HIE available today including directed exchange, query-based exchange and consumer-mediated exchange.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.23	Chapter 3, Page 3-6	**Term: Home under care of home health service organization** **Definition:** For the purposes of coding items 15A, 16A, and 44D, this code should be used when a patient is: • Admitted from/discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs)—whether home attendant, nursing aides, certified attendants, etc.; • Admitted from/discharged/transferred to a foster care facility with home care; or • Admitted from/discharged to home under a home health agency with DME. • This code should not be used for home health services provided by a: • DME supplier; or • Home IV provider for home IV services.	**Term: Home under care of home health service organization** **Definition:** For the purposes of coding items 15A, 16A, and 44D, this code should be used when a patient is admitted from/discharged/transferred to home with any services from a Medicare certified home health agency.	Updated definition.
3.24	Chapter 3, Page 3-6	**Term: Hospice** **Did not exist**	**Term: Hospice** **Definition:** A program for terminally ill persons. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.25	Chapter 3, Page 3-6	**Term: Inactivation** **Did not exist**	**Term: Inactivation** **Definition:** A type of correction allowed under the IRF Correction Policy. When an erroneous record has been accepted into the iQIES database, an inactivation request is required. This removes the erroneous record from the active file to an archive (history file). A new record to replace the removed record must be completed and submitted to iQIES.	Added new term and definition.
3.26	Chapter 3, Page 3-6	**Term: Inattention** **Did not exist**	**Term: Inattention** **Definition:** Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated, or darting attention).	Added new term and definition.
3.27	Chapter 3, Page 3-6	**Term: Injury (except major)** **Did not exist**	**Term: Injury (except major)** **Definition:** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.	Added new term and definition.
3.28	Chapter 3, Page 3-6	**Term: Injury Related to a Fall** **Did not exist**	**Term: Injury Related to a Fall** **Definition:** Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.29	Chapter 3, Page 3-6	**Term: International Classification of Diseases, 10th Edition, Clinical Management (ICD-10)** **Definition:** A listing of diagnoses and identifying codes used to report diagnoses for individuals.	**Term: International Classification of Diseases, 10th Edition, Clinical Management (ICD-10)** **Definition:** Official system of assigning codes to diagnoses associated with hospital utilization in the United States. The ICD-CM contains a numerical list of the disease code numbers in tabular form, an alphabetical index to the disease entries	Updated definition.
3.30	Chapter 3, Page 3-7	**Term: Legal Name** **Did not exist**	**Term: Legal Name** **Definition:** Patient's name as it appears on the Medicare card. If the patient is not enrolled in the Medicare program, the patient's name as it appears on a Medicaid card or other government-issued document is used.	Added new term and definition.
3.31	Chapter 3, Page 3-7	**Term: Long-Term Care Facility** **Did not exist**	**Term: Long-Term Care Facility** **Definition:** An institution that is engaged primarily in providing medical and nonmedical care to people who have a chronic illness or disability. These facilities provide care to people who cannot be cared for at home or in the community. Long-term care facilities provide a wide range of personal care and health services for individuals who cannot take care of themselves because of physical, emotional, or mental health issues. The provision of nonskilled care and related services for residents in long-term care can include, but is not limited to, supportive services such as dressing, bathing, using the bathroom, diabetes monitoring, and medication administration.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.32	Chapter 3, Page 3-7	**Term: Major Injury** **Did not exist**	**Term: Major Injury** **Definition:** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.	Added new term and definition.
3.33	Chapter 3, Page 3-8	**Term: Medicare Beneficiary Identifier (MBI)**	**Term: Medicare Beneficiary Identifier (MBI)** **Definition:** The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.	Added new term and definition.
3.34	Chapter 3, Page 3-8	**Term: Medication Follow-Up** **Did not exist**	**Term: Medication Follow-Up** **Definition:** The process of contacting a physician (or physician-designee) to communicate the identified medication issue and addressing all physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day at the latest.	Added new term and definition.
3.35	Chapter 3, Page 3-8	**Term: Modification** **Did not exist**	**Term: Modification** **Definition:** A type of correction allowed under the IRF Correction Policy. A modification is required when an IRF-PAI record has been accepted by iQIES, but the information in the record contains errors. The modification will correct the record in iQIES.	Added new term and definition.
3.36	Chapter 3, Page 3-8	**Term: National Provider Identifier (NPI)**	**Term: National Provider Identifier (NPI)** **Definition:** A unique Federal number that identifies providers of health care services. The NPI applies to the IRF and all of its patients.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.37	Chapter 3, Page 3-8	**Term: On Admission** **Did not exist**	**Term: On Admission** **Definition:** As close to the actual time of admission as possible.	Added new term and definition.
3.38	Chapter 3, Page 3-9	**Term: Planned Discharge** **Did not exist**	**Term: Planned Discharge** **Definition:** A discharge where the patient is nonemergently, medically released from care at the IRF, for longer than 3 days, for some reason arranged for in advance.	Added new term and definition.
3.39	Chapter 3, Page 3-9	**Term: Potential (or Actual) Clinically Significant Medication Issue** **Did not exist**	**Term: Potential (or Actual) Clinically Significant Medication Issue** **Definition:** A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.	Added new term and definition.
3.40	Chapter 3, Page 3-9	**Term: Pressure Ulcer/Injury** **Did not exist**	**Term: Pressure Ulcer/Injury** **Definition:** Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.	Added new term and definition.
3.41	Chapter 3, Page 3-9	**Term: Prospective Payment System (PPS)** **Definition:** A system of payments to a health care facility at a predetermined rate for treatment regardless of the cost of care for a specific patient.	**Term: Prospective Payment System (PPS)** **Definition:** A method of payments to a health care facility at a predetermined rate for treatment regardless of the cost of care for a specific patient.	Updated definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.42	Chapter 3, Page 3-9	**Term: Quality Measure** **Did not exist**	**Term: Quality Measure** **Definition:** Tools that help measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.	Added new term and definition.
3.43	Chapter 3, Page 3-10	**Term: State Medicaid Provider Number** **Did not exist**	**Term: State Medicaid Provider Number** **Definition:** Medicaid Provider Number established by a State.	Added new term and definition.
3.44	Chapter 3, Page 3-10	**Term: Submission Confirmation Page** **Did not exist**	**Term: Submission Confirmation Page** **Definition:** The initial feedback generated by the iQIES system after an IRF-PAI data file is electronically submitted. This page acknowledges receipt of the submission file but does not examine the file for any warnings and/or errors. Warnings and/or errors are provided on the Final Validation Report.	Added new term and definition.
3.45	Chapter 3, Page 3-10	**Term: Submission Date** **Did not exist**	**Term: Submission Date** **Definition:** Refers to the date on which the completed IRF-PAI is submitted to iQIES.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.46	Chapter 3, Page 3-10	**Term: Unplanned Discharge** **Did not exist**	**Term: Unplanned Discharge** **Definition:** An unplanned transfer of the patient to be admitted to another hospital/facility that results in the patient's absence from the IRF for longer than 3 calendar days (including the date of transfer) or the patient's discharge from the IRF; or a transfer of the patient to an emergency department of another hospital to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation, which results in the patient's absence from the IRF for longer than 3 calendar days; or when a patient unexpectedly decides to go home or to another hospital/facility (e.g., patient prefers to complete treatment in an alternate setting).	Added new term and definition.
3.47	Chapter 3, Page 3-10	**Term: Unstageable Pressure Ulcer/Injury** **Did not exist**	**Term: Unstageable Pressure Ulcer/Injury** **Definition:** Visualization of the wound bed is necessary for accurate numerical staging. If the extent of soft tissue damage cannot be visualized or palpated in the wound bed, that pressure ulcer/injury should be classified as unstageable. For example, pressure ulcers/injuries may be unstageable due to eschar or slough or non-removable dressing/device.	Added new term and definition.

Chapter 3				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
3.48	Chapter 3, Page 3-10	**Term: Worsening in Pressure Ulcer/Injury Status** **Did not exist**	**Term: Worsening in Pressure Ulcer/Injury Status** **Definition:** Pressure ulcer/injury "worsening" is defined as a pressure ulcer/injury that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1–4 (using the staging assessment determinations assigned to each stage, starting at stage 1, and increasing in severity to stage 4) on a discharge assessment as compared with the admission assessment. To denote the absence of a pressure ulcer/injury or that there is no skin breakdown or evidence of damage, indicate that there are zero pressure ulcers/injuries.	Added new term and definition.
3.49	Chapter 3, Page 3-10	**Did not exist**	**Common Acronyms**	Added table with common acronyms.

Chapter 4

Chapter 4				
Edit #	**Chapter, Section, Page**	**IRF-PAI Manual Version 4.0 – Effective October 1, 2022**	**IRF-PAI Manual Version 4.2 – Effective October 1, 2024**	**Description of Change**
4.1	Chapter 4, Page 4-1	Additional information about iQIES and how to create an account is available at https://iqies.cms.gov/ and the qtso webpage at https://qtso.cms.gov/news-and-updates/register-iqies-account-action-required-0	Additional information about iQIES and how to create an account is available at https://iqies.cms.gov/ and the QIES Technical Support Office (QTSO) webpage at https://qtso.cms.gov/news-and-updates/register-iqies-account-action-required-0	Replaced acronym with full name.