CHAPTER 3: CLARIFICATION OF TERMINOLOGY

Term	Definition
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.
Ancillary services	Health services other than room and board. These may include x-ray, laboratory, and therapy services.
Another Inpatient Rehabilitation Facility	For the purposes of coding items 15A, 16A, and 44D, this code should be used when a patient is admitted from/transferred to another IRF.
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 Part A fee-for-service inpatient rehabilitation services.
Board and care, assisted living, group home	A non-institutional community residential setting that includes home health services, homemaker/personal care services, or meal services.
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	Centers for Medicare & Medicaid Services.
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.

Term	Definition
Critical Access Hospital (CAH)	For the purposes of coding items 15A, 16A, and 44D, this code should be used to identify an admission/transfer to a CAH for inpatient care. Admission, discharge, or transfer to a CAH swing bed should still be coded with Code 61. 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: • 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. A Medicare-participating hospital must meet the following criteria to be designated by CMS as a CAH: • 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. A CAH may also be granted "swing-bed" approval to provide post-hospital skilled nursing facility-level care in its inpatient beds. 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.
Discharge	A Medicare patient in an IRF is considered discharged when one of the following occurs: 1. The patient is formally released. 2. The patient dies in the IRF.
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

Term	Definition
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 - 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 themself or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered a fall.
Home	For the purposes of coding items 15A, 16A, and 44D, 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, this code should be used when a patient is: • Admitted from/discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs)—whether home attendant, nursing aides, certified attendants, etc.; • Admitted from/discharged/transferred to a foster care facility with home care; or • Admitted from/discharged to home under a home health agency with DME. This code should not be used for home health services provided by a: • DME supplier; or • Home IV provider for home IV services.
Hospice (home)	For the purposes of coding items 15A, 16A, and 44D, 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, 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.

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.
Inpatient Psychiatric Facility	For the purposes of coding items 15A, 16A, and 44D, 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, 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)	A listing of diagnoses and identifying codes used to report diagnoses for individuals.
Interoperability/ Interoperable	"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)." Section 4003 of the 21st Century Cures Act, available at: https://www.healthit.gov/topic/interoperability
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 3 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.
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 Hospital (LTCH)	For the purposes of coding items 15A, 16A, and 44D, this code should be used when admitting/discharging/transferring a patient to a long-term care hospital.

Term	Definition
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 one 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	For the purposes of coding items 15A, 16A, and 44D, 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: • The level of care the patient is receiving; and • Whether the bed is Medicare certified or not.
Medicare	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. • 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.
Onset Days	The number of days from acute onset of the impairment to admission to the IRF.
Orthosis	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.
Outlier	Observation outside a certain range differing widely from the rest of the data.
Outlier Payment	An additional payment beyond the standard federal prospective payment for cases with unusually high costs.
Participation	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).
Patient Assessment Instrument	A document that contains clinical, demographic, and other information on a patient.
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

Term	Definition
Private home or apartment	For the purposes of coding items 15A, 16A, and 44D, refers to non-institutional community 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 system of payments 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.
Rehabilitation Impairment Category (RIC) Clinician	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, refers to a short-term acute care hospital.
Skilled Nursing Facility (SNF)	For the purposes of coding items 15A, 16A, and 44D, 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.
Swing bed	For the purposes of coding items 15A, 16A, and 44D, refers to or 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.
Week	A period of 7 consecutive calendar days beginning with the date of admission to the IRF.