SECTION A: ADMINISTRATIVE INFORMATION

Identification Information

Intent: The intent of these items is to document information about the patient.

1. **Facility Information:**
   A. **Facility Name:** Enter the full name of the facility.
   B. **Facility Medicare Provider Number:** Enter the facility Medicare provider number. Verify the number through the business office.
2. **Patient Medicare Number:** Enter the patient's Medicare Number (Part A). Verify the number through the business office.

   NOTE: For those patients with a Medicare Advantage (Medicare Part C) Plan, a Medicare number is still needed to complete this section of the IRF-PAI. For additional information regarding how to obtain this number, reference the IRF PPS FY 2010 final rule (74 FR 39799).
   NOTE: In an effort to fight identity theft for Medicare beneficiaries, CMS has replaced the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI).

   January 1, 2020 and later: *Enter the MBI. Do not report the patient's SSN-based HICN.*
3. **Patient Medicaid Number:** Enter the patient's Medicaid Number. Verify the number through the business office.

   NOTE: This item is mandatory if the patient is a Medicaid recipient.
4. **Patient First Name:** Enter the patient's first name. Verify this information through the business office.

5A. **Patient Last Name:** Enter the patient's last name. Verify this information through the business office.

5B. **Patient Identification Number:** Enter the patient's medical record number or other unique identifier.

6. **Birth Date:** Enter the patient's birthdate. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., *1938*).
7. **Social Security Number:** Enter the patient's SSN. Verify the number with the patient and/or business office.

   NOTE: If the patient is unwilling to disclose their SSN or if the facility is unable to obtain this information, a blank value can be submitted without causing the IRF-PAI to be rejected.
8. **Gender:** Enter the patient's gender as:

   1- Male; 2- Female

10. **Marital Status:** Enter the patient's marital status at the time of admission.

    1- Never Married; 2- Married; 3- Widowed; 4- Separated; 5- Divorced

    NOTE: If the patient is unwilling to disclose their marital status or if the facility is unable to obtain this information, a blank value can be submitted without causing the IRF-PAI to be rejected.

11. **Zip Code of Patient's Pre-Hospital Residence:** Enter the zip code of the patient's pre-hospital residence.

Admission Information

Intent: The intent of these items is to document information about the patient's stay.

12. **Admission Date:** Enter the date that the patient was admitted to the IRF. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31*), and *YYYY* is the full year (e.g., *2014*).

13. **Assessment Reference Date:** This is the 3rd calendar day of the rehabilitation stay, which represents the last day of the 3-day admission assessment time period. These 3 calendar days are the days during which the patient's clinical condition should be assessed. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., *2014*). **Example:** If Admission Date is 07/04/2014, then the Assessment Reference Date is 07/06/2014.

    NOTE: If the stay is less than 3 calendar days, the admission assessment reference date is the last day of the stay (either day 1 or day 2).
    NOTE: If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days, although assessment data gathered on the discharge date (the day the patient is admitted to Acute Care from the IRF) may be used to code the admission quality improvement (QI) items.

Examples

1. Patient was admitted to IRF on 07/04/2014. Patient was discharged to acute care on 07/06/2014. Patient returned to IRF on 07/07/2014.

   Coding: The assessment reference date would be 07/07/2014. Day 1 would be 07/04/2014, Day 2 would be 07/05/2014, and Day 3 would be 07/07/2014.

2. Patient was admitted to IRF on 07/204/014. Patient was discharged to acute care on 07/05/2014. Patient returned to IRF on 07/06/2014.

   Coding: The assessment reference date would be 07/07/2014. Day 1 would be 07/04/2014, Day 2 would be 07/06/2014, and Day 3 would be 07/07/2014.

14. **Admission Class:** Enter the admission classification of the patient, as defined below:

    1- Initial Rehab: This is the patient's first admission to any inpatient rehabilitation facility for this impairment.
    2- THIS CODE IS NO LONGER VALID
    3- Readmission: This is a stay in which the patient was previously admitted to an inpatient rehabilitation facility for this impairment but is **NOT** admitted to the current rehabilitation program DIRECTLY from another rehabilitation program.
    4- Unplanned Discharge: This is a stay that lasts less than 3 calendar days because of an unplanned discharge (e.g., due to a medical complication).

5- Continuing Rehabilitation: This is part of a rehabilitation stay that began in another rehabilitation program. The patient was admitted directly from another inpatient rehabilitation facility.

15A. **Admit From:** Enter the setting from which the patient was admitted to rehabilitation.

01- Home (private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (medical facility)
61- Swing bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

NOTE: Definitions of Patient Status Codes for Item 15A, 16A, and 44D can be found in Chapter 3: Clarification of Terminology.

16A. **Pre-Hospital Living Setting:** Enter the setting where the patient was living prior to being hospitalized.

01- Home (private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (medical facility)
61- Swing bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

17. **Pre-Hospital Living With:** Enter the relationship of any individuals who resided with the patient prior to the patient's hospitalization. If more than one person qualifies, enter the first appropriate category on the list.

    Note: Complete this item *only* if you selected code 01- Home in Item 16A-Pre-hospital Living Setting.

    01- Alone
    02- Family/Relatives
    03- Friends
    04- Attendant
    05- Other

Payer Information

Intent: The intent of these items is to document information about the patient's payment source.

20. **Payment Source:** Enter the source of payment for inpatient rehabilitation services. Enter the appropriate category for both primary and secondary source of payment.

    02- Medicare Fee For Service; 51- Medicare-Medicare Advantage; 99- Not Listed
    A. Primary Source
    B. Secondary Source

Examples and Specific Coding Tips for Change in Payer Source

1. **Scenario 1:** The patient is admitted to an IRF on December 20, 2018. On January 1, 2019, the patient becomes eligible for Medicare (either by turning 65 in the month of January or by becoming eligible due to a disability or by some other means).

   Coding and Rationale: According to Medicare's billing rules in the Medicare Claims Processing Manual, Chapter 3, Section 40 (Pub. 100-04 located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html), the hospital (including an IRF) can only begin billing Medicare for the stay when the patient becomes eligible for Medicare, which in this example is January 1, 2019. Since Medicare's portion of the stay begins on that day, we also require the facility to complete an IRF-PAI for the patient based on that day being day "1" of the Medicare stay.

2. **Scenario 2:** The patient is admitted to the IRF on January 9, 2019 as an enrollee of a Medicare Advantage Plan. On February 1, 2019, the patient officially dis-enrolls from the Medicare Advantage Plan and is covered instead under the Medicare fee-for-service program.

   Coding and Rationale: According to Chapter 1, Section 90 of the Medicare Claims Processing Manual (Pub. 100-04 located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html), whichever payer the patient is enrolled in at the time of admission continues to be the payer for the patient's entire stay. Thus, the Medicare Advantage Plan would continue to be the payer for the patient's entire IRF stay and the facility would not complete another IRF-PAI. The IRF stay would continue as planned under the Medicare Advantage Plan.

3. **Scenario 3:** The patient is admitted to the IRF on January 19, 2019 as a Medicare fee-for-service beneficiary. On February 20, 2019, the patient officially enrolls in a Medicare Advantage Plan.

   Coding and Rationale: According to Chapter 1, Section 90 of the Medicare Claims Processing Manual (Pub. 100-04 located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html), whichever payer the patient is enrolled in at the time of admission continues to be the payer for the patient's entire stay. Thus, Medicare fee-for-service would continue to be the payer for the patient's entire IRF stay and the facility would not complete another IRF-PAI. The IRF stay would just continue as planned under Medicare fee-for-service.

Medical Information

Intent: The intent of these items is to document information about the patient's medical condition.

21. **Impairment Group:** For the admission assessment, enter the code that best describes the primary reason for admission to the rehabilitation program (codes for this item are listed in the table listing Impairment Group Codes in Appendix A).
22. **Etiologic Diagnosis:** Enter the ICD code(s) to indicate the etiologic problem that led to the impairment for which the patient is receiving rehabilitation (Item 21, Impairment Group). Refer to Section 2, 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.
23. **Date of Onset of Impairment:** Enter the onset date of the impairment that was coded in Item 21 (Impairment Group). The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., *2014*).

    NOTE: If a condition has an insidious onset, or if the exact onset date is unknown for any reason, follow these general guidelines:

    - If the year and month are known, but the exact day is not, use the first day of the month (e.g., MM/01/YYYY).
    - If the year is known, but the exact month is not, use the first of January of that year (e.g., 01/01/YYYY).
    - If the year is an approximation, use the first of January of the approximate year (e.g., *01/01/YYYY*).

Coding Tips

The following represents more specific instructions for determining date of onset for major impairment groups:

Impairment Group	Date of Onset
Stroke	Date of admission to acute hospital. If this is not the patient's first stroke, enter the date of the most recent stroke
Brain Dysfunction	
Traumatic	Date of Injury
Non-traumatic	More recent date: date of surgery (e.g., removal of brain tumor) or date of diagnosis
Neurological Conditions	
Multiple Sclerosis	Date of exacerbation
All Remaining Neurological Conditions	Date of diagnosis

Impairment Group	Date of Onset
Spinal Cord Dysfunction	
Traumatic	Date of injury
Non-traumatic	More recent date: date of surgery (e.g., removal of tumor) or date of diagnosis
Orthopedic Conditions	
Fractures	Date of fracture
Replacement	Date of surgery
Pulmonary Disorders	
COPD	Date of initial diagnosis (not exacerbation)
Pulmonary Transplant	Date of surgery
Medically Complex Conditions	
Infections	Date of admission to acute hospital
Neoplasms	Date of admission to acute hospital
Nutrition	Date of admission to acute hospital
Circulatory	Date of admission to acute hospital
Respiratory	Date of admission to acute hospital
Terminal Care	Date of admission to acute hospital
Skin Disorders	Date of admission to acute hospital
Medical/Surgical	Date of admission to acute hospital
Other Medically Complex Conditions	Date of admission to acute hospital
Other Impairment Groups	
Amputation	Date of most recent surgery
Arthritis	Date of diagnosis (if arthroplasty, see impairment group “Orthopedic Conditions”)
Pain Syndromes	Date of onset related to cause (e.g., fall, injury)
Cardiac Disorders	More recent date: Date of diagnosis (event) or date of surgery (e.g., bypass, transplant)
Burns	Date of burn(s)
Congenital Deformities	Date of birth
Other Disabling Impairment	Date of diagnosis
Major Multiple Trauma	Date of trauma
Developmental Disabilities	Date of birth
Debility	Date of admission to acute hospital

NOTE: If there was no admission to an acute hospital prior to the admission to the inpatient rehabilitation facility, record as the date of onset the date of diagnosis of the impairment which led to the admission to the rehabilitation facility.

24. **Comorbid Conditions:** Enter up to 25 ICD codes for comorbid conditions. A patient comorbidity is defined as a secondary condition a patient may have in addition to the primary

diagnosis for which the patient was admitted to the IRF. Enter ICD codes which identify comorbid conditions that are not already included in the Impairment Group Code (IGC).

General Coding Tips

- The patient comorbidity/ies listed in Item 24 of the IRF-PAI should have significant impact on the patients' course of treatment for their primary diagnosis. Comorbidities that are identified on the day prior to the day of the rehabilitation discharge or the day of discharge should ***not*** be listed on the discharge assessment, since these comorbidities have less effect on the resources consumed during the entire stay.
- A payment adjustment will be made if one of the comorbidities listed in the appropriate List of Tier Comorbidities (located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html) is recorded in Item 24. If more than one comorbidity is present, the comorbidity that results in the highest payment will be used to adjust payment.

  NOTE: Providers should complete the number of spaces that coincides with the number of comorbid conditions the patient has. Providers do not need to complete all 25 spaces of this item unless, of course, the patient has 25 comorbid conditions. **Example:** The patient has 15 comorbid conditions. The provider should complete 15 spaces for this item.

24A. **Arthritis Conditions:** Enter one of the following codes to indicate whether one or more of the arthritis conditions recorded in items #21 (Impairment Group), #22 (Etiologic Diagnosis), or #24 (Comorbid Conditions) meet all of the applicable regulatory requirements for IRF classification (in 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii)).

0- No; 1- Yes

- If the code 0- No is entered into this item, then that means that either the patient does not have any arthritis conditions recorded in items #21, #22, or #24 of the IRF-PAI or that the arthritis conditions recorded in #21, #22, or #24 of the IRF-PAI fail to meet the applicable regulatory requirements for IRF classification (in 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii)).
- If the code 1- Yes is entered into this item, then this claim may be selected by the Medicare Administrative Contractor (MAC) for review of the documentation in the IRF medical record to assure that the patient has met all of the applicable regulatory requirements, including that the patient has completed an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the IRF admission. CMS expects that the IRF will obtain copies of the therapy notes from the outpatient therapy or from the therapy services provided in other less intensive settings and include these in the patient's medical record at the IRF (in a section for prior records). These prior records will be available to the MAC staff who reviews the medical records for compliance with the applicable regulatory requirements.

NOTE: Below references 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii) for additional information about the regulatory requirements.

- (x) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
- (xi) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
- (xii) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

NOTE: As discussed in Chapter 3, Section 140.1.1 of the Medicare Claims Processing Manual (Pub. 100-04), which can be downloaded from the CMS website at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html, "an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings" in these regulations means the following:

- An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission.
- However, there may be cases when, in the A/B MAC (A)'s judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the A/B MAC (A) has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the A/B MAC (A)

considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings.

- Regardless of which interpretation or definition is used by the A/B MAC (A) with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. The outpatient therapy services (or services in other less intensive settings) must immediately precede the IRF admission or result from a systemic disease activation immediately before admission.

25A. **Height on admission (in inches):** Record the most recent height of measurement for the patient.

Coding Instructions

- Measure the patient's height in accordance with the facility's policies and procedures, which should reflect current standards of practice (shoes off, etc.).
- Only enter a height that has been directly measured by your facility staff. Do not enter a height that is self-reported or derived from documentation from another provider setting.
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.
- When reporting height for a patient with bilateral lower extremity amputations, measure and record the patient's current height (i.e., height after bilateral amputations).

26A. **Weight on admission (in pounds):** Record the initial weight measurement for the patient.

Coding Instructions

- Measure the patient's weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.).
- If the patient has been weighed multiple times during the assessment period, use the first weight.
- Only enter weight that has been directly measured by your facility staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.
- Use mathematical rounding (e.g., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.
- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code ("-") and document the rationale on the patient's medical record.

Discharge Information

Intent: The intent of these items is to document information about the patient's discharge from the IRF.

40. **Discharge Date:** Enter the date that the patient is discharged from the IRF or, in the case of a patient that dies in the IRF, the date of expiration. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31*), and *YYYY* is the full year (e.g., *2014*).

41. **Patient discharged against medical advice?** Enter one of the following codes:

    0- No; 1- Yes

42. **Program Interruptions:** A program interruption is defined as the situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the 3rd calendar day. Use the following codes to indicate that a program interruption occurred:

    0- No, there were no program interruptions
    1- Yes, there was one or more program interruption(s)

43. **Program Interruption Dates:** If one or more program interruptions occurred (i.e., Item 42 is coded 1- Yes), enter the interruption date and return date of each interruption. The interruption date is defined as the day when the interruption began (i.e., the day the patient was discharged from the inpatient rehabilitation facility). The return date is defined as the day when the interruption ended (i.e., the day the patient returned to the inpatient rehabilitation facility). As noted above for Item 42, a program interruption is defined as the situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The dates should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., *2014*).

    43A. 1st Interruption Date
    43B. 1st Return Date
    43C. 2nd Interruption Date
    43D. 2nd Return Date
    43E. 3rd Interruption Date
    43F. 3rd Return Date

44C. **Was patient discharged alive?**

    0- No; 1- Yes

44D. **Patient's discharge destination/living setting, using codes below:**
Answer only if 44C = 1; if 44C = 0, skip to item 46

01- Home (private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (medical facility)
61- Swing bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed
NOTE: **The IRF-PAI discharge date must be the same as the claim date.**

45. **Discharge to Living With:**

Code only if item 44C is 1- Yes and 44D is 01- Home; Code using 1- Alone; 2- Family/Relatives; 3- Friends; 4- Attendant; 5- Other

46. **Diagnosis for Interruption or Death:** Code using the ICD code indicating the reason for the program interruption or death (e.g., acute myocardial infarction, acute pulmonary embolus, sepsis, ruptured aneurysm, etc.). If the patient has more than one interruption, record the most significant diagnosis in this item.

47. **Complications during rehabilitation stay:** Enter up to six (6) ICD codes reflecting complications. The ICD codes entered here, including E-codes, represent complications or comorbidities that began after the rehabilitation stay started. To clarify the instructions on the IRF-PAI, the word "began" means any condition recognized or identified during the rehabilitation stay. These codes must not include the complications and/or comorbidities recognized on the day of discharge or the day prior to the day of discharge. These data will be used by CMS as part of its ongoing research and to determine what, if any, refinements should be made to the IRF PPS payment rates. These ICD codes identify complications and/or comorbid conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.

Relationship Between Complications and Comorbid Conditions: All ICD codes listed as Complications (Item 47) may also appear in Item 24 as Comorbid Conditions. Coding conditions that were identified after the start of the rehabilitation stay separately from conditions identified at the start of the rehabilitation stay will allow CMS as part of its ongoing research to determine what, if any, refinements should be made to the IRF PPS.

Therapy Information

Intent: The intent of these items is to document information about the patient's therapy.

O0401. Week 1: Total Number of Minutes Provided: This item will be completed as part of the patient's discharge assessment. In this section, the IRF will record how many minutes of Individual, Concurrent, Group, and Co-Treatment therapy the patient received, according to each therapy discipline (that is, physical therapy, occupational therapy, and speech-language pathology), during the first week of the IRF stay.

> **NOTE:** A week is a 7 consecutive calendar day period starting with the day of admission. This item should be completed regardless of whether the patient stays a full 7 days.

Example for O0401

1. The patient is admitted to the IRF on 11/1/2015 and is discharged on 11/5/2015.

   > **Coding:** Week 1 should include therapy minutes provided beginning 11/1/2015 (Day 1 of the IRF stay) through 11/5/2015 (Day 5 of the IRF stay).

O0402. Week 2: Total Number of Minutes Provided: This item will be completed as part of the patient's discharge assessment. In this section, the IRF will record how many minutes of Individual, Concurrent, Group, and Co-Treatment therapy the patient received, according to each therapy discipline (that is, physical therapy, occupational therapy, and speech-language pathology) during the second week of the IRF stay.

> **NOTE**: Week 2 begins on Day 8 of the IRF stay and this item is completed regardless of whether the week is a full 7 days. This item should be completed regardless of whether the patient stays a full 14 days.

Examples for O0402

1. The patient is admitted to the IRF on 11/1/2015 and is discharged on 11/14/2015.

   > **Coding:** Week 1 should include therapy minutes provided beginning 11/1/2015 (Day 1 of the IRF stay) through 11/7/2015 (Day 7 of the IRF stay). Week 2 should include therapy minutes provided beginning 11/8/2015 (Day 8 of the IRF stay) through 11/14/2015 (Day 14 of the IRF stay).

2. The patient is admitted to the IRF on 11/1/2015 and is discharged on 11/11/2015.

   > **Coding:** Week 1 should include therapy minutes provided beginning 11/1/2015 (Day 1 of the IRF stay) through 11/7/2015 (Day 7 of the IRF stay). Week 2 should include therapy minutes provided beginning 11/8/2015 (Day 8 of the IRF stay) through 11/11/2015 (Day 11 of the IRF stay).

Note: The therapy items on the IRF-PAI are strictly a data collection exercise *only* for weeks 1 and 2 of the IRF stay and should not be used as a way of documenting the amount of therapy provided. While these therapy data collection items are not being used as verification to ensure providers are meeting the intensive therapy coverage requirements, providers should continue to ensure they are satisfying all coverage requirements regarding intensive therapy.

Helpful Terminology and Information

- **Individual Therapy:** The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) to one patient at a time (this is sometimes referred to as "one-on-one" therapy).
- **Concurrent Therapy:** The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating two patients at the same time who are performing different activities.

  NOTE: When conducting concurrent and group therapy sessions, start and end times do not need to be the same for all patients participating. The exact time spent for each patient participating in a concurrent or group therapy session should be reported as such. Any additional time either prior to or following participation in a group or concurrent therapy session that a patient receives one-on-one therapy should be recorded as individual therapy. We believe that providers will be able to accurately and effectively document the amount of time that the patient is receiving therapy, as well as the correct mode.
- **Group Therapy:** The provision of therapy services by one licensed/certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating two to six patients at the same time who are performing the same or similar activities.

  NOTE: The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances, in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF.

  NOTE: The therapist may only provide therapy to one group at a time. Example: One therapist is not allowed to provide therapy to two groups of six patients. This will NOT meet the definition stated above.
- **Co-Treatment Therapy:** The provision of therapy services by more than one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed therapist) from different therapy disciplines to one patient at the same time.

  NOTE: Co-treatment is appropriate for specific clinical circumstances and would not be suitable for all patients; therefore, its use should be limited. Co-treatment may not be used for the accommodation of staffing schedules. The specific benefit to the patient of the co-treatment must be well-documented in the IRF medical record.

Examples of Modes of Therapy

1. **Individual Therapy:** A speech-language pathologist treats only Patient A for 30 minutes for aphasia therapy following a stroke.

   Coding: Patient A's speech-language therapy would be coded as 30 minutes of individual therapy on the IRF-PAI.

2. **Concurrent Therapy:** Patient A begins physical therapy to address lower extremity strengthening at 9:00 am. Patient B enters at 9:30 am and begins working with the same therapist on upper extremity range of motion. Both patients engage with the PT until 10:00 am. At that time, Patient A leaves and Patient B continues their exercises until 10:30 am.

   Coding: Patient A should be recorded as receiving individual therapy from 9:00 am to 9:30 am and concurrent therapy from 9:30 am to 10:00 am. Patient B should be recorded as receiving concurrent therapy from 9:30 am to 10:00 am and individual therapy from 10:00 am to 10:30 am. Thus, a total of 30 minutes of individual physical therapy and 30 minutes of concurrent physical therapy would be recorded for both patients.

3. **Group Therapy:** A speech-language pathologist is working with Patients A, B, C, and D in a communication group. At 2:00 pm the group begins with all four patients present. At 2:12 pm, Patient A leaves to go to the bathroom and returns at 2:28 pm. At 2:37 pm, Patient B leaves for an appointment and does not return. The communication group ends at 3:00 pm. This scenario should be coded as follows:

   Coding:
   Patient A – Total minutes of Group therapy: 44 minutes (2:00 pm to 2:12 pm, 2:28 pm to 3:00 pm)
   Patient B – Total minutes of Group therapy: 37 minutes (2:00 pm to 2:37 pm)
   Patient C – Total minutes of Group therapy: 60 minutes (2:00 pm to 3:00 pm)
   Patient D – Total minutes of Group therapy: 60 minutes (2:00 pm to 3:00 pm)

   NOTE: If at any time there is only one patient remaining from the original group, then the time spent with this patient would be coded as individual therapy.

4. **Co-Treatment:** A physical therapist and occupational therapist do a transfer exercise with Patient D for 30 minutes.

   Coding: A total of 30 minutes of co-treatment time would be coded for each discipline (PT and OT) on the IRF-PAI for this session.

General Coding Examples

1. The patient was admitted to the IRF on 10/19/2015 following a stroke. The patient's therapy regimen was as follows: On 10/19/2015, the patient was evaluated by all three therapy disciplines. The Physical Therapist (PT) evaluation took 65 minutes, the Occupational Therapist (OT) evaluation took 50 minutes, and the Speech-Language Pathologist (SLP) evaluation took 75 minutes.

   Coding: Individual PT: 65 minutes, Individual OT: 50 minutes, Individual SLP: 75 minutes

2. On 10/20/2015, the patient was seen for a one-on-one (individual therapy) PT session in the morning for 30 minutes to work on gait training. Additionally, the patient worked on lower extremity strengthening in the afternoon at the same time as another patient who was working on upper extremity strengthening with PT for 40 minutes. OT and SLP saw the patient at the same time for 60 minutes to work on feeding and swallowing, respectively.

Coding: Individual PT: 30 minutes, Concurrent PT: 40 minutes, OT Co-Treatment: 60 minutes, SLP Co-Treatment: 60 minutes

3. On 10/21/2015, the patient was treated by PT along with 3 other patients in a group balance activity for 45 minutes. The patient was then seen for a one-on-one (individual therapy) OT session to address cognitive perception for 60 minutes. The patient was also seen for a one-on-one (individual therapy) SLP session during lunch for dysphagia for 68 minutes.

   Coding: Group PT: 45 minutes, Individual OT: 60 minutes, Individual SLP: 68 minutes

4. On 10/22/2015, the patient was seen for a one-on-one (individual therapy) PT session in the morning for 50 minutes for gait training. The patient was then seen for a one-on-one (individual therapy) PT session in the afternoon for a transfer activity for 30 minutes. The patient was later seen for a one-on-one (individual therapy) OT session for 60 minutes to address activities of daily living (ADLs). Lastly, the patient was seen for a one-on-one (individual therapy) SLP session during lunch for dysphagia for 58 minutes.

   Coding: Individual PT: 80 minutes, Individual OT: 60 minutes, Individual SLP: 58 minutes

5. On 10/23/2015, the patient was seen for a one-on-one (individual therapy) PT session for endurance training for 65 minutes. The patient then attended an OT cooking group for 45 minutes along with four other patients. The patient was then seen for a one-on-one (individual therapy) SLP session for 30 minutes to do oral motor exercises and another one-on-one (individual therapy) SLP session 40 minutes during lunch for swallowing therapy.

   Coding: Individual PT: 65 minutes, Group OT: 45 minutes, Individual SLP: 70 minutes

6. On 10/24/2015, the patient was seen for a one-on-one (individual therapy) PT session for 60 minutes of gait training. OT and SLP saw the patient together for dysphagia and feeding therapy during lunch for 70 minutes.

   Coding: Individual PT: 60 minutes, OT Co-Treatment: 70 minutes, SLP Co-Treatment: 70 minutes

7. On 10/25/2015, PT treated the patient for 65 minutes in a group of six people and they worked on upper and lower extremity strengthening. The patient was seen for a one-on-one (individual therapy) OT session to work on ADL training for 45 minutes and SLP then saw the patient at the same time as one other person while the patient worked on oral motor exercises and the other patient was doing a cognitive exercise for 30 minutes.

   Coding: Group PT: 65 minutes, Individual OT: 45 minutes, Concurrent SLP: 30 minutes

8. Item O0401. Week 1: Total Number of Minutes Provided should be filled out as follows:

   O0401A: Physical Therapy
   a) Total minutes of individual therapy 300
   b) Total minutes of concurrent therapy 40
   c) Total minutes of group therapy 110
   d) Total minutes of co-treatment therapy 0

O0401B: Occupational Therapy
a) Total minutes of individual therapy 215
b) Total minutes of concurrent therapy 0
c) Total minutes of group therapy 45
d) Total minutes of co-treatment therapy 130

O0401C: Speech-Language Pathology
a) Total minutes of individual therapy 271
b) Total minutes of concurrent therapy 30
c) Total minutes of group therapy 0
d) Total minutes of co-treatment therapy 130

General Coding Tips

- Therapy minutes cannot be rounded for the purposes of documenting therapy provided in an IRF.
- Therapy evaluations do count as the initiation of therapy services.
- The time spent in family conferences does not count towards counting therapy minutes on the IRF-PAI.
- "Therapy time" is time spent in direct contact with the patient. Time spent documenting in the patient's medical record, unsupervised modalities, and significant periods of rest are examples of time not spent in direct contact with the patient and, therefore, may not be documented in this section of the IRF-PAI.
- If the patient has an interrupted stay, record the total number of minutes of therapy the patient received in the IRF for that week the same as if the interrupted stay did not occur. As long as the IRF records the interrupted stay in items 42 and 43 of the IRF-PAI, we will account for the presence of the interrupted stay in analyzing the data.

A1005. Ethnicity

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

Item Rationale

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

Steps for Assessment

1. Ask the patient to select the category or categories that most closely correspond to the patient's ethnicity from the list in A1005, Ethnicity.
   - Individuals may be more comfortable if this and the subsequent question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their ethnic background".
2. Respondents should be offered the option of selecting one or more ethnic designations.
3. If a patient **is unable to respond**, a proxy response may be used.
4. If neither the patient nor a proxy is able to provide a response to this item, use medical record documentation.
5. If a patient **declines to respond**, do not code based on a proxy response or medical record documentation.

Coding Instructions

Complete as close to the time of admission as possible. Check all that apply.

- If the patient **can provide a response**, check the box(es) indicating the ethnic category or categories identified by the patient.
- **Code X, Patient unable to respond,** if the patient was unable to respond.
  - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X, Patient unable to respond.
  - If the patient was unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, Code X, Patient unable to respond, **only**.
- **Code Y, Patient declines to respond**, if the patient declines to respond.
  - In the cases where the patient declines to respond, Code Y, Patient declines to respond, **only**.
  - If the patient **declines to respond** do not code based on a proxy input or medical record documentation.

Examples

1. The patient is admitted following an acute cerebrovascular accident (CVA) with mental status changes and is unable to respond to questions regarding their ethnicity. The patient's caregiver informs the nurse that the patient is Cuban.

   Coding: A1005, Ethnicity would be **coded as D, Yes, Cuban** and **X, Patient unable to respond**.

   Rationale: If a patient is unable to respond but the proxy provides the response, code both the proxy response and X, Patient unable to respond.

2. The patient is admitted following a total hip arthroplasty (THA) and declines to respond to questions regarding their ethnicity.

   Coding: A1005, Ethnicity would be **coded as Y, Patient declines to respond**.

   Rationale: If a patient declines to respond to this item, then the only response option that should be coded is Y, Patient declines to respond. No attempts should be made to use proxy input or medical record documentation to complete A1005, Ethnicity when a patient declines to respond.

A1010. Race

A1010. Race What is your race?	
↓ Check all that apply	
☐	A. White
☐	B. Black or African American
☐	C. American Indian or Alaska Native
☐	D. Asian Indian
☐	E. Chinese
☐	F. Filipino
☐	G. Japanese
☐	H. Korean
☐	I. Vietnamese
☐	J. Other Asian
☐	K. Native Hawaiian
☐	L. Guamanian or Chamorro
☐	M. Samoan
☐	N. Other Pacific Islander
☐	X. Patient unable to respond
☐	Y. Patient declines to respond
☐	Z. None of the above

Item Rationale

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

Steps for Assessment

1. Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race.

- Individuals may be more comfortable if this and the preceding question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their racial background".

2. Respondents should be offered the option of selecting one or more race category.
3. If a patient **is unable to respond**, a proxy response may be used.
4. If neither the patient nor a proxy is able to provide a response to this item, use medical record documentation.
5. If a patient **declines to respond**, do not code based on a proxy response or medical record documentation.

Coding Instructions

Complete as close to the time of admission as possible. Check all that apply.

- If the patient **can provide a response** check the box(es) for indicating the race category or categories identified by the patient.
- **Code X, Patient unable to respond,** if the patient was unable to respond.
  - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X, Patient unable to respond.
  - If the patient is unable to respond and no other resources (proxy input or medical record documentation) provided the necessary information, Code X, Patient unable to respond, **only**.
- **Code Y, Patient declines to respond,** if the patient declines to respond.
  - In the cases where the patient declines to respond, Code Y, Patient declines to respond, **only.**
  - If the patient **declines to respond** do not code based on proxy input or medical record documentation to complete this item.
- **Code Z, None of the above,** if the patient reports or it is determined from proxy or medical record documentation that none of the listed races apply to the patient.

Examples

1. The patient has severe dementia with agitation. During the admission assessment, the patient is unable to provide their race. The patient's caregiver informs the nurse that the patient is Korean and African American.

   Coding: A1010, Race would be **coded as B, Black or African American, H, Korean,** and **X, Patient unable to respond**.

   Rationale: If a patient is unable to respond but the proxy provides the response, code both the proxy response(s) and X, Patient unable to respond.

2. The patient declines to provide their race during the admission assessment stating, "I'd rather not answer".

   Coding: A1010, Race would be **coded as Y, Patient declines to respond**.

   Rationale: If a patient declines to respond to this item, then code only Y, Patient declines to respond. No attempts should be made to use proxy input or medical record documentation to complete A1010, Race when a patient declines to respond.

3. The patient is admitted to the IRF following a recent CVA resulting in confusion and is unable to inform the admitting nurse which race applies to them. The proxy reports that none of the listed races apply to the patient.

   Coding: A1010, Race would be **coded as X, Patient unable to respond** and **Z, None of the above**.

   Rationale: If a patient is unable to respond, proxy input may be used to code A1010, Race. When a patient is unable to respond but proxy input can provide the necessary information, code both the information from the proxy input, in this case Z, None of the above, **and** X, Patient unable to respond.

A1110. Language

A1110. Language	
Enter code	**A. What is your preferred language?** **B. Do you need or want an interpreter to communicate with a doctor or health care staff?** 0. **No** 1. **Yes** 9. **Unable to determine**

Item Rationale

- Language barriers can lead to social isolation, depression, and patient safety issues.
- Language barriers can interfere with accurate assessment.

Steps for Assessment

1. Ask for the patient's preferred language.
2. Ask if the patient needs or wants an interpreter to communicate with a doctor or health care staff.
3. If the patient themself – or with the assistance of an interpreter – is unable to respond to A1110A, What is your preferred language? or A1110B, Do you need or want an interpreter? a proxy response is permitted.
4. If neither the patient nor a proxy is able to provide a response to A1110A or A1110B, medical record documentation may be used.

Coding Instructions for A1110A

- Enter the preferred language the patient primarily speaks or understands.
- If the patient or any available source cannot or does not identify preferred language, enter a dash ("-") in the first box. A dash indicates "no information". CMS expects dash use to be a rare occurrence.

Coding Instructions for A1110B

- **Code 0, No,** if the patient indicates there is no need or want of an interpreter to communicate with a doctor or health care staff.
  - If the patient is unable to indicate the need or want of an interpreter, proxy input may be used.
  - If the patient is unable and a proxy response is not available, then medical record documentation may be used.
- **Code 1, Yes,** if the patient indicates the need or want of an interpreter to communicate with a doctor or health care staff. Ensure that preferred language is indicated.
  - If the patient is unable to indicate the need or want of an interpreter, proxy input may be used.

  - If the patient is unable and a proxy response is not available, then medical record documentation may be used.

- **Code 9, Unable to determine,** if no source can identify whether the patient wants or needs an interpreter.

Coding Tips and Special Populations

Complete as close to the time of admission as possible.

- An organized system of signing, such as American Sign Language (ASL), can be reported as the preferred language if the patient needs or wants to communicate in this manner.

A1250. Transportation

A1250. Transportation (from NACHC©) Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	
↓ Check all that apply	
☐	A. Yes, it has kept me from medical appointments or from getting my medications
☐	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	C. No
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

Item Rationale

- Access to transportation for ongoing health care and medication access needs is essential to effective care management.
- Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.

Steps for Assessment

1. Ask the patient:
   - "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?"
   - "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?"
2. Patient should be offered the option of selecting more than one yes designation, if applicable.
3. If the patient is unable to respond, a proxy response may be used.
4. If neither the patient nor a proxy is able to provide a response to this item, medical record documentation may be used.
5. If the patient declines to respond, do not code based on proxy input or medical record documentation.

Coding Instructions

Complete as close to the time of admission as possible and within 3 days of discharge.

- **Code A,** if the patient indicates that lack of transportation has kept the patient from medical appointments or from getting medications.
- **Code B,** if the patient indicates that lack of transportation has kept the patient from non-medical meetings, appointments, work, or from getting things that the patient needs.

- **Code C,** if the patient indicates that a lack of transportation has not kept the patient from medical appointments, getting medications, non-medical meetings, appointments, work, or getting things that the patient needs.
- **Code X, Patient unable to respond,** if the patient was unable to respond.
  - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X, Patient unable to respond.
  - If the patient was unable to respond and no other resources (proxy, or medical record documentation) provided the necessary information, Code X, Patient unable to respond, **only**.
- **Code Y, Patient declines to respond,** if the patient declines to respond.
  - In the cases where the patient declines to respond, Code Y, Patient declines to respond, **only**.
  - If the patient **declines to respond** do not code based on proxy input or medical record documentation to complete this item.

Example

1. The patient is admitted with multiple sclerosis. The patient is confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No proxy with related information is available, but the patient's medical record indicates that the patient's caregiver uses their car to transport the patient wherever the patient needs to go.

   Coding: A1250, Transportation would be **coded as Code C, No** and **Code X, Patient unable to respond**.

   Rationale: If neither the patient nor a proxy is able to provide a response, but the medical record documentation can provide the necessary information, code both the information in the medical record and X, Patient unable to respond.

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code	0. **No** - Current reconciled medication list not provided to the subsequent provider → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge* 1. **Yes** - Current reconciled medication list provided to the subsequent provider

Item Rationale

- The transfer of a current reconciled medication list at the time of discharge can improve care coordination and quality of care, can help subsequent providers reconcile medications, and may mitigate adverse outcomes related to medications. Communication of medication information at discharge is critical to ensure safe and effective transitions from one health care setting to another.

Steps for Assessment

1. Determine if the patient was discharged to one of the subsequent providers defined below under Coding Tips, based on discharge location item 44D.
2. If yes, determine if, at the time of discharge, your facility provided a current reconciled medication list to the patient's subsequent provider.

Coding Instructions

Within 3 days of discharge, complete as close to the time of discharge as possible.

- **Code 0, No,** if at discharge to a subsequent provider, your facility did not provide the patient's current reconciled medication list to the subsequent provider, or the patient was not discharged to a subsequent provider.
- **Code 1, Yes,** if at discharge to a subsequent provider, your facility did provide the patient's current reconciled medication list to the subsequent provider.

Coding Tips

- **At the time of discharge** – This is the period of time as close to the actual time of discharge as possible. This time may be based on facility, State, or Federal guidelines for data collection at discharge.
- **A subsequent provider –** For the purposes of this item, a subsequent provider is based on the discharge locations in 44D and defined as any of the following:

  02- Short-term General Hospital
  03- Skilled Nursing Facility (SNF)
  04- Intermediate care
  06- Home under care of organized home health service organization
  50- Hospice (home)
  51- Hospice (medical facility)

61- Swing bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)

- While the patient may receive care from other providers after discharge from your facility, such as primary care providers, other outpatient providers, and residential treatment centers, these locations are not considered to be a subsequent provider for the purpose of coding this item.
- **Current Reconciled Medication list:** This refers to a list of the patient's current medications at the time of discharge that was reconciled by the facility prior to the patient's discharge.
- Your facility should be guided by current standards of care and any applicable regulations and guidelines (e.g., Conditions of Participation) in determining what information should be included in a current reconciled medication list.

DEFINITION

MEANS OF PROVIDING A CURRENT RECONCILED MEDICATION LIST
Providing the current reconciled medication list at the time of discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record [EHR], giving providers access to a portal).

Additional Considerations for Important Medication List Content

Defining the completeness of that medication list is left to the discretion of the providers and patient who are coordinating this care.

An example of items that could be on a reconciled medication list can be but are not limited to a list of the current prescribed and over-the-counter medications, nutritional supplements, vitamins, and/or homeopathic and herbal products administered by any route at the time of discharge. A reconciled medication list could also include important information about: (1) the patient, including their name, date of birth, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions; and (2) each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, and/or any special instructions. However, this information serves as guidance, and as stated prior, the completeness of the medication list is left to the discretion of the providers and patient.

Documentation sources for reconciled medication list information include electronic and/or paper records. Some examples of such records are discharge summary records, a Medication Administration Record, an Intravenous Medication Administration Record, a home medication list, and physician orders.

Examples

1. The patient is being discharged from an IRF to an acute care hospital in the same health care system which uses the same electronic health record (EHR), also sometimes referred to as an electronic medical record (EMR) (see definition of EHR/EMR in A2124 and in Chapter 3, Clarification of Terminology). The patient's current reconciled medication list at the time of discharge from the IRF unit is accessible to the subsequent acute care hospital staff admitting the patient, and this is how the medication list is shared.

   Coding: A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge would be **coded 1, Yes**.

   Rationale: Having access to the patient's medication list through the same EHR system is one way to transfer a medication list. This code of 1, Yes, is used for this passive means of transferring the medication list when the sending and receiving provider can access the same EHR system.

2. The patient is not taking any prescribed or over-the-counter medications at the time of discharge.

   Coding: If the lack of any medications for a patient is clearly documented and communicated to the subsequent provider when the patient is discharged, **code 1, Yes**, that the medication list was transferred. If this information is not communicated to the subsequent provider, **code 0, No**.

   Rationale: Information confirming that the patient is not taking any medications at discharge is important for the subsequent provider.

3. The patient was transferred to an acute care hospital with a reconciled medication list that included a list of their current medications, but with less additional information than usually provided by the IRF at discharge due to the urgency of the situation. Some of the contraindications for the medications, patient weight and height, and dates taken were omitted from the medication list.

   Coding: A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge would be **coded 1, Yes**.

   Rationale: As long as a current reconciled list of medications is provided to the admitting provider, this item should be coded 1, Yes.

4. The patient's reconciled medication list was electronically faxed to the subsequent provider and this action is documented in the patient's clinical record. However, the subsequent provider's records do not show documentation that the fax was successfully received.

   Coding: A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge would be **coded 1, Yes**.

   Rationale: Documentation of the subsequent provider's successful receipt of the reconciled medication list is not a required component of this item.

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

See guidance starting on page A-34 for coding the route(s) of transmission of the medication list to the subsequent provider. The guidance addresses coding the route(s) of transmission to the subsequent provider (A2122) and to the patient (A2124) together because of the overlap in the definitions of the routes.

A2123. Provision of Current Reconciled Medication List to Patient at Discharge

A2123. Provision of Current Reconciled Medication List to Patient at Discharge At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family, and/or caregiver?	
Enter code	0. **No** - Current reconciled medication list not provided to the patient, family, and/or caregiver → *Skip to B1300, Health Literacy* 1. **Yes** - Current reconciled medication list provided to the patient, family, and/or caregiver

Item Rationale

- Communication of medication information to the patient at discharge is critical to ensuring safe and effective discharges. The item, collected at the time of discharge, can improve care coordination and quality of care, aids in medication reconciliation, and may mitigate adverse outcomes related to medications.
- It is recommended that a reconciled medication list that is provided to the patient, family, and/or caregiver use consumer-friendly terminology and plain language to ensure that the information provided to patients and caregivers is clear and understandable.
  For an example of plain language resources for healthcare information see:
  https://www.plainlanguage.gov/resources/content-types/healthcare/

Steps for Assessment

1. Determine if the patient was discharged to 01, Home or 99, Not Listed on discharge location item 44D, defined below under Coding Tips.
2. If yes, determine if, at discharge, your facility provided the patient's medication list to the patient, family, and/or caregiver.

Coding Instructions

Within 3 days of discharge, complete as close to the time of discharge as possible.

- **Code 0, No,** if at discharge to a home setting (44D=01), or a not listed location (44D=99), your facility did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver. Or the patient was discharged to a subsequent provider.
- **Code 1, Yes,** if at discharge to a home setting (44D=01), or a not listed location (44D=99), your facility did provide the patient's current reconciled medication list to the patient, family, and/or caregiver.

Coding Tips

- **At the time of discharge** – This is the period of time as close to the actual time of discharge as possible. This time may be based on facility, State, or Federal guidelines for data collection at discharge.
- **A home setting –** A home setting is defined as the following as coded in 44D:

01. Home (private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)

- **99 - Not listed**
- **Patient/family/caregiver** – The recipient of the current reconciled medication list can be the patient and/or a family member and/or other caregiver in order to code 1, Yes, a current reconciled medication list was transferred. It is not necessary to provide the current reconciled medication list to all of these recipients in order to code 1, Yes.

Examples

1. The patient is not taking any prescribed or over-the-counter medications at the time of discharge.

   Coding: If it is clearly documented that the patient is taking no medications and this is then clearly communicated to the patient, family, and/or caregiver when the patient is discharged, A2123, Provision of Current Reconciled Medication List to Patient at Discharge would be **coded 1, Yes**, that the medication list was transferred. If this information is not communicated to the patient, family, and/or caregiver, **code 0, No**.

   Rationale: Information confirming that the patient is not taking any medications at discharge is important for the patient, family, and/or caregiver.

2. The patient is cognitively impaired and unable to manage their medications after discharge. The patient's medication list is provided to the patient's sister, who will be the patient's primary caregiver.

   Coding: A2123, Provision of Current Reconciled Medication List to Patient at Discharge would be **coded 1, Yes**.

   Rationale: The medication list must be provided to the patient, a family member, or a caregiver in order to code 1, Yes. In this example, the patient's sister is a family member and a caregiver, so code 1, Yes.

3. The patient chooses to leave the facility before their treatment is completed. The patient tells the charge nurse on the way out the door that the patient's ride is waiting for them, and the patient is going home. The charge nurse explains that the patient has not completed their course of treatment and is not ready to be discharged, but the patient insists on leaving now and proceeds out of the facility.

   Coding: A2123, Provision of Current Reconciled Medication List to Patient at Discharge would be **coded 0, No**.

   Rationale: No medication list review was completed, and no medication list was provided to the patient as they discharged against medical advice (AMA) and did not want to keep their ride waiting.

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.	
Route of Transmission	**Check all that apply** ↓
A. Electronic Health Record	☐
B. Health Information Exchange	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

Item Rationale

- This item collects important data to monitor how medication lists are transmitted at discharge.

Steps for Assessment

1. Identify all routes of transmission that were used to provide the patient's current reconciled medication list to the subsequent provider.

Coding Instructions

Within 3 days of discharge, complete as close to the time of discharge as possible.

Select the codes that correspond to the routes of transmission used to provide the medication list to the subsequent provider.

- **Check A2122A, Electronic Health Record,** if your facility has an EHR, sometimes referred to as an electronic medical record (EMR) and used it to transmit or provide access to the reconciled medication list to the subsequent provider. This would include situations where both the discharging and receiving provider have direct access to a common EHR system. Checking this route does not require confirmation that the subsequent provider has accessed the common EHR system for the medication list.
- **Check A2122B, Health Information Exchange,** if your facility participates in a Health Information Exchange (HIE) and used the HIE to electronically exchange the current reconciled medication list with the subsequent provider.
- **Check A2122C, Verbal,** if the current reconciled medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider.
- **Check A2122D, Paper-based,** if the current reconciled medication list was transmitted to the subsequent provider using a paper-based method, such as a printout, fax, or efax.

- **Check A2122E, Other Methods,** if the current reconciled medication list was transmitted to the subsequent provider using another method not listed above (e.g., texting, email, CDs).

A2124. Route of Current Reconciled Medication List Transmission to Patient

A2124. Route of Current Reconciled Medication List Transmission to Patient Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.	
Route of Transmission	**Check all that apply** ↓
A. Electronic Health Record (e.g., electronic access to patient portal)	☐
B. Health Information Exchange	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

Item Rationale

- This item collects important data to monitor how medication lists are transmitted at discharge.

Steps for Assessment

1. Identify all routes of transmission that were used to provide the patient's current reconciled medication list to the patient, family, and/or caregiver.

Coding Instructions

Within 3 days of discharge, complete as close to the time of discharge as possible.

Select the codes that correspond to the routes of transmission used to provide the medication list to the patient.

- **Check A2124A, Electronic Health Record,** if your facility has an EHR and used it to transmit or provide access to the reconciled medication list to the patient, family, and/or caregiver. This could include providing the patient with direct access to their EHR medication information through a patient portal. Checking this route does not require confirmation that the patient has accessed the medication list from the portal.
- **Check A2124B, Health Information Exchange,** if your facility participates in a Health Information Exchange (HIE) and used the HIE to exchange the current reconciled medication list electronically with the patient, family, and/or caregiver.

DEFINITIONS

PORTAL

A portal is a secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection.
Office of the National Coordinator. What is a patient portal?
https://www.healthit.gov/faq/what-patient-portal

EHR/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.
https://www.healthit.gov/faq/what-electronic-health-record-ehr

- **Check A2124C, Verbal,** if the current reconciled medication list information was verbally communicated to the patient, family, and/or caregiver.
- **Check A2124D, Paper-based:** if the current reconciled medication list was transmitted to the patient, family, and/or caregiver using a paper-based method such as a printout, fax, or efax.
- **Check A2124E, Other Methods,** if the current reconciled medication list was transmitted to the patient, family, and/or caregiver using another method, not listed above (e.g., texting, email, CDs).

Coding Tips for A2122 and A2124

- The route of transmission usually is established with each subsequent provider, depending on how they are able to receive information from your facility. The route(s) may not always be documented in the patient's record. It will be helpful to understand and document how your facility typically transmits information to each subsequent provider at discharge to prepare for coding this item.
- More than one route of transmission may apply. Check all that apply.

Examples

1. An IRF is discharging and sending a patient to a hospital by ambulance. The driver obtains a printout and brings the patient's medication list to the hospital. The facility follows up with a call to the subsequent provider and discusses the patient's medications.

   Coding: Check D, Paper-based and **C, Verbal** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

   Rationale: Two routes for transmitting the medication list information were used – a paper copy of the list (D) and follow up verbal discussion (C). Both of these occurred at the time of discharge.

2. A home health agency (HHA) is preparing to admit a patient who will be discharged from the IRF soon. The HHA intake nurse has secure access to the IRF's EHR to obtain important care planning information from the patient's records, including the medication list.

   Coding: Check A, Electronic Health Record for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

   Rationale: The IRF provided access to the patient's medication list through their EHR. Even if there is no confirmation that the HHA intake nurse accessed the medication list from the IRF's EHR system, code A, Electronic Health Record because it was made available by the IRF.

3. The patient receives a paper copy of their medication list, receives education about their medications by the IRF pharmacist at discharge, and is notified that the IRF's patient portal is another means through which the patient can obtain their discharge medication list.

   Coding: Check A, Electronic Health Record, C, Verbal, and **D, Paper-based** for A2124, Route of Current Reconciled Medication List Transmission to Patient.

Rationale: The copy of the medication list is paper-based (D). The information about the patient's medication list was also communicated verbally by the pharmacist at the time of discharge (C). The patient portal uses the IRF's EHR to provide access to the medication list (A). It is not necessary to confirm that the patient is a registered user of and accessed the patient portal in order to code EHR (A) as a route.

4. A PAC provider participates in a regional HIE, as does a local acute care hospital. When patients are discharged to this acute care hospital, the PAC provider's discharge medication list is included in the medications section of a transfer summary document from their EHR, which is electronically exchanged through the HIE.

   Coding: **Check A, Electronic Health Record** and **B, Health Information Exchange** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

   Rationale: The medication information is exchanged by the regional HIE. Code as EHR (A) since it was used to generate and exchange the information, and as HIE (B) since it is the means through which information exchange is possible with external providers.

5. An IRF has developed an interface that allows documents from their EHR to be electronically faxed to the subsequent provider.

   Coding: **Check D, Paper-based** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

   Rationale: Faxing information is considered paper-based as faxed documents are comparable to hard copy documents, and not computable.

6. A post-acute care facility generates and sends the current reconciled medication list electronically from the medication administration record (MAR) and treatment administration record (TAR) and electronically sends via email to the subsequent provider.

   Coding: **Check E, Other Methods** for A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider.

   Rationale: Providing the medication list through email is considered "Other Method" for coding this item. The source of the medication list is not the EHR and it is not transmitted directly to the subsequent provider's EHR so do NOT check EHR (A).