The Centers for Medicare & Medicaid Services
INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT (IRF-PAI) MANUAL

Version 4.4 Change Table

CMS Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Contacts

For further information regarding the IRF QRP, please visit the CMS IRF QRP Web site:
https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility

Questions regarding information presented in this manual should be directed to
IRF.questions@cms.hhs.gov.

IRF-PAI 4.4 Item Set

Below is a list of changes to the IRF-PAI 4.4.

Section	Item #	Added/Removed	Item Description
Identification Information	8	Removed	Gender
Identification Information	14	Removed	Admission Class
Section A	A0810	Added	Sex
Section A	A1250	Removed	Transportation
Section A	A1255	Added	Transportation
Section O	O0350	Removed	Patient's COVID-19 vaccination is 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 4.2 – Effective October 1, 2024	IRF-PAI Manual Version 4.4 – Effective October 1, 2026	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, updated web links, reorganized information, updated version number from 4.2 to 4.4.	--
0.2	All sections	Version 4.2, Effective October 1, 2024	Version 4.4, Effective October 1, 2026	Updated version number and effective date in the footer.

Chapter 1

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 4.2 – Effective October 1, 2024	IRF-PAI Manual Version 4.4 – Effective October 1, 2026	Description of Change
1.1	Chapter 1, Page 1-4	• 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 ▪ Safety ▪ Chronic conditions ▪ Seamless care coordination ▪ Equity ▪ Affordability and efficiency ▪ Wellness and prevention ▪ Behavioral health	[Removed]	Updates to Background of the IRF QRP

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		○ The Cascade of Meaningful Measures describes in increased detail 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/meaningful-measures-initiative		

Chapter 2, Overview

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 4.2 – Effective October 1, 2024	IRF-PAI Manual Version 4.4 – Effective October 1, 2026	Description of Change
2.0.1	Chapter 2, Overview, Page 2-3	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 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 IRF-PAI is applicable to all patients aged one and older 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.	Updates to requirements for IRF-PAI item completion
2.0.2	Chapter 2, Overview, Page 2-3	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 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.	The applicable IRF-PAI Version 4.4 must be completed for eligible patients who have been *admitted or discharged on or after* 12:00 a.m. on October 1, 2026. The applicable IRF-PAI Version 4.4 must also be completed for eligible patients who have been *admitted prior to* 12:00 a.m. on October 1, 2026 and are discharged (or who die) on or after 12:00 a.m. on October 1, 2026.	Updates to completion requirements for IRF-PAI version 4.4

Chapter 2, Section A

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2.A.1	Chapter 2, Section A, Page A-2	**8. Gender:** Enter the patient's gender as: *1- Male; 2- Female*	**[Removed]**	Removal of item 8. Gender
2.A.2	Chapter 2, Section A, Page A-3	**14. Admission Class:** Enter the admission classification of the patient, as defined below: *1- Initial Rehab:* This is the patient's first admission to any inpatient rehabilitation facility for this impairment. *3- Readmission:* This is a stay in which the patient was previously admitted to an inpatient rehabilitation facility for this impairment but is **NOT** admitted to the current rehabilitation program DIRECTLY from another rehabilitation program. *4- Unplanned Discharge:* This is a stay that lasts less than 3 calendar days because of an unplanned discharge (e.g., due to a medical complication). *5- Continuing Rehabilitation:* This is part of a rehabilitation stay that	**[Removed]**	Removal of item 14. Admission Class

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		began in another rehabilitation program. The patient was admitted directly from another inpatient rehabilitation facility.		
2.A.3	Chapter 2, Section A, Page A-18	--	**A0810. Sex** **Item Rationale** • Assists in correct identification • Provides demographic sex-specific health trend information **Coding Instructions** • **Code 1,** if the patient is male. • **Code 2,** if the patient is female.	Addition of item A0810. Sex and coding instructions
2.A.4	Chapter 2, Section A, Page A-18	**Item Rationale** • The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity. • The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for	**Item Rationale** ~~• The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity.~~ ~~• The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and~~	Revisions to item rationale and steps for assessment for A1005. Ethnicity

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		documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards. • Collection of ethnicity data is an important step in improving quality of care and health outcomes. • Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute care settings. • These categories are NOT used to determine eligibility for participation in any Federal program.	~~tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.~~ ~~• Collection of ethnicity data is an important step in improving quality of care and health outcomes.~~ • Standardizing self-reported data collection for race allows for the equal comparison of data across multiple healthcare settings and is an important step in improving quality of care and health outcomes. ~~post-acute care settings.~~ These categories are NOT used to determine eligibility for participation in any Federal program.	
2.A.5	Chapter 2, Section A, Page A-21	**Item Rationale** • The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including race. • The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conforms to the 2011	**Item Rationale** ~~• The ability to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including race.~~ ~~• The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.~~	Revisions to item rationale and steps for assessment for A1010. Race

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		Health and Human Services Data Standards.
		• Collection of race data is an important step in improving quality of care and health outcomes.
		• Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute care settings.
		• These categories are NOT used to determine eligibility for participation in any Federal program.
		
		Steps for Assessment
		1. Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race.
		  • Individuals may be more comfortable if this and the subsequent question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their ethnic background."
			~~• Collection of race data is an important step in improving quality of care and health outcomes.~~
			• Standardizing self-reported data collection for race allows for the equal comparison of data across multiple healthcare settings and is an important step in improving quality of care and health outcomes. ~~post-acute care settings.~~ These categories are NOT used to determine eligibility for participation in any Federal program.
			
			Steps for Assessment
			1. Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race.
			  ~~• Individuals may be more comfortable if this and the subsequent question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their ethnic background."~~	

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2.A.6	Chapter 2, Section A, Page A26	## A1250. Transportation ### Item Rationale • Access to transportation for ongoing health care and medication access needs is essential to effective care management. • Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections with available community resources. ### Steps for Assessment 1. Ask the patient: 2. "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?" 3. "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?" 4. The patient should be offered the option of selecting more than one yes designation, if applicable. 5. If the patient is unable to respond, a proxy response may be used.	**[Removed]**	Removal of item A1250. Transportation

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		6. If neither the patient nor a proxy is able to provide a response to this item, medical record documentation may be used. 7. If the patient declines to respond, do not code based on proxy input or medical record documentation. **Coding Instructions** *Complete based on assessments that occur within the 3-day admission assessment time period or the 3-day discharge assessment time period.* **Code A,** if the patient indicates that lack of transportation has kept the patient from medical appointments or from getting medications. **Code B,** if the patient indicates that lack of transportation has kept the patient from non-medical meetings, appointments, work, or from getting things that the patient needs. **Code C,** if the patient indicates that a lack of transportation has not kept the patient from medical appointments, getting medications, non-medical meetings, appointments, work, or getting things that the patient needs.		

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		Code X, Patient unable to respond, if the patient was unable to respond. o In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X, Patient unable to respond. o If the patient was unable to respond and no other resources (proxy, or medical record documentation) provided the necessary information, Code X, Patient unable to respond, **only**. **Code Y, Patient declines to respond,** if the patient declines to respond. o In the cases where the patient declines to respond, Code Y,		

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		Patient declines to respond, **only**. ○ If the patient **declines to respond** do not code based on proxy input or medical record documentation to complete this item. **Coding Tip** • 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. **Example** 8. The patient is admitted with multiple sclerosis. The patient is confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No proxy with related information is available, but the patient's medical record indicates that the patient's		

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		caregiver uses their car to transport the patient wherever the patient needs to go. **Coding:** A1250, Transportation would be **coded as Code C, No** and **Code X, Patient unable to respond**. **Rationale:** If neither the patient nor a proxy is able to provide a response, but the medical record documentation can provide the necessary information, code both the information in the medical record and X, Patient unable to respond.		
2.A.7	Chapter 2, Section A, Page A-26	--	A1255. Transportation **Item Rationale** • Access to transportation for ongoing healthcare and medication access needs, particularly for those with chronic diseases, is essential to successful care management. • Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections	Addition of item A1255. Transportation item rationale, steps for assessment, coding instructions, and examples.

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			with available community resources. **Steps for Assessment** 1. Ask the patient: • "In the past 12 months, has lack of reliable transportation kept you from medical appointments, meeting, work, or from getting things needed for daily living?" 2. Ask the patient to select the response that most closely corresponds to the patient's transportation status from the list in A1255. 3. If the patient declines to respond, code 7, Patient declines to respond, and do not code based on proxy input or medical record documentation. 4. If the patient is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative. 5. Only use medical record documentation to code A1255, Transportation if the patient is unable to respond and no family member, significant other, and /or guardian/legally	

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			authorized representative provides a response to this item. **Coding Instructions** *Complete based on assessments that occur within the 3-day admission assessment time period.* **Code O, Yes,** if the patient indicates that in the past 12 months, a lack of reliable transportation has kept them from medical appointments, meetings, work, or from getting things needed for daily living. **Code 1, No,,** if the patient indicates that in the past 12 months, a lack of reliable transportation has not kept them from medical appointments, meetings, work, or from getting things needed for daily living. **Code 7, Patient declines to respond,** if the patient declines to respond. ○ If the patient **declines to respond** do not code based on other resources (family, significant other, or legally authorized representative, or medical records). **Code 8, Patient is unable to respond,** if the patient was unable to respond and no other resources (family, significant other, or	

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			legally authorized representative or medical records) provided the necessary information. **Coding Tip** • If the patient is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical records, select the response that applies. **Examples** 1. The patient is admitted with multiple sclerosis. The patient is confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No family, significant other, or legally authorized representative with information about transportation is available, but the patient's medical record indicates that in the past 12 months, the patient's caregiver used their car to transport the patient wherever the patient needed to go. **Coding:** A1255, Transportation would be **coded as Code 1, No**	

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			Rationale: Neither the patient nor their family, significant other, or legally authorized representative was able to provide a response, but the medical record documentation provided the necessary information regarding transportation. 2. The patient indicates that in the last 12 months, they have not had reliable transportation, which has occasionally kept them from attending medical appointments. **Coding:** A1255, Transportation would be **coded as Code 0, Yes.** **Rationale:** The patient reported they have not had access to reliable transportation in the last 12 months, which has kept them from medical appointments, meetings, work or from getting things needed for daily living.	

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2.A.8	Chapter 2, Section A, Page A-28	A1400. Payer Information **Item Rationale** • The FY 2023 IRF PPS Final Rule finalized the collection of IRF-PAI quality data on all patients receiving care in an IRF, regardless of payer (87 FR 47073 through 47082). This means there must be an IRF-PAI Admission assessment completed on all patients at the beginning of their IRF stay and an IRF-PAI Discharge assessment completed on all patients at the end of their IRF stay.	A1400. Payer Information **Item Rationale** • The FY 2023 IRF PPS Final Rule finalized the collection of IRF-PAI quality data on all patients aged one and older receiving care in an IRF, regardless of payer (87 FR 47073 through 47082). This means there must be an IRF-PAI Admission assessment completed on all patients aged one and older at the beginning of their IRF stay and an IRF-PAI Discharge assessment completed on all patients at the end of their IRF stay.	Updates to item rationale for A1400. Payer Information
2.A.9	Chapter 2, Section A, Page A-33	Additionally, new IRF-PAI admission and discharge assessments would be completed, where at admission: ○ 12, Admission Date = 01/01/2025 ○ 13, Assessment Reference Date = 01/03/2025 ○ 14, Admission Class = [1, Initial Rehab]	Additionally, new IRF-PAI admission and discharge assessments would be completed, where at admission: ○ 12, Admission Date = 01/01/2025 ○ 13, Assessment Reference Date = 01/03/2025 ○ ~~14, Admission Class = [1, Initial Rehab]~~	Removed coding instructions for Item 14. Admission class.

Chapter 2, Section D

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2.D.1	Chapter 2, Section D, Page D-4	Attempt to conduct the interview with ALL patients. • If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank**, then end the interview and leave D0160, Total Severity Score blank. • If Column 1 equals 0, enter 0 in Column 2. • If Column 1 equals 9 or dash (–), leave Column 2 blank. • If no assessment is conducted for Patient Mood, then in each row D0150A through D0150I, enter a dash (–) in Column 1, leave Column 2 blank, and code 99 for D0160, Total Severity Score.	Attempt to conduct the interview with ALL patients aged one and older. • If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank**, then end the interview and leave D0160, Total Severity Score blank. • If Column 1 equals 0, enter 0 in Column 2. • If Column 1 equals 9 or dash (–), leave Column 2 blank. • If no assessment is conducted for Patient Mood, then in each row D0150A through D0150I, enter a dash (–) in Column 1, leave Column 2 blank, and code 99 for D0160, Total Severity Score. • In the rare situation that the patient cannot provide a frequency, following a yes response to a symptom in Column 1, enter a dash in Column 2. CMS expects a dash response to be rare.	Updates to coding tips for D0150. Patient Mood Interview (PHQ-2 to 9)

Chapter 2 Section J

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2.J.1	Chapter 2 Section J Page J-9	**DEFINITION** **FALL** • Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (e.g., a patient pushes another patient). • An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall.	**DEFINITION** **FALL** • Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. ~~Falls are not a result of an overwhelming external force (e.g., a patient pushes another patient).~~ • An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered an intercepted fall. • An exception would be if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance during balance training, it would	Updated definition to reflect updates to guidance.

			be reported as both a fall and a major injury in J1800 - Any Falls Since Admission and J1900 – Number of Falls Since Admission.	
2.J.2	Chapter 2 Section J Page J-11	2. A patient is participating in balance training during a therapy session. The therapist is intentionally challenging the patient's balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides steadying/contact guard assistance to allow the patient to maintain standing. **Coding**: J1800, any falls since admission would be coded 0, no. **Rationale**: the patient's balance was intentionally being challenged, so a loss of balance is anticipated by the physical therapist. When assistance is provided to a patient to allow them to maintain standing during an anticipated loss of balance, this is not considered a fall or "intercepted fall."	2. A patient is participating in balance training during a therapy session. The therapist is intentionally challenging the patient's balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides steadying/contact guard assistance to allow the patient to maintain standing. **Coding**: J1800, any falls since admission would be coded 0, No. **Rationale**: the patient's balance was intentionally being challenged, so a loss of balance is anticipated by the physical therapist. ~~When assistance is provided to a patient to allow them to maintain standing during an anticipated loss of balance, this is not considered a fall or "intercepted fall."~~ When the patient experiences an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training, unless there was a fall or "intercepted" fall that resulted in a major injury, it	Revised to reflect updates to guidance.

			would not be coded as a fall in J1800.	
2.J.3	Chapter 2 Section J Page J-14	**Coding Tips** • Include all falls that occurred since the time of admission. This would include any falls that occurred outside of the IRF during a program interruption. • 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.	**Coding Tips** • Include all falls that occurred since the time of admission. This would include any falls that occurred outside of the IRF during a program interruption. • Fractures confirmed to be pathologic (vs traumatic) are not to be considered a major injury resulting from a fall • 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.	Coding Tips revised to reflect updates to guidance.

2.J.4	Chapter 2 Section J Page J-14	**DEFINITIONS** **NO INJURY** No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall. **INJURY (EXCEPT MAJOR)** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain. **MAJOR INJURY** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma.	**DEFINITIONS** ~~**NO INJURY**~~ ~~No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.~~ **INJURY (EXCEPT MAJOR)** Includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain. **MAJOR INJURY** Includes, but is not limited to, traumatic bone fractures, joint dislocations/~~,~~ subluxations, internal organ injuries, amputations, traumatic spinal cord injuries, head injuries, and crush injuries ~~closed head injuries with altered consciousness, and subdural hematoma~~.	Revised the definitions to reflect updates to guidance.
2.J.5	Chapter 2 Section J Page J-16	**Examples** --	4. The therapist had a patient, who has Parkinson's disease, stand on one foot during their therapy session to intentionally challenge the patient's balance. Despite safety precautions, including contact guard assistance and safety mats, the patient fell while standing on one foot and landed on their left side. Due to pain and swelling in their left wrist, the physician ordered a left wrist x-ray for the patient. The x-ray confirmed a distal radius fracture (non-	Added to reflect updates to guidance.

			displaced) of the left wrist. **Coding**: J1800 would be **coded 1, Yes** and J1900C would be **coded 1, One**. **Rationale:** Despite safety precautions in place the patient sustained a radius fracture, a major injury, during a therapeutic intervention with physical therapy where their balance was being intentionally challenged. This is being considered a fall as there was a major injury even though the fall and major injury occurred when the patient's balance was being intentionally challenged.	
2.J.6	Chapter 2 Section J Page J-16	**Examples** --	**Differentiating from Traumatic vs Pathological Fractures** 5. A patient with osteoporosis falls, resulting in a right hip fracture. The physician confirms that the fracture is a result of the patient's bone disease and not a result of the fall. **Coding**: J1800 would be **coded 1, Yes** and J1900C would be **coded 0, None**. **Rationale:** The physician determined that the fracture was a pathological fracture and was a result of osteoporosis. Because it is	Added to reflect updates to guidance.

			not considered a traumatic fracture it would not be considered a major injury. 6. A patient with osteoporosis falls, resulting in a right hip fracture. The physician confirms that the fracture is a result of the patient's fall and not due to the patient's history of osteoporosis. **Coding**: J1800 would be **coded 1, Yes** and J1900C would be **coded 1, One**. **Rationale:** Because the physician determined that the fracture was a result of the fall it would be considered a traumatic fracture and therefore would be considered a major injury.	

Chapter 2, Section M

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2.M.1	Chapter 2, Section M, Page M-7	**Step 3: Determine "Present on Admission"** --	9. If a pressure ulcer/injury was unstageable on admission and then becomes unstageable for another reason, it should be considered "present on admission" at the new unstageable status. For example, if a patient is admitted with a deep tissue injury, but later the injury opens, the wound bed is covered with slough, and the wound is still unstageable, this wound would still be considered "present on admission."	Updates to Step 3: Determine "Present on Admission"

Chapter 2, Section O

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2.O.1	Chapter 2, Section O, Page O-11	**O0350: Patient's COVID-19 Vaccination Is Up to Date** **Item Rationale** • The intent of this item is to report if a patient is up to date with their COVID-19 vaccine status. • Age is the strongest risk factor for severe coronavirus disease 2019 (COVID-19) outcomes. In 2020, persons aged 65 years or older accounted for 81% of United States (U.S.) COVID-19-related deaths. • Severe illness caused by COVID-19 means that the person with COVID-19 may require hospitalization, intensive care, ventilator support for breathing, or may even die. • A strong infection prevention and control program (IPCP) is vital to protect both patients and healthcare personnel (HCP). • Remaining up to date with all recommended COVID-19 vaccine doses is critical to protect both staff and patients from SARS-CoV-2 infection. • COVID-19 vaccines currently approved or authorized by the U.S. Food & Drug Administration (FDA) are effective in reducing the risk of serious outcomes of COVID-19, including severe disease, hospitalization, and death. • Efforts to increase the number of people in the United States who are up to date with their COVID-19 vaccines remain an important strategy for preventing illnesses, hospitalizations, and deaths from COVID-19. • A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. Serious problems from	[Removed]	Removal of item O0350: Patient's COVID-19 Vaccination Is Up to Date

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		COVID-19 vaccine are very rare. More information about potential side effects of the COVID-19 vaccine, precautions, and contraindications can be found on the Centers for Disease Control and Prevention (CDC) webpage "Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States" at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications. **Guidelines for Assessment** • Vaccination status may be determined based on information from any available source. Review the patient's medical record or documentation of COVID-19 vaccination and/or interview the patient, family, or other caregivers or health care providers to determine whether the patient is up to date with their COVID-19 vaccine. • If the patient is **not up to date**, and the facility has the vaccine available, ask the patient if they would like to receive the COVID-19 vaccine. DEFINITION **UP TO DATE WITH COVID-19 VACCINES** For the definition of "up to date," providers should refer to the CDC webpage, "Stay Up to Date with COVID-19 Vaccines," at https://www.cdc.gov/covid/vaccines/stay-up-to-date.html?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html **Coding Instructions** **Code 0, No**, patient is not up to date if the patient does not meet the CDC's definition of "up to date."		

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		○ This includes patients who have not received one or more recommended COVID-19 vaccine doses **for any reason** including medical, religious, or other qualified exemptions. ○ This includes patients for whom vaccination status cannot be determined. **Code 1, Yes**, patient is up to date if the patient meets the CDC's definition of "up to date." A dash (-) is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence. **Coding Tips** • If there is conflicting information regarding a patient's vaccination status, use clinical judgment to determine if the patient is up to date with their COVID-19 vaccine based on information from any available source. • Current COVID-19 vaccine recommendations are available on the CDC webpage "Stay Up to Date with COVID-19 Vaccines" at https://www.cdc.gov/covid/vaccines/stay-up-to-date.html?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html		

Chapter 2, Supplement

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2.S.1	Chapter 2 Supplement, Page S-11	• The following rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2," which is the number of items in Column 2 that are blank (or skipped). An item in Column 2 could be blank if the corresponding item in Column 1 was equal to 9, No response, or a dash (symptom not assessed). ○ If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values. ○ If any of the items in Column 2 are blank (or skipped), then omit their values when computing the sum.	• The following rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2," which is the number of items in Column 2 that are blank (or skipped) or dashed. An item in Column 2 could be blank if the corresponding item in Column 1 was equal to 9, No response, or a dash (symptom not assessed). ○ If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values. ○ If any of the items in Column 2 are blank (or skipped) or dashed, then omit their values when computing the sum.	Updates to Patient Mood Interview Scoring
2.S.2	Chapter 2 Supplement, Page S-12	In this example, all of the items in Column 2 have non-missing values (i.e., none of the values are blank). Therefore,	In this example, all of the items in Column 2 have non-missing values (i.e., none of the values are blank or dashed). Therefore, the	Updates to Patient Mood Interview Example

		the value of D0160 is equal to the simple sum of the values in Column 2, which is 14.	value of D0160 is equal to the simple sum of the values in Column 2, which is 14.	
2.S.2	Chapter 2 Supplement, Page S-13	In this example, one of the items in Column 2 (D0150C2) has a missing value (it is blank) and the other eight items have non-missing values. D0160 is computed as follows: 1. Compute the sum of the eight items with non-missing values. This sum is 11. 2. Multiply this sum by 1.125. In the example, 11 x 1.125 = 12.375. 3. Round the result to the nearest integer. In the example, 12.375 rounds to 12. 4. Place the rounded result in D0160.	In this example, one of the items in Column 2 (D0150C2) has a missing value (it is ~~blank~~ dashed) and the other eight items have non-missing values. D0160 is computed as follows: 1. Compute the sum of the eight items with non-missing values. This sum is 11. 2. Multiply this sum by 1.125. In the example, 11 x 1.125 = 12.375. 3. Round the result to the nearest integer. In the example, 12.375 rounds to 12. 4. Place the rounded result in D0160.	Updates to Patient Mood Interview Example

Chapter 3

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 4.2 – Effective October 1, 2024	IRF-PAI Manual Version 4.4 – Effective October 1, 2026	Description of Change
3.1	Chapter 3, Page 3-4	**Fall** Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. A fall is not a result of an overwhelming external force (e.g., a patient pushes another patient). An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall.	**Fall** Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. ~~A fall is not a result of an overwhelming external force (e.g., a patient pushes another patient).~~ An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall. An exception would be if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance during balance training, it would be reported as both a fall and a major injury in J1800 - Any Falls Since Admission and J1900 – Number of Falls Since Admission.	Update to the definition of a fall
3.2	Chapter 3, Page 3-6	**Injury (except Major)** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the	**Injury (except Major)** Includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related	Update to definition of Injury (except Major)

		patient to complain of pain.	injury that causes the patient to complain of pain.	
3.3	Chapter 3, Page 3-7	**Major Injury** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.	**Major Injury** Includes, but is not limited to, traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, traumatic spinal cord injuries, ~~closed~~ head injuries, and crush injuries. ~~with altered consciousness, subdural hematoma.~~	Update to definition of Major Injury
3.4	Chapter 3, Page 3-10	**Unplanned Discharge** 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).	[Removed]	Removal of definition of unplanned discharge specified for item 14. Admission Class

Chapter 4

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 4.2 – Effective October 1, 2024	IRF-PAI Manual Version 4.4 – Effective October 1, 2026	Description of Change
4.1	Chapter 4, Page 4-1	## 4.1 Coding Forms The Centers for Medicare & Medicaid Services (CMS) provides a user tool free of charge that uses the data submitted using the IRF-PAI on a question-by-question basis. This user tool is accessed via the Internet Quality Improvement and Evaluation System (iQIES). Because these data are used for payment purposes, it is critical to complete the questions on the IRF-PAI carefully and accurately. As shown in the CMS patient data system flow diagram below, patient data are collected within the facility and entered into iQIES. These data are used for payment purposes and quality reporting. In addition, the data will be used to develop an analytical database for monitoring and assessing implementation of the IRF prospective payment system.	## 4.1 Coding Forms ~~The Centers for Medicare & Medicaid Services (CMS) provides a user tool free of charge that uses the data submitted using the IRF-PAI on a question-by-question basis. This user tool is accessed via the Internet Quality Improvement and Evaluation System (iQIES). Because these data are used for payment purposes,~~ It is critical to complete the questions on the IRF-PAI carefully and accurately. As shown in the CMS patient data system flow diagram below, patient data are collected within the facility and ~~entered into~~ submitted to iQIES. These data are used for payment purposes and quality reporting. In addition, the data will be used to develop an analytical database for monitoring and assessing implementation of the IRF prospective payment system.	Updates to the CMS patient data system
4.2	Chapter 4, Page 4-2	## 4.2 CMS Patient Data System Flow Figure 1 depicts the following steps: 1. Complete the assessment on paper or in an electronic health record (EHR) application.	## 4.2 CMS Patient Data System Flow Figure 1 depicts the following steps: 1. Complete the assessment on paper or in an electronic health record (EHR) application.	Revisions to Figure 1 and steps in the CMS Patient Data System

		2. Enter assessment information into the iQIES software. Once all sections are complete, save the assessment. Complete and save the discharge assessment information. • If using an EHR, save completed assessments to a zip file. 3. Submit the assessment in iQIES. • The assessment goes to the National Database/CMS Repository. • A success or failure notification indicates if upload was successful. 4. The CMS Case Mix Group (CMG) is created after entering the (discharge) assessment information into iQIES (step 2). 5. The IRF submits a Medicare claim. 6. The Medicare Administrative Contractor (MAC) processes the claim through its software system, called the "Pricer" software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data, to calculate the IRF's prospective payment.	~~Enter assessment information into the iQIES software. Once all sections are complete, save the assessment. Complete and save the discharge assessment information.~~ • If using an EHR, save completed assessments to a zip file. 2. Submit the assessment in iQIES. • The assessment goes to the ~~National Database/~~CMS Repository. • A success or failure notification indicates if upload was successful. 3. The CMS Case Mix Group (CMG) is ~~created~~ generated after entering the (discharge) assessment information into ~~iQIES~~ the data entry software. iQIES will also recalculate the CMG Code as part of the record processing. If the value calculated by the data entry software is different than the iQIES calculated value, the provider should submit the iQIES calculated value on the Medicare claim. ~~(step 2).~~ 4. The IRF submits a Medicare claim. 5. The Medicare Administrative Contractor (MAC) processes the claim through its software system, called the "Pricer" software. The Pricer software uses the CMG code ~~number~~, along with other specific claim data elements and provider-specific data, to calculate the IRF's prospective payment.	

Chapter 5

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 4.2 – Effective October 1, 2024	IRF-PAI Manual Version 4.4 – Effective October 1, 2026	Description of Change
5.1	Chapter 5 Page 5-1	**5.1 Submitting the IRF-PAI** All Medicare-participating IRFs must complete and submit required IRF-PAI assessment records to the Centers for Medicare & Medicaid Services (CMS) Internet Quality Improvement and Evaluation System (iQIES) for all patients, regardless of payer. After completion of the required assessment(s), each provider must create electronic transmission files that meet the technical requirements detailed in the current IRF-PAI Data Submission Specifications, available on the CMS IRF Quality Reporting Program Technical Information website at https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-technical-information. Alternatively, the IRF can complete the IRF-PAI assessments online within iQIES.	**5.1 Submitting the IRF-PAI** All Medicare-participating IRFs must complete and submit required IRF-PAI assessment records to the Centers for Medicare & Medicaid Services (CMS) Internet Quality Improvement and Evaluation System (iQIES) for all patients, aged one and older, regardless of payer. After completion of the required assessment(s), each provider must create electronic transmission files that meet the technical requirements detailed in the current IRF-PAI Data Submission Specifications, available on the CMS IRF Quality Reporting Program Technical Information website at https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-technical-information. ~~Alternatively, the IRF can complete the IRF-PAI assessments online within iQIES.~~	Updates to instructions for submitting the IRF-PAI
5.2	Chapter 5 Page 5-4	**5.4 IRF-PAI Correction Policy** • Specific user roles within iQIES allow the provider to modify or inactivate assessments originally	**5.4 IRF-PAI Correction Policy** • Specific user roles within iQIES allow the provider to modify or inactivate assessments originally submitted	Clarifications to IRF-PAI correction policy

		submitted electronically to CMS. It is the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in its provider software system.	electronically to CMS. It is the provider's responsibility to ensure that any corrections or changes made to an accepted record ~~using the iQIES user tool~~ are reflected in its provider software system.	
5.2	Chapter 5 Page 5-6	These items **cannot** be corrected with a Modification Request: Record Event Identifiers 12: Admission Date 13: Assessment Reference Date (ARD) 40: Discharge Date Patient Identifiers 4: Patient First Name 5A: Patient Last Name 6: Birth Date 7: Social Security Number (SSN) 8: Gender When a Modification Request record is submitted, iQIES will process the record as follows: 1. The system will attempt to locate the existing record in the iQIES database for this IRF using specific items, which are located in Chapter 2, Section A, and this includes the patient identifiers (e.g., last name, first name, SSN, birth date, gender), the facility identifier (i.e., facility and state code), and the assessment-related dates (i.e., admission date or discharge date).	These items **cannot** be corrected with a Modification Request: Record Event Identifiers 12: Admission Date 13: Assessment Reference Date (ARD) 40: Discharge Date Patient Identifiers 4: Patient First Name 5A: Patient Last Name 6: Birth Date 7: Social Security Number (SSN) ~~8: Gender~~ A0810: Sex When a Modification Request record is submitted, iQIES will process the record as follows: 1. The system will attempt to locate the existing record in the iQIES database for this IRF using specific items, which are located in Chapter 2, Section A, and this includes the patient identifiers (e.g., last name, first name, SSN, birth date, ~~gender~~ sex), the facility identifier (i.e., facility and state code), and the	Updates to reflect removal of item 8. Gender

			assessment-related dates (i.e., admission date or discharge date).	
5.3	Chapter 5 Page 5-7	Note: Specific user roles within iQIES will allow the provider to modify assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.	Note: Specific user roles within iQIES will allow the provider to modify assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record ~~using the iQIES user~~ tool are reflected in their provider software system.	Updates to instructions for modifying the IRF-PAI
5.4	Chapter 5 Page 5-7	**5.6.2 Inactivation Requests** An Inactivation Request (Transaction Type Code = 3) should be used when a record has been accepted into iQIES but the corresponding event did not occur. For example, an IRF-PAI Discharge assessment record was submitted for a patient but there was no actual discharge. This request should also be used when one or more event identifiers and/or patient identifiers are found to be in error. An Inactivation Request **must** be completed when any of the following items are inaccurate: Record Event Identifiers 12: Admission Date 13: Assessment Reference Date (ARD) 40: Discharge Date Patient Identifiers 4: Patient First Name 5A: Patient Last Name 6: Birth Date 7: Social Security Number (SSN)	**5.6.2 Inactivation Requests** An Inactivation Request (Transaction Type Code = 3) should be used when a record has been accepted into iQIES but the corresponding event did not occur. For example, an IRF-PAI ~~Discharge~~ assessment record was submitted for a patient but there was no actual discharge. This request should also be used when one or more event identifiers and/or patient identifiers are found to be in error. An Inactivation Request **must** be completed when any of the following items are inaccurate: Record Event Identifiers 12: Admission Date 13: Assessment Reference Date (ARD) 40: Discharge Date Patient Identifiers 4: Patient First Name 5A: Patient Last Name 6: Birth Date 7: Social Security Number (SSN)	Updates to instructions for inactivation requests

		8: Gender **Note:** Any item in the previous list that was submitted as part of the original record must also be submitted as part of the Inactivation Request, and values for each item must match in the erroneous record and the inactivation record. For example, if 7, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record. If an Admission Date (12), ARD (13), or Discharge Date (40) is incorrect or if one or more patient identifiers are found to be in error, the provider must inactivate the erroneous record in iQIES, complete and submit a new IRF-PAI assessment record with the event and patient identifiers, and ensure that the clinical information is accurate. When an Inactivation Request is submitted, iQIES will process the record as follows: 1. The system will attempt to locate the existing record in the iQIES database for the IRF using specific items (given in Chapter 2, Section A), including the patient identifiers (e.g., last name, first name, SSN, birth date, gender), the facility identifier (i.e., facility ID and state code), and the assessment-related dates (e.g., admission date, or discharge date). 2. If the existing record is not found in the iQIES database, the submitted Inactivation Request will be rejected, and a fatal error will be reported to the IRF on the IRF-PAI	~~8: Gender~~ A0810: Sex **Note:** Any item in the previous list that was submitted as part of the original record must also be submitted as part of the Inactivation Request, and values for each item must match in the erroneous record and the inactivation record. For example, if 7, Social Security Number, was left blank on the original record, it should be left blank on the inactivation record. If an Admission Date (12), ARD (13), or Discharge Date (40) is incorrect or if one or more patient identifiers are found to be in error, the provider must inactivate the erroneous record in iQIES, complete and submit a new IRF-PAI assessment record with the event and patient identifiers and ensure that the clinical information is accurate. When an Inactivation Request is submitted, iQIES will process the record as follows: 1. The system will attempt to locate the existing record in the iQIES database for the IRF using specific items (given in Chapter 2, Section A), including the patient identifiers (e.g., last name, first name, SSN, birth date, ~~gender~~ sex), the facility identifier (i.e., facility ID and state code), and the assessment-related dates (e.g., admission date, or discharge date). 2. If the existing record is not found in the iQIES database, the submitted Inactivation Request will be rejected, and a fatal error will be reported to the IRF on the IRF-PAI Submitter Validation Report and the IRF-PAI Facility Final Validation Report.	

		Submitter Validation Report and the IRF-PAI Facility Final Validation Report. 3. If the existing record is found, the erroneous record will be removed from the active records in the iQIES database and archived within the iQIES database. **Note:** Specific user roles within iQIES will allow the provider to inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record using the iQIES user tool are reflected in their provider software system.	3. If the existing record is found, the erroneous record will be removed from the active records in the iQIES database and archived within the iQIES database. **Note:** Specific user roles within iQIES will allow the provider to inactivate assessments originally submitted electronically to CMS. It will be the provider's responsibility to ensure that any corrections or changes made to an accepted record ~~using the iQIES user tool~~ are reflected in their provider software system.	
5.4	Chapter 5 Page 5-8	In the event that this error has occurred, the provider must contact the iQIES Help Desk at iQIES@cms.hhs.gov or 1-800-339-9313 to obtain the IRF-PAI Manual Assessment Deletion Request form. The provider is responsible for completing the form. The provider must submit the completed form to the iQIES Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The iQIES Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the iQIES Help Desk will work through the request with the provider.	In the event that this error has occurred, the provider will need to create and submit a change request within iQIES. Directions on how to submit an IRF-PAI Manual Assessment Deletion Request can be found in the CMS iQIES Assessment Management for Assessment Submitter manual (available on the following website: https://qtso.cms.gov/software/iqies/reference-manuals). ~~must contact the iQIES Help Desk at iQIES@cms.hhs.gov or 1-800-339-9313 to obtain the IRF-PAI Manual Assessment Deletion Request form. The provider is responsible for completing the form. The provider must submit the completed form to the iQIES Help Desk at the address on the form via Certified Mail through the United States Postal Service (USPS). The~~	Updates to instructions for special manual record deletion requests

			~~iQIES Help Desk will contact CMS for approval upon receipt of such a request. Upon CMS approval of the manual deletion request, the iQIES Help Desk will work through the request with the provider.~~	

Appendix D

Edit #	Chapter, Section, Page	IRF-PAI Manual Version 4.2 – Effective October 1, 2024	IRF-PAI Manual Version 4.4 – Effective October 1, 2026	Description of Change
D.1	Appendix D, Page D-3	**1. Overview** Beginning with the FY 2012 IRF/PPS Final Rule, the Centers for Medicare & Medicaid Services (CMS) adopted the requirement that inpatient rehabilitation facilities (IRFs) are to report data on National Healthcare Safety Network (NHSN) measures. Currently, there are a total of four measures: • National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure [CMIT Measure ID #00459 (CBE-endorsed)] • Influenza Vaccination Coverage Among Healthcare Personnel Measure[CMIT Measure ID #00390 (CBE-endorsed)] • National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure [CMIT Measure ID #00462 (CBE-endorsed)] • COVID-19 Vaccination Coverage among Healthcare Personnel Measure [CMIT Measure ID #00180 (CBE-endorsed)] Each IRF must submit data for the NHSN CAUTI Outcome Measure and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure on all patients from all inpatient locations, regardless of payer. Additionally, each IRF must submit	**1. Overview** Beginning with the FY 2012 IRF/PPS Final Rule, the Centers for Medicare & Medicaid Services (CMS) adopted the requirement that inpatient rehabilitation facilities (IRFs) are to report data on National Healthcare Safety Network (NHSN) measures. Currently, there are a total of ~~four~~ three measures: • National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure [CMIT Measure ID #00459 (CBE-endorsed)] • Influenza Vaccination Coverage Among Healthcare Personnel Measure[CMIT Measure ID #00390 (CBE-endorsed)] • National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure [CMIT Measure ID #00462 (CBE-endorsed)] • ~~COVID-19 Vaccination Coverage among Healthcare Personnel Measure [CMIT Measure ID #00180 (CBE-endorsed)]~~ Each IRF must submit data for the NHSN CAUTI Outcome Measure and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure on all patients from all inpatient locations, regardless of payer. Additionally, each IRF must submit Influenza Vaccination Coverage Among Healthcare Personnel data for all healthcare personnel (HCP) physically working in the inpatient locations for at least 1 day between October 1 and March 31. ~~Each IRF must also submit data on~~	Updates to CDC NHSN instructions

		Influenza Vaccination Coverage Among Healthcare Personnel data for all healthcare personnel (HCP) physically working in the inpatient locations for at least 1 day between October 1 and March 31. Each IRF must also submit data on the COVID-19 Vaccination Coverage among HCP for all HCP eligible to work in the facility for at least 1 day during the reporting period. IRFs report four categories of HCP to NHSN: employees, licensed independent practitioners (LIPs), adult students/trainees and volunteers, and other contract personnel. Compliance with the IRF Quality Reporting Program (QRP) requires submission of data for the NHSN CAUTI Outcome Measure and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure irrespective of whether patients have the infection or event of interest during the reporting period. In the event that no patients have the infection or event of interest during the reporting period, the IRF is still required to submit monthly denominator counts (i.e., device days and patient days) along with the "no event" indicators to CDC's NHSN. For reporting of the NHSN CAUTI Outcome Measure and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, CDC's NHSN requires that data be submitted on a monthly basis and strongly encourages IRFs to enter each month's data within 30 days of the end of the month in which they are collected (e.g., data for October should be entered into the NHSN by November 30). As of October 1, 2018, IRFs are no longer required to submit data for NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure for	~~the COVID-19 Vaccination Coverage among HCP for all HCP eligible to work in the facility for at least 1 day during the reporting period.~~ IRFs report four categories of HCP to NHSN: employees, licensed independent practitioners (LIPs), adult students/trainees and volunteers, and other contract personnel. Compliance with the IRF Quality Reporting Program (QRP) requires submission of data for the NHSN CAUTI Outcome Measure and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure irrespective of whether patients have the infection or event of interest during the reporting period. In the event that no patients have the infection or event of interest during the reporting period, the IRF is still required to submit monthly denominator counts (i.e., device days and patient days) along with the "no event" indicators to CDC's NHSN. For reporting of the NHSN CAUTI Outcome Measure and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, CDC's NHSN requires that data be submitted on a monthly basis and strongly encourages IRFs to enter each month's data within 30 days of the end of the month in which they are collected (e.g., data for October should be entered into the NHSN by November 30). As of October 1, 2018, IRFs are no longer required to submit data for NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure for the IRF QRP. However, reporting on this data is required for certain IRFs based on state and local mandates. Please check your state and local mandates to ensure you are in compliance with their reporting requirements. While CMS strongly agrees with CDC's recommended reporting time frames (providers should report an infection within 30 days following the event), for the purpose of meeting data submission requirements related to applicable annual increase factor (AIF), providers must submit all data collected during a given calendar year (CY) quarter no later	

		the IRF QRP. However, reporting on this data is required for certain IRFs based on state and local mandates. Please check your state and local mandates to ensure you are in compliance with their reporting requirements. While CMS strongly agrees with CDC's recommended reporting time frames (providers should report an infection within 30 days following the event), for the purpose of meeting data submission requirements related to applicable annual increase factor (AIF), providers must submit all data collected during a given calendar year (CY) quarter no later than the quarterly data submission deadlines, approximately 4.5 months or 135 days following the end of each CY quarter. Although providers must submit monthly data, providers are not required to log onto the NHSN on a monthly basis to submit these data. Providers may log on and submit data for all 3 months within a given CY quarter at the same time, providing that data are submitted prior to the CY quarterly deadlines. Please visit the IRF QRP webpage for additional information regarding the data submission deadlines at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.html CDC has an annual facility survey that is specific to IRFs and has specific location types to support facilities with data submission for the IRF QRP. Additionally, acute care hospitals (ACHs) can include ACH units designated as IRFs (CMS-certified Rehabilitation Unit mapped as a location within the hospital, i.e., the CMS Certification Number (CCN) for the Rehabilitation Unit includes	than the quarterly data submission deadlines, approximately 4.5 months or 135 days following the end of each CY quarter. Although providers must submit monthly data, providers are not required to log onto the NHSN on a monthly basis to submit these data. Providers may log on and submit data for all 3 months within a given CY quarter at the same time, providing that data are submitted prior to the CY quarterly deadlines. Please visit the IRF QRP webpage for additional information regarding the data submission deadlines at: ~~https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.html~~ https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-data-submission-deadlines. CDC has an annual facility survey that is specific to IRFs and has specific location types to support facilities with data submission for the IRF QRP. Additionally, acute care hospitals (ACHs) can include ACH units designated as IRFs (CMS-certified Rehabilitation Unit mapped as a location within the hospital, i.e., the CMS Certification Number (CCN) for the Rehabilitation Unit includes an "R" or "T" in the 3rd position). For information about other IRF locations within NHSN, please see the CDC's NHSN website at: https://www.cdc.gov/nhsn/pdfs/irf/Updating-IRF-locations-within-NHSN.pdf These IRF units will be required to complete a small annual survey found within their ACH facility. Questions on this small survey are only to be answered with information from the CMS-certified IRF unit. For more information, including operational guidance and updates on the reporting of the NHSN CAUTI Outcome Measure, the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, and the Influenza Vaccination Coverage Among Healthcare Personnel, ~~and the COVID-19 Vaccination Coverage among Healthcare Personnel data~~	

		an “R” or “T” in the 3rd position). These IRF units will be required to complete a small annual survey found within their ACH facility. Questions on this small survey are only to be answered with information from the CMS-certified IRF unit. For more information, including operational guidance and updates on the reporting of the NHSN CAUTI Outcome Measure, the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, the Influenza Vaccination Coverage Among Healthcare Personnel, and the COVID-19 Vaccination Coverage among Healthcare Personnel data under the IRF QRP, please visit the CDC’s NHSN webpage at: https://www.cdc.gov/nhsn/inpatient-rehab/index.html Reporting of the NHSN CAUTI Outcome Measure, the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, and the COVID-19 Vaccination Coverage among Healthcare Personnel data is required. To fulfill the CMS IRF QRP requirements, each facility’s data for the NHSN CAUTI Outcome Measure and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure must be entered into the CDC’s NHSN no later than 135 days after the end of the reporting quarter. In other words, for first quarter (Q1) data (January 1–March 31) to be shared with CMS, data must be entered into NHSN by August 15. CDC submits the data to CMS on behalf of the facility, according to the facility’s monthly reporting plan. Data submitted to CDC more than 135 days after the end of the reporting quarter, such as data submitted to the CDC NHSN after August 15 for Q1 of that same CY, will not be provided to	~~under the IRF QRP,~~ please visit the CDC’s NHSN webpage at: https://www.cdc.gov/nhsn/inpatient-rehab/index.html Reporting of the NHSN CAUTI Outcome Measure, the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, and the Influenza Vaccination Coverage Among Healthcare Personnel ~~COVID-19 Vaccination Coverage among Healthcare Personnel~~ data is required. To fulfill the CMS IRF QRP requirements, each facility’s data for the NHSN CAUTI Outcome Measure and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure must be entered into the CDC’s NHSN no later than 135 days after the end of the reporting quarter. In other words, for first quarter (Q1) data (January 1–March 31) to be shared with CMS, data must be entered into NHSN by August 15. CDC submits the data to CMS on behalf of the facility, according to the facility’s monthly reporting plan. Data submitted to CDC more than 135 days after the end of the reporting quarter, such as data submitted to the CDC NHSN after August 15 for Q1 of that same CY, will not be provided to CMS and will not be considered for the purpose of compliance determination. IRFs are able to review data submitted to CMS on their behalf through the “Analysis – Reports” function within NHSN. More information regarding the location and interpretation of these reports can be found on the CDC webpage: https://www.cdc.gov/nhsn/ps-analysis-resources/reference-guides.html For the Influenza Vaccination Coverage Among Healthcare Personnel data, the reporting period consists of the influenza vaccination season. The data collection reporting period is from October 1 of a given year through March 31 of that subsequent year, and final data must be submitted by May 15 of the same subsequent year. For Influenza Vaccination Coverage Among Healthcare Personnel reporting, entering a single influenza vaccination summary report at the end of the reporting period for the	

		CMS and will not be considered for the purpose of compliance determination. IRFs are able to review data submitted to CMS on their behalf through the "Analysis – Reports" function within NHSN. More information regarding the location and interpretation of these reports can be found on the CDC webpage: https://www.cdc.gov/nhsn/ps-analysis-resources/reference-guides.html For the Influenza Vaccination Coverage Among Healthcare Personnel data, the reporting period consists of the influenza vaccination season. The data collection reporting period is from October 1 of a given year through March 31 of that subsequent year, and final data must be submitted by May 15 of the same subsequent year. For Influenza Vaccination Coverage Among Healthcare Personnel reporting, entering a single influenza vaccination summary report at the end of the reporting period for the influenza season will meet the minimum data requirements for NHSN participation. However, CDC encourages HCP influenza vaccination summary counts to be updated on a monthly basis, and each update kept on printed paper copy, so that they can be used at the facility level to monitor vaccination rates and inform influenza vaccination activities. More information on data collection time frames and data submission deadlines can be found on the IRF Quality Reporting Data Submission Deadlines webpage, specifically in the Downloads section at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.html	influenza season will meet the minimum data requirements for NHSN participation. However, CDC encourages HCP influenza vaccination summary counts to be updated on a monthly basis, and each update kept on printed paper copy, so that they can be used at the facility level to monitor vaccination rates and inform influenza vaccination activities. More information on data collection time frames and data submission deadlines can be found on the IRF Quality Reporting Data Submission Deadlines webpage, specifically in the Downloads section at ~~https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.html~~ https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-data-submission-deadlines.	

D.2	Appendix D, Page D-5	--	***NHSN CDI Outcome Measure Reporting*** For reporting data on the NHSN CDI Outcome Measure under the IRF QRP, IRFs must adhere to the definitions and reporting requirements for CDI LabID events as specified in the NHSN Multidrug-Resistant Organism (MDRO) and Clostridioides difficile Infection (CDI) Module protocol http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf.For more information, please see the Operational Guidance for Inpatient Rehabilitation Facilities to Report Clostridioides difficile Infection (CDI) Laboratory-Identified (LabID) Event Data to CDC's NHSN for the Purpose of Fulfilling CMS's Quality Reporting Program Requirements at https://www.cdc.gov/nhsn/pdfs/cms/irfs/irf-cdi-op-guidance.pdf.	Added information about NHSN CDI Outcome measure reporting
D.3	Appendix D, Page D-6	***NHSN COVID-19 Vaccination Coverage among Healthcare Personnel Reporting*** For reporting data on the COVID-19 Vaccination Coverage among Healthcare Personnel measure under the IRF QRP, IRFs must adhere to the definitions and reporting requirements for this measure as specified in the CDC's NHSN *Weekly COVID-19 Vaccination Module for Healthcare Personnel*, available at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/protocol-hcp-508.pdf To report the COVID-19 Vaccination Coverage among Healthcare Personnel data, the NHSN Healthcare Personnel Safety (HPS) Component must be activated. As of June 2022, a monthly reporting plan is no longer required. Instead, upon saving or uploading data, users agree to the following:	**[Removed]**	Removal of COVID-19 Vaccination Coverage among Healthcare Personnel measure

		a. The data are consistent with definitions outlined in NHSN surveillance protocols (including tables of instructions and frequently asked questions). b. The data will be sent to CMS to fulfill CMS quality reporting requirements (when applicable). The *Weekly COVID-19 Summary Data Form for Healthcare Personnel* is used to collect data on summary COVID-19 vaccination counts among HCP eligible to work in the facility for at least 1 day during the reporting period. IRFs can enter data each week, defined as Monday through Sunday. IRFs can also edit and update data after the initial data entry. The form includes brief instructions for collecting and entering each data element (see https://www.cdc.gov/nhsn/forms/57.219-p.pdf). CMS requires that IRFs collect and report this data every quarter to meet compliance requirements for reporting COVID-19 Vaccination Coverage among Healthcare Personnel data.		
D.4	Appendix D, Page D-7	**Reminder:** IRFs can be enrolled in NHSN as Acute Care Hospital units designated as IRFs **OR** as freestanding Inpatient Rehabilitation Facilities. If your IRF is not enrolled in NHSN as a separate facility, and instead is currently submitting data as part of an acute care hospital, i.e., as an acute care hospital unit designated as an IRF**,** it must have its own	**Reminder:** IRFs can be enrolled in NHSN as units in an Acute Care Hospital ~~units~~ or other settings designated as IRFs **OR** as freestanding Inpatient Rehabilitation Facilities. If your IRF is not enrolled in NHSN as a separate facility, and instead is currently submitting data as part of an acute care hospital, i.e., as an acute care hospital unit designated as an IRF**,** it must have its own	Updates to general NHSN reporting guidelines

		unique IRF CCN. If you have questions or need assistance, please contact IRFCoverage@cms.hhs.gov	unique IRF CCN. If you have questions or need assistance, please contact IRFCoverage@cms.hhs.gov	
D.5	Appendix D, Page D-8	Guidance on the Healthcare Personnel Safety Component and COVID-19 Vaccination Coverage among Healthcare Personnel reporting categories can be found at: https://www.cdc.gov/nhsn/hps/weekly-covid-vac/index.html	**[Removed]**	Removal of COVID-19 Vaccination Coverage among Healthcare Personnel measure
D.6	Appendix D, Page D-10	**15.** Fill out the Healthcare Personnel COVID-19 Vaccination Cumulative Summary Form. This form can be found at: https://www.cdc.gov/nhsn/forms/57.219-p.pdf. Instructions for completing the form can be found at: COVID-19 Vaccination Staff TOI June 2023_508 (cdc.gov)	**[Removed]**	Removal of COVID-19 Vaccination Coverage among Healthcare Personnel measure
D.6	Appendix D, Page D-11	**4. Additional Tips and Hints** • Follow the step-by-step instructions in the NHSN Facility Administrator Enrollment Guide, found at: www.cdc.gov/nhsn/pdfs/gen-support/facilityadminenrollmentguidecurrent.pdf ○ You must complete the steps in order.	**4. Additional Tips and Hints** • Follow the step-by-step instructions in the NHSN Facility Administrator Enrollment Guide, found at: www.cdc.gov/nhsn/pdfs/gen-support/facilityadminenrollmentguidecurrent.pdf ○ You must complete the steps in order. ○ Allow several days for this process, because several steps require you to wait for information from CDC.	Updates to hints and tips

		○ Allow several days for this process, because several steps require you to wait for information from CDC. • Use Internet Explorer, which is the only browser that supports the NHSN. • Use the buttons and arrows on the NHSN Web pages instead of the browser's "back" button.	~~• Use Internet Explorer, which is the only browser that supports the NHSN~~ • Use the buttons and arrows on the NHSN Web pages instead of the browser's "back" button.	
D.7	Appendix D, Page D-12	• Facilities will have approximately 135 days following the end of a quarter before NHSN freezes the NHSN CAUTI Outcome Measure, the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, and the COVID-19 Vaccination Coverage among Healthcare Personnel measure and CDC sends the data to CMS.	• Facilities will have approximately 135 days following the end of a quarter before NHSN freezes the NHSN CAUTI Outcome Measure, and the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, ~~and the COVID-19 Vaccination Coverage among Healthcare Personnel measure~~ and CDC sends the data to CMS. • For the Influenza Vaccination Coverage Among Healthcare Personnel measure, the reporting period for the influenza season is from October 1 of a given year through March 31 of that subsequent year and must be submitted by May 15 of the same subsequent year. Facilities can edit their data after May 15, but the revised data will not be shared with CMS.	Updates to hints and tips
D.8	Appendix D, Page D-12	• A CAUTI Standardized Infection Ratio (SIR) will be generated using the 2015 national IRF data as the baseline for data from 2015.	• A CAUTI Standardized Infection Ratio (SIR) will be generated using the ~~2015~~ 2022 national IRF data as the baseline for data from ~~2015~~ 2025.	Updates to SIRs

D.9	Appendix D, Page D-13	• CDI SIRs will be generated using 2015 national IRF data as the baseline for data from 2015 and forward.	• CDI SIRs will be generated using ~~2015~~ 2022 national IRF data as the baseline for data from ~~2015~~ 2025 and forward.	Updates to SIRs
D.10	Appendix D, Page D-13	**Notes on Reporting COVID-19 Vaccination Coverage among Healthcare Personnel** • Data are to be collected for four required categories of individuals (employees, licensed independent practitioners, adult students/trainees and volunteers, and other contract personnel) who are eligible to work in the healthcare facility for at least 1 day during the reporting period. Only the first three categories of HCP are included in the COVID-19 Vaccination Coverage among Healthcare Personnel measure denominator. • Data are to be collected in the COVID-19 vaccination data reporting module in the NHSN Healthcare Personnel Safety (HPS) Component. • The FY 2024 IRF PPS final rule modified the COVID-19 Vaccination Coverage among Healthcare Personnel measure, replacing the term "complete vaccination course" with the term "up to date" in the HCP vaccination	**[Removed]**	Removal of COVID-19 Vaccination Coverage among Healthcare Personnel measure

		definition. IRFs should refer to the definition of "up to date" as of the first day of the quarter, which can be found at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf. Facilities are to report the cumulative number of healthcare personnel eligible to work in the healthcare facility for at least 1 day during the reporting period who are considered up to date with CDC-recommended COVID-19 vaccines. • Facilities are required to submit the COVID-19 vaccination data for at least 1 week per month. Facilities can report data for more than once a week; however, this is not mandatory. The week-end date determines the month in which a week is included. • CDC will submit the COVID-19 vaccination summary data report quarterly to CMS. HCP COVID-19 vaccination summary data submitted to NHSN will be reported by CDC to CMS for each facility by CCN. An accurate CCN is essential. • Facilities are required to report summary-level vaccination data and not individual-level vaccination data. • Facilities will always be able to review the COVID-19 Vaccination Coverage among Healthcare Personnel data that are entered into NHSN. Facilities will		

		always be able to review the final healthcare personnel COVID-19 vaccination summary data report that is transmitted to CMS.		
D.10	Appendix D, Page D-15	**Additional Information** • Frequently asked questions about the NHSN in general are located at www.cdc.gov/nhsn/faqs/FAQ_general.html • Frequently asked questions about the COVID-19 Vaccination Data are located at https://www.cdc.gov/nhsn/hps/weekly-covid-vac/faqs.html# • Direct questions and/or comments about the definitions, measure specifications, or the process of reporting and submitting the NHSN CAUTI Outcome Measure, the Influenza Vaccination Coverage Among Healthcare Personnel measure, the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, or the COVID-19 Vaccination Coverage among Healthcare Personnel measure via NHSN for the IRF QRP to the CDC NHSN Help Desk at NHSN@cdc.gov. Each message will be forwarded to the appropriate person and a response will be sent to you. • All other questions and/or comments about these measures for the IRF QRP should be e-mailed to IRF.questions@cms.hhs.gov	**Additional Information** • Frequently asked questions about the NHSN in general are located at www.cdc.gov/nhsn/faqs/FAQ_general.html • ~~Frequently asked questions about the COVID-19 Vaccination Data are located at https://www.cdc.gov/nhsn/hps/weekly-covid-vac/faqs.html#~~ • Direct questions and/or comments about the definitions, measure specifications, or the process of reporting and submitting the NHSN CAUTI Outcome Measure, the Influenza Vaccination Coverage Among Healthcare Personnel measure, or the NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, ~~or the COVID-19 Vaccination Coverage among Healthcare Personnel measure~~ via NHSN for the IRF QRP to the CDC NHSN Help Desk at NHSN@cdc.gov. Each message will be forwarded to the appropriate person and a response will be sent to you. • All other questions and/or comments about these measures for the IRF QRP should be e-mailed to IRF.questions@cms.hhs.gov	