

CHAPTER 3: GLOSSARY AND COMMON ACRONYMS

Term	Definition
Active Diagnoses	Diagnoses (conditions or diseases) that have a direct relationship to the patient's current functional, cognitive, mood, or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
Activities of Daily Living (ADLs)	Activities performed as part of a person's daily routine such as self-care, bathing, dressing, eating, and toileting.
Activity	The performance of a task or action by an individual (definition from the World Health Organization's International Classification of Functioning, Disability and Health [ICF]).
Activity Limitation	A restriction or lack of ability to perform an activity in the manner or within a range considered normal for a person of the same age, culture, and education.
Admission Date	The date a person enters the IRF and is admitted as a patient. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the first day of admission.
Ambulation	Self-mobilization along a surface on foot, step by step so that one foot is always in contact with the ground. Ambulation may include walking short or long distances and walking on different surfaces as specified in the assessment item. Movement from place to place, which usually includes walking.
Another Inpatient Rehabilitation Facility	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code should be used when a patient is admitted from/transferred to another IRF, or remained a patient of the same IRF under a new payer.
Assessment Period	The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge.
Assessment Reference Date (ARD)	The specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period. For the admission assessment, the Assessment Reference Date is the third calendar day that the patient has been in the IRF. For the discharge assessment, the Assessment Reference Date is the date that the patient is discharged from the IRF, or the date that the patient ceases to receive Medicare inpatient rehabilitation services.
Assessment Schedule	Refers to when assessments must be coded and transmitted. The assessment and discharge assessment schedules are illustrated in Charts 1, 2, and 3 in Chapter 2 of this manual.
Assessment Submission	The electronic submission of the IRF-PAI data to iQIES. The data are required to be in formats that conform to standard record layouts and data dictionaries, and pass standardized edits as defined by CMS. Chapter 4 of this manual and the IRF Data Submission Specifications on the CMS IRF Data Specifications webpage (https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/data-specification) provide detailed information. Additionally the IRF Quality Reporting Program Technical Information webpage (https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-technical-information) provides updates and resources related to IRF data collection and submission.

Term	Definition
Board and Care, Assisted Living, Group Home	A non-institutional community residential setting that includes homemaker/personal care services or meal services.
Body Mass Index (BMI)	Number calculated from a person’s weight and height. BMI is a reliable indicator of body fat and is used as an indicator to identify possible weight problems for adults.
Case Mix Group (CMG)	A patient classification system that groups together inpatient medical rehabilitation patients who are expected to have similar resource utilization needs and outcomes.
CMS Certification Number (CCN)	Replaces the term “Medicare/Medicaid Provider Number” in survey, certification, and assessment-related activities.
Comorbidity	A secondary condition a patient may have in addition to the primary diagnosis for which the patient was admitted to the IRF. The patient comorbidity/ies listed in item 24 of the IRF-PAI should have significant impact on the patient’s treatment for their primary diagnosis.
Complication	A specific patient condition that affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category, and which began after the rehabilitation stay started.
Confusion Assessment Method (CAM©)	An instrument that screens for overall cognitive impairment as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments.
Contact with Physician (or Physician-Designee)	Communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue, AND a response from the physician (or physician-designee) to convey prescribed/ recommended actions in response to the medication issue. Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status. Communication can be directly to/from the physician (or physician-designee), or indirectly through physician’s office staff on behalf of the physician (or physician-designee), in accordance with the legal scope of practice.

Term	Definition
<p>Critical Access Hospital (CAH)</p>	<p>For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code should be used to identify an admission/transfer to a CAH for inpatient care. However, admission, discharge, or transfer to a CAH swing bed should still be coded with Code 61.</p> <p>CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoPs) as well as a separate payment method. The following providers may be eligible to become CAHs:</p> <ul style="list-style-type: none"> • Currently participating Medicare hospitals; • Hospitals that ceased operations on or after November 29, 1989; or • Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center. <p>A Medicare-participating hospital must meet the following criteria to be designated by CMS as a CAH:</p> <ul style="list-style-type: none"> • Be located in a State that has established a State Medicare Rural Hospital Flexibility Program; • Be designated by the State as a CAH; • Be located in a rural area or an area that is treated as rural; • Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified as a CAH based on State designation as a “necessary provider” of health care services to residents in the area; • Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services; • Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units); • Demonstrate compliance with the CAH CoPs found at 42 CFR Part 485 subpart F; and • Furnish 24-hour emergency care services 7 days a week. <p>A CAH may also be granted “swing-bed” approval to provide post-hospital skilled nursing facility-level care in its inpatient beds.</p> <p>In addition to the 25 inpatient CAH beds, a CAH may also operate a psychiatric and/or a rehabilitation distinct part unit of up to 10 beds each. These units must comply with the Hospital Conditions of Participation.</p>
<p>Delirium</p>	<p>A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations.</p>
<p>Discharge</p>	<p>A Medicare patient in an IRF is considered discharged when one of the following occurs:</p> <ol style="list-style-type: none"> 1. The patient is formally released. 2. The patient dies in the IRF.
<p>Discharge Date</p>	<p>The date a patient leaves the IRF. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual Discharge Date for item 40 of the IRF-PAI. If a discharge is delayed, the Discharge Date is the day the patient actually leaves the IRF.</p>

Term	Definition
Disorganized Thinking	Evidenced by rambling, irrelevant, and/or incoherent speech.
Drug Regimen Review	The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using, and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
Electronic Health Record (EHR)/ Electronic Medical Record (EMR)	An electronic health record (EHR), sometimes referred to as an electronic medical record (EMR), is an electronic version of a patient's medical history that is maintained by the provider over time. This may include key clinical data relevant to that person's care under a particular provider, including demographics, progress notes, medical conditions, diagnoses, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. https://www.healthit.gov/faq/what-electronic-health-record-ehr
Etiologic Diagnosis	The etiologic problem that led to the impairment for which the patient is receiving rehabilitation. Enter the ICD code to indicate the impairment (item 21 of the IRF-PAI - Impairment Group). Refer to Appendix A of this manual for ICD codes associated with specific Impairment Groups. Commonly used ICD codes are listed, but the list is not exhaustive. Consult with health information management staff and current ICD coding books for exact codes.
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 themselves 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.
Fatal File Error	An error in the IRF-PAI submission file format that causes the entire file to be rejected; therefore, the individual assessment records in the submission file are not validated or stored in the iQIES. The Submitter Final Validation Report identifies Fatal File Error(s). The IRF must contact its software support to resolve the problem with the submission file. Once the submission file problem is resolved, the submission file and associated IRF-PAI assessment records must be resubmitted.
Fatal Record Error	An error in an IRF-PAI assessment record that results in the assessment record being rejected. The Final Validation Report lists the assessment records that were rejected. The IRF-PAI must correct error(s) on each assessment record that was rejected, and resubmit.
Federal Register	The official daily publication of rules, proposed rules, and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential documents. It is a publication of the National Archives and Records Administration, and is available by subscription and online.

Term	Definition
Final Validation Report (FVR)	A report generated after the successful submission of IRF-PAI assessment record files. This report lists all of the patients for whom assessments have been submitted in a particular submission batch and displays all errors and/or warnings that occurred during the validation process. Each individual record is listed on the FVR as “accepted” or “rejected.” Accepted records are added to the iQIES database. Rejected records are not added to the iQIES database and must be corrected and resubmitted.
Health Information Exchange (HIE)	Health Information Exchange (HIE) allows health care professionals and patients to appropriately access and securely share a patient’s medical information electronically. There are many health care delivery scenarios driving the technology behind the different forms of HIE available today including directed exchange, query-based exchange, and consumer-mediated exchange.
Home	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this includes home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; and assisted living facilities.
Home Under Care of Home Health Service Organization	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code should be used when a patient is admitted from/discharged/transferred to home with any services from a Medicare certified home health agency.
Hospice	A program for terminally ill persons. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient’s family or caregiver.
Hospice (Home)	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code should be used if the patient was admitted from/discharged to their own home or an alternative setting that is the patient’s “home,” such as a nursing facility, and did/will receive in-home hospice services.
Hospice (Medical Facility)	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code should be used if the patient was admitted from/discharged to an inpatient facility that is qualified and the patient received/will receive the general inpatient hospice level of care, or, if the patient was admitted from/discharged to an inpatient facility that is qualified and the patient received/will receive hospice inpatient respite level of care.
Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function.
Impairment Group Code	Describes the primary reason that the patient is being admitted to the rehabilitation program and relates directly to the goals of the rehabilitation program.
Inactivation	A type of correction allowed under the IRF Correction Policy. When an erroneous record has been accepted into the iQIES database, an inactivation request is required. This removes the erroneous record from the active file to an archive (history file). A new record to replace the removed record must be completed and submitted to iQIES.
Inattention	Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated, or darting attention).

Term	Definition
Incomplete Stay	Patients who meet the criteria for an incomplete stay include patients who are discharged to an acute care setting (such as short-stay acute hospital, Critical Access Hospital, inpatient psychiatric facility, or long-term care hospital), patients who die while in the IRF, patients who leave the IRF against medical advice, and patients with a length of stay less than 3 days. For patients with incomplete stays, the discharge self-care and mobility items are skipped.
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.
Injury Related to a Fall	Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.
Inpatient Psychiatric Facility (IPF)	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code should be used when a patient is admitted from/transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.
Intermediate Care	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code is defined at the State level for specifically designated intermediate-care facilities. It is also used to designate patients admitted from/discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification.
International Classification of Diseases, 10th Edition, Clinical Management (ICD-10-CM)	Official system of assigning codes to diagnoses associated with hospital utilization in the United States. The ICD-10-CM contains a numerical list of the disease code numbers in tabular form and an alphabetical index to the disease entries.
Interoperability/ Interoperable	<p>“The term ‘interoperability’, with respect to health information technology, means such health information technology that— “(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; “(B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and “(C) does not constitute information blocking as defined in section 3022(a).”</p> <p>Section 4003 of the 21st Century Cures Act, available at: https://www.healthit.gov/topic/interoperability</p>
Interrupted Stay	A stay by a patient who is discharged from the IRF and returns to the same IRF within 3 consecutive calendar days. Since Medicare treats this situation as one combined IRF stay, the IRF would not need to repeat all of the required documentation when the patient returns to the IRF after the interruption. However, it is expected that the IRF update the information in the patient’s medical record to make sure that it is current (i.e., update the patient’s condition, comorbidities, rehabilitation goals, plan of care, etc.). Of course, the patient must continue to meet the criteria for admission to an IRF, and all of the elements required during the patient’s stay (such as the three physician visits per week, the weekly interdisciplinary team meetings, etc.) must continue to take place. If the patient returns to the IRF in 4 or more consecutive days (i.e., it is not considered an interrupted stay), then all of the required documentation must be completed as with any “new” IRF patient.

Term	Definition
Legal Name	Patient’s name as it appears on the Medicare card. If the patient is not enrolled in the Medicare program, the patient’s name as it appears on a Medicaid card or other government-issued document is used.
Length of Stay (LOS)	The number of days a patient spends in the IRF. The day of discharge is not counted in the length-of-stay calculation. Length of stay does not include the interrupted stay days. It includes all days that the patient is in the IRF for the midnight census.
Long-Term Care Facility	An institution that is engaged primarily in providing medical and nonmedical care to people who have a chronic illness or disability. These facilities provide care to people who cannot be cared for at home or in the community. Long-term care facilities provide a wide range of personal care and health services for individuals who cannot take care of themselves because of physical, emotional, or mental health issues. The provision of nonskilled care and related services for residents in long-term care can include, but is not limited to, supportive services such as dressing, bathing, using the bathroom, diabetes monitoring, and medication administration.
Long-Term Care Hospital (LTCH)	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code should be used when admitting/discharging/transferring a patient to a long-term care hospital. An LTCH is a facility certified as a hospital and designated as a long-term care hospital under the Medicare program (as denoted by the last four digits of its six-digit CMS Certification Number [CCN] in the range of 2000–2299).
Major Injury	Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.
Major Surgery	Generally, for the purposes of the IRF-PAI, major surgery refers to a procedure that meets all the following criteria: (1) the patient was an inpatient in an acute care hospital for at least 1 day in the 100 days prior to admission to the IRF, and (2) the surgery carried some degree of risk to the patient’s life or the potential for severe disability.
Medicaid	A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.
Medicaid Nursing Facility	<p>For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, this code should be used when a patient is admitted from/transferred to a nursing facility that has no Medicare certified beds. If any beds at the facility are Medicare certified, then the provider should use either status Code 03 or 04, depending on:</p> <ul style="list-style-type: none"> • The level of care the patient is receiving; and • Whether the bed is Medicare certified or not.

Term	Definition
Medicare	<p>A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities.</p> <ul style="list-style-type: none"> • Medicare Part A: The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, home health agencies, and hospices. • Medicare Part B: The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services. • Medicare Part C (Medicare Advantage): Plans that are offered by private companies approved by Medicare.
Medicare Beneficiary Identifier (MBI)	<p>A randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously used SSN-based Medicare HIC Number (HICN). Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.</p>
Medication Follow-Up	<p>The process of contacting a physician (or physician-designee) to communicate the identified medication issue and addressing all physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day at the latest.</p>
Modification	<p>A type of correction allowed under the IRF Correction Policy. A modification is required when an IRF-PAI record has been accepted by iQIES, but the information in the record contains errors. The modification will correct the record in iQIES.</p>
National Provider Identifier (NPI)	<p>A unique Federal number that identifies providers of health care services. The NPI applies to the IRF and all of its patients.</p>
On Admission	<p>As close to the actual time of admission as possible.</p>
Onset Days	<p>The number of days from acute onset of the impairment to admission to the IRF.</p>
Orthosis	<p>An appliance (device) applied over a portion of a limb or the trunk and used to support or immobilize body parts, correct or prevent deformity, or assist or restore function. Anti-embolic (and other) stockings, abdominal binders, and elastic wraps are examples of orthoses.</p>
Outlier	<p>Observation outside a certain range differing widely from the rest of the data.</p>
Outlier Payment	<p>An additional payment beyond the standard federal prospective payment for cases with unusually high costs.</p>
Participation	<p>An individual's involvement in life situations in relation to health conditions, body functions and structures, and activities and contextual factors (definition from the World Health Organization's ICF).</p>
Patient Assessment Instrument	<p>A document that contains clinical, demographic, and other information on a patient.</p>
Planned Discharge	<p>A discharge where the patient is nonemergently, medically released from care at the IRF, for longer than 3 days, for some reason arranged for in advance.</p>

Term	Definition
Portal (e.g., Patient or Provider Portal)	A secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, providers and patients can view health information such as current medications, recent doctor visits, and discharge summaries. Office of the National Coordinator, What is a patient portal? Available from https://www.healthit.gov/faq/what-patient-portal
Potential (or Actual) Clinically Significant Medication Issue	A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.
Pressure Ulcer/Injury	Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.
Private Home or Apartment	For the purposes of coding items 15A, 16A, and 44D, refers to non-institutional residential settings that include any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities and independent housing for the elderly.
Prospective Payment System (PPS)	A method of payment to a health care facility at a predetermined rate for treatment regardless of the cost of care for a specific patient.
Prosthesis	A device that replaces a body part.
Qualified	A healthcare professional practicing within their scope of practice and consistent with Federal, State, and local law and regulations.
Quality Measure	Tool that helps measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.
Rehabilitation Impairment Category (RIC)	The highest level of classification for the payment (Case Mix Group) categories. The RIC is not recorded on the IRF-PAI but is assigned by the software based on the Admission Impairment Group code.
Short-Term General Hospital	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, refers to a short-term acute care hospital. A Short-Term General Hospital has contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.
Skilled Nursing Facility (SNF)	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, refers to a Medicare-certified nursing facility in anticipation of skilled care. For hospitals with an approved swing bed arrangement, use Code 61 - Swing Bed. This code should be used regardless of whether or not the patient had/has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay was/will be covered by Medicare.
State Medicaid Provider Number	Medicaid Provider Number established by a State.
Submission Confirmation Page	The initial feedback generated by the iQIES system after an IRF-PAI data file is electronically submitted. This page acknowledges receipt of the submission file but does not examine the file for any warnings and/or errors. Warnings and/or errors are provided on the Final Validation Report.

Term	Definition
Submission Date	Refers to the date on which the completed IRF-PAI is submitted to iQIES.
Swing Bed	For the purposes of coding items 15A, 16A, and 44D of the IRF-PAI, refers to patients admitted from/discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement. When a patient is admitted from/discharged from an acute hospital to a Critical Access Hospital (CAH) swing bed, use Code 61.
Transfer (in the case of a short stay transfer policy)	The release of a Medicare inpatient from one IRF to another IRF, an acute care hospital, a long-term care hospital, a skilled nursing facility, or a nursing facility that qualifies to receive Medicare or Medicaid payments.
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).
Unstageable Pressure Ulcer/Injury	Visualization of the wound bed is necessary for accurate numerical staging. If the extent of soft tissue damage cannot be visualized or palpated in the wound bed, that pressure ulcer/injury should be classified as unstageable. For example, pressure ulcers/injuries may be unstageable due to eschar or slough or non-removable dressing/device.
Week	A period of 7 consecutive calendar days beginning with the date of admission to the IRF.
Worsening in Pressure Ulcer/Injury Status	Pressure ulcer/injury "worsening" is defined as a pressure ulcer/injury that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1–4 (using the staging assessment determinations assigned to each stage, starting at stage 1, and increasing in severity to stage 4) on a discharge assessment as compared with the admission assessment. To denote the absence of a pressure ulcer/injury or that there is no skin breakdown or evidence of damage, indicate that there are zero pressure ulcers/injuries.

Common Acronyms

Acronym	Definition
ADLs	Activities of Daily Living
AIF	Annual Increase Factor
ARD	Assessment Reference Date
BMI	Body Mass Index
CAH	Critical Access Hospital
CAM	Confusion Assessment Method
CCN	CMS Certification Number
CDC	Centers for Disease Control and Prevention
CMG	Case Mix Group
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DME	Durable Medical Equipment
DTI	Deep Tissue Injury
EHR/EMR	Electronic Health Record/Electronic Medical Record
FVR	Final Validation Report
FY	Fiscal Year
HHA	Home Health Agency
HICN	Health Insurance Claim Number
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
ICD	International Classification of Diseases
ICD-CM	International Classification of Diseases–Clinical Modification
IPF	Inpatient Psychiatric Facility
IPPS	Inpatient Prospective Payment System
iQIES	Internet Quality Improvement and Evaluation System
IRF	Inpatient Rehabilitation Facility or Unit
IRF-PAI	Inpatient Rehabilitation Facility Patient Assessment Instrument
IRF QRP	Inpatient Rehabilitation Facility Quality Reporting Program
LOS	Length of Stay
LTCH	Long-Term Care Hospital

Acronym	Definition
MBI	Medicare Beneficiary Identifier
NHSN	National Healthcare Safety Network
NPI	National Provider Identifier
OMB	Office of Management and Budget
PPS	Prospective Payment System
PVS	Persistent Vegetative State
QTSO	QIES Technical Support Office
RIC	Rehabilitation Impairment Category
RRB	Railroad Retirement Board
SAMS	Secure Access Management Services
SNF	Skilled Nursing Facility
SSN	Social Security Number