Change Tables for Proposed IRF-PAI Version 1.5 and Version 2.0

Table 1. Proposed IRF-PAI Version 1.5 Change Table – Effective October 1, 2017 (Changes from Version 1.4 to 1.5)

No.	Item(s) Affected	Item/Text Affected	IRF-PAI Version 1.4	Proposed IRF-PAI Version 1.5	Rationale for Change/Comments
1.	**Admission Discharge**	**N/A**	**Version 1.4**	**Version 1.5**	Updated version number
2.	**Admission Discharge**	**N/A**	**N/A**	**Admission** and **Discharge** headings	Added Admission and Discharge heading on each page of the Admission and discharge assessments, respectively, for clarity
3.	**Admission Discharge**	**Footer**	**IRF-PAI Version 1.4 Effective October 1, 2016**	**Proposed IRF-PAI Version 1.5 Effective October 1, 2017**	Updated
4.	**Admission Discharge**	**Quality Indicators Section Headings and Titles**	**White and gray font and header background**	**Black and bold font and header background**	Updated background and font in headers to increase contrast between text and background
5.	**Admission Discharge**	**27**	**Swallowing Status** 3 - Regular Food: solids and liquids swallowed safely without supervision or modified food consistency 2 - Modified Food Consistency/Supervision: subject requires modified food consistency and/or needs supervision for safety 1 - Tube/Parenteral Feeding: tube/parenteral feeding used wholly or partially as a means of sustenance	**DELETED**	This voluntary item is no longer needed, as a new item has been added to Section K

Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
1.	**Admission Discharge**	**N/A**	**Version 1.5**	**Version 2.0**	Updated version number
2.	**Admission Discharge**	**Footer**	**Proposed IRF-PAI Version 1.5 Effective October 1, 2017**	**Proposed IRF-PAI Version 2.0 - Effective October 1, 2018**	Updated
3.	**Admission Discharge**	**N/A**	**N/A**	Punctuation and style revisions applicable throughout the instrument	Punctuation and style revisions to be consistent with MDS and LTCH CARE Data Set
4.	**Admission**	**B0100**	**New Item**	**B0100. Comatose** **Persistent vegetative state/no discernible consciousness.** 0. **No** → Continue to B0200, Hearing**.** 1. **Yes** → Skip to GG0100, Prior Functioning: Everyday Activities.	New item added to indicate coma status and to align with Minimum Data Set and LTCH CARE Data Set
5.	**Discharge**	**B0100**	**New Item**	**B0100. Comatose** **Persistent vegetative state/no discernible consciousness.** 0. **No** → Continue to C1310, Signs and Symptoms of Delirium**.** 1. **Yes** → Skip to G0130, Self-Care.	New item added to indicate coma status and to align with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
6.	**Admission**	**B0200**	**New Item**	**B0200. Hearing** (3-day assessment period) **Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate**: No difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty**: Difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. **Moderate difficulty**: Speaker has to increase volume and speak distinctly 3. **Highly impaired**: Absence of useful hearing	New item added to assess Hearing in Section B – Hearing, Speech, and Vision and to align with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
7.	**Admission**	**B1000**	**New Item**	**B1000. Vision** (3-day assessment period) **Ability to see in adequate light** (with glasses or other visual appliances) 0. **Adequate**: Sees fine detail, such as regular print in newspapers/books 1. **Impaired**: Sees large print, but not regular print in newspapers/books 2. **Moderately impaired**: Limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired**: Object identification in question, but eyes appear to follow objects 4. **Severely impaired**: No vision or sees only light, colors or shapes; eyes do not appear to follow objects	New item added to assess Vision in Section B – Hearing, Speech, and Vision and to align with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
8.	**Admission**	**BB0800**	**BB0800. Understanding Verbal Content** (3-day assessment period) **Understanding Verbal Content** (with hearing aid or device, if used and excluding language barriers) 4. **Understands:** Clear comprehension without cues or repetitions 3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand 2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand 1. **Rarely/Never Understands**	**BB0800. Understanding Verbal and Non-Verbal Content** (3-day assessment period) **Understanding Verbal and Non-Verbal Content** (with hearing aid or device, if used, and excluding language barriers) 4. **Understands:** Clear comprehension without cues or repetitions 3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand 2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand 1. **Rarely/Never Understands**	Added clarification that Non-Verbal Content can also be considered when coding this item Added comma for clarification

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
9.	**Admission**	**C0200**	**C0200. Repetition of Three Words** **Ask patient:** *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed****. Now tell me the three words."* **Number of words repeated by patient after first attempt:** 3. **Three** 2. **Two** 1. **One** 0. **None** After the patient's first attempt, say *"I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture*." You may repeat the words up to two more times.	C0200. Repetition of Three Words Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."* Number of words repeated after first attempt 3. Three 2. Two 1. One 0. None After the patient's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.	Instructions and response option wording were modified to align with wording in Minimum Data Set and LTCH CARE Data Set Response content and codes are consistent with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
10.	**Admission**	**C0300** **C0300A** **C0300B** **C0300C**	**C0300. Temporal Orientation: Year, Month, Day** **A. Ask patient:** *"Please tell me what year it is right now."* Patient's answer is: 3. **Correct** 2. **Missed by 1 year** 1. **Missed by 2 to 5 years** 0. **Missed by more than 5 years or no answer** **B. Ask patient:** *"What month are we in right now?"* Patient's answer is: 2. **Accurate within 5 days** 1. **Missed by 6 days to 1 month** 0. **Missed by more than 1 month or no answer** **C. Ask patient:** *"What day of the week is today?"* Patient's answer is: 1. **Correct** 0. **Incorrect or no answer**	**C0300. Temporal Orientation (orientation to year, month, and day)** Ask patient: *"Please tell me what year it is right now."* **A. Able to report correct year** 3. **Correct** 2. **Missed by 1 year** 1. **Missed by 2-5 years** 0. **Missed by > 5 years** or no answer Ask patient: *"What month are we in right now?"* **B. Able to report correct month.** 2. **Accurate within 5 days** 1. **Missed by 6 days to 1 month** 0. **Missed by > 1 month** or no answer Ask patient: *"What day of the week is today?"* **C. Able to report correct day of the week** 1. **Correct** 0. **Incorrect** or no answer	Instructions and response option wording were modified to align with wording in Minimum Data Set and LTCH CARE Data Set Response content and codes are consistent with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
11.	**Admission**	**C0400** **C0400A** **C0400B** **C0400C**	**C0400. Recall** **Ask patient**: "*Let's go back to the first question. What were those three words that I asked you to repeat*?" If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word. **A. Recalls "sock"?** 2. **Yes,** no cue required 1. **Yes,** after cueing ("something to wear") 0. **No,** could not recall **B. Recalls "blue"?** 2. **Yes**, no cue required 1. **Yes**, after cueing ("a color") 0. **No**, could not recall **C. Recalls "bed"?** 2. **Yes,** no cue required 1. **Yes,** after cueing ("a piece of furniture") 0. **No,** could not recall	**C0400. Recall** Ask patient: "*Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. **A. Able to recall "sock"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("something to wear") 0. **No -** could not recall **B. Able to recall "blue"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("a color") 0. **No** - could not recall **C. Able to recall "bed"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("a piece of furniture") 0. **No -** could not recall	Instructions and response option wording were modified to align with wording in Minimum Data Set and LTCH CARE Data Set Response content and codes are consistent with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
12.	**Admission**	**C1310** **C1310A** **C1310B** **C1310C** **C1310D**	**New Item**	**C1310. Signs and Symptoms of Delirium (from CAM©)** Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record (3-day assessment period). **A. Acute Onset Mental Status Change** **Is there evidence of an acute change in mental status** from the patient's baseline? 0. **No** 1. **Yes** **Enter Codes in Boxes** **B. Inattention -** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? **C. Disorganized thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?	New item added to assess signs and symptoms of delirium in Section C – Cognitive Patterns and to align with Minimum Data Set and LTCH CARE Data Set The admission item differs from the discharge item by specifying a "3-day assessment period" Technical expert panel was supportive of use of the CAM in IRFs

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
				D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria? • **vigilant** - startled easily to any sound or touch • **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch • **stuporous** - very difficult to arouse and keep aroused for the interview • **comatose** - could not be aroused **Coding:** 0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	
13.	**Discharge**	**C1310** **C1310A** **C1310B** **C1310C** **C1310D**	**New Item**	**C1310. Signs and Symptoms of Delirium (from CAM©)** (within the last seven days). **A. Acute Onset Mental Status Change** **Is there evidence of an acute change in mental status** from the patient's baseline? 0. **No** 1. **Yes**	New item added to assess signs and symptoms of delirium in Section C – Cognitive Patterns to align with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
				Enter Codes in Boxes **B. Inattention -** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? **C. Disorganized thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? **D. Altered level of consciousness -** Did the patient have altered level of consciousness as indicated by any of the following criteria? • **vigilant** - startled easily to any sound or touch • **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch • **stuporous** - very difficult to arouse and keep aroused for the interview • **comatose** - could not be aroused **Coding:** 0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	Technical expert panel was supportive of the use of the CAM in IRFs The discharge item differs from the admission version of this item by specifying the assessment time period to be "within the last 7 days"

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
14.	**Admission Discharge**	**C1310 (footnote)**	**N/A – footnote associated with new item**	*Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.*	Added footnote associated with C1310
15.	**Admission Discharge**	**Section D**	**New Section**	**Section D - Mood**	Added new section to accommodate PHQ-2 items
16.	**Admission Discharge**	**D0150**	**New Item**	**D0150. Patient Health Questionnaire 2 (PHQ-2©)** **Say to patient:** *"Over the last 2 weeks, have you been bothered by any of the following problems?"* If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the patient: "About how often have you been bothered by this?" Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency. **1. Symptom Presence** 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	Added PHQ-2 to assess for symptoms of depression and for consistency and standardization with the LTCH CARE Data Set Public comments supportive of using less burdensome PHQ-2 rather than PHQ-9; suggested screening for depression symptoms to ensure that this important condition is captured as early as possible, increasing the likelihood of being able to prevent development of severe depression.

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
				2. Symptom Frequency 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day) **Enter scores in boxes.** A. *Little interest or pleasure in doing things?* B. *Feeling down, depressed, or hopeless?*	Technical expert panel satisfied with the reliability, validity, and utility of the PHQ-2 as a screener for depressive symptoms
17.	**Admission Discharge**	**D0150 (footnote)**	**N/A –footnote associated with new item**	*Copyright © Pfizer Inc. All rights reserved. Reproduced with permission.*	Added footnote associated with D0150 item
18.	**Admission Discharge**	**Section E**	**New Section**	**Section E – Behavioral Symptoms**	Added new section to accommodate new behavioral symptoms items

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
19.	**Admission Discharge**	**E0200 E0200A E0200B E0200C**	**New Item**	**E0200. Behavioral Symptom – Presence & Frequency** Note presence of symptoms and their frequency. **Enter Codes in Boxes** **A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) **B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others) **C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) **Coding:** 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**	Added Behavioral Symptoms to align with Minimum Data Set and LTCH CARE Data Set Expert input suggested that documenting the occurrence of these behaviors and their frequency would be useful **Note. Given the 7-day lookback, it is expected that assessors will obtain this information at admission from providers in previous setting, likely through the IRF pre-screen process. The assessment time period covers 4 days prior to admission and the first 3 days of the patient's IRF stay.

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
20.	**Admission**	**GG110 GG0110A GG0110B GG0110C GG0110D GG0110E GG0110Z**	**GG0110. Prior Device Use.** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury. **Check all that apply** **A. Manual wheelchair** **B. Motorized wheelchair or scooter** **C. Mechanical lift** **D. Walker** **E. Orthotics/Prosthetics.** **Z. None of the above**	**GG0110. Prior Device Use.** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury. **Check all that apply** **A. Manual wheelchair** **B. Motorized wheelchair and/or scooter** **C. Mechanical lift** **D. Walker** **E. Orthotics/Prosthetics** **Z. None of the above**	Added "and/" for clarification
21.	**Admission**	**GG0130 Discharge goal coding**	**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).**	**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).**	Added instructions indicating that the activity not attempted codes may be used to code goal items
22.	**Admission Discharge**	**GG0130 Coding options**	**From 6-point scale** **05. Setup or clean-up assistance –** Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior or following the activity.	**From 6-point scale** **05. Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior or following the activity.	Removed capitalization for stylistic consistency within the instrument

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
23.	**Admission Discharge**	**GG0130 Coding options**	**From 6-point scale** **04. Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.	**From 6-point scale** 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.	Added "contact guard" and changed "or" to "and/or" for clarification Removed capitalization
24.	**Admission Discharge**	**GG0130**	**If activity was not attempted, code the reason:** 07. **Patient refused** 09. **Not applicable** 88. Not attempted due to **medical condition or safety concerns**	**If activity was not attempted, code the reason:** 07. **Patient refused** 09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical condition or safety concerns**	Added definition of 09 for clarification Added new code to allow reporting of environmental limitations
25.	**Admission Discharge**	**GG0130A**	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.	Revised wording of the item definition for clarification

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
26.	**Admission Discharge**	**GG0130B**	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.	Revised wording of the item definition for clarification
27.	**Admission Discharge**	**GG0130C**	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.	Revised wording of the item definition for clarification
28.	**Admission Discharge**	**GG0130E**	**E. Shower/bathe self:** The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.	Revised wording of the item definition for clarification
29.	**Admission Discharge**	**GG0130F**	**F. Upper body dressing:** The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.	Revised wording of the item definition for clarification
30.	**Admission Discharge**	**GG0130H**	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.	Revised wording of the item definition for clarification

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
31.	**Admission**	**GG0170 Discharge goal coding**	**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).**	**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).**	Added instructions indicating that the activity not attempted codes may be used to code goal items
32.	**Admission Discharge**	**GG0170 Coding option**	**From 6-point scale** **05. Setup or clean-up assistance –** Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior or following the activity.	**From 6-point scale** **05. Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior or following the activity.	Removed capitalization
33.	**Admission Discharge**	**GG0170 Coding option**	**From 6-point scale** **04. Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.	**From 6-point scale** 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.	Added "contact guard" and changed "or" to "and/or" for clarification Removed capitalization

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
34.	**Admission Discharge**	**GG0170 Coding option**	**If activity was not attempted, code the reason:** 07. **Patient refused** 09. **Not applicable** 88. Not attempted due to **medical condition or safety concerns**	**If activity was not attempted, code the reason:** 07. **Patient refused** 09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical condition or safety concerns**	Added definition of 09 for clarification. Added new code to allow reporting of environmental limitations
35.	**Admission Discharge**	**GG0170A**	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back.	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.	Added "on the bed" for clarification
36.	**Admission Discharge**	**GG0170C**	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items
37.	**Admission Discharge**	**GG0170D**	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items. Added "wheelchair" for clarification

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
38.	**Admission Discharge**	**GG0170E**	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items
39.	**Admission Discharge**	**GG0170F**	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.	**F. Toilet transfer:** The ability to get on and off a toilet or commode.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items
40.	**Admission**	**GG0170H1**	**H1. Does the patient walk?** 0. **No,** and walking goal **is not** clinically indicated -> Skip to GG0170Q1. Does the patient use a wheelchair/scooter? 1. **No,** and walking goal **is** clinically indicated -> Code the patient's discharge goal(s) for items GG0170I, J, K, L, M, N, O, and P. For admission performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter? 2. **Yes** *Continue to GG0170I. Walk 10 feet*	**Item deleted**	The skip pattern is associated with the item Walk 10 feet
41.	**Discharge**	**GG0170H3**	**H3. Does the patient walk?** 0. **No** → *Skip to GG0170Q3. Does the patient use wheelchair/scooter?* 2. **Yes** → Continue to GG0170I. Walk 10 feet	**Item deleted**	The skip pattern is associated with the item Walk 10 feet

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
42.	**Admission**	**GG0170I**	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If admission performance is coded 07, 09, 10, or 88 --> Skip to GG0170M, 1 step (curb).*	Added skip pattern that was previously associated with GG0170H1
43.	**Discharge**	**GG0170I**	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If discharge performance is coded 07, 09, 10, or 88 --> Skip to GG0170M, 1 step (curb).*	Added skip pattern that was previously associated with GG0170H3
44.	**Admission Discharge**	**GG0170L**	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.	Revised wording of the item definition for clarification
45.	**Admission Discharge**	**GG0170M**	**M. 1 step (curb):** The ability to step over a curb or up and down one step.	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step	Added for clarification
46.	**Admission**	**GG0170Q1**	**Q1. Does the patient use a wheelchair/scooter?** 0. **No** *Skip to H0350. Bladder Continence* 1. **Yes** *Continue to GG0170R. Wheel 50 feet with two turns*	**Q1. Does the patient use a wheelchair and/or scooter?** 0. **No ->** *Skip to H0350, Bladder Continence* 1. **Yes ->** *Continue to GG0170R, Wheel 50 feet with two turns*	Added for clarification

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
47.	**Discharge**	**GG0170Q3**	**Q3. Does the patient use a wheelchair/scooter?** 0. **No ->** Skip to J1800. Any Falls Since Admission 1. **Yes ->** *Continue to GG0170R. Wheel 50 feet with two turns*	**Q3. Does the patient use a wheelchair and/or scooter?** 0. **No ->** *Skip to J1800, Any Falls Since Admission* 1. **Yes ->** *Continue to GG0170R, Wheel 50 feet with two turns*	Added for clarification
48.	**Admission**	**GG0170RR1**	**RR1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**RR1. Indicate the type of wheelchair or scooter used.** 1**. Manual** 2. **Motorized**	Added for clarification
49.	**Discharge**	**GG0170RR3**	**RR3. Indicate the type of wheelchair/scooter used.** **1. Manual** **2. Motorized**	**RR3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**	Added for clarification
50.	**Admission**	**GG0170SS1**	**SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**	Added for clarification
51.	**Discharge**	**GG0170SS3**	**SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**SS3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**	Added for clarification

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
52.	**Discharge**	**J1800**	**J800. Any Falls Since Admission** Has the patient had any falls since admission? 0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)* 1. **Yes** → *Continue to J1900. Number of Falls Since Admission*	**J1800. Any Falls Since Admission** Has the patient had any falls since admission? 0. **No** → *Skip to K0520, Nutritional Approaches* 1. **Yes** → *Continue to J1900. Number of Falls Since Admission*	Modified skip pattern to reflect addition of item K0520 on discharge
53.	**Discharge**	**Section K**	**New Section**	**Section K – Swallowing/Nutritional Status**	Adding new section on discharge to accommodate item K0520
54.	**Admission**	**K0110** **K0110A** **K0110B** **K0110C**	**K0110. Swallowing/Nutritional Status** (3-day assessment period) Indicate the patient's usual ability to swallow. **Check all that apply** **A. Regular food** -Solids and liquids swallowed safely without supervision or modified food or liquid consistency. **B. Modified food consistency/supervision** -Patient requires modified food or liquid consistency and/or needs supervision during eating for safety. **C. Tube/parenteral feeding** - Tube/parenteral feeding used wholly or partially as a means of sustenance.	N/A – delete K0110	Item deleted and replaced with K0520 for purpose of alignment with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
55.	**Admission**	**K0520** **K0520A1** **K0520B1** **K0520C1** **K0520D1** **K0520Z1**	**New item**	**K0520. Nutritional Approaches** Check all of the following nutritional approaches that were performed during the first 3 days of admission. **1. Performed during the first 3 days of admission.** ↓ **Check all that apply** **A. Parenteral/IV feeding** **B. Feeding tube** - nasogastric or abdominal (e.g., PEG) **C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids) **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol) **Z. None of the above**	Added to IRF-PAI to align with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
56.	**Discharge**	**K0520** **K0520A2** **K0520B2** **K0520C2** **K0520D2** **K0520Z2**	**New item**	**K0520. Nutritional Approaches** Check all of the following nutritional approaches that were performed during the last 7 days. **2. Performed during the last 7 days.** **↓ Check all that apply** **A. Parenteral/IV feeding** **B. Feeding tube** - nasogastric or abdominal (e.g., PEG) **C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids) **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol) **Z. None of the above**	Added to IRF-PAI to align with Minimum Data Set and LTCH CARE Data Set A 7-day lookback period provides more information about changes in the patient's status over the course of rehabilitation, which can be useful in care planning, particularly in the context of care transitions
57.	**Admission Discharge**	**Section M heading**	**Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage**	**Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage**	Added the term "injury" to be inclusive of updated terminology supported by the National Pressure Ulcer Advisory Panel (NPUAP) Item wording aligns with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
58.	**Admission**	**M0210**	**M0210. Unhealed Pressure Ulcer(s)** **Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** -> *Skip to O0100. Special Treatments, Procedures, and Programs* 1. **Yes** -> *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*	**M0210. Unhealed Pressure Ulcers/Injuries** **Does this patient have one or more unhealed pressure ulcers/injuries?** 0. **No** -> *Skip to N2001, Drug Regimen Review* 1. **Yes** -> *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*	Deleted text to clarify Added the term "injury" to be inclusive of updated terminology supported by NPUAP Modified skip pattern to be consistent with addition of new section (N) Item wording aligns with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
59.	**Discharge**	**M0210**	**M0210. Unhealed Pressure Ulcer(s)** **Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** -> *Skip to O0100. Special Treatments, Procedures, and Programs* 1. **Yes** -> *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*	**M0210. Unhealed Pressure Ulcers/Injuries** **Does this patient have one or more unhealed pressure ulcers/injuries?** 0. **No** -> *Skip to N2005, Medication Intervention* 1. **Yes** -> *Continue to M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*	Deleted text to clarify Added the term "injuries" to be inclusive of updated terminology supported by NPUAP Modified skip pattern to be consistent with addition of new section (N) Item wording aligns with Minimum Data Set and LTCH CARE Data Set
60.	**Admission Discharge**	**M0300**	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage**	**M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage**	Added the term "injuries" to be inclusive of updated terminology supported by NPUAP Item wording aligns with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
61.	**Admission Discharge**	**M0300A**	**Number of Stage 1 pressure ulcers**	1. **Number of Stage 1 pressure** injuries	Added the number one to be consistent with other items in the section Replaced the term "ulcers" with "injuries" as the term "injuries" indicates intact skin which better aligns with criteria for Stage 1 Item wording aligns with Minimum Data Set and LTCH CARE Data Set
62.	**Discharge**	**M0300D1**	**D1. Number of Stage 4 pressure ulcers** - If 0 -> *Skip to M0300E. Unstageable - Non-removable dressing*	**D1. Number of Stage 4 pressure ulcers** - If 0 -> *Skip to M0300E, Unstageable: Non-removable dressing/device*	Added for clarification
63.	**Admission**	**M0300E M0300E1**	**E. Unstageable - Non-removable dressing:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers due to non-removable dressing/device**	**E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**	Added the word "device" for clarification Item wording aligns with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
64.	**Discharge**	**M0300E** **M0300E1** **M0300E2**	**E. Unstageable - Non-removable dressing:** Known but not stageable due to non-removable dressing/device 1. **Number of unstageable pressure ulcers due to non-removable dressing/device** → *If 0 Skip to M0300F. Unstageable, Slough and/or eschar.* 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission	**E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device 1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** → *If 0 Skip to M0300F, Unstageable, Slough and/or eschar.* 2. **Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission - enter how many were noted at the time of admission**	Added the term "injuries" to be inclusive of updated terminology supported by NPUAP Item wording aligns with Minimum Data Set and LTCH CARE Data Set
65.	**Admission**	**M0300G** **M0300G1**	**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution. 1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure** injuries presenting as deep tissue injury	Removed the term "suspected deep tissues injury in evolution" and added language to be consistent with updated NPUAP terminology Item wording aligns with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
66.	**Discharge**	**M0300G** **M0300G1** **M0300G2**	**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution. 1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** *If 0 → Skip to M0800. Worsening in Pressure Ulcers Status Since Admission* 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission.	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable** pressure injuries presenting as deep tissue injury If 0 → *Skip to N2005, Medication Intervention* 2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission.	Removed the term "suspected deep tissue injury in evolution" and replace with "deep tissue injury" to be consistent with updated NPUAP terminology Item wording aligns with Minimum Data Set and LTCH CARE Data Set
67.	**Discharge**	**M0800**	**M0800. Worsening in Pressure Ulcer Status Since Admission** Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission. If no current pressure ulcer at a given stage, enter 0 **A. Stage 2** **B. Stage 3** **C. Stage 4** **D. Unstageable - Non-removable dressing** **E. Unstageable - Slough and/or eschar** **F. Unstageable - Deep tissue injury**	N/A – delete items	Deleted to reduce provider burden Alignment with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
68.	**Discharge**	**M0900** **M0900A** **M0900B** **M0900C** **M0900D**	**M0900. Healed Pressure Ulcer(s)** Indicate the number of pressure ulcers that were: (a) present on **Admission; and** (b) have completely closed (resurfaced with epithelium) upon **Discharge**. If there are no healed pressure ulcers noted at a given stage, enter 0. **A. Stage 1** **B. Stage 2** **C. Stage 3** **D. Stage 4**	N/A – delete items	Deleted to reduce provider burden
69.	**Admission** **Discharge**	**Section N**	**N/A – new section**	**Section N. Medications**	New section added on admission and discharge to accommodate Drug Regimen Review quality measure items N2001, N2003, and N2005

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
70.	**Admission**	**N2001**	**New Item**	**N2001. Drug Regimen Review** **Did a complete drug regimen review identify potential clinically significant medication issues?** 0. **No - No issues found during review** → *Skip to O0100, Special Treatments, Procedures, and Programs* 1. **Yes - Issues found during review** → *Continue to N2003, Medication Follow-up* 9. **NA - Patient is not taking any medications**→ *Skip to O0100, Special Treatments, Procedures, and Programs*	New item added to collect data for drug regimen review quality measure
71.	**Admission**	**N2003**	**New Item**	**N2003. Medication Follow-up** **Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?** 0. **No** 1. **Yes**	New item added to collect data for drug regimen review quality measure Alignment with Minimum Data Set and LTCH CARE Data Set

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
72.	**Discharge**	**N2005**	**New Item**	**N2005. Medication Intervention** **Did the facility contact and complete physician (or physician-designee) prescribed/ recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?** **0. No** **1. Yes** **9. NA - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications**	New item added to collect data for drug regimen review quality measure Alignment with Minimum Data Set and LTCH CARE Data Set
73.	**Admission**	**O0100**	**O0100. Special Treatments, Procedures, and Programs** **↓ Check if treatment applies at admission**	**O0100. Special Treatments, Procedures, and Programs** Check all of the following treatments, procedures, and programs that were performed during the first 3 days of admission. For chemotherapy and dialysis, check if it is part of the patient's treatment plan. **a. Performed during the first 3 days of admission.** **↓ Check all that apply.**	The 3-day lookback period was clarified for internal consistency with assessment time periods in the IRF-PAI and to document treatments, procedures and programs that were performed in the first 3 days of the stay Alignment with Minimum Data Set and LTCH CARE Data Set.

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le 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
74.	**Discharge**	**O0100**	**New Item**	**O0100. Special Treatments, Procedures, and Programs** Check all of the following treatments, procedures, and programs that were performed during the last 14 days. **b. Performed during the last 14 days.** **↓ Check all that apply.**	The 14-day lookback period was chosen to achieve standardization with Minimum Data Set and the LTCH CARE Data Set A 14-day lookback period provides useful information for care planning and risk evaluation, especially in the context of transfers of care
75.	**Admission Discharge (Note: '3' denotes admission and '4' denotes discharge)**	**O0100** **O0100A3** **O0100A4** **O0100A2a3** **O0100A2a4** **O0100A3a3** **O0100A3a4** **O0100A10a3** **O0100A10a4**	**New Item**	**A. Chemotherapy** (if checked, please specify below) A2a. IV A3a. Oral A10a. Other	New item added to align with Minimum Data Set and LTCH CARE Data Set Public comment and subject matter experts support breaking the parent item "chemotherapy" into type of chemotherapy to distinguish patient complexity/burden of care

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
76.	**Admission** **Discharge**	**O0100B3** **O0100B4**	**New Item**	**B. Radiation**	New item added to align with Minimum Data Set and LTCH CARE Data Set
77.	**Admission** **Discharge**	**O0100C3** **O0100C4** **O0100C2a3** **O0100C2a4** **O0100C3a3** **O0100C3a4**	**New Item**	**C. Oxygen Therapy** (if checked, please specify below) C2a. Continuous C3a. Intermittent	New item added to align with Minimum Data Set and LTCH CARE Data Set Public comment and subject matter experts support breaking the parent item "oxygen therapy" into continuous or intermittent to distinguish patient complexity/burden of care

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
78.	**Admission Discharge**	**O0100D3 O0100D4 O0100D2a3 O0100D2a4 O0100D3a3 O0100D3a4**	**New Item**	**D. Suctioning** (if checked, please specify below) D2a. Scheduled D3a. As needed	New item added to align with Minimum Data Set and LTCH CARE Data Set Public comment and subject matter experts support breaking the parent item "suctioning" into frequency of suctioning to distinguish patient complexity/burden of care
79.	**Admission Discharge**	**O0100E3 O0100E4**	**New Item**	**E. Tracheostomy Care**	New item added to align with Minimum Data Set and LTCH CARE Data Set
80.	**Admission Discharge**	**O0100F3 O0100F4**	**New Item**	**F. Invasive Mechanical Ventilator**	Collecting information on use of invasive mechanical ventilation support is important for assessing cost and case complexity in IRFs and useful for care transfer

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Table 2. Proposed IRF-PAI Version 2.0 Change Table – Effective October 1, 2018 (Changes from Version 1.5 to 2.0) (continued)

No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
81.	**Admission Discharge**	**O0100G3 O0100G4 O0100G2a3 O0100G2a4 O0100G3a3 O0100G3a4**	**New Item**	**G. Non-invasive Mechanical Ventilator (BiPAP/CPAP)** (if checked, please specify below) G2a. BiPAP G3a. CPAP	New item added to align with Minimum Data Set and LTCH CARE Data Set In public comment, there was support for breaking the parent item into child items: BiPAP and CPAP
82.	**Admission Discharge**	**O0100H3 O0100H4 O0100H3a3 O0100H3a4 O0100H4a3 O0100H4a4 O0100H10a3 O0100H10a4**	**New Item**	**H. IV Medications** (if checked, please specify below) H3a. Antibiotics H4a. Anticoagulation H10a. Other	New item added to align with Minimum Data Set and LTCH CARE Data Set In public comment, there was support for further delineating types of IV medications
83.	**Admission Discharge**	**O0100I3 O0100I4**	**New Item**	**I. Transfusions**	New item added to align with Minimum Data Set and LTCH CARE Data Set
84.	**Admission Discharge**	**O0100J3 O0100J4 O0100J2a3 O0100J2a4 O0100J3a3 O0100J3a4**	**New Item**	**J. Dialysis** (if checked, please specify below) J2a. Hemodialysis J3a. Peritoneal dialysis	New item added to align with Minimum Data Set and LTCH CARE Data Set In public comment, there was support for breaking out the parent item "dialysis" into type of dialysis

(continued)

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No.	Item(s) Affected	Item / Text Affected	Proposed IRF-PAI Version 1.5	Proposed IRF-PAI Version 2.0 (Note: Proposed modifications to existing items are presented in BLUE font)	Rationale for Change/Comments
85.	**Admission**	**O0100N**	**O0100N. Total Parenteral Nutrition**	N/A – delete item	Deleted to align with Minimum Data Set and LTCH CARE Data Set. Total parental nutrition will be assessed as part of new item in Section K, K0520
86.	**Admission** **Discharge**	**O0100O3** **O0100O4** **O0100O2a3** **O0100O2a4** **O0100O3a3** **O0100O3a4** **O0100O4a3** **O0100O4a4** **O0100O10a3** **O0100O10a4**	**New Item**	**O. IV Access** (if checked, please specify below) O2a. Peripheral IV O3a. Midline O4a. Central line (e.g., PICC, tunneled, port) O10a. Other	New item added to align with the Minimum Data Set and LTCH CARE Data Set In public comment, there was support for breaking out the parent item into types of IV access
87.	**Admission** **Discharge**	**O0100Z3** **O0100Z4**	**New Item**	**Z. None of the above**	New item added to align with Minimum Data Set and LTCH CARE Data Set