

**Specifications for IRF-PAI Submission Files  
For Submission from the Inpatient Rehabilitation Facility to the National Assessment  
Collection Database**

***Data Specification Notes: Version 1.01A Revision 7***

***Changes with Version 1.01A Revision 7***

The version 1.01A Revision 7 data specification notes have been finalized as of July 29, 2011. The Print Date of the revised 1.01A data specifications has a date of 7/29/2011. The revision to these data specifications takes effect 10/01/2011. The change that was made with Version 1.01A Revision 7 of the data specifications is the following:

1. SBMTD\_CMG\_VRSN\_TXT (Submitted CMG version code) of the Body Record Detail was updated as follows:
  - The value “2.60” was added to the range.
  - Consistency check #7 changed as follows:

“7. If the discharge date (40) of the assessment is on or after October 1, 2010 and before October 1, 2011 then the submitted CMG version code should be 2.50. Failure to use 2.50 will result in a non-fatal error (warning).”
  - Consistency check #8 was added as follows:

“8. If the discharge date (40) of the assessment is on or after October 1, 2011 then the submitted CMG version code should be 2.60. Failure to use 2.60 will result in a non-fatal error (warning).”

***Data Specification Notes: Version 1.01A Revision 6***

***Changes with Version 1.01A Revision 6***

The version 1.01A Revision 6 data specification notes have been finalized as of July 30, 2010. The Print Date of the revised 1.01A data specifications has a date of 7/30/2010. The revision to these data specifications takes effect 10/01/2010. The change that was made with Version 1.01A Revision 6 of the data specifications is the following:

2. SBMTD\_CMG\_VRSN\_TXT (Submitted CMG version code) of the Body Record Detail was updated as follows:
  - The value “2.50” was added to the range.
  - Consistency check #6 changed as follows:

“6. If the discharge date (40) of the assessment is on or after October 1, 2009 and before October 1, 2010 then the submitted CMG version code should be 2.40. Failure to use 2.40 will result in a non-fatal error (warning).”
  - Consistency check #7 was added as follows:

“7. If the discharge date (40) of the assessment is on or after October 1, 2010 then the submitted CMG version code should be 2.50. Failure to use 2.50 will result in a non-fatal error (warning).”

3. Removed the following statement from the footer of each of the data submission specification reports:

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### **Changes with Version 1.01A Revision 5**

The version 1.01A Revision 5 data specification notes have been finalized as of July 31, 2009. The Print Date of the revised 1.01A data specifications has a date of 7/31/2009. The revision to these data specifications takes effect 10/01/2009. The change that was made with Version 1.01A Revision 5 of the data specifications is the following:

1. SBMTD\_CMG\_VRSN\_TXT (Submitted CMG version code) of the Body Record Detail was updated as follows:
  - The value "2.40" was added to the range.
  - Consistency check #5 changed as follows:

"5. If the discharge date (40) of the assessment is on or after October 1, 2008 and before October 1, 2009 then the submitted CMG version code should be 2.30. Failure to use 2.30 will result in a non-fatal error (warning)."
  - Consistency check #6 was added as follows:

"6. If the discharge date (40) of the assessment is on or after October 1, 2009 then the submitted CMG version code should be 2.40. Failure to use 2.40 will result in a non-fatal error (warning)."

### **Data Specification Notes: Version 1.01A Revision 4**

### **Changes with Version 1.01A Revision 4**

The version 1.01A Revision 4 data specification notes have been finalized as of July 31, 2008. The Print Date of the revised 1.01A data specifications has a date of 7/31/2008. The revision to these data specifications takes effect 10/01/2008. The change that was made with Version 1.01A Revision 4 of the data specifications is the following:

1. SBMTD\_CMG\_VRSN\_TXT (Submitted CMG version code) of the Body Record Detail was updated as follows:
  - The value "2.30" was added to the range.
  - Consistency check #4 changed as follows:

"4. If the discharge date (40) of the assessment is on or after October 1, 2007 and before October 1, 2008 then the submitted CMG version code should be 2.20. Failure to use 2.20 will result in a non-fatal error (warning)."
  - Consistency check #5 was added as follows:

“5. If the discharge date (40) of the assessment is on or after October 1, 2008 then the submitted CMG version code should be 2.30. Failure to use 2.30 will result in a non-fatal error (warning).”

### ***Data Specification Notes: Version 1.01A Revision 3***

#### ***Changes with Version 1.01A Revision 3***

The version 1.01A Revision 3 data specification notes have been finalized as of July 31, 2007. The Print Date of the revised 1.01A data specifications has a date of 7/31/2007. The revision to these data specifications takes effect 10/1/2007. The change that was made with Version 1.01A Revision 3 of the data specifications is the following:

1. SBMTD\_CMG\_VRSN\_TXT (Submitted CMG version code) of the Body Record

Detail was updated as follows:

- The value “2.20” was added to the range.
- Consistency check #3 changed as follows:

”3. If the discharge date (40) of the assessment is on or after October 1, 2006 and before October 1, 2007 then the submitted CMG version code should be 2.10. Failure to use 2.10 will result in a non-fatal error (warning).”
- Consistency check #4 was added as follows:

“4. If the discharge date (40) of the assessment is on or after October 1, 2007 then the submitted CMG version code should be 2.20. Failure to use 2.20 will result in a non-fatal error (warning).”

**Data Specification Notes: Version 1.01A Revision 2****Changes with Version 1.01A Revision 2**

The version 1.01A Revision 2 data specification notes have been finalized as of July 31, 2006. The Print Date of the revised 1.01A data specifications has a date of 7/31/2006. The revision to these data specifications takes effect 10/1/2006. The change that was made with Version 1.01A Revision 2 of the data specifications is the following:

**2. SBMTD\_CMV\_VRSN\_TXT (Submitted CMG version code) of the Body Record**

Detail was updated as follows:

- The value "2.10" was added to the range.
- Consistency check #2 changed as follows:
  - "2. If the discharge date (40) of the assessment is on or after October 1, 2005 and before October 1, 2006 then the submitted CMG version code should be 2.00. Failure to use 2.00 will result in a non-fatal error (warning)."
- Consistency check #3 was added as follows:
  - "3. If the discharge date (40) of the assessment is on or after October 1, 2006 then the submitted CMG version code should be 2.10. Failure to use 2.10 will result in a non-fatal error (warning)."

**Data Specification Notes: Version 1.01A Revision 1****Changes with Version 1.01A Revision 1**

The version 1.01A Revision 1 data specification notes have been finalized as of August 10, 2005. The Print Date of the revised 1.01A data specifications has a date of 8/10/2005. The revision to these data specifications takes effect 10/1/2005. The change that was made with Version 1.01A Revision 1 of the data specifications is the following:

**1. SBMTD\_CMV\_VRSN\_TXT (Submitted CMG version code) of the Body Record**

Detail was updated as follows:

- The value "2.00" was added to the range.
- Consistency check #2 was added as follows:
  - "2. If the discharge date (40) of the assessment is on or after October 1, 2005 then the submitted CMG version code should be 2.00. Failure to use 2.00 will result in a non-fatal error (warning)."

**Data Specification Notes: Version 1.01A****Changes with Version 1.01A**

The version 1.01A data specification notes have been finalized as of August 1, 2002. The changes that were made with Version 1.01A of the data specifications are the following:

1. Updated the "picture" for Fac\_Name (facility name) in the Header Record Detail to X(50).

2. Updated the "picture" for Fac\_Name (facility name) in the Header Record Summary to X(50).
3. Updated the version number on all sections to version 1.01A.
4. VERSION\_CD2 (data specifications version code) in the Body Record Detail was updated as follows:
  - The value "1.01A" was added to the range.
  - Consistency check #3 was added as follows:

"3. If a record is submitted using the old version of the specifications (1.00A), then a non-fatal warning will indicate that an old version is being used."
5. Item 2 (Body Record Detail)– Patient Medicare Number was updated as follows: Consistency #1 was changed to:

"\*1. This field must not be blank if 20A or 20B is coded 02 or 51."
6. Item 3 (Body Record Detail) – Patient Medicaid Number was updated as follows:
  - Consistency #2 from version 1.00A was removed:

"\*2. This field must not be blank if 20B is coded 03 or 52."
7. Item 6 (Body Record Detail) – Birth Date was updated as follows: Consistency #1 was updated to remove any reference to 23 (Date of Onset) as follows:

"\*1. This date must be earlier than all of the following dates that are present in the record (not blank): 12 (Admission Date), 13 (Assessment Reference Date), 40 (Discharge Date), and 43A -43F (Program Interruption Dates). This date must also be earlier than the current date."
8. Item 7 (Body Record Detail) – Social Security Number was updated as follows:
  - The valid range was changed to "Valid Code, sp (9)".
  - Consistency check #1 was changed to the following:

"\*1. If present in the record (not blank), the length must be 9 and all numeric."
9. Item 13 (Body Record Detail) – Assessment Reference Date: Consistency #1 was changed to the following (removing the comparisons to the Interrupted Stay Dates in Item 43):

"\*1. This date must be earlier than or the same as 40 (Discharge Date)."
10. Item 20A (Body Record Detail) – Primary Payment Source was updated as follows:
  - The valid range was changed to "01-16, 51-52".
  - Consistency #1 was changed to the following:

"\*1. IRF-PAI can only be submitted if 20A is equal to 02 or 51 or if 20B is equal to 02 or 51."
  - Added consistency #2 as follows:

"\*2. This item cannot be equal 02 or 51 if Item 20B is equal to 02 or 51."
11. Item 20B (Body Record Detail) – Secondary Payment Source was updated as follows:
  - The valid range was changed to "01-16, 51-52, sp(2)".
  - Consistency #1 was changed to:

"\*1. IRF-PAI can only be submitted if 20A is equal to 02 or 51 or if 20B is equal to 02 or 51."
  - Added consistency #2 as follows:

"\*2. This item cannot equal 02 or 51 if Item 20A is equal to 02 or 51."
12. Item 21d (Body Record Detail) – Impairment Group: Discharge: Added the following formatting information:

"If character 8 is a space, then character 9 must be a space."
13. Item 22 (Body Record Detail) – Etiologic Diagnosis Code was updated as follows:
  - Removed consistency #1:

"\*1. This item cannot contain a code that starts with "V57" (e.g., V57.1 or V57.89 are not allowed)."
  - Moved consistency #2 to consistency #1

14. Item 23 (Body Record Detail) – Date of Onset: Changed consistency #2 as follows:  
"2. If this date is present in the record (not blank), it must be earlier than or the same as the following dates present in the record (not blank): 40 (Discharge Date), 43A-43F (Program Interruption Dates) and the current date."
15. Item 26 (Body Record Detail) – Delirious: Admission was updated as follows:
- Removed consistency #1:  
"1. (If both items 25 and 26 have been completed, then this item must be equal to zero if item 25 is equal to one)."
  - Added new consistency #1:  
"1. Completion of this item is voluntary. If this item is not completed, a blank value is allowed."
16. Item 39Na (Body Record Detail) – Communication-Comprehension: Admission: Valid range was changed to "01-07" to match the IRF-PAI Training manual.
17. Item 39Oa (Body Record Detail) – Communication-Expression: Admission: Valid range was changed to "01-07" to match the IRF-PAI Training manual.
18. Item 40 (Body Record Detail) – Discharge Date was updated as follows:
- Combined consistency #1 and #2 to form the new consistency #1 as follows:  
"1. This date must be later than or the same as the following dates if present in the record (not blank): 43A-43F (Program Interruption Dates)."
  - Moved consistency #3 to consistency #2.

### ***Files Included in the Data Specifications***

This document and several accompanying documents describe CMS's data specifications for submitting IRF-PAI data from an inpatient rehabilitation facility to the National Assessment Collection Database. Below is a list of the documents included with these specifications:

- DS101A.pdf This document (11 pages).
- HD101A.pdf Detailed specifications for the header record (7 pages).
- HS101A.pdf Summary specifications for the header record (2 pages).
- BD101A.pdf Detailed specifications for the body record (89 pages).
- BS101A.pdf Summary specifications for the body record (16 pages).
- ID101A.pdf Detailed specifications for the inactivation record (5 pages).
- IS101A.pdf Summary specifications for the inactivation record (1 page).
- TD101A.pdf Detailed specifications for the trailer record (1 page).
- TS101A.pdf Summary specifications for the trailer record (1 page).
- AppendixA.pdf RIC codes and associated impairment group codes

All of these documents are Adobe Acrobat® files. You must have the Adobe Acrobat® reader to view and print these files. The Adobe Acrobat® reader can be downloaded and distributed for free and is available from many sites on the Internet including the following:

<http://www.adobe.com>

### ***Microsoft Access Specification File***

The data specifications include a Microsoft Access database file that was used to generate the data specification reports. This file may be useful to programmers or others who need to work with the data specifications.

The database contains four tables:

- **Header\_Record\_Definition.** Contains detailed specifications for the header record.
- **Body\_Record\_Definition.** Contains detailed specifications for the body record.
- **Inactivation\_Record\_Definition.** Contains detailed specifications for the inactivation record.
- **Trailer\_Record\_Definition.** Contains detailed specifications for the trailer record.

### **Submission File Structure**

A valid submission file consists of fixed length ASCII records. All records in the file must consist of 1258 data bytes followed by a carriage return (ASCII 013) and then a line feed (ASCII 010) for a total of 1260 bytes. Byte 1258 of each record must contain a % (percent sign) to indicate end of data.

Each submission file consists of a **Header Record** as the first record, one or more **Body Records (Assessment Records) and/or Inactivation Records**, and a **Trailer Record** as the last record. The records between the header and trailer records may consist entirely of body records, entirely of inactivation records, or any mixture of the two types of records. Body and/or inactivation records may be in any order within a submission file and the two types of records may be kept separate or may be intermingled. However, each submission file must contain at least one record that is either a body or inactivation record.

### **Header Record**

The header record has *A2* (capital A followed by two) in the first two bytes. The document **HD101A.pdf** presents a detailed layout for the header record. The header record contains basic identifying information for the facility submitting the IRF-PAI data and for contact persons and phone numbers to use in the event that the file is in error. An abbreviated version of the header record layout is presented in the document **HS101A.pdf**.

### **Body Record**

The body record has *B2* (capital B followed by two) in the first two bytes. The document **BD101A.pdf** presents a detailed layout for the body record. The body record contains information for a single IRF-PAI patient assessment. All body records consist of exactly the same fields in the exact the same order. An abbreviated version of the body record layout is presented in the document **BS101A.pdf**.

### **Inactivation Record**

The inactivation record has *X2* (capital X followed by two) in the first two bytes. The document **ID101A.pdf** presents a detailed layout for the inactivation record. The inactivation record contains information that identifies a previously submitted body record that the inpatient rehabilitation facility wishes to inactivate. See "Submission of Inactivation Records" later in this

document for a description of the use of the inactivation records. An abbreviated version of the inactivation record layout is presented in the document **IS101A.pdf**.

### Trailer Record

The trailer record has Z2 (capital Z followed by two) in the first two bytes. The document **TD101A.pdf** presents a detailed layout for the trailer record. The trailer record indicates the end of the submission file, and this record includes a count of the total records in the file including the header and trailer records. An abbreviated version of the data record layout is presented in the document **TS101A.pdf**.

### Appendix A

The document **AppendixA.pdf** contains Rehabilitation Impairment Categories and associated Impairment Group Codes. This list of impairment group codes is to be utilized for Item 21 (Impairment Group) on the IRF-PAI. Only the codes included on this list are valid codes for this field. Any code used in this field that is not on this list will result in record rejection.

### Field by Field Specifications

The detailed record layout and data specifications for each type of record (header, body, inactivation, and trailer) provide the information necessary to construct an acceptable submission file. Each detailed record layout specification report (e.g., BD101A.pdf) contains the following report elements for each data item:

- **Item.** This report element provides the field name in the record layout. Where a field corresponds to an IRF-PAI form item, the field name is the item number designated on the form. For example, item 12 (Admission Date) on the IRF-PAI assessment form is referred to in the body record specifications as Item 12.
- **Description.** This element provides a verbal description of the data field.
- **Len.** The length of the data item in the record layout.
- **Start.** The starting byte of the data item in the record layout.
- **End.** The ending byte of the data item in the record layout.
- **Picture.** A COBOL-style picture specification for the data field.
- **Type.** Indicates the type of field.
- **Text.** Indicates a variable length text field (e.g., a city name).
- **Date.** Indicates a date field (all date fields must be formatted YYYYMMDD).
- **Code.** Indicates that the field can possess any one of a limited set of coded values.
- **Count.** Indicates an integer count field.
- **Filler.** Indicates a field that must be blank filled.



- **Range.** Indicates the range of valid values that a field can assume. Note that the convention *sp(x)* is used to indicate spaces (e.g., *sp(1)* indicates a single space, *sp(5)* indicates 5 spaces).
- **Format info.** Provides information about how data must be formatted (e.g., right justified, zero filled, etc.).
- **Consistency required.** Provides information about the logical relationships between the current field and other fields in the layout. The following are some examples of how this report element is used:
  - **Skip patterns.** The response to some IRF-PAI items is contingent upon the response to other items.
  - **Checklist patterns.** Some checklists allow only one item in the list to be checked. Other checklists allow multiple responses (i.e., “check all that apply”). Some responses (e.g., “none of the above”) preclude responses to the other items in the list.
  - **Date relationships.** Certain dates on IRF-PAI assessment have logical relationships with other dates on the assessment.

### **Body Record Date Consistency**

The body record contains the following date fields:

Item 6 Birth Date  
Item 12 Admission Date  
Item 13 Assessment Reference Date  
Item 23 Date of Onset of Impairment  
Item 40 Discharge Date  
Item 43A First Interruption Date  
Item 43B First Return Date  
Item 43C Second Interruption Date  
Item 43D Second Return Date  
Item 43E Third Interruption Date  
Item 43f Third Return Date

The purpose of this section is to describe the rules that govern the relationships among these dates. One of the rules involves the number of days between certain dates. Please note that these calculations are based upon **calendar** days, not workdays.

These consistency rules are of two types. The first type involves date sequencing, which insures that the chronological order of dates is logical (e.g., it is illogical for a patient’s Birth Date to

occur later than the Admission Date). Violations of these rules are fatal errors that will lead to record rejection by the National Assessment Collection Database.

The second type of rule involves timing. Dates on the IRF-PAI record are used to check the timing of certain events (e.g., that the number of days between various events doesn't exceed the regulatory thresholds). Because inpatient rehabilitation facilities are required to always submit data even if these timing rules are not followed, these consistency checks are not fatal; they will result only in warnings and the records with timing rule violations will **not** be rejected when submitted to the National Assessment Collection Database.

The first section below describes the fatal errors associated with the date sequencing rules. The remainder of this section describes the timing rules.

## Date Sequencing Rules

Date sequencing rules refer to the chronological order of the events described by the dates listed below. There is a logical sequence implied by these dates that must be followed. For example, it is illogical for the patient Birth Date to be later than the Admission Date. Each body record must follow these date sequencing rules or fatal errors will occur, leading to rejection of the record when it is submitted to the National Assessment Collection Database.

The chronological sequence of IRF-PAI dates is as follows:

1. Item 6 Birth Date
2. Item 23 Date of Onset of Impairment
3. Item 12 Admission Date
4. Item 43A First Interruption Date
5. Item 43B First Return Date
6. Item 43C Second Interruption Date
7. Item 43D Second Return Date
8. Item 43E Third Interruption Date
9. Item 43F Third Return Date
10. Item 13 Assessment Reference Date
11. Item 40 Discharge Date

To determine whether dates are in the proper chronological sequence in a body record, do the following:

1. Exclude any dates from this list that do not occur (are blank) in the record (e.g., some Interruption Dates may not be completed.).
2. Each remaining date must be less than or equal to every date which follows in the list.
3. A fatal error will occur if any date in the list is later than any other date that follows on the list.

There are a few additional fatal date edits:

1. No date can be later than the current date.
2. Item 6 (Birth Date) can be no more than 140 years prior to the current date.
3. Item 12 (Admission Date) cannot be earlier than 1980.

The consistency checks described in the detailed body specifications incorporate these sequencing rules and list violations as fatal errors.

## Timing Rules

Currently, there is one timing rule in the IRF-PAI data specifications. It is as follows:

1. Item 13 (Assessment Reference Date) usually must be 2 days after item 12 (Admission Date). This implies the following test: Item 13 (Assessment Reference Date) - Item 12 (Admission Date) = 2

Failure to follow this rule will result in a warning message; the National Assessment Collection Database will still accept the record.

## Submission Timing Rules

Currently, there is only one submission timing rule. If an assessment is submitted 28 days or more after the discharge date, the IRF-PAI may be subject to penalties. Such records will not be rejected, but warning messages will be issued.

## Duplicate Records

When an assessment is submitted to the National Assessment Collection Database, the assessment is checked to determine if it is an original assessment or a duplicate assessment. If all of the following information on the submitted assessment matches that on an assessment already in the database, the record will be rejected as a duplicate assessment. The information used to determine if the assessment is a duplicate record is as follows:

- Identical Facility
- Identical Resident
- Identical Admission Date
- Identical Correction Number

## Correction Procedures

After an assessment has been completed, data entry has been finalized, and the assessment has been submitted to the national database, no further changes should normally be made to the assessment record. However, corrections are allowed if a data entry error has been made. The purpose of this section is to describe the proper procedures for making corrections.

The discussion of correction procedures below uses two terms that need to be defined.

- ***CORRECTION\_NUM*** is a counter field in the body record (bytes 58-59) that is used to track corrections made to an assessment record. This counter field must always be set to *00* when a record is initially submitted. Under certain circumstances (described below) it must be incremented to indicate that a correction record is being submitted (i.e., *01* would be used for the first correction to the assessment record, *02* for the second correction, and so on).

- **Key fields** are fields used by the National Assessment Collection Database to uniquely identify an assessment. The table below lists the key fields contained on an assessment record.

Key Fields	
<b>Patient Identifiers:</b>	
Item 4	Patient First Name
Item 5A	Patient Last Name
Item 6	Birth Date
Item 7	Social Security Number
Item 8	Gender
<b>IRF-PAI Identifiers:</b>	
FAC_ID	Unique Facility ID code
<b>Assessment Event Identifiers:</b>	
Item 12	Admission Date