APPENDIX BB Patient_____ Numeric Identifier_____

5.	**DEVICES AND RESTRAINTS**	(*USE THE FOLLOWING* ***CODES FOR LAST 3 DAYS***) 0. Not used 3. Daily use - days only 1. Used less than daily 4. Night and day, but not constant 2. Daily use - night only 5. Constant use for full 24 hours (with periodic release)	
		a. Full bed rails on BOTH open sides of bed	
		b. Other types of side rails used (e.g., half rail, one side)	
		c. Trunk restraint	
		d. Chair prevents rising	

SECTION L. FUNCTIONAL PROGNOSIS

1.	**FUNCTIONAL IMPROVEMENT GOALS** **(Code for last 24 hours)**	*For* ***all but discharge assessment****—code for clinical staff expectations of patient goals in the areas listed below by time of discharge.* *For* ***discharge assessment****, code for staff expectation of patient functional goal in the post discharge period.* 0. No goal exists 1. Goal-improvement, full recovery to premorbid status anticipated 2. Goal-improvement, partial recovery anticipated 3. Goal-improvement, recovery uncertain 4. Goal-maintenance, prevention of further decline			
		ADLs		**e.** Toileting	
		a. Bed mobility/transfer		**OTHER**	
		b. Dressing		**f.** Medication management	
		c. Eating		**g.** Pain control	
		d. Locomotion		**h.** Managing finances	
2.	**ATTRIBUTES RELEVANT TO REHABILITATION**	*CODE*: 0. No 1. Yes 8. UNKNOWN			
		a. Patient believes he/she is capable of increased independence			
		b. Patient unable to recognize new limitations			
		c. Patient fails to initiate or to continue to carry out ADLs (once initiated) for which he/she has some demonstrated capability			
3.	**CHANGE OVER LAST 3 DAYS**	*CODE*: 0. Improved 1. About the same as at admission (or last assessment if this is not an admission assessment) 2. Worse			
		a. Change in overall **functional status** over **last 3 days**			
		b. Change in overall **health status** over **last 3 days**			
4.	**ESTIMATED LENGTH OF STAY FROM DATE OF ADMISSION**	*How long patient is expected to stay in current setting prior to return to community* (***count from date of admission in item A2, including that day***) 0. 1-6 days 4. 91 or more days 1. 7-13 days 5. Discharge to community not expected 2. 14-30 days 6. Expected discharge will be to another health care setting - prior to return to community 3. 31-90 days			

SECTION M. RESOURCES FOR DISCHARGE

1.	**AVAILABLE SOCIAL SUPPORTS** **(Family/close friends)**	*CODE*: 0. No 1. Possibly yes 2. Definitely yes *Presence of one or more family members (or close friends) who are* ***willing and able*** *to provide support after discharge*	
		a. Emotional support	
		b. Intermittent physical support with ADLs or IADLs — less than daily	
		c. Intermittent physical support with ADLs or IADLs — daily	
		d. Full time physical support (as needed) with ADLs or IADLs	
		e. All or most of necessary transportation	
2.	**CAREGIVER STATUS**	*CODE*: 0. No 1. Yes	
		a. Family (or close friend) overwhelmed by patient's illness	
		b. Family relationship(s) require unusual amounts of staff time	

			A Prior to adm	B Perm disch	C Temp disch
3.	**LIVING ARRANGEMENT**	**A.** ***CODE*** *for* ***permanent*** *living arrangement* ***prior to admission*** **B.** ***CODE*** *for* ***permanent*** *arrangement expected* ***at discharge*** *or actual discharge site if this is a discharge assessment* (**A3=5**) **C.** ***CODE*** *for* ***initial*** *arrangement expected at discharge—if different than column* ***M3B*** (otherwise, leave blank) or actual discharge site if this is a discharge assessment (**A3=5**)			
		a. Type of residence 0. UNKNOWN 1. Private home 2. Private apartment 3. Rented room 4. Board and care/assisted living/group home 5. Homeless (with or without shelter) 6. Long-term care facility (nursing home) 7. Post acute care SNF 8. Hospice 9. Acute unit/hospital 10. Other			
		b. Live(d) with 0. UNKNOWN 1. Alone 2. Spouse only 3. Spouse and other(s) 4. Child (not spouse) 5. Other relative(s) (not spouse or children) 6. Friends 7. Group setting 8. Personal care attendant 9. Other			

BILLING CODE 4120–03–P

Appendix BBB—Item-by-Item Guide to the Minimum Data Set for Post Acute Care (MDS–PAC)

1.1 Required Assessments and Associated Forms

The following rules apply to HCFA's MDS–PAC to be used by rehabilitation hospitals and rehabilitation units in acute care hospitals.

The content of the MDS–PAC patient assessment instrument is recorded on the following required forms:

The Minimum Data Set-Post Acute (MDS–PAC) is designed to be used for admission assessments, reassessments, and discharge assessments. These forms contain Section AA (Identification Information) through M (Resources for Discharge). There are three separate forms which are entitled ''Basic Assessment Tracking Form'', ''Interrupted Stay Tracking Form'', and ''Full Assessment Form''. Whenever an item is on all three forms, there will be no distinguishing notation. However, if an item(s) is (are) to be asked only on a particular form, there will be a statement in the ''coding'' section.

1.2 Overview to the Item-by-Item Guide to MDS–PAC

This Manual is to be used in conjunction with the MDS–PAC forms.

It provides information to facilitate completion of an accurate and uniform patient assessment. Item-by-item instructions focus on:

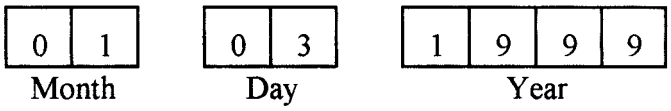
- The intent of items included on the MDS–PAC.
- Supplemental definitions and instructions for completing MDS–PAC items.
- Reminders of which MDS–PAC items require a different observation and information about the patient other than the standard 3-day observation period.
- Sources of information to be consulted in completing specific MDS–PAC items.
- Examples to illustrate MDS–PAC coding responses.

1.3 How Can This Manual Be Used?

Use this manual alongside the MDS–PAC forms, keeping the forms in front of you at all times. The MDS–PAC form itself contains a wealth of information. Learn to rely on it as a resource for many of the definitions and procedural instructions necessary for proper assessment. The amplifying information in this manual should facilitate successful use of the MDS–PAC forms.

Coding Conventions

- Dates—Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 1999 is recorded as:



- The standard no-information code is either a ''circled'' dash or an ''NA''. This code indicates that all available sources of information have been exhausted; that is the information is *not available*, and despite exhaustive probing, it remains unavailable. The use of NA code is very limited. For example, ''NA'' cannot be used in Section E. If an activity has not occurred in the last 3 days, a code of ''8'' must be used.
- NONE OF THE ABOVE is a response item to several items (for example., G3, Infections, box l). Check this item where none of the responses apply; it should not be used to signify lack of information about the item.
- ''Skip'' Patterns—There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to ''skip'' over the next item (or several items) and go on to another (for example, B1, Comatose, directs the assessor to ''skip'' to Section E. if B1 is answered ''1''—Yes''. The intervening items from B2–D3 would not be scored. If B1 was recorded as ''0''—''No'', then the assessor would continue with item B2.).

A useful technique for visually checking the proper use of the ''skip'' pattern instructions is to circle the ''skip'' instructions before going to the next appropriate item.

- The ''8'' code is for use in Section E., Functional Status. The use of this code is limited to situations where the ADL activity was not performed and therefore an objective assessment of the resident's performance is not possible. Its primary use is with bed-bound residents who neither transferred from bed nor moved between locations over the entire 3 day period of observation.

The items from the MDS–PAC forms are presented in a sequential basis in this manual. Each item is accompanied by a statement of intent (rationale for assessment), definitions, assessment processes, and coding instructions. Many items are accompanied by patient examples to illustrate coding concepts.

The chart that follows summarizes the recommended approach to assist you in becoming familiar with the MDS–PAC. The initial time investment in this multi-step review process will have a major payback on the quality of your patient assessments using the MDS–PAC.

Carefully review these item-by-item instructions. The time-frame of the assessment, the processes, the coding options and items have been developed to reflect the needs of post-acute patients.

Recommended Approach for Becoming Familiar With the MDS–PAC

(A) First, review the MDS–PAC forms.

- Notice how sections are organized and where information is to be recorded.
- Work through one section at a time.
- Examine item definitions and response categories.
- Review procedural instructions, time frames, and general coding conventions. Note that the assessment reflects activities over the last 3 days unless otherwise indicated.
- Are the definitions and instructions clear? Do they differ from current practice at your facility? What areas require further clarification?
- Complete the MDS–PAC assessment for a patient at your facility. Draw only on your knowledge of this individual. Enter the appropriate codes on the MDS–PAC form. Where your review could benefit from additional information, make note of that fact. Where might you secure additional information?

(B) Complete the initial pass through this manual.

- Go on to this step only after first reviewing the MDS–PAC form and trying to complete as many items as possible for a patient known to you.
- As you read this manual, clarify questions that arose as you used the MDS–PAC for the first time to assess a patient. Note sections of this manual that help to clarify coding and procedural questions you may have had.
- Once again, read the instructions that apply to a single section of the MDS–PAC. Make sure you understand this information before going on to another section. Review the test case you completed. Would you still code it the same way? It will take time to go through all this material. Do it slowly. Do not rush. Work through the Manual one section at a time.
- Are you surprised by any MDS–PAC definitions, instructions, or case examples? For example, do you understand how to code ADLs? Or Mood?
- Do any definitions or instructions differ from what you thought you learned when you reviewed the MDS–PAC form?
- Would you now complete your initial case differently?
- Are there definitions or instructions that differ from current practice patterns in your facility?
- Make notations next to any section(s) of this Manual you have questions about.

In a second pass through this manual, focus on issues that were more difficult or problematic in the first pass.

- Further familiarize yourself with definitions and procedures that differ from current practice patterns or seem to raise questions.
- Reread each of the case examples presented throughout this chapter.
- (D) The third pass through this manual will provide you with another opportunity to review the material in this manual.
- (E) Future use of information in this manual:

• Keep this manual at hand during the assessment process.

• Where necessary, review the intent of each item in question.

• This manual is a source of information. Use it to increase the accuracy of your assessments.

1.4 What Is the Standard Format Used in This Manual?

To facilitate completion of the MDS–PAC assessment and to ensure consistent interpretation of items, this manual presents the following types of information for many (but not all) items:

Intent: Reason(s) for including the item (or set of items) in the MDS–PAC, including discussions of how the information will be used by clinical staff to identify patient problems and develop the plan of care.

Definition: Explanation of key terms.

Process: Sources of information and methods for determining the correct response for an item. Sources include:

• Patient interview, observation, and examination.

• Clinical records, facility records, transmittal records (at admission), physician orders, laboratory data, medication records, treatment sheets, flow sheets (for example, vital signs, weights, intake and output), care plans, and any similar documents in the facility record system.

• Discussion with multidisciplinary facility staff—licensed and nonlicensed staff caregivers.

• Discussion with the patient's family, particularly during the admission assessment period, when available.

• Attending physician.

Coding: Proper method of recording each response, with explanations of individual response categories.

1.5 Item-by-Item Instructions for the MDS–PAC Forms

The item-by-item instructions follow the sequence of items on the HCFA MDS–PAC. This will facilitate your use of this guide as a reference tool.

Basic Assessment Tracking Form

Section AA. Identification Information

Intent: This section provides the key information to uniquely identify each patient as well as the reason for assessment.

1. Legal Name of Patient

Definition: Legal name in the clinical record. This must be the same as the patient's Medicare record legal name.

Coding: Use printed letters. Enter in the following order:

a. First Name.

b. Middle initial (leave blank if no middle name).

c. Last/Family Name.

d. Suffix—meaning Jr., Sr., III, etc.

2. Admission Date

a. Date the stay began.

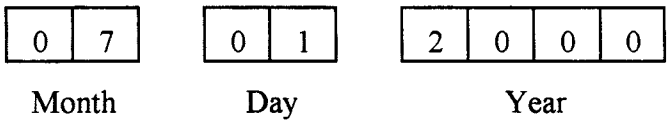
Intent and Definition: For the current precipitating event/problem, this is the date when the patient first became a rehabilitation patient in your facility.

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the person was first admitted to receive rehabilitative care for the current precipitating event/problem. This admission date should correspond with the admission date used by the billing office to initially begin this stay.

Process: Review the clinical record. If it is unclear on what date the stay for the current precipitating event/problem began, clarify with the admissions/business or medical record departments.

Coding: For a one digit month or day, place a zero in the box. For example: July 1, 2000, should be entered as follows:



b. Date Medicare-covered Part A stay began.

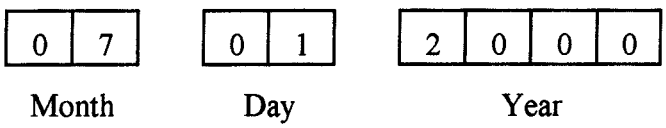
Intent and Definition: For the current precipitating event/problem, this is the date of the current stay when the patient first started receiving Medicare-covered Part-A services in your facility. Complete this date only if this date is different than the date in item AA2A ''Date the stay began.''

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the patient first started to be furnished Medicare-covered Part A services in your rehabilitation facility for the current precipitating event/problem. This date should correspond with the date used by the billing office to initially start billing Medicare for this stay.

Process: Review the clinical record. If it is unclear what date the person first started being furnished Medicare-covered Part A services for the current stay and for the current precipitating event/problem, clarify with the admissions/business or medical record departments.

Coding: For a one digit month or day, place a zero in the first box. For example: July 1, 2000, should be entered as follows:



3. Reason for Assessment

Intent and Definition: To document the key reason for completing the MDS–PAC assessment.

Process: Calculate the length of time the patient has been receiving Medicare-covered Part A services during the current stay. Then determine the type of assessment for which the data must be collected and recorded on the MDS–PAC.

Coding: Code for appropriate assessment.

1. Admission assessment (covers first 3 days)—Completed on day 4.

2. Reassessment—Completed on day 11.

3. Reassessment—Completed on day 31.

4. Reassessment—Completed on day 61.

5. Discharge assessment—After the assessment reference date for the discharge MDS–PAC assessment is determined, the completion date for the discharge MDS–PAC assessment must be set. The completion date

for the discharge MDS–PAC assessment must be the fifth calendar day following the discharge MDS–PAC assessment reference date. To count the 5 calendar days following the discharge MDS–PAC assessment reference date count the discharge MDS–PAC assessment reference date as day 1 of the 5 calendar days. For example, if the MDS–PAC assessment reference date is May 1, 2000, then the MDS–PAC completion date would be May 5, 2000.

The following tables illustrate the relationship between the type of MDS–PAC assessment (the Day 4, Day 11, Day 30, Day 60, and discharge assessment), and the observation time period, the assessment reference date, and the MDS–PAC completion date. In addition, for each type of MDS–PAC assessment the tables depict the associated encoding date and by when the data for that type of assessment must be transmitted.

TABLE 1.—MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	Hospitalization episode covered by this assessment:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period.	Day 10	Day 16.
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23.
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43.
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73.

Table 1 above represents the generic assessment schedule and other associated MDS–PAC dates. The term ''day'' refers to the number of calendar days during the patient's current hospitalization that the patient has been hospitalized as a Medicare Part-A patient.

Table 2 below is an example of how Table 1 would be applied using actual calendar dates. In Table 2 it is assumed that the patient was admitted on April 3, 2001.

TABLE 2.—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	4/5/01	4/6/01	4/12/01	4/18/01
Day 11	Days 8 to 10	4/12/01	4/13/01	4/19/01	4/25/01
Day 30	Days 28 to 30	5/2/01	5/3/01	5/9/01	5/15/01
Day 60	Days 58 to 60	6/1/01	6/2/01	6/8/01	6/14/01

TABLE 3.—EXAMPLE APPLYING THE MDS–PAC DISCHARGE ASSESSMENT DATES

MDS–PAC assessment type	Discharge date*	MDS–PAC assessment reference date	MDS–PAC must Be completed on:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Discharge Assessment	5/1/00	5/1/00	5/5/00	5/11/00	5/17/00

*This is either when the first of the following occurs: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services.

4. Assessment Reference Date

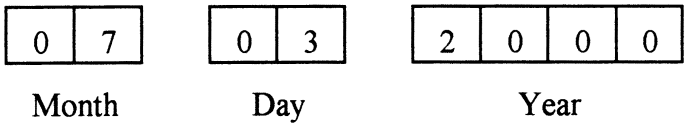
Intent: To establish a common reference point for all staff participating in the patient's assessment. Although staff members may work on completing a patient's MDS–PAC on different days (for example, begin entering demographics on day 1 of admission, and complete functional assessment on day 3), establishment of the assessment reference date ensures the commonality of the assessment period. It starts the ''clock'' so that all assessment items refer to the patient's status, treatment regimen, and resource utilization during the same period of time. Many items require the ''counting'' of the number of treatments, visits, or procedures, making a common temporal reference point crucial for accuracy.

Definition: This is the last day in the MDS–PAC assessment process, that is, the last day of the 3-day MDS–PAC observation period. It is the designated endpoint of the observation period. In order to gain accurate information for the interdisciplinary team, it is essential for everyone to focus on the same time period (that is, for most items, this day and the two that preceded it.) It is from this date that all time references are measured. For a discharge assessment, including an unexpected discharge, see the explanation under ''Process'' below.

For instance, if an item indicates ''in the past 3 days'' this 3 day period is calculated from the last day of the MDS–PAC observation period (that is, the third day and the two days that preceded it.)

Process: Refer to item AA2—''Admission Date''. The date entered in AA2b or if no date is entered in AA2b then the date entered in AA2a must be used to calculate the assessment reference date that must be used for the Day 4, Day 11, Day 30, or Day 60 assessments. The assessment reference date for the discharge assessment is the day when one of either of these two events occurs first: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services. The MDS–PAC discharge assessment process is started only at the first point in time either of these events occur. There may be cases when a patient ceases receiving inpatient rehabilitation Medicare-covered services, but is not discharged from the IRF.

Coding: Beginning with the left-most box enter the month, day, and year of the assessment reference date. Do not leave any boxes blank. If the month or day contains only a single digit, place a ''0'' in the first box. For example: July 3, 2000, should be entered as follows:



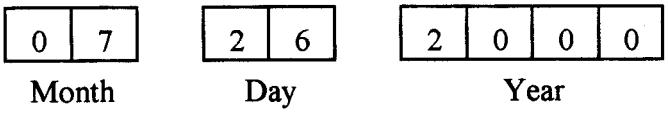
5. Discharge Status

a. Last day of stay.

Intent and Definition: To establish the date when either of these two events occurs first: (1) The individual is discharged as an inpatient from the IRF and physically leaves the facility, or (2) the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services whether or not the patient physically leaves the facility.

Process: Consult the physician's orders. In cases when the patient is discharged ''Against Medical Advice'' (AMA) refer to the documentation in the clinical record progress notes and the physician's orders.

Coding: Beginning with the left-most box enter the month, day, and year of discharge. Do not leave any boxes blank. If the month or day contains only a single digit, place a ''0'' in the first box. For example July 26, 2000, should be entered as:



b. If discharged, status at discharge.

Intent: The intent of this item is to determine the patient's status upon discharge.

Definition: This is the patient's clinical and rehabilitation program status at discharge.

Process: Consult with members of the interdisciplinary team. Examine the documentation in the patient's clinical record. Talk to the patient and family if necessary.

Coding

0. Rehabilitation program complete for this stay and return not anticipated.

1. Patient left, against medical advice, prior to completion of plan of care.

2. Acute problem, discharge to acute hospital.

3. Patient died.

6. Social Security and Medicare Numbers

Intent: To record patient identifier numbers.

Process: Review the patient's medical record face sheet (usually at the front of the chart). To ensure accuracy, review a copy of the patient's Social Security (SS) card and Medicare card, if possible. In rare cases, the patient will have neither a Social Security number nor a Medicare number. When this occurs, another type of identification number may be used (for example, a railroad insurance number).

Coding: Begin printing one number per box starting with the left-most box. Recheck each number to be sure you have entered the digits in the correct order.

a. Enter the Social Security number as specified in the medical record or on the Social Security card.

b. Enter the Medicare number as indicated in the medical record. However, if the patient does not have a Medicare number but instead has a comparable railroad insurance number, then enter that number in these boxes and indicate that this is not a Medicare number by placing the letter ''C'' in first box of the ''b'' boxes.

7. Medical Record Number

Definition: A patient's identification number designated by the facility.

Process: Review the patient's medical record ''face sheet'' (usually at the front of the chart) for the medical record number. If the number is missing, obtain the number from the facility's Medical Records Department.

Coding: Begin printing one number per box starting with the left-most box. Recheck the number to be sure you have entered the digits in the correct order.

8. Facility Provider Number

Intent: To record the facility identifier numbers.

Definition: The identification numbers assigned to health care facilities by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; others will have Federal (Medicare) and State (Medicaid) identification numbers. ''Medicaid only'' facilities have a Federal as well as a State number. The Medicaid Federal number has a ''letter'' in the third box.

Process: Obtain the facility's Medicare and Medicaid numbers from the facility's business office. Once you have these numbers, they apply to all patients of that facility.

Coding: Begin printing one number per box starting with the left-most box. Recheck each number to be sure you have entered the digits in the correct order. Remember, there must be at least one provider number indicated, and there may be two, one for the state, one for the federal.

9. Medicaid Number

Intent: An identifying number for tracking purposes.

Process: Review the patient's medical record face sheet (usually at the front of the chart). Review a copy of the patient's Medicaid card to ensure accuracy, if possible.

Coding: Begin printing one number per box starting with the left-most box. Recheck the number to be sure you have entered the digits in the correct order.

- If the Medicaid application is pending, place a ''+'' in the first box.
- If the patient does not receive Medicaid benefits, place an ''N'' in the first box.

10. Gender

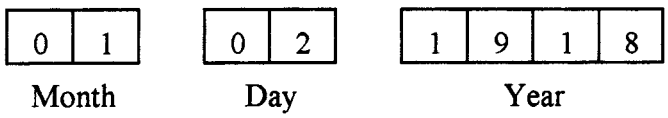
Coding

1. Male.

2. Female.

11. Birthdate

Coding: Beginning with the left-most box enter the month, day, and year of birth. If you do not know the patient's full birthdate you may enter a partial birthdate, but the partial birthdate must at least include the patient's year of birth. If the month or day contains only a single digit, place a ''0'' in the first box. For example: January 2, 1918 should be entered as:



Note: It's not unheard of to mistakenly enter today's date in this location. Make sure you have entered the date of birth.

12. Ethnicity/Race

Intent: The documentation of ethnicity and race per nationally established standards.

Process: Ask the patient and/or family member what best describes their race and ethnic background.

Coding: Check all that apply.

Ethnicity

a. Hispanic or Latino.

Race

b. American Indian/Alaskan Native.
c. Asian.
d. Black or African American.
e. Native Hawaiian or other Pacific Islander.
f. White.

13. Interrupted Stay

Note: This item only appears on the interrupted stay tracking form.

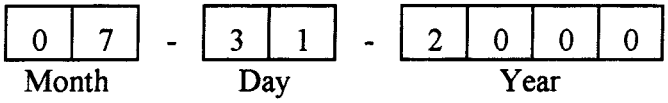
Intent and Definition: To track patients that have an interruption in their stay. An interrupted stay is one in which a patient is discharged from a rehabilitation facility and returns to the same rehabilitation facility in 3 calendar days or less. For purposes of the MDS–PAC assessment process, if a patient has an interrupted stay, then—(1) No new Day 4 MDS–PAC assessment would be performed; and (2) The required scheduled MDS–PAC update assessments must still be performed. Note: A patient that returns to the same rehabilitation facility more than 3 calendar days after being discharged is considered a ''new'' patient in terms of the MDS–PAC assessment schedule process.

In counting the 3 calendar day time period to determine the length of the interrupted stay, the first day of the start of the interrupted stay is counted as ''day 1,'' with midnight of that day serving as the end of that calendar day. The next 2 calendar days that immediately follow would be days two and three. If the patient returns to the rehabilitation facility by midnight of the third calendar day, then it would be determined that the patient had an interrupted stay of 3 calendar days or less.

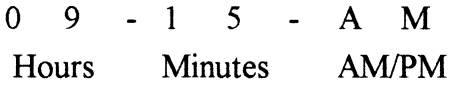
a. Date/time departed from the rehabilitation unit/hospital.

Process: Consult the clinical record, talk to physician and nursing staff.

Coding: If the patient has not had an interrupted stay, the boxes will remain blank. Otherwise, use all boxes. For a one-digit month or day, place a zero in the first box. July 31, 2000, should be entered as follows:



A time of 9:15 am should be entered as follows:

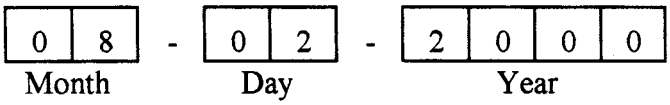


b. Date/time returned to the rehabilitation unit/hospital.

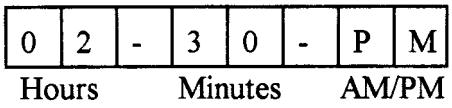
Process: Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department.

Coding: If patient has not had an interrupted stay, leave the boxes blank. Otherwise, use all the boxes. For a one-digit month or day, place a zero in the first box.

August 2, 2000, should be entered as follows:



A time of 2:30 pm should be entered as follows:



14. Clinician Completing Assessment

Note: This item only appears on the interrupted stay tracking form. This is NOT the same as Section AB ''Assessment Attestation''.

Intent: To ensure that the data recorded on the Interrupted Stay Tracking Form is accurate and submitted to the HCFA MDS–PAC system within 7 calendar days of the date recorded in item AA13b. The date recorded in item AA13b is ''day 1'' when starting to count the 7 calendar days in order to determine the 7 calendar day time period.

Definition: The clinician who signs item AA14a must be a physician, registered nurse, physical therapist, or occupational therapist.

Process: As necessary examine the clinical record, and consult with other members of the interdisciplinary care team to obtain the data needed prior to completing this item.

Coding: After signing your name print your name at AA14b to AA14e. Indicate your credentials in the box at AA14f.

Section AB. Assessment Attestation

1. Person Completing the Assessment

Intent and Definition: A licensed clinician who is a physician, registered nurse, physical therapist, or occupational therapist must sign and certify that—(1) The assessment is complete; and (2) The data recorded for the assessment items are to the best of his or her belief accurately recorded and accurately depict the patient's clinical status.

Process: Examine the MDS–PAC to determine if according to the instructions that the required data for each item has been accurately recorded.

Coding: The physician, registered nurse, physical therapist, or occupational therapist signs his/her name on line AB1a. The date that he or she signed the assessment as complete and accurate is entered in the boxes of AB1g and his/her name must be printed on the line that starts at AB1b. In the box for item AB1f enter the code number that identifies the type of licensed clinician signing item AB1a.

2. Signatures of Staff Completing Part of the Assessment

Intent: Each individual who completes a portion of the assessment must sign and certify to the accuracy of the items he or she has completed.

Coding: On lines AB2a–AB2f each person who has completed any MDS–PAC item signs their name, writes their credentials, indicates what section(s) or item(s) he or she completed, and writes the date of his or her signature.

Section A. Demographic/Admission Information History

Intent: This section provides the key information to uniquely identify each patient as well as the reason for assessment.

1. Legal Name of Patient

Definition: Legal name in the clinical record. This must be the same as the patient's Medicare record legal name.

Coding: Use printed letters. Enter in the following order:

a. First Name.

b. Middle initial (leave blank if no middle name).

c. Last/Family Name.

d. Suffix—meaning Jr., Sr., III, etc.

2. Admission Date

a. Date the stay began.

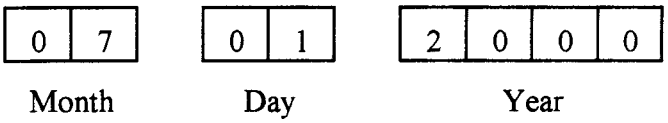
Intent and Definition: For the current precipitating event/problem, this is the date when the patient first became a rehabilitation patient in your facility.

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the person was first admitted to receive rehabilitative care for the current precipitating event/problem. This admission date should correspond with the admission date used by the billing office to initially begin this stay.

Process: Review the clinical record. If it is unclear what date the stay for the current precipitating event/problem began, clarify with the admissions/ business or medical record departments.

Coding: For a one digit month or day, place a zero in the box. For example: July 1, 2000, should be entered as follows:



b. Date Medicare-covered Part-A stay began.

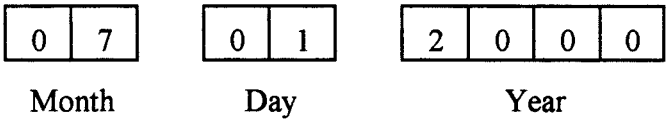
Intent and Definition: For the current precipitating event/problem, this is the date of the current stay when the patient first started receiving Medicare-covered Part-A services in your facility. Complete this date only if this date is different than the date in item A2a ''Date the stay began.''

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the patient first started to be furnished Medicare-covered Part-A services in your rehabilitation facility for the current precipitating event/problem. This date should correspond with the date used by the billing office to initially start billing Medicare for this stay.

Process: Review the clinical record. If it is unclear what date the person first started being furnished Medicare-covered Part A services for the current stay and for the current precipitating event/problem, clarify with the admissions/ business or medical record departments.

Coding: For a one digit month or day, place a zero in the first box. For example: July 1, 2000, should be entered as follows:



3. Reason for Assessment

Intent and Definition: To document the key reason for completing the MDS–PAC assessment.

Process: Calculate the length of time the patient has been receiving Medicare-covered Part-A services during the current stay. Then determine the type of assessment for which the data must be collected and recorded on the MDS–PAC.

Coding: Code for appropriate assessment.

1. Admission assessment (covers first 3 days)—Completed on day 4.

2. Reassessment—Completed on day 11.

3. Reassessment—Completed on day 31.

4. Reassessment—Completed on day 61.

5. Discharge assessment—After the assessment reference date for the discharge MDS–PAC assessment is determined, the completion date for the discharge MDS–PAC assessment must be set. The completion date for the discharge MDS–PAC assessment must be the fifth calendar day following the discharge MDS–PAC assessment reference date. To count the 5 calendar days following the discharge MDS–PAC assessment reference date count the discharge MDS–PAC assessment reference date as day 1 of the 5 calendar days. For example, if the MDS–PAC assessment reference date is May 1, 2000, then the MDS–PAC completion date would be May 5, 2000.

The following tables illustrate the relationship between the type of MDS–PAC assessment (the Day 4, Day 11, Day 30, Day 60, and discharge assessment), and the observation time period, the assessment reference date, and the MDS–PAC completion date. In addition, for each type of MDS–PAC assessment the tables depict the associated encoding date and by when the data for that type of assessment must be transmitted.

TABLE 1.—MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed on:	Hospitalization episode covered by this assessment:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period.	Day 10	Day 16.
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23.
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43.
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73.

Table 1 above represents the generic assessment schedule and other associated MDS—PAC dates. The term ''day'' refers to the number of calendar days during the patient's current hospitalization that the patient has been hospitalized as a Medicare Part A patient.

Table 2 below is an example of how Table 1 would be applied using actual calendar dates. In Table 2 it is assumed that the patient was admitted on April 3, 2001.

TABLE 2.—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	04/05/01	04/06/01	04/12/01	04/18/01
Day 11	Days 8 to 10	04/12/01	04/13/01	04/19/01	04/25/01
Day 30	Days 28 to 30	05/02/01	05/03/01	05/09/01	05/15/01
Day 60	Days 58 to 60	06/01/01	06/02/01	06/08/01	06/14/01

TABLE 3.—EXAMPLE APPLYING THE MDS–PAC DISCHARGE ASSESSMENT DATES

MDS–PAC assessment type	Discharge date	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Discharge Assessment	5/01/00	5/01/00	5/05/00	5/11/00	5/17/00

*This is either when the first of the following occurs: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services.

4. Admission Status

Intent: The purpose of this item is to determine if the patient has been previously admitted for rehabilitation of this problem.

Process: Talk to the patient and family if necessary. Review the medical record to determine what type of facility this patient has been admitted from.

Coding: Place the number of the most appropriate code in the box.

0. First admission to inpatient rehabilitation services.

1. Readmission to rehabilitation but not directly from other rehabilitation.

2. Readmission directly from other rehabilitation.

5. Goals for Stay

Intent: To document the expected outcomes of the patient's post acute care stay. It is possible and common to have more than one goal for the stay.

Definition: a. Medical stabilization—Patient's condition is unstable and requires frequent medical and nursing monitoring (for example, vital signs; drug levels; laboratory evaluation) and interventions (for example, titrating drug dosages; transfusions) in an effort to achieve a steady state/program of care.

b. Rehabilitation/Functional Improvement—Care is directed towards the attainment of baseline (or prior to the precipitating event) level of function in a selected area or areas, for example, activities of daily living, instrumental activities of daily living, cognitive status, communication status, or psychosocial functioning.

c. Recuperation—Care directed towards recovery from an illness by regaining health or strength. Often includes patient or family caregiver teaching to prepare for different level of care (for example, medication management; energy conservation; ostomy care).

d. Monitoring to avoid clinical complication—For a medically stable patient, care directed at systematic monitoring of the patient's condition through observation (that is, clinical signs and symptoms) and measurement of physical parameters (that is, lab values; respiratory function tests) with the intent of preventing complications associated with the patient's clinical condition.

e. Palliative care—A primary goal of care is to provide comfort and quality of life through the prevention and control of symptoms near the end of life. Palliative care often includes active treatment of associated conditions in an effort to promote a sense of well-being at the end of life (for example, antidepressant drugs/psychotherapy for depression; physical therapy as an adjunct to pain management and prevention of pressure ulcers; nutritional counseling).

Coding: Code each possible goal with one of the following responses, as appropriate:

0. No.

1. Yes.

6. Admitted From (At admission date A2)

Intent: To facilitate care planning by documenting the place from which the patient was admitted to the facility on the date recorded in item A2.

Definition: 1. Private home—Any house or condominium in the community whether owned by the patient or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled.

2. Private apartment—Any apartment in the community whether owned by the patient or another person.

3. Rented room—A rented room in a private house, boarding house, or hotel.

4. Board and care/group home—A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home

health, homemaker, personal care, meal service, transportation, etc.

5. Assisted living—A housing option for older adults who need some assistance with activities of daily living (ADLs) but do not require 24-hour nursing care.

6. Homeless shelter—A community-based shelter for individuals who do not have a place to reside.

7. Transitional living—A community based supervised setting where individuals are taught skills so that they can live independently in the community.

8. Long term care facility (nursing home)—A licensed health facility that provides 24-hour skilled or intermediate nursing care.

9. Post acute care SNF—Facility (or designated beds within a SNF) dedicated to the care of patients with intense rehabilitative or clinically complex needs. Most patients are admitted to the post acute care facility from an acute hospital, or rehabilitation hospital. These patients will have a short, intense stay in the post acute care SNF.

10. Acute care hospital (not rehabilitation unit)—A facility licensed as an acute care hospital which focuses primarily on the diagnosis and treatment of acute medical (and in some cases psychiatric) disorders.

11. Rehabilitation unit (in acute care hospital)—A unit within an acute care hospital that focuses on the acute rehabilitation of individuals who have been functionally affected by disease or injury.

12. Rehabilitation hospital—A facility licensed as a rehabilitation hospital that focuses on the physical rehabilitation of individuals who have been functionally affected by disease or injury.

13. Long term care hospital—A facility licensed as a long-term care hospital. Included are hospitals that focus on the management of clinically complex patients, chronic medical needs, chronic disease, etc. (includes chronic disease hospitals, and long term acute care hospitals).

14. Psychiatric hospital/unit—A facility licensed as a psychiatric hospital or unit which focuses on the diagnosis and treatment of psychiatric disorders.

15. MR/DD facility (exclude group home)—A facility which specializes in the management and rehabilitation of individuals with mental retardation or developmental disorders. Examples include mental retardation or developmental disabilities facility (including MR/DD institutions) and intermediate care facilities for the mentally retarded (ICF/MRs).

16. Other hospital—Any other hospital not categorized above (may include in-patient hospice programs).

17. Outpatient surgery center—A stand-alone or hospital-affiliated outpatient surgery center designated to provide perioperative care (no inpatient beds). Includes same-day surgery units.

18. Other—Any other setting not categorized above.

Process: Review the medical record. If unavailable in medical record, ask patient or family.

Coding: Choose only one answer and enter the appropriate code in the box provided.

7. Precipitating Event Prior to Admission

a. Time of onset of the precipitating event or problem that directly preceded admission into this facility (time from admission date—item A2).

Intent: This item seeks to provide the care team with some perspective on the event that caused the admission.

Process: Review medical record for history of the event or problem using admission date to the facility (item A2) as a reference point. If necessary, clarify with patient or family.

Coding: Enter the number that best represents the time period in which the precipitating event occurred. This information is obtained only on admission, but must be coded and submitted to the HCFA MDS–PAC system for each subsequent (for example, the Day 11) assessment.

0. Within last week.

1. Within last 8–14 days.

2. 15–30 days ago.

3. 31–60 days ago.

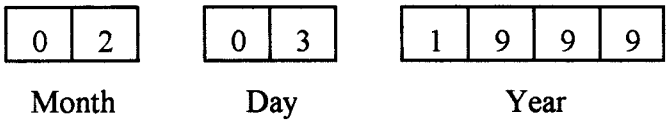
4. More than 60 days ago.

b. Date of admission of most recent acute care hospitalization (within last 90 days).

Intent: This item (in addition to the next) gives perspective on the amount of time the patient spent in the hospital. If there was NO hospitalization in the last 90 days, leave this section blank and move on to item A8.

Process: Review the medical record. Hospital discharge summaries are the most efficient means to gather this information, if available. If unavailable, consult with patient or family.

Code: Enter the date of admission to the hospital in space provided. For a one-digit month or day, place a zero in the first box. For example: February 3, 1999, should be entered as:



c. Reason for most recent acute care hospitalization (within last 90 days).

Definition: Hospitalization—The patient was formally admitted to an acute care hospital by a physician as an inpatient with an overnight stay. This category does not include day surgery or outpatient services.

New problem—A condition that is distinctly different or unrelated to any previously identified disease or condition of the patient.

Exacerbation—Recurrence or aggravation of symptoms or increase in the severity of a previously identified disease or condition.

Process: Review medical record. If necessary, clarify with patient or family.

Coding: Using the following codes, enter the number that best represents the reason the patient was most recently hospitalized.

0. Not Hospitalized at any time in last 90 days.

1. New problem.

2. Exacerbation.

3. Both (New Problem and Exacerbation).

8. Primary and Secondary Payment Sources for Stay (Per diem)

Intent: To document the payment source(s) that covers the daily per diem services for this post acute stay.

Definition: Per diem—Room, board, nursing services and other services included in the routine daily charge.

Process: Consult with the business or billing office to review current payment sources. Do not rely exclusively on information recorded in the patient's medical record (usually the face sheet at the front of the chart) as the patient's clinical condition may trigger different sources of payment during the stay. It's important to capture all methods of payment; usually business offices track such information.

Coding: Using the following list, enter the code which best indicates the primary and secondary payment sources in the appropriate boxes. In Column A, code for the primary payment source for the stay. In Column B, code for the secondary payment source for the stay.

Note: The code for Column B can't be the same as the code in Column A.

0. None—no insurance coverage, no private pay.

1. Medicare.

2. Medicaid.

3. CHAMPUS.

4. Department of Veterans Affairs.

5. Managed Care/HMO—Medicare.

6. Managed Care/HMO—non-Medicare.

7. Private insurance.

8. Private pay—self or family pays, includes private pay by patient or family.

9. Worker's Compensation.

10. Other payment—examples include Commission for the Blind, Alzheimer's Association.

9. Marital Status

Process: Ask patient or family member.

Coding: Choose the code that best describes the patient's current marital status. If the patient is in a ''Common Law'' marriage, enter code ''2'', Married. Common Law marriage—a couple who have been co-habitating and who consider themselves as being married, even though not legally married.

1. Never married.

2. Married.

3. Widowed.
4. Separated.
5. Divorced.

10. Education (Highest Level Completed)

Intent: To record the highest level of education the patient attained. Knowing this information is useful for assessment (for example, interpreting cognitive patterns or language skills), care planning (for example, deciding how to focus a planned recovery program), and planning for patient education in self-care skills.

Definition: The highest level of education attained.

1. No schooling: Patient/family state that patient received no formal schooling at all.
2. 8th grade or less: Patient attended school through 8th grade level or less.
3. 9th–11th grade: Patient completed school at 9th, 10th, or 11th grade.
4. High School: Patient obtained high school diploma—completed school through the twelfth grade or GED.
5. Technical or Trade School: Include schooling in which the patient received a non-degree certificate in any technical occupation or trade (for example, carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).
6. Some College: Includes completion of some college courses at a junior (community) college, associate's degree, or incomplete bachelor's degree.
7. Bachelor's degree: Includes any undergraduate bachelor's level college degree.
8. Graduate Degree: Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

Note: If assessor has been unsuccessful in determining educational information, the assessor may use a ''dash'' symbol to indicate information not available.

Process: Ask the patient or family. If a part of your facility's standard intake record, review the patient's record.

Coding: Code for the best response. For MR/DD patients who have received special education services, code ''2'' (8th grade/less).

11. Language

Definition: (a.) Primary language—The language the patient primarily speaks or understands. If patient is unable to speak at the present time, code for language familiar to patient prior to the precipitating event.

Process: Determine patient's primary language by asking the patient or family. If a part of your facility's standard intake record, review the patient's record.

Coding: Given the choices provided, indicate what the patient identifies as their primary language.

0. English.
1. Spanish.
2. French.
3. Other, specify in A11b.

(b.) If the patient's primary language is other than English, Spanish, or French, enter 3 for Other in item A11a, and print the primary language in item A11b beginning in the left-most box.

12. Dominant Hand

Intent: To document which hand the patient considers to be the ''dominant'' hand. Knowing the patient's ''handedness'' can facilitate rehabilitation and assist in the detection of neurological and functional diagnoses.

Definition: The dominant hand describes what is usually referred to as ''handedness'' and reflects the area of the brain that is most dominant.

Process: Ask patient, family, or therapy staff.

Coding: Indicate which hand the individual has considered to be dominant since childhood. If an individual feels that both hands are equal (ambidextrous), enter code ''3'', unable to determine. Also use code ''3'' if you are unable to obtain this information from the patient, family or medical record.

If Right handed, code ''1''.
If Left handed, code ''2''.
If Unable to determine, code ''3''.

13. Mental Health History

Intent: To document a primary or secondary diagnosis of psychiatric illness or developmental disability.

Definition: Patient has one of the following:

• A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but

• Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

• The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;

AND

• The treatment history indicates that the individual has experienced either: (a) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (for example, partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Process: Review the patient's record *only.* For a ''Yes'' response to be entered, there must be written documentation (that is, verbal reports from the patient or patient's family are not sufficient).

Coding: Enter ''0'' for No or ''1'' for Yes.
0. No.
1. Yes.

14. Conditions Related to MR/DD Status (Mental Retardation/Developmental Disabilities)

Intent: To document presence of mental retardation or developmental disabilities with and without organic conditions.

Process: Review the patient's record only. Condition must be documented in the clinical record. Examples of organic conditions related to MR/DD are rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

Coding: If organic condition is present, check if condition is related to MR/DD status present before age 22. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

1. Not applicable—No MR/DD.
2. MR/DD with no organic condition.
3. MR/DD with organic condition.

15. Responsibility/Legal Guardian

Intent: To record who has responsibility for participating in decisions about the patient's health care, treatment, financial affairs, and legal affairs. Depending on the patient's condition, multiple options may apply. For example, a patient with moderate dementia may be competent to make decisions in certain areas, although in other areas a family member will assume decision-making responsibility. Or a patient may have executed a limited power of attorney to someone responsible only for legal affairs.

Definition: a. Legal guardian—Someone who has been appointed after a court hearing and is authorized to make decisions for the patient, including giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only by another court hearing.

b. Other legal oversight—Use this category for any other program in your State whereby someone other than the patient participates in or makes decisions about the patient's health care and treatment.

c. Durable power of attorney/health care—Documentation that someone other than the patient is legally responsible for health care decisions if the patient becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the patient's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the patient at any time.

d. Patient responsible for self—Patient retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the patient is the responsible party.

e. NONE OF THE ABOVE.

Process: Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by state law. The descriptions provided here are for general information only. Refer to the law in your State and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the patient and the patient's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the patient's record in order for the item to be checked on the MDS–PAC form.

Coding: Check all that apply.

16. Advance Directives

Intent: To document the existence of any legal directives to guide the health care team in making treatment decisions, whether made by the patient him/herself or a legal proxy. This documentation must be in the medical record to be considered current and binding. The absence of pre-existing directives for the patient provides an opportunity for a discussion by the clinical team with the patient and family regarding the patient's wishes. Any discrepancies between the patient's current stated wishes and what is said in legal documents in the patient's file should be resolved immediately.

Definition: a. Living will—A document specifying the patient's preferences regarding measures used to prolong life when there is a terminal prognosis.

b. Do not resuscitate—In the event of respiratory or cardiac failure, the patient, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the patient's respiratory or circulatory function.

c. Do not hospitalize—A document specifying that the patient is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

d. Treatment restrictions—The patient or responsible party (family or legal guardian) does not wish the patient to receive certain medical treatments. Examples include, but are not limited to: blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (for example, reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party. Treatment restrictions could also include:

• *Feeding restrictions*—The patient or responsible party (family or legal guardian) does not wish the patient to be fed by artificial means (for example, tube, intravenous nutrition) if unable to be nourished by oral means.

• *Medication restrictions*—The patient or responsible party (family or legal guardian) does not wish the patient to receive life-sustaining medications (for example, antibiotics, chemotherapy).

e. NONE OF THE ABOVE.

Process: You will need to familiarize yourself with the legal status of each type of directive in your State. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the patient's wishes until their legal status is determined.

Review the patient's record for documentation of the patient's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Some patients at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether the new patient has ever created an advance directive (for example, ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the patient's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

Coding: The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.

• The patient (or proxy) should always be involved in the discussion to ensure informed decision-making. If the patient's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS–PAC item only after the preference has been documented.

• If the patient's preference is in areas that require supporting orders by the attending physician (for example, do not resuscitate, do not hospitalize, feeding restrictions, other treatment restrictions), check the MDS–PAC item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded but patient's or proxy's preference is not indicated, discuss with the patient's physician and check the MDS–PAC item only after documentation confirming that the patient's or proxy's wishes have been entered into the record.

• If your facility has a standard protocol for withholding particular treatments from all patients (for example, no facility staff member may resuscitate or perform CPR on any patient; facility does not use feeding tubes), check the MDS–PAC item only if the advanced directive is the individual preference of the patient (or legal proxy), regardless of the facility's policy or protocol.

Coding: Check all that apply. If none of the directives are verified by documentation in the medical records, check NONE OF ABOVE.

Section B. Cognitive Patterns

Intent: To assess the patient's ability to think coherently, remember and organize thoughts into actions, including daily self-care activities. These items focus on the patient's functional performance, including demonstration of ability to remember recent and past events, to perform key decision making skills. This information can significantly contribute to the development of a post acute plan of care, including the discharge plan.

Questions about cognitive function and memory can be threatening or sensitive for some patients. Some may react defensively or get agitated and emotional if unable to remember or answer the questions. These are not uncommon reactions to ''performance anxiety'' and feelings of being exposed, embarrassed, or frustrated if the patient is aware that he or she cannot respond cogently. It is important to recognize these feelings and to be as supportive as possible.

It is important to establish an environment that enables the patient to function at their optimal level. The first few days of admission to a post acute setting can be overwhelming. Be sure to interview the patient in a private, quiet area (for example, limit distractions and interruptions as much as possible), and not in the presence of other patients or family, unless the patient would prefer that they stay. Using a non-judgmental approach to questioning will help create a needed sense of trust between the assessor and the patient. Clarify and validate your findings with the patient's family or other clinicians as needed. This input is especially important for those patients with limited communication skills or language barriers.

Engage the patient in general conversation to help establish rapport.

• Actively listen and observe for clues to help you structure your assessment. Remember that repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.

• Be open, supportive, and reassuring during your conversation with the patient (for example, ''Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you'').

If the patient becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting during the three-day observation/assessment period but may be ongoing during the entire assessment period. Say to the agitated patient, for example, ''Let's talk about something else now,'' or ''We don't need to talk about that now. We can do it later''. Observe the patient's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

1. Comatose

Intent: To record whether the patient's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

Process: Review medical record for documentation.

Coding: Enter the appropriate number in the box.

If the patient has been diagnosed as comatose or in a persistent vegetative state, code ''1'' (Yes) and Skip to Section E. If the patient is not comatose, or is semi-comatose, code ''0'' (No) and proceed to the next item (B2).

2. Memory/Recall Ability

Intent: To determine a patient's ability to remember recent and past events (that is, short-term, long-term, situational and procedural memory).

Process: a. Short-term memory OK: Ask the patient to describe a recent event that both of you have had the opportunity to remember (you should be able to validate that patient's memory with your knowledge of such events). Examples include what the patient had for breakfast, when the last pain medication dosage was received, (you can validate the patient's recollection with information from the medical record). For persons with verbal communication deficits,

non-verbal responses are acceptable (for example, when asked how many children visited today, they can correctly tap out a response of the appropriate number). If there is no positive indication of memory ability, code ''1'', Memory problem.

b. Long-term memory OK: Engage in conversation about past events that are meaningful to the patient (for example, family, hospitalization, work experience). Ask questions for which you can validate the answers (from your review of the medical record, general knowledge, the patient's family). For patients with limited communication skills, ask family members about their perception of the patient's memory. If the patient demonstrates difficulty remembering key events of long ago, code ''1'', Memory problem.

c. Situational memory OK: This item refers to two abilities that can be demonstrated by the patient within the facility: (1) The patient's ability to recognize the names and faces of staff whom they frequently encounter, AND (2) the patient's ability to remember the location of places regularly visited (for example, bedroom, meal room/dining area, activity room, therapy room). IMPORTANT: For coding purposes, the patient must demonstrate positive abilities in BOTH types of situations to be coded as ''0'', Memory OK. If she/he demonstrates difficulty in one or both areas code as ''1'', Memory problem.

• Recognize staff names and faces—The patient distinguishes staff caregivers from family members, strangers, visitors, and other patients. It is not necessary that the patient remembers all staff members' names, but to recognize them as staff caregivers (that is, nurse, therapist) vs. others.

• Remember the location of places regularly visited—The patient is able to locate or recognize key areas of the facility that they frequent regularly. It is not necessary for the patient to know his/her room number but he/she should be able to find the way to his room, recognize the purposes of particular rooms, etc.

d. Procedural Memory OK: This MDS–PAC item refers to the ability to perform sequential activities. Dressing is an example of such a task as it requires multiple steps to complete the entire task. The patient must be able to perform or remember to perform all or most all of the steps in order to be scored a ''0'' Memory O.K. If the patient demonstrates difficulty in two or more steps, code as ''1'' Memory Problem.

Coding: For each type of memory:

Code ''0'' in the box provided, if memory OK.

Code ''1'' in the box provided, if memory problem is demonstrated.

3. Cognitive Skills for Daily Decision Making

Intent: To record the patient's ability and actual performance in making every day decisions about tasks or activities of daily living. This item is especially important for assessment and care planning for 2 reasons: (1) The information can alert health care providers to new changes (decline or improvement) in the patient's cognitive function, and (2) the information can alert staff to a discrepancy between a patient's capacity for decision-making and their current level of performance, which may indicate that caregivers or family may be inadvertently fostering the patient's dependence. It may have an impact on the course of treatment outcomes and discharge plan.

For persons who have been acutely ill, it is important to determine the patient's ''baseline'' cognitive skills from some point prior to the current admission (Note: this instrument uses a time period prior to the assessment reference date [item AA4]), as well as his/her current skills (Note: the last 3 days, and the time immediately prior to precipitating event), so that the clinician can make a comparison for diagnostic and care planning purposes. Even slight deviations (decline) from baseline may be secondary to a variety of causes including: (1) The outcome of a recent acute event (for example, a primary neurological event such as a CVA; post anesthesia), (2) an evolving acute illness or exacerbation of disease (for example, infection; congestive heart failure; dehydration; drug effects or interactions; depression), or (3) a progression of a chronic neurological condition (for example, Alzheimer's disease; Huntington's disease). Detecting change is the first step in determining whether the change is due to a remediable condition or chronic decline. Likewise, follow-up measurements can provide an indication of success of treatment programs, prognosis for independent living, etc.

(a) Making decisions regarding tasks of daily life.

Process: This assessment should be conducted through conversation with direct care staff, a review of the clinical record (chart), in addition to personally observing and interacting with the patient [Note—this personal interaction can occur in the course of regular ongoing care activities; or it can be a part of a planned MDS–PAC interview/observation where a series of issues are reviewed—cognition, mood, ADLs, activities]. Your inquiry should focus on whether the patient is actively making choices, plans, and decisions, and not whether staff believe the patient might be capable of doing so. Remember, the intent of this item is to record what the patient is doing (performance). Where a health care provider or family member takes decision-making responsibilities away from the patient regarding tasks of everyday living or the patient does not participate in decision-making (which may happen when patients take on the ''sick'' role), consider the patient to have impaired performance in decision making. In this case document how they function now rather than your supposition of their capacity to function. Consult with family and health care providers where necessary to clarify patient decision making.

Coding: Enter the number that most accurately characterizes the patient's cognitive performance in making decisions regarding the tasks of daily life over the last three days.

0. Independent—The patient's decisions in planning and executing daily routines and making decisions were consistent, reasonable, safe, and organized reflecting lifestyle, culture, values.

1. Modified Independence—The patient was organized in daily routines and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

2. Minimally Impaired—For the most part, the patient was organized in daily routines and made safe decisions, but in specific situations the patient demonstrated poor decision-making skills requiring directions or cues or supervision at those times.

3. Moderately Impaired—The patient demonstrated poor decision making skills that could place his/her safety at risk. The patient needs reminders, cues and supervision in planning, organizing, correcting, and carrying out daily routines. Cues and supervision are required at all times.

4. Severely Impaired—The patient's decision making was severely impaired: the patient never (or rarely) makes decisions.

(b) Is now more impaired in decision making than prior to precipitating event (item A7a).

Intent: To record whether the patient is now more impaired than she/he was at a specified period in time prior to the precipitating event (that is, the current score to item B3a is higher that it would have been prior to the precipitating event).

Process: Through patient interview, family reports, or review of earlier clinical record, compare the patient's current skills in daily decision making with their skills immediately prior to the precipitating event [Item A7a].

Coding: Enter the number corresponding to the most appropriate response.

0. No or unsure.

1. Yes, more impaired today.

4. Indicators of Delirium—Periodic Disordered Thinking/Awareness

Intent: To assess and record behavioral signs that may indicate that delirium is present. The characteristics of delirium are usually manifested behaviorally, and therefore can be observed. For example, disordered thinking, a typical characteristic of delirium, may be first observed as rambling, irrelevant, or incoherent speech. Other typical behaviors are described in the definitions below.

Many acute conditions (for example, infections; congestive heart failure) and treatment (for example, polypharmacy; anesthesia; anticholinergic drugs) can have a deleterious effect on cognitive performance and the development of delirium, particularly in persons with the following risk factors: over age 80 years, prior history of cognitive impairment, recent hip fractures, complex medical conditions and drug regimens, recent hospitalization, and history or signs/symptoms of depression. The incidence rate of delirium among acute care hospital patients is as high as 41% and often occurs by day 2 through 6 of the hospitalization. Approximately 48–96% of patients continue to have some behavioral and cognitive symptoms by discharge. With the shortening of hospital stays, and the shift towards earlier discharge to post acute environments it is crucial for clinicians to identify and monitor for behavioral

manifestations of delirium for two reasons: (1) to identify new or worsening signs that herald the onset of a treatable acute condition, and (2) to document the progression of changes over time for discharge planning.

Definition: a. Easily distracted—(for example, has difficulty paying attention, does not complete tasks or conversations without getting sidetracked)

b. Periods of altered perception or awareness of surroundings—(for example, moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. Episodes of disorganized speech—(for example, speech is incoherent, nonsensical, irrelevant, rambling from subject to subject; loses train of thought)

d. Periods of restlessness—(for example, fidgeting or picking at skin, clothing, napkins, etc.; frequently changing positions; repetitive physical movements or calling out)

e. Periods of lethargy—(for example, sluggishness, staring into space; difficult to arouse; little body movement)

f. Mental function varies over the course of the day—(for example, alertness and behaviors vary during the course of the day, sometimes better, sometimes worse; sometimes present, sometimes not)

Process: Observe patient and interview staff.

Coding: Code for the patient's behavior in the last seven days regardless of what you believe the cause to be—focus on when the manifested behavior first occurred. Accurate assessment requires conversations with staff and family who have direct knowledge of patient's behavior over this time.

0. Behavior not present.

1. Behavior present, not of recent onset.

2. Behavior present over last 7 days appears different from the patient's usual functioning (for example, new onset or worsening).

Section C. Communication/Vision Patterns

Intent: To document the patient's sensory function (for example, ability to hear and see with assistive devices, if used, and/or environmental adjustments, if necessary) and ability to understand and communicate with others.

Communication—There are many possible causes for communication problems experienced by elderly and post acute patients. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a patient might have aphasia as well as long standing hearing loss; or he might have dementia with word finding difficulties and a hearing loss. The patient's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions.

Vision—Visual limitations or difficulties may be related to the aging process as well as to diseases common in aged and chronically ill persons (for example, cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurologic diseases). It is important to identify visual impairment. Some conditions may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the patient's residual visual abilities. In the post acute setting, identifying and addressing visual impairment is an important part of preparing the patient for tasks related to self-care upon potential discharge to a more independent care setting (for example, reading medication and food labels; safely negotiating a living environment; using the stove).

1. Hearing

Intent: To evaluate the patient's ability to hear (with hearing appliance, if used, and/or environmental adjustments, if necessary) during the last 3-day period. Identifying impairments early in the post acute stay can facilitate the development of necessary adaptions for discharge. Often the environment can have an impact on the patient's ability to hear and must be considered in the assessment.

Process: If the patient has an adaptive hearing device/aid/appliance, evaluate hearing ability with the working device in place. Interview the patient (ask about hearing function) and observe for hearing function during your verbal interactions. Use a variety of observations to make your assessment (for example, one-on-one vs. group situations). Always be mindful of environmental factors that may influence your assessment (for example, call bells; vacuum cleaners; suctioning equipment; roommate's conversations; outside noises, etc.). If necessary to clarify exact hearing level, consult with the patient's family, primary caregivers, or speech or hearing specialists.

Be alert to what you have to do to communicate with the patient. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the patient needs to see your face to know what you are saying, or if you have to take the patient to a more quiet area to conduct the interview—all of these are cues that there is a hearing problem, and should be indicated in coding this section.

Coding: Enter the number that corresponds to the most correct response.

0. Hears adequately—The patient hears all normal conversational speech, social interaction, including when using the phone, and watching TV.

1. Minimal difficulty—The patient hears speech at conversational levels but has difficulty hearing when the environment is not quiet or when he/she is in group situations. Background noise affects hearing.

2. Hears in special situations only—The patient is hearing deficient but compensates and hears better when the speaker increases volume, adjusts his voice tone, and/or speaks distinctly; or the patient can hear only when the speaker's face is clearly visible.

3. Highly impaired/absence of useful hearing—The patient hears only some sounds and frequently fails to respond even when speaker adjusts tone and volume, speaks slowly and distinctly, or is positioned face-to-face with the patient. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

2. Modes of Communication

Intent: To record the types of communication techniques (for example, alternative verbal or non-verbal techniques) used by the patient to make his or her needs or wishes known.

Definition: a. Hearing aid—An apparatus used by those with impaired hearing for amplifying sound.

b. Lip reading—Understanding spoken word by means of visualization of the speaker's mouth and lips.

c. Signs/gestures/sounds—This category includes non-verbal expressions used by the patient to communicate with others.

- Actions may include pointing to words, objects, people; facial expressions; using physical gestures such as nodding head twice for ''yes'' and once for ''no'' or squeezing another's hand in the same manner.
- Sounds may include grunting, banging, ringing a bell, etc.

d. Writing messages to express or clarify needs—Patient writes notes to communicate with others.

e. NONE OF THE ABOVE.

Process: Interact with the patient and observe for any reliance on non-verbal expression (physical gestures, such as pointing to objects), either in one-on-one communication or in group situations. Consult with the direct care staff from all shifts. For patient with limited communication skills, have staff ask patient's family if there are additional effective means of communication.

Coding: Check the boxes for each method used by the patient to communicate his or her needs. If the patient does not use any of the listed items, check NONE OF THE ABOVE.

3. Making Self Understood (Expression)

Intent: To document the patient's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these. In order to monitor the patient's progress, the assessment reflects the patient's status at 2 points in time: over the last 3 days, and immediately prior to the precipitating event (A7a).

(a) Expressing information content—however able.

Process: Interact with the patient. Observe and listen to the patient's efforts to communicate with you using the assistive devices/modes of expression they would normally use to communicate. Consult with the primary caregivers (over all shifts), and speech-language pathologist, if possible, who will be able to report on observations of patient's interactions with others in different

settings (for example, one-on-one, groups) and different circumstances (for example, when calm, when agitated) and different times of day. If direct care staff are uncertain and you require further clarification, consult with family members who frequently visit the patient (if such a person is present).

Coding: Enter the number corresponding to the patient's ability to make self understood over the last 3 days.

0. Understood—The patient expresses ideas clearly, without difficulty.

1. Usually Understood—The patient may have difficulty expressing ideas (finding words or finishing thoughts) but is able to make him/herself understood if the listener is patient and gives him/her time to express himself. Little or no prompting required by the listener.

2. Often Understood—The patient has difficulty finding the right words or finishing thoughts, resulting in delayed or incomplete responses. The patient usually requires some prompting/cuing by the listener to complete or clarify the message (make self understood).

3. Sometimes Understood—The patient has limited ability, but expresses simple, concrete requests regarding at least basic needs that would be generally understood (for example, food, drink, sleep, toilet, pain).

4. Rarely or Never Understood—The patient is not able to communicate effectively. At best, this communication is such that it required staff to interpret the meaning of highly individual, patient-specific sounds or body language (for example, indicated presence of pain or need to use the toilet).

(b) Is now more impaired in making self understood by others than was prior to precipitating event (item A7a).

Process: Through patient interview, family reports, or review of earlier clinical record compare patient's current ability to make self understood (last 3 days) with their ability prior to the precipitating event [Item A7a]).

Coding: Enter the number corresponding to the most appropriate response.

0. No, or unsure.

1. Yes, more impaired today.

4. Speech Clarity

Intent: To document the quality/intelligibility of the patient's speech (not the content or appropriateness).

Definition: Speech—the expression of articulate words.

Process: Throughout the course of the assessment the patient will have many opportunities to talk with you. Listen to the clarity of speech. To assess speech quality over the last 3 days also confer with primary caregivers.

Coding: Enter the number corresponding to the response which best describes the clarity and quality of the patient's speech in the last 3 days.

0. Clear speech—utters distinct, intelligible words.

1. Unclear speech—utters slurred or mumbled words.

2. No speech—absence of spoken words.

5. Ability to Understand Others (Comprehension)

Intent: To describe the patient's ability to comprehend information whether communicated to the patient orally, in writing, or in sign language or Braille. This item measures not only the patient's ability to hear messages but also to process and understand language. In order to monitor the patient's progress, the assessment reflects the patient's status at 2 points in time: the last 3 days, and immediately prior to a more distant precipitating event (A7a).

(a) Understanding verbal information content (however able) with hearing appliance, if used.

Process: Assess the patient using whatever assistive devices/methods (for example, hearing aids) that the patient would usually use in communicating with others. Interact with the patient. Throughout the assessment process and at other times observe the patient and determine his/her ability to comprehend your questions and statements. Try to observe the patient's interactions with others, in different situations and times of day. Consult with primary staff caregivers (over all shifts), and speech-language pathologist (if present) to clarify patient understanding at different times and in different settings. If direct care staff are uncertain and you require further clarification, consult with family member who frequently visits the patient (if such person is present).

Coding: Enter the number corresponding to the patient's ability to comprehend (understand others) over the last 3 days.

0. Understands—The patient clearly comprehends the speaker's message(s) and demonstrates this understanding through words or actions/behaviors.

1. Usually Understands—The patient may miss some part or intent of the message but comprehends most of it. The patient may have periodic difficulties integrating information but generally demonstrates comprehension, by responding in words or actions. Little or no prompting required.

2. Often Understands—The patient may miss some part or intent of the message. When the messenger(s) (staff or family) rephrase or simplify the message(s) or use gestures, and specifically inquires as to the patient's understanding of what is being communicated, the patient's comprehension is enhanced. This type of prompting occurs often.

3. Sometimes Understands—The patient demonstrates frequent difficulties integrating information and responds adequately only to simple and direct questions or directions/cues (for example, one-step commands such as ''close your eyes'')

4. Rarely/Never Understands—The patient demonstrates very limited ability to understand communication. Based on the patient's verbal and nonverbal responses, staff have difficulty determining whether the patient comprehends messages, or the patient can hear sounds but does not understand messages.

(b) Is now more impaired in understanding others than was prior to precipitating event (Item A7a).

Process: Through patient interview, family reports, or review of earlier clinical record compare patient's current ability to understand others (last 3 days) with their ability immediately prior to the precipitating event [Item A7a].

Coding: Enter the number corresponding to the most appropriate response.

0. No or unsure.

1. Yes, more impaired today.

6. Vision

Intent: To evaluate the patient's ability to see close objects in adequate lighting, using the patient's customary visual appliances for close vision (for example, glasses; contact lenses; magnifying glass). Adequate lighting is defined as the amount of light that is sufficient or comfortable for a person with normal vision.

Process: • Ask the patient about his or her visual abilities for close vision (for example, to see newsprint, menus, greeting cards), use of glasses, contact lenses, etc.

• To validate the patient's reported vision, ask the patient to look at regular-size print in a book or newspaper using whatever visual appliance he or she customarily uses for close vision (for example, glasses, magnifying glass). Then ask the patient to read a few words aloud, starting with larger headlines and ending with the finest, smallest print.

• Be sensitive to the fact that some patients are not literate or are unable to read English. In such cases, ask the patient to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.

• If the patient is unable to communicate or follow your directions for testing vision, observe the patient's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the patient has any visual ability.

(a) Ability to see in adequate light and with glasses, if used.

Coding: Enter the code that best describes the patient's visual ability given adequate light and use of his/her customary visual aids.

0. Adequate—The patient sees fine detail, including regular print in newspapers/books.

1. Impaired—The patient sees large print, but not regular print in newspapers/books.

2. Moderately Impaired—The patient has limited vision, is not able to see newspaper headlines, but can identify objects in his or her environment.

3. Highly Impaired—The patient's ability to identify objects in his or her environment is in question, but eye movements appear to follow objects (for example, people walking by).

Note: Many patients with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such patients appear to ''track'' or follow moving objects in their environment with their eyes. For patients who appear to do this, use code ''3'', Highly Impaired. Even though these are gross measures, with our current limited technology, this is the best general assessment you can do under the circumstances.

4. Severely Impaired—The patient has no vision; reports seeing only light or colors, but eyes do not appear to follow objects (for example, people walking by).

(b) Is now more impaired in vision than was prior to precipitating event (Item A7a).

0. No or unsure.

1. Yes, more impaired today.

Section D. Mood and Behavior Patterns

Mood distress is a serious condition that is associated with significant morbidity and mortality. It may be precipitated by acute illness, loss of independence (whether temporary or permanent), a new diagnosis (possibly terminal), pain, effects of medications, etc. Although changes in mood and behavior can happen to anyone, persons at particular risk for disorders such as depression are those with prior history of mood disorders, mild to moderate cognitive impairment, pain, and unstable health conditions. Many clinicians and patients perceive changes in mood and behavior to be normal, expected reactions to crisis (for example, deteriorating health). Although such reactions are common, it is crucial to identify the particular signs of distress, assess the frequency of their occurrence, and determine whether they are easily altered. Then clinicians can develop an appropriate treatment plan based on the impact of the mood or behavioral indicators on the patient's quality of life and well-being, ability to participate in the post acute treatment and discharge plans, etc.

1. Indicators of Depression, Anxiety, Sad Mood

Intent: To record the frequency of indicators observed in the last 3 days, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of psychic distress may be expressed directly by the patient who is depressed, anxious, or sad. However, direct statements such as ''I'm so depressed'' are often rare; signs must be often ''teased'' out by clinicians through observation and interview. Distress may be more commonly expressed in the following ways:

VERBAL EXPRESSIONS OF DISTRESS

a. Patient made negative statements—for example, ''Nothing matters; Would rather be dead than live this way; What's the use; Let me die.''

b. Persistent anger with self or others—for example, easily annoyed, anger at presence in post acute care, anger at care received.

c. Expressions of what appear to be unrealistic fears—for example, fear of being abandoned, left alone, being with others, afraid of nighttime.

d. Repetitive anxious complaints/concerns (non-health related)—for example, persistently seeks attention/reassurance regarding therapy or others' schedules, meals, laundry, clothing, relationship issues, when family will visit.

e. Repetitive health complaints—for example, persistently seeks medical attention, obsessive concern with body functions, obsessive concern with vital signs.

Distress may also be expressed non-verbally and identified through observation of the patient in the following areas during usual daily routines:

SAD, APATHETIC ANXIOUS APPEARANCE

f. Sad, pained, worried facial expressions—for example, furrowed brows.

g. Crying, tearfulness.

h. Repetitive physical movements—for example, pacing, hand wringing, restlessness, fidgeting, picking.

SLEEP CYCLE ISSUES

Distress can also be manifested in disturbed sleep patterns.

i. Insomnia/change in usual sleep patterns—for example, difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep.

LOSS OF INTEREST

These items refer to a change in the patient's usual pattern of behavior.

j. Withdrawal from activities of interest—for example, no interest in long standing activities or being with family/friends.

k. Reduced social interaction—for example, less talkative, more isolated.

Process: Initiate a conversation with the patient, being cognizant of earlier statements by (or observations of) the patient. Some patients are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when asked directly how they feel. For patients who verbalize their feelings, ask how long these conditions have been present. Other patients may be unable to articulate their feelings (that is, cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe the patient carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the patient during the three days covered by this assessment. Consult with direct-care staff over all shifts, if possible, or other clinicians who work with the patient, or family who have direct knowledge of the patient's typical and current behavior. Relevant information may also be found in the clinical record, although this can vary.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the patient in the last 3 days. Remember, code regardless of what you believe the cause to be.

0. Indicator not exhibited in last 3 days.

1. Exhibited on 1–2 of last 3 days.

2. Exhibited on each of last 3 days.

2. Mood Persistence

Intent: To identify if one or more indicators of depressed, sad or anxious mood [Item D1] were easily altered by attempts to ''cheer up'', console, or reassure the patient over the last three days.

Process: The information on which to base this judgement is gathered as part of the conversations, observation, and record reviews for D1 (the individual indicators of mood state). The key factor here is the need to assess whether (when aggregated across the several mood indicators) the patient cannot be easily consoled, reassured or cheered up.

Coding: One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to cheer up, console, or reassure the patient over last 3 days.

0. No mood indicators or always easily altered.

1. Partially altered or easily altered on only some occasions.

2. All aspects of mood not easily altered.

3. Behavioral Symptoms

Intent: To identify the frequency of behavioral symptoms over the last 3 days that cause distress to the patient, or are distressing or disruptive to other patients or staff members. Such behaviors include those that are potentially harmful to the patient, or disruptive in the environment, even if staff or other patients appear to understand or have adjusted to them (for example, ''Mrs. R. doesn't mean anything by calling out. She does it because she's confused right now.'')

Behavioral symptoms can be associated with an acute illness, a change in medication, or simply a response to or change in the environment. Acknowledging and documenting behavioral symptoms provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care.

Note: Documentation of the patient's behavioral status in the medical record may not be accurate, valid, or complete, and it is not intended to be the only source of information. (See Process below). However, once the frequency and alterability of behavioral symptoms is determined, subsequent documentation should more accurately reflect the patient's status and response to interventions.

Definition: a. Wandering—Locomotion with no discernible, rational purpose. A wandering patient may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (for example, a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair use.

Do not include pacing back and forth as wandering behavior. If it occurs, it should be documented in Item D1h, ''Repetitive physical movements''.

b. Verbally Abusive Behavioral Symptoms—Other patients or staff were threatened, screamed at, or cursed at.

c. Physically Abusive Behavioral Symptoms—Other patients or staff were hit, shoved, scratched, or sexually abused.

d. Socially Inappropriate/Disruptive Behavioral Symptoms—Includes disruptive sounds, excessive noise, screams, self-abusive acts, sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

e. Resists care—Resists taking medications/injections, ADL assistance, help with eating, or changes in position. This category does not include instances where the patient has made an informed choice not to follow a course of care (for example, patient has exercised his or her right to refuse treatment, and reacts negatively if staff try to reinstate treatment).

Signs of resistance may be verbal or physical (for example, verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, and their presence should prompt further investigation of their cause (for example, fear of pain, fear of falling, poor comprehension, anger, poor

relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Take an objective view of the patient's behavioral symptoms. The coding for this item focuses on the patient's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to record all behavioral symptoms. The fact that staff have become used to the behavior and minimize the patient's presumed intent (''He doesn't really mean to hurt anyone. He's just frightened.'') is not pertinent to this coding. Does the patient manifest the behavioral symptom or not?

Observe the patient and how he/she responds to caregiver attempts to deliver care to him or her. Consult with staff who provide direct care on all three shifts. A symptomatic behavior may be present and might not be seen because it occurs during intimate care on another shift. Therefore, it is especially important to solicit input from direct caregivers (including nurse assistants) who have contact with the patient.

Simply relying on written notes in the patient record is not sufficient. You must be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (for example, staff are working with severely cognitively and functionally impaired patients (for example, in a head trauma unit) and are used to patients' wandering, noisiness, etc.). Focus staff attention on what has been the individual patient's actual behavior over the last three days. Finally, although it may not be complete, review the clinical record for documentation of behaviors you may not have seen, nor staff reported. When such a note is found, review the patient's status with staff. Is the note correct? Is it within the appropriate time frame of the record?

Coding: Behavioral symptom frequency in last 3 days.

Record the frequency of behavioral symptoms manifested by the patient across all three shifts.

Code ''0'' if the described behavioral symptom was not exhibited in last three days. This code applies to patients who have never exhibited the behavioral symptom or those who have previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, or a behavior-management program. For example: A ''wandering'' patient who has not wandered in the last three days because he was restricted to bedrest and had a private duty nurse attending to him would be coded ''0''—Behavioral symptom not exhibited in last three days.

Code ''1'' if the described behavioral symptom occurred on 1 day.

Code ''2'' if the described behavioral symptom occurred on 2 days.

Code ''3'' if the described behavioral symptom occurred daily or more frequently (that is, multiple times each day) in the last 3 days.

Section E. Functional Status

Patients in post-acute care settings will have acute (and often chronic) illnesses, and they will be subject to a variety of factors that can severely impact self-sufficiency. For example, cognitive deficits can limit a person's ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete the ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Individualized plans of care can be successfully developed only when the patient's self-performance has been accurately assessed, including the amount and type of support being provided to the patient by others.

For patients in post acute settings, the focus of the admission assessment is twofold: (1) to determine baseline functional performance levels, and (2) to determine if these levels have recently changed. This information will then be used as a basis for developing a plan of care (for example, targeted rehabilitation and other services) with the goal of leading the patient to an expeditious and coordinated discharge to home or a lower level of care.

1. Activities of Daily Living (ADL) Self-Performance Summary (Over Last Three Days)

Intent: To record a summary of the patient's self-care performance in activities of daily living (that is, what the patient actually did for himself or herself or how much verbal or physical help was required by staff members) during the last three days. This requires a review of all ADL activities over this period.

Definition: ADL SELF–PERFORMANCE—Measures what the patient actually did (not what he or she might be capable of doing) within each ADL category over all shifts for all episodes over the last three days according to a performance-based scale.

a. Bed Mobility—How patient moves to and from a lying position, turns side to side, and positions the body while in bed.

b. Transfer—Bed/Chair—How patient moves between surfaces-that is, to/from bed, chair, wheelchair standing position. This definition excludes movement to/from bath or toilet, which is coded under Transfer Toilet (item E1i) and Transfer Tub/Shower (item E1l).

c. Locomotion—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, locomotion is defined as self-sufficiency once in the chair.

d. Walk in Facility—How patient walks in different areas of the facility. For a patient who uses a wheelchair exclusively, this would be coded as ''8'' (Activity did not occur).

e. Dressing Upper Body—How patient dresses and undresses (street clothes, underwear) above the waist. Includes prostheses, orthotics, fasteners, pullovers, etc.

f. Dressing Lower Body—How patient dresses and undresses (street clothes, underwear) from the waist down. Includes prostheses, orthotics (for example, anti-embolic stockings), belts, pants, skirt, shoes and fasteners.

g. Eating—How patient eats and drinks (regardless of skill). Includes intake or nourishment by other means (for example, tube feeding, total parenteral nutrition).

h. Toilet Use—How patient uses the toilet room (or commode, bed pan, urinal), adjusts clothes before and after using toilet, manages perineal hygiene, changes pad, manages ostomy or catheter. (EXCLUDE transfer to toilet which is coded under item E1i, Transfer Toilet).

i. Transfer Toilet—How patient moves on and off toilet or commode or bedpan.

j. Grooming/Personal Hygiene—How patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup; and washing/drying face and hands (EXCLUDE baths and showers which are coded in item E1k, Bathing).

k. Bathing—How patient takes full-body bath/shower or sponge bath (EXCLUDE washing of back and hair and TRANSFER [which is coded in item E1l, Transfer Tub/Shower]). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. Note: For this item and item E1l below, you must code for most dependent episode.

l. Transfer Tub/Shower—How patient transfers in/out of tub/shower. Code for most dependent episode.

Process: In order to promote the highest level of functioning among patients, clinical staff must first identify what the patient actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cuing, physical support, etc.)

A patient's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (for example, willing to perform for a nurse assistant he or she likes), medications and changes in underlying functional capacity. The responsibility of the person completing the assessment is to capture the total picture of the patient's ADL self-performance over the 3-day period, 24 hours a day—that is, not only how the evaluating clinician sees the patient, but how the patient performs on other shifts as well.

In order to accomplish this, you will need to know about the multiple episodes of the activity over the last 3-days—for example, how the patient dressed and undressed the upper body yesterday, the day before yesterday, and the day before that. To gather this information, there are two obvious sets of people to talk with—the patient and direct care staff—and when you have these conversations, be sure to plan to discuss all ADLs (get the total picture)—that is, if possible, talk with the patient and direct care staff on all three shifts (including weekends) and review documentation used to communicate with staff across shifts.

Ask questions pertaining to all aspects of the ADL activity definitions. For example,

when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the patient moves to and from a lying position, how the patient turns from side to side, and how the patient positions himself or herself while in bed. A patient can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Be sure to consider each activity definition fully.

The wording used in each coding option is intended to reflect real-world situations, where slight variations are common. Where variations occur, the coding ensures that the patient is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Set up Help only, Supervision, Minimal Assistance) permit one or two exceptions for the provision of heavier care. This is clinically useful and increases the likelihood that staff will code ADL Self-Performance items consistently and accurately.

The following chart provides general guidelines for recording accurate ADL Self-Performance.

Guidelines for Assessing (Item E1) ADL Self-Performance (Last 3 Days)

- The coding options for E1 record the patient's actual level of involvement in self-care and the type and amount of support actually received during the last three days—requiring that you have knowledge of all episodes of each of the ADLs (or as near as possible to all episodes).
- Do not record your assessment of the patient's capacity for involvement in self-care—that is, what you believe the patient might be able to do for himself or herself based on demonstrated skills or physical attributes. An assessment of functional prognosis is covered in Item L1 (Functional Improvement Goals by Discharge).
- Do not record the type and level of assistance that the patient ''should'' be receiving according to the written plan of care. The type and level of assistance actually provided may be quite different from what is indicated in the plan. Record what is actually happening.
- Engage direct care staff from all shifts who have cared for the patient over the last three days in discussions regarding the patient's ADL functional performance. Remind staff that the focus is on the last three days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.
- When you are uncertain that the patient could perform the activity as described or conversely where you wonder why the patient is not more independent, observe a regularly scheduled session where this activity is carried out (for example, eating a meal, dressing in the morning). Observation will both help you to validate reported behaviors and will be useful as you go forward to care planning.

Here is a typical conversation between the RN and a nurse assistant regarding a patient's Bed Mobility assessment:

R.N. ''Describe to me how Mrs. L positions herself in bed. By that I mean, once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side, and positioning herself?''

N.A. ''She can lay down and sit up by herself, but I help her turn on her side.''

R.N. ''She lays down and sits up without any verbal instructions or physical help?''

N.A. ''No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself.'' se supervision

R.N. ''How do you help her turn side to side?''

N.A. ''She can help turn herself by grabbing onto her siderail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position.''

R.N. ''Do you lift her by yourself or does someone help you?''

N.A. ''I do it by myself.''

R.N. ''How many times during the last three days did you give this type of help?''

N.A. ''Every time she was turned.''

Provided that ADL function in Bed Mobility was similar on all shifts, Mrs. L would receive an ADL Self-Performance (in the last three days) Code of ''4''.

Now review the first two exchanges in the conversation between the RN and the nurse assistant. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of either the patient's skills or the nurse assistant's actual workload, or whether the current plan of care was being implemented.

Coding: For each ADL category, code the appropriate response for the patient's actual performance during the last three days. Consider the patient's performance during all shifts, as function may vary. For example, for eating, a patient may receive 3 meals per day and two supplemental feedings. Thus, over 3 days, there would have been 15 feeding episodes. It is this performance experience that forms the basis for scoring item E1g.

0. Independent—No help, or set up or staff oversight/supervision –OR–help, setup or supervision provided only 1 or 2 times during period (with any task or subtask). [See examples of Setup Help in the box following these coding options.]

1. Setup Help Only—Article or device provided or placed within reach of patient 3 or more times. [See examples of Setup Help in the box following these coding options.]

2. Supervision—Oversight, encouragement, or cuing provided 3 or more times during period–OR–Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for a total of 3 or more episodes of help or supervision).

3. Minimal Assistance (Limited Assistance)—Patient highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times –OR– Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help).

4. Moderate Assistance (Extensive Assistance)—Patient performed part of activity on own (50% or more of subtasks) BUT help of the following type(s) was provided 3 or more times:

- Weight-bearing support (for example, holding weight of one or both lower limbs, trunk).
- Full staff performance of a task (some of time) or discrete subtask.

5. Maximal Assistance—Patient involved but completed less than 50% of subtasks on own (includes 2 + person assist), received weight bearing help or full performance of certain subtasks 3 or more times.

6. Total Assistance (Total Dependence)—Full staff performance of the activity during the entire period.

8. Activity Did Not Occur—During the last three days, the ADL activity was not performed by the patient or staff. In other words, the specific activity did not occur at all.

For example: A patient who was restricted to bed for the entire three day period and was never transferred from the bed would receive a code of ''8'' for Transfer (Item E1b).

However, do not confuse a patient who is totally dependent in an ADL activity (Code 6—Total Dependence) with the activity itself not occurring. For example: A patient who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A patient who is highly involved in giving himself a tube feeding is not totally dependent and should be coded as a ''3.''

Note: Each of these ADL Self-Performance scoring categories is exclusive. There is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided.

There will be times when there is no one type or level of assistance provided to the patient 3 or more times during a three-day period. However the sum total of support of various types will be provided three or more times. In this case, code for the least dependent self-performance category where the patient received that level or more dependent support 3 or more times during the 3 day period. Please review the following example for clarification of this principle.

Examples of Setup Help

- For bed mobility—Handing the patient the bar on a trapeze apparatus.
- For transfer—Giving the patient a transfer board or locking/unlocking the wheels on a wheelchair for a safe transfer.
- For locomotion.

Walking—Handing the patient a walker or cane.

Wheeling—Locking/unlocking the brakes on the wheelchair or adjusting the foot pedals to facilitate foot motion while wheeling.

- For dressing—Retrieving clothes from closet and laying out on the patient's bed; handing the patient a shirt; retrieving a prosthesis or orthotic.
- For eating—Cutting meat and opening containers at meals; giving one food category at a time.
- For toilet use—Handing the patient a bedpan or placing articles necessary for changing ostomy appliance within reach.

• For personal hygiene—Providing a wash basin and grooming articles.

• For bathing—Placing bathing articles at tub side within the patient's reach; handing the patient a towel upon completion of the bath.

2. ADL Assist Codes

Intent: To identify and document the level of weight bearing ADL assistance provided to the patient over the last 3 days.

Definition: a. Bed mobility—How patient moves to and from lying position, turns side to side, and positions body while in bed.

b. Transfer bed/chair—How patient moves between surfaces-to or from: bed, chair, wheelchair, standing position (Exclude to or from bath or toilet).

c. Locomotion—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, how the patient moves once in the wheelchair.

d. Walk in facility—How the patient walks in room, corridor, or other place in the facility.

e. Dressing upper body—How the patient dresses and undresses (street clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.

f. Dressing lower body—How the patient dresses and undresses (street clothes, underwear) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners.

g. Eating—How the patient eats and drinks (regardless of skill) includes intake of nourishment by other means (for example, tube feeding, total parenteral nutrition).

h. Toilet use—How patient uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes (Exclude transfer to toilet).

i. Transfer/Toilet—How patient moves on and off toilet or commode

j. Grooming/Personal hygiene—How the patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing and drying face, and hands (Excludes baths and showers).

k. Bathing—How patient takes full body bath or shower or sponge bath (Exclude washing of back and hair and transfer). Includes how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, perineal area.

l. Transfer tub/shower—How the patient transfers in and out of the tub or shower.

Coding: Code for the most help in the last 3 days.

0. Neither code applies.

1. Weight bearing support with 1 limb (arm or leg).

2. 2+ person physical assist.

3. ADL Changes

Intent: In this item the assessor compares the patient's current ADL function to self performance prior to the precipitating event item A7a.

Definition: a. The number of ADL areas (listed under E1) in which the patient is now more impaired in self performance than was prior to the precipitating event (A7a) determines the appropriate coding.

b. The number of ADL areas (from E1 above) in which patient was independent prior to precipitating event (item A7a).

Coding: Place the appropriate number of ADL areas in box a and box b.

4. Instrumental Activities of Daily Living (IADLs)

Intent: The intent of these items is to examine the areas of function that are most commonly associated with independent living.

Process: The patient is to be questioned directly about his or her capacity to perform the usual activities around the home or community in the last 24 hours of a 3-day assessment period. If the patient performed or contributed to the performance of the IADL task during this period (meal preparation, medication management, etc) this performance should be considered when coding. However, be aware that a patient's partial involvement in an activity in the last 24 hours may not necessarily express that patient's full capacity to perform the task.

For example: A patient may have performed part of the medication management with assistance from staff. Staff assistance may have been provided because medication containers are different than what the patient was used to at home. The patient states that within the last 24 hours, he or she could have performed the medication task if he or she had been in his or her own home. In fact, the patient had been independent prior to admission, and there have been no cognitive or functional changes that might cause you to call the patient's judgement into question. The assessor would code E4d as ''0'' Independent.

In talking to the patient, you are both involved in a process of speculation about IADL activities that did not occur at the facility, leading to the assessor's active coding decision.

Definition: a. Meal preparation—How meals are prepared (for example, planning meals, assembling ingredients, cooking, setting out food and utensils.)

b. Managing finances—Paying for newspaper or TV service, using the cafeteria.

c. Phone Use—How telephone calls are made or received (using assistive devices such as large numbers on the telephone, voice amplification as needed.)

d. Medication Management—How medications are managed (for example, remembering to take medications, opening bottles, taking correct dosage of pills, filling syringe, giving injections, applying ointments.)

e. Stairs—How moves up and down stairs (for example, one flight of steps, using handrails as needed.)

f. Car Transfer—How patient moves in and out of a car. Includes opening door, sitting, and rising from seat.

Coding: CAPACITY TO PERFORM INSTRUMENTAL ACTIVITIES OF DAILY LIVING—If patient had been required to carry out the activity as independently as possible, SPECULATE AND CODE for what you would consider the patient's capacity (ability) would have been to perform the activity in the last 24 hours of the 3-day assessment period.

0. Independent—Would have required no help, setup or supervision.

1. Setup Help Only—Would have required help that would have been limited to providing or placing an article/device within reach of the patient; all other tasks would have been performed by the patient on his or her own.

2. Supervision—Would have required oversight, encouragement or cuing.

3. Limited Assistance—On some occasion(s) could have done on own, other times would have required help.

4. Moderate Assistance—While patient could have been involved, would have required presence of helper at all times, and would have performed 50% or more of subtasks on own.

5. Maximal Assistance—While patient could have been involved, would have required presence of helper at all times, and would have performed less than 50% of all subtasks on own.

6. Total Dependence—Full performance of the activity by other person would have been required at all times (no residual capacity exists).

5. IADL Areas Now More Limited

Intent: In this item the assessor compares the patient's current capacity to perform IADLs to self performance with IADLs prior to the precipitating event (Item A7a).

Process: Compare all the IADL capacity self performance area codes (for Items E4a–f) to the patient's function prior to the precipitating event. Determine the overall number of IADL areas that the patient is now more limited in.

Coding: Code for the most appropriate category.

0. None.

1. Some (1–3 IADL areas).

2. All or most (4–6 IADL areas).

6. Devices/Aids

Intent: To record the type of appliances, aids, or assistive devices the patient used over the last 3 days.

Definition: Locomotion Devices

a. Cane/crutch—A cane is a slender stick held in the hand and used for support during walking. Includes 3 or 4 prong canes. A crutch is a device for aiding a patient with walking. Usually it is a long staff with padded crescent-shaped portion at the top that is placed under the armpit.

b. Walker—A mobile device used to assist a patient with walking. Usually consists of a stable platform made of metal tubing that the patient grasps while taking a step. The patient then moves the walker forward and makes another step. Also check this item in those instances where the patient walks with a wheelchair or Meri-Walker for support. [For Meri-Walkers, if the patient is standing most of the time in the Meri-Walker and using it as a walker, code as a walker—if the patient sits in the Meri-Walker most of the time—code it as a wheelchair.]

c. Wheelchair/scooter—Includes use of a hand-propelled wheelchair as well as motorized chair or scooter, includes wheeling self and being wheeled by others.

Other Aids

d. Adaptive eating utensil—A device that is specially designed to help the patient be independent in eating. Some examples are, built-up spoon, rocker knife, plate guard, special mug.

e. Mechanical lift—A mechanical device such as a Hoyer lift, used to lift a patient.

f. Orthotics/prosthesis—An orthotic is a device added to the upper or lower extremities to stabilize or immobilize present deformity, protect against injury, or assist with function (for example, arm sling, finger splint). A prosthesis is a replacement of a missing body part by an artificial substitute, such as an artificial extremity. A device of a natural function.

g. Postural support (while sitting)—A device (pads, pillows, boards) used to maintain the patient's position while in a chair or wheelchair.

h. Slide Board—A flat surfaced board (usually polished to a smooth finish) used to help a patient transfer from bed to chair or chair to bed.

i. Other Adaptive Devices—Include assistive/adaptive devices such as trapezes, braces.

j. NONE OF THE ABOVE.

Process: Observe, interview patient or staff.

Coding: Check all that apply.

7. Stamina

Intent: Moderate physical activity in connection with activities of everyday life or chosen activities can help to keep patients fit in many ways. Below a certain threshold of activity, functional decline may be accelerated. Activities can include domestic IADLs (for example, light housework), or chosen physical activities (for example, recreation, going out to shop or walk).

It is necessary to understand if the patient is motivated, what the patient's needs may be, what barriers need to be overcome, and whether health education is needed.

Many people are interested in maintaining health. They usually know that lifestyle practices may be important, but they often need concrete information about how important their own life style is for health maintenance. For example, the patient may understand questions on walking and eating, but may not be willing to take corrective action.

Definition: Hours of physical activity at two points in time—examples of physical activity include exercise, therapy sessions, walking, house cleaning, grocery shopping: (A) in last 24 hours and (B) immediately prior to precipitating event (A7a).

Process: Talk to the patient and family members if required. In assessing patient self-involvement, confirm patient stamina estimates. Talk to staff. Determine performance in last 24 hours and prior to precipitating event (Item A7a) and code accordingly.

Coding: Note—Item E7 has two coding columns, Column A and Column B.

0. None.
1. Less than one hour per day.
2. 1 to 2 hours per day.
3. 2+ to 3 hours per day.
4. 3+ to 4 hours per day.
5. More than 4 hours per day.

8. Walking and Stair Climbing

Intent: Walking is a crucial activity when considering a discharge back to the community. The interdisciplinary team members need current information about the patient's walking ability. This knowledge will help the team in devising an accurate service delivery and care plan resulting in an expeditious and coordinated discharge home.

CODE for walking or stair climbing episode that represents the most consistent pattern over the last 24 hours of the 3-day assessment period (includes episodes during therapy, activities, etc.)

Process: Observe the patient and interview staff.

Coding: a. Farthest distance walked without sitting down.

0. 150+ feet.
1. 51–149 feet.
2. 25–50 feet.
3. 10–24 feet.
4. Less than 10 feet.
8. ACTIVITY DID NOT OCCUR.

b. Walking support provided.

0. None.
1. Set up help only.
2. Supervision.
3. One person physical assistance.
4. Two+ person physical assistance.
8. ACTIVITY DID NOT OCCUR.

c. Stair climbing.

Intent: This item gives an indication of the patients stamina as measured by stair-climbing activity.

Process: Talk with the patient and family member if necessary. Consult with therapy staff who have observed or assisted the patient in stair climbing activity in the last 24 hours.

Definition: A full flight of stairs consists of 12–14 stairs (steps). A partial flight of stairs consists of 4 to 6 stairs (steps).

Coding: Code for the most dependent episode of stair climbing activity when the activity attempted in the last 24 hours. Note: There are only three possible codes when the patient does 4–6 stairs (steps) only (code—2, 5, 6).

0. Complete Independence—Up and down full flight of stairs with NEITHER physical help NOR support device.

1. Modified Independence—Up and down full flight of stairs with NO physical help and any of following:

Use of one or more supportive devices (support devices includes the required use of hand rails).

OR Use of an appliance (that is, cane, brace, prosthesis, walker).

OR Excessive time to climb the stairs (3 or more times normal).

2. Supervision—Up/down full flight of stairs with supervision or cuing–OR–up and down partial flight with NO physical help (device may or may not be used).

3. Minimal Assistance—Contact guard/steadying/assistance to go up/down full flight of stairs.

4. Moderate Assistance—Some weight bearing help to go up/down full flights of stairs, patient does most on own.

5. Maximal Assistance—Patient had limited involvement in going up/down full flight of stairs, staff perform more than 50% of effort–OR–receives physical help on partial flight of stairs.

6. Total Assistance—Did not go up/down 4–6 stairs (OR has 2-person assist) OR totally dependent.

8. Activity did not occur in last 24 hours.

9. Balance Related to Transitions

Intent: Balance is a key component of a patient's ability to transfer from standing to seated position and from seated to standing position. Problems with stability involve provision of support (either staff member or device) to ensure a safe transfer. It is important to assess a person's ability to balance in order that interventions (strength training exercises, safety awareness, restorative nursing, nursing-based rehabilitation) can be implemented to prevent injuries and foster increased independence in the patient.

Process: Over the last 24 hours, assess how the patient: transfers from seated to standing position, or turns and faces the opposite direction. Because this assessment is to be based on the most dependent episode over the last 24 hours, base both on your own observations and reports of staff.

Definition: a. Moved from seated to standing position.

b. (While standing) turned around and faced the opposite direction.

Coding: Code for the most dependent in the last 24 hours.

0. Smooth transition; stabilizes without assistance.

1. Transition not smooth, but able to stabilize without assistance.

2. Transition not smooth, unable to stabilize without assistance.

8. ACTIVITY DID NOT OCCUR.

10. Neuro-musculo-skeletal Impairment

Process: Review the patient's record for documentation of impairment of this type. An obvious example of a patient with this problem is someone who is comatose. Other patients at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new safety pin or wooden ''orange stick'' (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.
- Do not use pins with agitated or restless patients. Abrupt movements can cause injury.
- Ask the patient to close his or her eyes. If the patient cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
- Lightly press the pointed end of the pin or stick against the patient's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the patient's arms, trunk, and legs. Ask the patient to report if the sensation is ''sharp'' or ''dull.''
- Compare the sensations in symmetrical areas on both sides of the body.
- If the patient is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.

• For patients who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (for example, wincing, grimacing, surprise), body motions (for example, pulling the limb away, pushing the examiner) or sounds (for example, ''Ouch!'') to determine if they can feel pain.

Definition: a. Leg (hip, knee, ankle, foot).

b. Arm (shoulder, elbow, wrist, hand).

c. Trunk and neck.

Coding: Code for the most limited in the last 24 hours.

A. Joint mobility/range of motion at joints listed (code for most impaired joint).

0. No impairment.

1. Impairment on one side.

2. Impairment on both sides.

B. Voluntary motor control (active, coordinated, purposeful movement—code for most dependent joint).

0. No loss.

1. Partial loss on one side.

2. Partial loss both sides.

3. Full loss one side.

4. Full loss both sides.

C. Intact touch/sensation on extremity (tactile sense) (Use same codes as E10B).

0. No loss.

1. Partial loss on one side.

2. Partial loss both sides.

3. Full loss one side.

4. Full loss both sides.

Section F. Bowel/Bladder Management

1. Bladder Continence

Intent: To describe the patient's pattern of bladder continence (control) over the last 7–14 days, and to compare current continence status to status prior to the current event which precipitated this post-acute stage. This information is key in care planning for incontinence.

Definition: Bladder Continence—Refers to control of urinary bladder function. This item describes the patient's bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the patient's ability to toilet self—for example, a patient can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The patient's self-performance in toilet use is recorded in Item E1h.

Process: Complete your review in the following order. Remember to consider continence patterns over the last 7–14 day period, 24 hours a day, including weekends.

(1) Review the patient's clinical record and any urinary elimination (bladder) flow sheets (if available).

(2) Validate the accuracy of written records with the patient. Make sure that your discussions are held in private. Control of bladder function is a sensitive subject, particularly for patients that are struggling to maintain control. Many people with poor control problems will try to hide their problems out of embarrassment or fear of retribution. Others will not report the problem to staff because they mistakenly believe that incontinence is a natural part of aging or certain disease processes and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many patients are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

(3) Validate continence patterns with people who know the patient well (for example, primary family member of a newly admitted patient, or direct care staff).

(4) When the information you have received is inconsistent and particularly if the staff report incontinence that is not reported by the patient, review for physical indications that the patient is in fact incontinent. This could include being present at scheduled toileting intervals, observing clothing, bed clothes, etc.

a. Control of urinary bladder function—(if patient dribbles, volume insufficient to soak through undergarments).

Coding: Choose the response that best reflects the patient's level of bladder continence in the last 7–14 days.

Code for the patient's actual bladder continence pattern—that is, the frequency with which the patient is wet and dry during the 7–14 day assessment period. Do not record the level of control the patient might have achieved under optimal circumstances. For bladder continence the difference between a ''5'' (Frequently Incontinent) and a ''6'' (Incontinent) is determined by the presence (''5'') or absence (''6'') of any bladder control.

0. Continent—Complete control; does not use any type of catheter or other urinary collection device.

1. Continent with Catheter—Complete control with any use of any type of catheter or urinary collection device that does not leak urine.

2. Biweekly Incontinence—Incontinent episodes less than once a week (that is, once in last 2 weeks).

3. Weekly Incontinence—Incontinent episodes once a week.

4. Occasionally Incontinent—Incontinent episodes 2 or more times a week, but not daily.

5. Frequently Incontinent—Tended to be incontinent daily, but some control present (that is, on day shift).

6. Incontinent—Has inadequate control of bladder, multiple daily episodes all or almost all of the time.

8. DID NOT OCCUR—No urine output from bladder.

b. Is now more impaired in bladder incontinence then was prior to precipitating event (item A7a).

Coding: 0. No, or unsure.

1. Yes, more impaired today.

2. Bladder Appliance.

Definition: a. External catheter (condom catheter)—A urinary collection appliance worn over the penis.

b. Indwelling catheter—A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. This item includes catheters inserted through the urethra or via supra-pubic incision.

c. Intermittent catheterization—A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the patient. Catheterization may occur as one-time event (for example, to obtain a sterile specimen) or as part of a bladder emptying program (for example, every shift in a patient with an underactive or a contractile bladder muscle).

d. Medications for control—medications administered to the patient for the purpose of improving control of the bladder.

e. Ostomy—Any type of ostomy of the urinary tract.

f. Pads, briefs—Any type of absorbent disposable or reusable undergarment or item, whether worn by the patient (for example, diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads when a patient is never or rarely incontinent.

g. Urinals, bedpan—A urinal is a container into which a patient urinates. A bedpan is a pan-shaped device placed under a patient for collecting urine (and feces)

Process: Consult with the nursing staff and the patient. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (for example, pads or briefs). If necessary, check the clinical record.

Coding: Code for the last 24 hours.

0. No.

1. Yes.

3. Bladder Appliance Support

Intent: This item is designed to identify the type of assistance or support a patient needs in order to use any of the bladder appliances listed in F2.

Coding: Code for the level of bladder appliance support provided to the patient in the last 24 hours.

0. No appliances (in item F2).

1. Use of appliances, did not require help or supervision.

2. Use of appliances, required supervision or set up.

3. Minimal contact assistance (light touch only).

4. Moderate assistance—patient able to do 50% or more of subtasks involved in using equipment.

5. Maximal assistance—patient able to do 25–49% of all subtasks involved in using equipment.

6. Total dependence—patient requires assistance in all subtasks involved in using bladder equipment.

4. Bowel Continence

Process: The assessment for bowel continence should be completed simultaneously with the bladder continence review. This will thus include a review of the patient's clinical record and any bowel records (if available). Validate the accuracy of written records with the patient. Make sure that your discussions are held in private. Control of bowel function is a sensitive issue. Be sure to ask about the nature of the problem in a sensitive, straightforward manner.

• Validate continence patterns with people who know the patient well (for example, primary family member of newly admitted patient, direct care staff).

• Remember to consider continence patterns over the last 7–14 day period, 24 hours a day, including weekends.

Coding: Code for bowel continence over the last 7–14 days.

0. Continent—Complete control, does not use ostomy device.

1. Continent with Ostomy—Complete control with use of ostomy device that does not leak stool.

2. Biweekly Incontinence—Incontinent episodes less than once a week (that is, once in last two weeks).

3. Weekly Incontinence—Incontinent episodes once a week.

4. Occasionally Incontinent—2 to 3 times a week.

5. Frequently Incontinent—4+ times a week but not all of the time.

6. Incontinent—All of the time.

8.DID NOT OCCUR—No bowel movement during the entire 14-day assessment period.

5. Bowel Appliances

Definition: a. Bedpan—A bedpan is a pan-shaped device placed under a patient for collecting feces (and urine).

b. Enema—Introduction of solutions into the rectum and colon in order to stimulate bowel activity and to cause emptying of the lower intestine.

c. Medication for control—Medications administered to the patient for the pupose of improving control of the bowels. These medications can include laxatives, stool softeners, stimulants as well as anti-diarrheal preparations.

d. Ostomy—Any type of ostomy of the gastrointestinal tract.

Coding: Code for use of bowel appliances for the last 3 days.

0. No.

1. Yes.

6. Bowel Appliance Support

Intent: This item is designed to identify the type of assistance or support a patient needs in order to use any of the bowel appliances listed in F5.

Coding: Code for the level of bowel appliance support provided to the patient in the last 24 hours.

0. No appliances (in item F5).

1. Use of appliances, did not require help or supervision.

2. Use of appliances, required supervision or set up.

3. Minimal contact assistance (light touch only).

4. Moderate assistance—patient able to do 50 percent or more of subtasks involved in using equipment.

5. Maximal assistance—patient able to do 25–49 percent of all subtasks involved in using equipment.

6. Total dependence—patient requires assistance in all subtasks involved in using bowel equipment.

Section G. Diagnoses

1. Impairment Group

Intent: This item identifies the Impairment Group that best describes the primary reason for admission to the rehabilitation program.

Process: Consult with attending physician.

Coding: Each Impairment Group has been assigned a two-digit ID number, a decimal point, and a unique number (from one to four digits) for the subgroups. Code for the major diagnostic category of the patient by selecting the Impairment Group which best describes the condition requiring admission to rehabilitation. Then select a subgroup, if appropriate. Code as specifically as possible.

REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES

Rehabilitation impairment category	Associated impairment group codes
01 Stroke (Stroke)	01.1 Left body involvement (right brain). 01.2 Right body involvement (left brain). 01.3 Bilateral Involvement. 01.4 No Paresis. 01.9 Other Stroke.
02 Traumatic brain injury (TBI)	02.21 Open Injury. 02.22 Closed Injury.
03 Nontraumatic brain injury (NTBI)	02.1 Non-traumatic. 02.9 Other Brain.
04 04 Traumatic spinal cord (TSCI)	04.210 Paraplegia, Unspecified. 04.211 Paraplegia, Incomplete. 04.212 Paraplegia, Complete. 04.220 Quadriplegia, Unspecified. 04.2211 Quadriplegia, Incomplete C1–4. 04.2212 Quadriplegia, Incomplete C5–8. 04.2221 Quadriplegia, Complete C1–4. 04.2222 Quadriplegia, Complete C5–8. 04.230 Other traumatic spinal cord dysfunction.
05 Nontraumatic spinal cord (NTSCI)	04.110 Paraplegia, unspecified. 04.111 Paraplegia, incomplete. 04.112 Paraplegia, complete. 04.120 Quadriplegia, unspecified. 04.1211 Quadriplegia, Incomplete C1–4. 04.1212 Quadriplegia, Incomplete C5–8. 04.1221 Quadriplegia, Complete C1–4. 04.1222 Quadriplegia, Complete C5–8. 04.130 Other non-traumatic spinal cord dysfunction.
06 Neurological (Neuro)	03.1 Multiple Sclerosis. 03.2 Parkinsonism. 03.3 Polyneuropathy. 03.5 Cerebral Palsy. 03.8 Neuromuscular Disorders. 03.9 Other Neurologic.
07 Fracture of LE (FracLE)	08.11 Status post unilateral hip fracture. 08.12 Status post bilateral hip fractures. 08.2 Status post femur (shaft) fracture. 08.3 Status post pelvic fracture.
08 Replacement of LE joint (ReplLE)	08.51 Status post unilateral hip replacement. 08.52 Status post bilateral hip replacements. 08.61 Status post unilateral knee replacement. 08.62 Status post bilateral knee replacements. 08.71 Status post knee and hip replacements (same side). 08.72 Status post knee and hip replacements (different sides).
08 Other orthopedic (Ortho)	08.9 Other orthopedic.

REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES—Continued

Rehabilitation impairment category	Associated impairment group codes
10 Amputation, lower extremity (AMPLE)	05.3 Unilateral lower extremity above the knee (AK). 05.4 Unilateral lower extremity below the knee (BK). 05.5 Bilateral lower extremity above the knee (AK/AK). 05.6 Bilateral lower extremity above/below the knee (AK/BK). 05.7 Bilateral lower extremity below the knee (BK/BK).
11 Amputation, other (AMP–NLE)	05.1 Unilateral upper extremity above the elbow (AE). 05.2 Unilateral upper extremity below the elbow (BE). 05.9 Other amputation.
12 Osteoarthritis (OsteoA)	06.2 Osteoarthritis.
13 Rheumatoid, other arthritis (RheumA)	06.1 Rheumatoid Arthritis. 06.9 Other arthritis.
14 Cardiac (Cardiac)	09 Cardiac.
15 Pulmonary (Pulmonary)	10.1 Chronic Obstructive Pulmonary Disease. 10.9 Other pulmonary.
16 Pain Syndrome (Pain)	07.1 Neck pain. 07.2 Back pain. 07.3 Extremity pain. 07.9 Other pain.
17 Major multiple trauma, no brain injury or spinal cord injury (MMT–NBSCI).	08.4 Status post major multiple fractures. 14.9 Other multiple trauma.
18 Major multiple trauma, with brain or spinal cord injury (MMT–BSCI).	14.1 Brain and spinal cord injury. 14.2 Brain and multiple fractures/amputation. 14.3 Spinal cord and multiple fractures/amputation.
19 Guillian Barre (FB)	03.4.
20 Miscellaneous (Misc)	*12.1 Spina Bifida. 12.9 Other congenital. 13 Other disabling impairments. 15 Developmental disability. 16 Debility. 17 Infection. 17.2 Neoplasms. 17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition. 17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition. 17.4 Circulatory disorders. 17.51 Respiratory disorders—Ventilator Dependent. 17.52 Respiratory disorders—Non-ventilator Dependent. 17.6 Terminal care. 17.7 Skin disorders. 17.8 Medical/Surgical complications. 17.9 Other medically complex conditions.
21 Burn (Burns)	11 Burns.

We are in the process of anayzing the effect of moving the few cases within this impairment category to one of the other spinal cord RICs (either 05 or 04 depending upon the ''fit'').

2. Other Diseases

Intent: To document the presence of diseases that have an impact or potential impact on the patient's overall function (physical, cognitive, mood and behavioral), treatment or discharge plans.

Definition: ENDOCRINE

a. Diabetes Mellitus 250.00—Any of several metabolic disorders characterized by abnormal insulin secretion and elevated blood glucose levels. Category includes insulin-dependent diabetes mellitus (IDDM) as well as other types (for example, non-insulin dependent diabetes mellitus [NIDDM], adult onset diabetes mellitus [AODM], gestational diabetes, and diabetes associated with particular conditions or medications).

b. Hypothyroidism 244.9—Under-activity of the thyroid gland (insufficiency of thyroid hormone) resulting in a decrease in the basal metabolic rate.

HEART/CIRCULATION

c. Cardiac arrhythmias 427.9—A disturbance in the cardiac electrical conduction system resulting in irregularities in heart rate and rhythm.

d. Congestive heart failure 428.0—A dysfunction that occurs when cardiac output is insufficient to meet the person's metabolic demands.

e. Coronary artery disease (CAD) 746.85—A narrowing of one or more of the coronary arteries by atherosclerotic plaque or vascular spasm; results in a decrease in oxygenated blood flow (ischemia) to the heart. Usually associated with angina.

f. Deep vein thrombosis 451.1—A condition in which a blood clot (thrombus) is formed in the deeper/larger veins, usually in the lower extremities.

g. Hypertension 401.9—A persistent elevation of systolic or arterial blood pressure. This category includes primary (essential) and secondary hypertension.

h. Hypotension 458.9—An absolute systolic blood pressure value of less than 90 mm Hg (or a decline of 20 mm Hg or greater in systolic blood pressure from the person's usual baseline, or a decline of 10 mm Hg or greater in diastolic blood pressure from the person's usual baseline). This category also includes orthostatic hypotension (a reduction ≥ 20 mm Hg in systolic blood pressure upon standing).

i. Peripheral vascular disease (arteries) 443.9—A variety of syndromes that result in decreased blood flow in the peripheral arterial vessels, usually of the lower extremities. This category includes arteriosclerosis obliterans, small vessel syndrome, Raynaud's phenomenon, arterial aneurysms (for example, thoracic, abdominal, popliteal), and temporal arteritis. Do not include deep vein thrombosis in this category; if present, use item G2f.

j. Post Acute MI (within 30 days) 410.92—The immediate period following the necrosis of myocardial tissue resulting from obstruction of a coronary artery.

k. Post heart surgery (for example, valve, CABG) V45.81—Cardiovascular surgery such

as percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), valve replacement, percutaneous balloon valvuloplasty.

l. Pulmonary embolism 415.1—Obstruction of one or more of the pulmonary arteries by a thrombus (blood clot).

m. Pulmonary failure 518.8—Failure of the respiratory system to meet oxygenation needs (severe hypoxemia).

n. Other cardiovascular disease 429.2—Any other cardiac diagnosis not coded elsewhere in Section G (for example, valvular heart disease).

MUSCULOSKELETAL

o. Fracture—hip V43.64—Hip fracture (for example, femoral neck; intertrochanteric; subcapital) that has been repaired via surgical arthroplasty or internal fixation. Category also includes fractures treated with traction that may have involved the surgical placement of pins. Also includes surgical hip replacement (for example, total or hemiarthroplasty) following fracture of the hip (for example, femoral neck; intertrochanteric; subcapital fractures, etc). Hips stabilized via open reduction and internal fixation (ORIF) with pins or screws would be included in this item.

p. Fracture—lower extremity 812.40—Any fracture of the lower extremity, other than hip fracture. Includes surgically and non-surgically treated fractures. Category does not include pathological fractures of the lower extremity; if the patient has a diagnosis of pathologic bone fracture of the lower extremity, code item G4.

q. Fracture(s)—other 829.0—Any other fracture type or location not captured in Section G.

r. Osteoarthritis 715.90—A progressive degenerative disease of joint cartilage and bone characterized by joint pain; may be accompanied by joint deformity and limitation of movement.

s. Osteoporosis 733.00—A metabolic bone disorder characterized by a loss of bone density resulting in weakened bones and susceptibility to fractures.

t. Rheumatoid Arthritis 714.0—A progressive degenerative joint disease characterized by recurrent inflammation of synovial tissue and joint deformities.

NEUROLOGICAL

u. Alzheimer's disease 331.0—A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

v. Aphasia or Apraxia (784.3, 784.69)—Symptoms of neurological defects characterized by a difficulty or inability to express thoughts (in speech or writing) or comprehend language (aphasia), or a difficulty/inability to carry out purposeful movements or use objects properly due to a failure to identify them or understand their meaning (apraxia).

w. Cerebral Palsy 343.9—A group of nonprogressive muscular and motor disorders secondary to a neurological defect or trauma at birth.

x. Dementia other than Alzheimer's disease 290.0—Includes diagnosis of organic brain syndrome (OBS) or Chronic Brain Syndrome (CBS), senile dementia, multi-infarct dementia, and dementia related to other neurological diseases other than Alzheimer's Disease (for example., Picks, Creutzfeld-Jacob, Huntington's Disease).

y. Hemiplegia/hemiparesis left side 342.90—Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on left side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

z. Hemiplegia/hemiparesis right side 342.90—Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on right side of body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

aa. Multiple sclerosis 340—A progressive central nervous system disease characterized by demyelination in brain and spinal cord resulting in various neurological symptoms (for example, paresthesias; motor disorders; diplopia or blindness; urinary incontinence); usually involves recurrent exacerbations and remissions.

ab. Parkinson's Disease 332.0—A progressive disease affecting the centers of the brain responsible for control and regulation of movement.

ac. Quadriplegia 344.00–344.09—Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of quadriplegia in the patient's record.

ad. Seizure Disorder 780.39—Disorder of cerebral function characterized by sudden attacks of altered consciousness, sensory changes, motor activity, or inappropriate behavior. May be focal (localized) or generalized.

ae. Spinal cord dysfunction—non-traumatic 336.9—A non-traumatic disorder affecting the spinal cord (for example, neoplasm; abscess; hematoma; neurologic manifestations of pernicious anemia; spina bifida); may be associated with pain, sensory impairment, abnormal reflexes, motor dysfunction.

af. Spinal cord dysfunction—traumatic 952.9—Alteration of neurological function (for example, motor, sensory, reflexes) secondary to compression or laceration of the spinal cord.

ag. Stroke (CVA) 436—A vascular insult to the brain that may be caused by intracranial bleeding, stenosis, thrombosis, infarcts, or emboli; may result in permanent neurological and physical dysfunction.

PSYCHIATRIC/MOOD

ah. Anxiety Disorder 300.00—A disorder characterized by prominent symptoms of anxiety or phobic avoidance. This category includes generalized anxiety disorder, panic disorder, phobias, obsessive-compulsive disorder, post-traumatic stress disorder, acute distress disorder, and other anxiety disorders (for example, due to general medical condition; substance-induced).

ai. Depression 311—A mood disorder often characterized by a depressed mood (for example, feels sad or empty; appears tearful), decreased ability to think or concentrate, loss of interest or pleasure in usual activities, insomnia or hypersomnia, loss of energy, change in appetite, feelings of hopelessness or worthlessness or guilt. May include thoughts of death or suicide.

aj. Other psychiatric disorders 300.9—Other diagnosed psychiatric disorders not coded elsewhere on this assessment (for example, psychotic disorders, such as anorexia, bulimia; eating disorders).

PULMONARY

ak. Asthma 493.9—Intermittent periods of wheezing and dyspnea as a result of variable and recurring airway obstruction.

al. COPD 496—A group of conditions resulting in generalized airway obstruction (particularly the small airways) associated with varying combinations of asthma, chronic bronchitis, and emphysema. May also be called COLD (chronic obstructive lung disease). This category also includes chronic restrictive lung diseases such as asbestosis.

Note: Do not code asthma or emphysema in this category if either of these are the patient's definitive diagnoses. If asthma only is present, code in item G2ak. If emphysema only is present, code in item G2am.

am. Emphysema 492.8—A specific chronic obstructive pulmonary disease which is characterized by destructive changes in the alveoli which reduce the surface area for gas exchange.

OTHER

an.Cancer 199.1—A diagnosis of a carcinoma characterized by a localized malignant tumor or abnormal cell growth that has not spread to other areas or systems of the body. This category also includes metastatic cancer—a diagnosis of a carcinoma characterized by a malignant tumor or abnormal cell growth that has spread to other areas or systems of the body.

ao. Post surgery-non-orthopedic, non-cardiac V50.9—Status post any surgical procedure not noted in Section G.

ap. Renal Failure 586—Derangement and insufficiency of renal excretory and regulatory function. This category includes acute (ARF) and chronic renal failure (CRF).

aq. NONE OF THE ABOVE

Process: Review patient's current medical record (including current physician treatment orders and nursing care plans), referral information and hospital discharge summary. If the patient was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD–9–CM codes that were current during the hospital stay. If these diagnoses are still present, record them using the appropriate code to categorize the nature of the patient's treatment regimen.

There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, accept statements by the patient that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

For example: If a new patient reports that he or she had a severe depression and was

seeing a private psychiatrist in the community, this information may not have been documented in records accompanying the patient from an acute care hospital to the post acute setting.

Physician involvement in this part of the assessment process would be beneficial. The physician can be asked to review the items in Section G at the time of visit closest to the scheduled MDS–PAC assessment. Use this scheduled visit as an opportunity to ensure that ''active'' diagnoses are noted and ''inactive'' diagnoses are appropriately designated. This is also an important opportunity to share the entire assessment with the physician. It is the responsibility of clinical staff to solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, share this section of the assessment with the physician and ask for his or her input.

Full physician review of the most recent assessment or ongoing input into the assessment currently being completed can be very useful to overall care planning. For the physician, the assessment completed by clinical staff can provide insights that would have otherwise not been possible. For clinical staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional consultation and follow-up.

Record a diagnosis only if the disease is being treated or monitored; or has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, do not place a code for item G2g (hypertension) if one episode occurred several years ago unless the hypertension is either currently being controlled with drug therapy, diet, biofeedback, etc., or is being regularly monitored for recurrence. Likewise gallbladder surgery that occurred 15 years ago would not be recorded in item G2ao (Post surgery—non-orthopedic, non-cardiac) unless it had a relationship to the patient's current health status.

Coding: Record all documented diagnoses in the appropriate category. Do not record any conditions that have been resolved and no longer affect the patient's functional status or care plan—leave the box blank. For each item that is present enter the most appropriate code to describe the patient's documented diagnosis.

[Blank] Not present.

1. Other primary diagnosis/diagnoses for current stay (not primary impairment). These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (for example, drug therapy; therapeutic rehabilitation services; laboratory monitoring); other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning).

3. Diagnosis present, patient monitored but condition is not being actively treated.

If none of the conditions in Section G2 apply, check NONE OF ABOVE (G2aq). If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section G2, record the general diagnosis in Section G2 and then enter the more detailed diagnosis (with ICD–9–CM code) under Section G4.

3. Infections

Intent: To document the presence of infections that have an impact or potential impact on the patient's overall function (physical, cognitive, mood and behavioral), treatment and/or discharge plans.

a. Antibiotic resistant infection—any infection in which the bacteria have developed a resistance to the effective actions of an antibiotic (for example, Methicillin resistant staphylococcus aureus [MRSA 041.11], Vancomycin-resistant enterococcus [VRE 041.9]).

b. Cellulitis 682.9—inflammation of cellular or connective tissue, spreading as in erysipelas. The process of inflammation spreading throughout the tissue is called cellulitis.

c. Hepatitis 070.9—an inflammatory process in the liver usually caused by viral infection. This category includes acute and chronic viral hepatitis.

d. HIV/AIDS 042—Code this item only if—(A) there is supporting documentation in the medical record of (1) a positive blood test result for the Human Immunodeficiency Virus (HIV), or (2) a diagnosis of Acquired Immuno-deficiency Syndrome (AIDS), or (3) a diagnosis of AIDS-related complex (ARC); or (B) if the patient (or surrogate decision-maker) informs you of the presence of any of these diagnoses.

e. Pneumonia 486—an acute bacterial or viral infection of the lungs.

f. Osteomyelitis 730.2—an infection of bone, usually caused by bacteria or other pathogens. This category also includes infection of a surgically-implanted prosthesis.

g. Septicemia 038.9—clinical manifestations of bacterial infection of the circulatory system (bacteremia) associated with inadequate tissue perfusion (hypotension, renal failure and risk of death).

h. Staphylococcus infection (other than item ''G3a'' above) 041.10—any infection identified as staphylococcus by culture that is not considered to be resistant to antibiotic treatment.

i. Tuberculosis (active) 011.90—Diagnosis of active tuberculosis as evidenced by symptoms and/or currently receiving drug therapy (for example, isoniazid (INH), ethambutol, rifampin, cycloserine). Includes patients who have converted to PPD positive tuberculin status and are receiving drug treatment.

j. Urinary Tract Infection 599.0—includes chronic and acute symptomatic infection. Code only if there is supporting documentation or significant laboratory findings in the medical record, or the patient is currently being treated or evaluated for a UTI.

k. Wound Infection (958.3, 998.59, 136.9)—Category includes documentation of infection(s) of any type of wound (for example, surgical; traumatic; pressure ulcer) of any part of the body. Note: Report of wound culture may or may not be present in the medical record; diagnosis may be based on presence of drainage, erythema, edema, etc. around wound site.

l. NONE OF THE ABOVE.

Process: Review patient's medical record.

Coding: Record all documented diagnoses of infection(s) in the appropriate category. Do not record any conditions that have been resolved and no longer affect the patient's functional status or care plan—leave the box blank. For each item that is present enter the most appropriate code to describe the patient's documented diagnosis.

[Blank] Not present.

1. Other primary diagnosis/diagnoses for current stay. These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (drug therapy; therapeutic rehabilitation services; laboratory monitoring; other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning; respiratory therapy).

3. Diagnosis present, patient monitored but condition is not being actively treated.

If none of the conditions in Section G3 apply, check NONE OF ABOVE (G3l). If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section G3, record the general diagnosis in Section G3 and then enter the more detailed diagnosis (with ICD–9–CM code) under Section G4.

For example: If the medical record states that the patient has ''Pneumocystis carinii pneumonia'' record the nature of this diagnosis in item G3e (Pneumonia) and then record the more specific diagnosis and ICD–9–CM code in Section G4.

4. Other Current or More Detailed Diagnoses and ICD–9 Codes

Intent: To identify and document conditions not listed in Items G1, G2 and G3 that have an impact or potential impact on the patient's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, therapeutic rehabilitation, discharge plan or risk of death. Also, to record more specific designations for general disease categories listed in Sections G2 and G3.

Process: Review patient's current medical record, referral information and hospital discharge summary.

Coding: If the patient does not have any other or more detailed diagnoses documented, leave the boxes blank.

Enter the description of the diagnoses on the lines provided. For each diagnosis complete the following:

Write in diagnosis in lines ''a'' through ''e''.

Column A: enter the ICD–9–CM code for the diagnosis in the boxes, AND

Column B: enter the code (from the following codes) that best characterizes the diagnosis.

1. Other primary diagnosis/diagnoses for current stay (not primary impairment). These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (for example, drug therapy; therapeutic rehabilitation services; laboratory monitoring); other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning).

3. Diagnosis present, patient monitored but condition is not being actively treated.

Any new diagnosis at reassessment or discharge is to be recorded in G4.

5. Complications/Comorbidities

Intent: To identify and document comorbidities that may effect the patient's functional status or health.

Definition: ''Complications, comorbid conditions, and high-risk medical disorders may occur with any Impairment Group when the occurrence delays or compromises rehabilitation by:

Existing prior to the rehabilitation program.

Occurring or existing during the rehabilitation program.

Causing subject transfer to acute care.

Causing subject death during the rehabilitation program'' (Uniform Data System for Medical Rehabilitation, Guide for the Uniform Data Set for Medical Rehabilitation-Version 5.1, Appendix A: UDSmr Policy Regarding ICD–9 Coding, p. A19.) NOTE: HCFA has excluded from the definition of comorbidities the recording of diagnoses by Rehabilitation Impairment Category. For example, stroke is not a comorbidity for the stroke Rehabilitation Impairment Category, cardiac is not a comorbidity for the cardiac Rehabilitation Impairment Category. The ''Rehabilitation Impairment Categories and Associated Impairment Group Codes'' were discussed previously in this guide.

Process: Review the patient's medical record, referral information, hospital discharge summary, and consult with other clinical staff.

Coding: For the comorbidities to enter in lines G5a thru G5d including the ICD–9–CM codes refer to ''Appendix C: List of Comorbidities'' which is one of the appendixes of this proposed rule. If no comorbid condition exists write in the words ''No comorbid condition'' once and enter ''0000.00'' in the associated boxes.

Section H. Medical Complexities

Intent: To record clinical signs, symptoms, and conditions that affect or could affect the patient's health, functional, and psychosocial status and to identify risk factors for illness, accidents, and functional decline. Such factors need to be considered for treatment, rehabilitation, and discharge planning.

Definition: Medical complexities—include a number of indicators which help clinicians and others form a picture of the clinical intensity and level of service the patient receives in the post acute setting.

1. Vital Signs

Intent: To record the status of the patient's vital signs (that is, pulse; blood pressure; respiratory rate; temperature).

Definition: Abnormal vital signs—see ranges in box below.

Process: To interpret whether vital signs are within the range of ''normal'' usually requires an evaluation of several measurements rather than relying on a single value at one point in time. Therefore, review the results from the evaluation of the patient's vital signs over the past three days. In addition to reviewing vital signs, review the patient's clinical record, specifically, vital signs ''flow sheets'', and physician or nursing documentation in the medical record, referral sheet, or discharge summary.

Coding: Code for the ''most abnormal'' set of vital signs over the last 3 days.

0. All vital signs were normal/standard (that is, when compared to standard values).

1. Vital signs abnormal, but not on all days during assessment period.

2. Vital signs consistently abnormal (on all days).

2. Problem Conditions

Intent: To record clinical signs, symptoms, and conditions that affect or could affect the patient's health, functional, and psychosocial status and to identify risk factors for illness, accidents, and functional decline. Such factors need to be considered for treatment, rehabilitation, and discharge planning.

Process: Gather information from a variety of sources. Begin by reviewing the discharge referral record and current medical record, including laboratory data, consultation reports, and nursing observations. This will be the primary source of information. Check that it is complete by soliciting input from all members of the interdisciplinary team, including direct care providers (for example, certified nurse assistants). Finally, in your scheduled contact with the patient to assess other areas, interview, observe, and examine the patient to ensure nothing has been overlooked. Remember, you are reviewing problem conditions that have been present in the last 3 days.

Definition: FALLS/BALANCE

a. Dizziness/vertigo/lightheadedness—The patient has experienced the sensation of unsteadiness, that he or she is ''turning'', or that the surroundings are whirling/spinning around; or if the patient complained specifically of dizziness/vertigo/or lightheadedness in the last 3 days.

b. Fell (since admission or last assessment)—Patient/family reports or medical record or discharge summary indicates the patient fell since admission or since last assessment.

c. Fell in 180 days prior to admission—Patient/family reports or medical record or discharge summary indicates the patient fell in the 180 days prior to admission.

CARDIAC/PULMONARY

d. Advanced cardiac failure (ejection fraction <25 percent)—Check if EITHER documented cardiac disease with significant decrease in cardiac output (for example, documented ejection fraction <25 percent) in last 60 days OR diastolic dysfunction, as indicated by repeated episodes of heart failure with a normal ejection fraction).

e. Chest pain/pressure on exertion—The patient experiences any type of pain in the chest (or radiating to arm or jaw pain), which may be described as burning, pressure, stabbing, or discomfort, etc. associated with physical exertion.

f. Chest pain/pressure at rest—The patient experiences any type of pain in the chest (or radiating to arm or jaw pain), which may be described as burning, pressure, stabbing, or discomfort, etc. that starts spontaneously and without physical exertion (at rest).

g. Edema-generalized—Generalized abnormal pooling or accumulation of fluid in tissues throughout the body (not limited to specific site).

h. Edema-localized—Abnormal pooling or accumulation of fluid in specific tissues (for example, pedal edema; lymphedema of upper extremity).

i. Edema-pitting—Abnormal pooling or accumulation of fluid in tissues. Assessed by pressing the patient's skin firmly with the thumb for at least five seconds behind the medial malleolus, dorsum of the foot, or over the shin. If present, a ''thumb print'' will remain over the area of edema.

j. Impaired aerobic capacity/endurance (tires easily, poor task endurance)—A symptom characterized by a limited ability to sustain a period of exercise or exertion due to decreased cardiac or respiratory function (may be as a result of disease or deconditioning).

FLUID STATUS—It is often difficult to recognize when a frail, ill person is experiencing fluid overload that could precipitate congestive heart failure, or alternatively dehydration. Ways to monitor the problem, particularly in patients who are unable to recognize or report the common symptoms of fluid variation, are as follows:

k. Constipation—The patient passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

l. Dehydrated: output exceeds input (for example, BUN/creatinine ratio >25)—check this item if the patient's laboratory results reveal a blood urea nitrogen (BUN) to creatinine ratio greater than 25 OR if the patient has 2 or more of the following indicators.

- Patient's fluid intake is less than 2500 ml of fluids daily (water or liquids in beverages, water in food/supplements/parenteral nutrition, IV fluids).
- Patient has clinical signs of dehydration (for example, dry mucous membranes, decrease in skin elasticity).
- Patient's fluid loss exceeds the amount of fluids he or she takes in (for example, loss from vomiting, fever, diarrhea that exceeds fluid replacement)—review the Input and Output record;

m. Diarrhea—Frequent elimination of watery stools from any etiology (for example, diet, viral or bacterial infection).

n. Internal bleeding—Includes gastrointestinal and other types of intestinal bleeding. Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools); any documented bleeding as diagnosed by GI evaluation or any evidence of current bleeding through rectal exam or guaiac testing. Could also include: hematuria (blood in urine); hemoptysis (coughing up blood); or severe epistaxis (nosebleed), etc. present over the last 3 days that did not spontaneously resolve or that occurred more than once.

o. Recurrent nausea/vomiting—Patient reports recurrent (more than one episode) sensations of having to vomit or actual regurgitation of stomach contents; code regardless of etiology (for example, drug side effect or toxicity; influenza; anxiety; obstruction; reaction to particular odors or sights).

p. Refusal/inability to take liquids orally—Patient either rejects intake of fluids (for example, liquids, jello, sorbets, etc.) as a conscious decision or pushes them away, OR has a physical condition that inhibits intake of oral liquids (for example, nausea/vomiting; dysphagia; severe candidiasis of oral mucosa, etc.).

OTHER

q. Delusions/Hallucinations—Delusions are fixed, false beliefs not shared by others that the patient holds even when there is obvious proof or evidence to the contrary (for example, belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the hospital/facility is poisoned).

Hallucinations are false perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (for example, hearing voices), visual (for example, seeing people, animals), tactile (for example, feeling bugs crawling over skin), olfactory (for example, smelling fumes), or gustatory (for example, having strange tastes).

r. Fever—Rectal temperatures above 100°Fahrenheit (38°Celsius) are considered significant. Many frail patients have normally low rectal baseline temperatures (for example, 96°). A fever is present when the patient's temperature (°F) is 2.4 degrees greater than the baseline temperature.

s. Hemi-neglect (inattention to one side)—For example, patient denies that their left arm belongs to them, shaves only on one side of face, ignores items to their left.

t. Cachexia (severe malnutrition)—A condition of undernutrition and wasting that may occur in a variety of chronic diseases and malignancies.

u. Morbid Obesity—According to a National Institute of Health consensus panel, a body weight that is double (twice) the ''ideal'' body weight of standard height-weight tables OR 100 pounds (45 g) overweight.

Extremely obese persons are at great risk of serious disorders, including diabetes, hypertension, osteoarthritis, impairment in psychosocial well-being, and death from cardiovascular disease. (Refer to the latest (1983) Metropolitan Life Insurance Company standard height-weight table below to identify ideal/desirable body weights).

HEIGHT AND WEIGHT TABLE FOR WOMEN

Height (in feet and inches)	Small frame	Medium frame	Large frame
4′10″	102–111	109–121	118–131
4′11″	103–113	111–123	120–134
5′0″	104–115	113–126	122–137
5′1″	106–118	115–129	125–140
5′2″	108–121	118–132	128–143
5′3″	111–124	121–135	131–147
5′4″	114–127	124–138	134–151
5′5″	117–130	127–141	137–155
5′6″	120–133	130–144	140–159
5′7″	123–136	133–147	143–163
5′8″	126–139	136–150	146–167
5′9″	129–142	139–153	149–170
5′10″	132–145	142–156	152–173
5′11″	135–148	145–159	155–176
6′0″	138–151	148–162	158–179

HEIGHT AND WEIGHT TABLE FOR MEN

Height (in feet and inches)	Small frame	Medium frame	Large frame
5′2″	128–134	131–141	138–150
5′3″	130–136	133–143	140–153
5′4″	132–138	135–145	142–156
5′5″	134–140	137–148	144–160
5′6″	136–142	139–151	146–164
5′7″	138–145	142–154	149–168
5′8″	140–148	145–157	152–172
5′9″	142–151	148–160	155–176
5′10″	144–154	151–163	158–180
5′11″	146–157	154–166	161–184
6′0″	149–160	157–170	164–188
6′1″	152–164	160–174	168–192
6′2″	155–168	164–178	172–197
6′3″	158–172	167–182	176–202
6′4″	162–176	171–187	181–207

v. End-stage disease, life expectancy of 6 or fewer months—The intent of this item is to heighten staff awareness of the potential terminal nature of the patient's condition so that an appropriate course of care can be developed. In one's best clinical judgement, the patient in the final (end) stage of a disease process (for example, COPD; malignancy; cardiac disease; Alzheimer's disease, etc.) and has only six or fewer months to live. Although it is often difficult to make such a prognosis, this judgement should be substantiated by a physician and the presence of a deteriorating clinical course.

w. NONE OF THE ABOVE—The patient has not experienced any of the above conditions.

Coding: Check all problems present in the last three days, unless other time frames are indicated. If none apply, check NONE OF THE ABOVE.

3. Respiratory Conditions

Intent: To identify and record signs, symptoms or conditions of respiratory distress that could have a direct or indirect affect on the patient's ability to function, participate in rehabilitation and on the patient's plan of care, including discharge. More than one condition may apply.

Definition: a. Inability to lie flat due to shortness of breath—In the last 3 days the patient reported feeling ''breathless'' or short of breath (dyspneic), or has been observed to be short of breath, while lying supine; requires more than one pillow or has the head of the bed mechanically raised in order to breathe more comfortably.

b. Shortness of breath with exertion—In the last 3 days the patient has reported becoming ''breathless'' or short of breath (dyspneic), or has been observed to be short of breath, even with mild exertion such as taking a bath, transferring from bed to chair, toileting.

c. Shortness of breath at rest—In the last three days the patient reported feeling ''breathless'' or short of breath (dyspneic), or was observed being short of breath, at rest (for example, sitting, talking).

d. Oxygen saturation < 90 percent—In the last 3 days the patient's oxygen saturation level (obtained by oximeter) was less than 90 percent (either while receiving or not receiving oxygen therapy).

e. Difficulty coughing and clearing airway secretions—In the last 3 days the patient reports or has been observed to be unable to cough effectively to expel respiratory secretions (for example, secondary to weakness, pain) or is unable to mobilize secretions or sputum from mouth (for example, secondary to dysphagia or pain) or tracheostomy (for example, secondary to viscosity of sputum; inability to physically remove secretions from tracheostomy entrance). Examples might include a post abdominal surgery patient unable to cough due to incisional pain, or a comatose patient that required suctioning to manage secretions.

f. Recurrent aspiration—In the last 3 days a patient with a history of at least one or more episodes of aspiration (inspiration) of fluids/food/secretions, etc. into lungs, exhibits clinical signs and symptoms of another episode. Recurrence often occurs in patients with swallowing difficulties or who receive tube feedings (that is esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

g. Recurrent Respiratory Infection—In the last 3 days patient with a history of respiratory infection (for example., pneumonia; bronchitis) with evidence of a recurrence (for example, prior infection not resolved with medical intervention; infection has been experienced multiple times).

h. NONE OF THE ABOVE—In the last 3 days none of the above conditions were present.

Process: Interview and observe the patient. Review the patient's medical record, including consultation reports by a respiratory therapist and laboratory data such as arterial blood gases (ABG's), as indicated.

Coding: Check all conditions that were present in the last three days. If no conditions apply, check NONE OF THE ABOVE.

4. Pressure Ulcers

Intent: To identify and document the presence, stage and number of pressure ulcers, and, if present, record the characteristics (that is the size, exudate, and predominant tissue) of the ulcer(s).

Definition: Pressure Ulcer—Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed (Agency for Health Care Policy Research, 1992).

Pressure Ulcer Stage—The following pressure ulcer staging definitions are consistent with the recommendations of the Agency for Health Care Policy Research (AHCPR, 1992) and the National Pressure Ulcer Advisory Panel (NPUAP, 1989). A shorter version of these definitions appear on the form as coding options for Items H4a (highest current pressure ulcer stage).

a. Highest current pressure ulcer stage.

0. No pressure ulcer.

1. (Stage 1) Any area of persistent skin redness.

2. (Stage 2) Partial loss of skin layers.

3. (Stage 3) Deep craters in the skin.

4. (Stage 4) Breaks in skin exposing muscle or bone.

5. Not stageable (necrotic eschar predominant, no prior staging available).

PUSH (Pressure Ulcer Healing Scale) Score—A tool to monitor pressure ulcer healing over time. The PUSH Score is measured by assessing wound size, amount of exudate, and characteristics of predominant tissue. The PUSH is used in Items 4c through 4f.

(a) Highest current pressure ulcer stage.

Intent: In conjunction with other items, to facilitate the monitoring of pressure ulcer healing or worsening over time.

Process: Examine the patient for pressure ulcers and determine pressure ulcer stage. Without a full body inspection, an ulcer can be missed. If the patient has more than one ulcer, determine which ulcer has the highest (worst) ulcer stage. This type of information may be found in referral records (including discharge summaries), clinical progress notes, flow sheets, or patient care plans. Review these records to determine the highest ulcer ever achieved for any ulcer the patient currently has.

Coding: Record the highest (worst) current pressure ulcer stage. If the predominant tissue of the ulcer is necrotic eschar, prohibiting accurate staging, code ''5'', Not Stageable (necrotic eschar predominant; no prior staging available). If the patient has no pressure ulcers, record ''0'' (No pressure ulcers) in the box provided.

(b) Number of current pressure ulcers.

Process: Examine the patient for pressure ulcers. Without a full body inspection, an ulcer can be missed. COUNT the number of pressure ulcers.

Coding: Record the number of pressure ulcers, including ulcers that cannot be accurately staged (that is, if the predominant tissue of the ulcer is necrotic eschar). If the patient has no pressure ulcers, record ''0'' (No pressure ulcers) in the box provided.

(c–f) PUSH Scale (Items c through f).

The next four items (c through f) represent the PUSH Scale 3.0 developed by the National Pressure Ulcer Advisory Panel (NPUAP, 1998) to monitor pressure ulcer healing over time. For purposes of this assessment there are three important things to remember for this section:

• The PUSH Scale (items ''c'' through ''f'') can only be calculated for ulcers of Stage 2 and higher OR for ulcers where necrotic eschar is the predominant tissue. If highest pressure ulcer stage is ''0'' or ''1'', enter code of ''0'' in c, d, e, and f.

• Select the LARGEST ulcer. Note: The largest ulcer may not necessarily be the ulcer with the highest ulcer stage.

• Although the PUSH Scale was designed to evaluate the healing of a pressure ulcer, its use in this assessment is to provide a ''snapshot'' of the status for the largest ulcer present at the time of the assessment. When tracked over time, we can know the highest PUSH score that characterizes the patient's pressure ulcer status.

(c) Length multiplied by width (open wound surface area).

Materials: You will need a centimeter ruler to measure the surface area of an open wound. Although it's not necessary, it is also helpful to use a calculator for multiplying ulcer measurements to calculate the total open wound surface area.

Process: • Using a centimeter ruler, measure the greatest length (head to toe) and the greatest width (side to side) of the ulcer margins (for example, the edges of the ''open'' areas). If necrotic eschar is the predominant tissue and the ulcer is not ''open'', measure from edge to edge of the eschar.

• Multiply these two measurements (length x width) to obtain an estimate of the surface area in square centimeters (cm^2). Do not guess! Always use a centimeter ruler and always use the same method each time the ulcer is measured.

Coding: Record the number that corresponds to the largest pressure ulcer's open wound surface area using the following codes:

0. 0 cm^2.
1. <0.3 cm^2.
2. 0.3–0.6 cm^2.
3. 0.7–1.0 cm^2.
4. 1.1–2.0 cm^2.
5. 2.1–3.0 cm^2.
6. 3.1–4.0 cm^2.
7. 4.1–8.0 cm^2.
8. 8.1–12.0 cm^2.
9. 12.1–24.0 cm^2.
10. >24 cm^2.

(d) Exudate amount.

Process: Estimate the amount of exudate (drainage) present after removal of the dressing and before applying any topical agent to the ulcer for the selected (largest) pressure ulcer.

Coding: Record the response that best estimates the amount of exudate (drainage).

0. None.
1. Light.
2. Moderate.
3. Heavy.

(e) Tissue Type.

Process: Inspect the selected (largest) pressure ulcer and note the tissue that occupies the majority of the ulcer bed. Divide the ulcer bed into four imaginary quadrants, each representing about ¼ of the original ulcer surface. Estimate the portion or amount of each tissue type on the ulcer. Determine the predominant tissue type on the ulcer.

Coding: Record the response that describes the most predominant tissue type.

0. Closed/Resurfaced—The wound is completely covered with epithelium (new skin).

1. Epithelial Tissue—For superficial ulcers, new pink or shiny tissue (skin) that grows in

from the edges or as islands on the ulcer surface.

2. Granulation Tissue—Pink or beefy red tissue with a shiny, moist, granular appearance.

3. Slough—Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps/or is mucinous.

4. Necrotic tissue (eschar)—Black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges and may be either firmer or softer than surrounding skin.

(f) Total PUSH (Pressure Ulcer Healing Scale) Score.

Process: Add up the scores from Items H4c (open wound surface area) + H4d (exudate amount) + H4e (tissue type). This sum represents the total PUSH Score.

Coding: Record the number that represents the Total PUSH Score in the box provided.

5. Other Skin Integrity

(a) Number of stasis ulcers (in the last 24 hours).

Definition: Stasis ulcer—An open lesion, usually of the ankle or lower third of the lower extremities, caused by chronic venous stasis or insufficiency. In the medical record one may also find this type of ulcer referred to as a ''venous ulcer'' or ulcer related to peripheral vascular disease (PVD).

Process: Examine the patient and review the clinical record. COUNT the number of stasis ulcers present in the last 24 hours.

Coding: Record the number of stasis ulcers in the box provided. If there are no stasis ulcers, code a ''0'' in the box.

(b) Number of surgical wounds (in the last 24 hours).

Definition: Surgical wounds—Includes healing and non-healing, open or recently closed (since onset of precipitating event in A7a) surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites or stomas.

Process: Examine the patient's body and COUNT the number of surgical wounds present in the last 24 hours.

Coding: Record the number of surgical wounds in the box provided. If there are no surgical wounds, code a ''0'' in the box.

(c) Ulcer resolved or healed in last 90 days.

Definition: Ulcer—For this item, the term ulcer refers to ANY lesion caused by pressure (that is, pressure ulcer; bedsore; decubitus ulcer) or venous stasis/insufficiency (that is, stasis ulcer).

Process: Review the patient's clinical record over the last 90 days for documentation of the presence of a pressure or stasis ulcer that has been healed (that is, closed/resurfaced; new tissue entirely covers the wound). Validate findings by examining the patient's body.

Coding: Record the most appropriate response to indicate that the patient had an ulcer that was resolved or healed in the last 90 days. If the patient did not have an ulcer that resolved in the last 90 days, use a code of ''0'' in the box. Note: The patient may still have other ulcers in various stages of healing.

0. No, or never had ulcer.

1. Yes.

6. Other Skin Problems or Lesions Present

Intent: To document the presence of skin problems other than ulcers or surgical wounds, and conditions that are risk factors for more serious problems.

Definition: a. Burns (second or third degree)—Includes burns from any cause (for example, heat, electricity, chemicals, radiation, or gases) that affects skin deeper than the epidermis or outermost layer of skin. This category does not include first degree burns (changes in skin color only).

b. Open lesions other than rashes, cuts (for example, cancer lesions, ulcers)—Any open area of the skin unrelated to pressure, venous stasis, surgery, trauma or rashes.

c. Rashes—Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (for example, eczema, heat, drugs, bacteria, fungus, viruses [such as herpes zoster, chicken pox], parasites [such as scabies, lice], contact with irritating substances such as urine or detergents, allergies, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

d. Skin tears or cuts (other than surgery)—Any traumatic break in the skin penetrating to subcutaneous tissue not caused by surgical puncture or incision. Examples include lacerations, punctures wounds, etc.

e. NONE OF THE ABOVE.

Review the patient's record for documentation of impairment of this type. An obvious example of a patient with this problem is someone who is comatose. Other patients at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders.

Process: Ask the patient if he or she has any problem areas. Ask the nurse assistant and examine the patient. Review the patient's record. You are assessing for skin problem areas present over the last 24 hours.

Coding: Check all that apply for the last 24 hours. If there is no evidence of such problems in the last 24 hours, check NONE OF THE ABOVE.

Section I. Pain Symptoms

Intent: The intent of this section is to identify other health conditions that have an impact on the patient's quality of life, health risks, and plan of care, including the discharge plan.

1. Pain Symptoms

Intent: To evaluate and record the presence, frequency and intensity of pain and how it is managed. Pain can impact the patient in many ways, including affecting his or her ability to meet established goals. It is essential that pain is assessed and an effective pain management plan put in place in order to optimize the patient's recovery and quality of life. Items I1a through I1b refer to pain in the last 3 days. In item I1c, how the patient's current perception of pain compares to pain status prior to precipitating event (item A7a). For care planning purposes these items can be used to determine the characteristics of the patient's pain and to monitor his or her response to pain management interventions.

Definition: Pain—pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the patient says it is. If the patient complains of pain, record that pain is present.

Pain assessment may depend on the observation of others (that is, cues), either because the patient does not complain, or is unable to verbalize or describe symptoms.

Process: This evaluation is based solely on the patient's perception of pain, or in cases where the patient has limited ability to communicate, staff's interpretation of behaviors that might indicate pain. Ask the patient to categorize the highest level of pain they have experienced over each time period.

Ask the patient if he or she has experienced any pain or discomfort in the last three days and ask him/her to describe it. If the patient states he or she has pain, take his or her word for it. Pain is a subjective experience.

Observe the patient for indicators of pain. Observation is particularly important in patients who are unable to communicate their experiences of pain. Indicators may include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, lying very still or decreasing usual activities (to prevent pain from occurring).

In severely cognitively impaired patients, the pain experience is particularly difficult to discern. For example, in patients who cannot verbalize that they are feeling pain, discomfort may be manifested by behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, code for the frequency and intensity of symptoms if in your best clinical judgement it is possible that the behavior could be caused by the patient experiencing pain.

Ask nurse assistants and therapists who work with the patient if the patient had complaints or indicators of pain the last three days.

Coding: For each of the following items (I1a through I1b) code for the HIGHEST LEVEL OF PAIN the patient experienced in the last three days, even while receiving treatments.

a. FREQUENCY—Measures how often the patient experiences pain (reports or shows evidence of pain).

Codes: 0. No pain.

1. Pain less than daily.

2. Daily—single shift.

3. Daily—multiple shifts.

b. INTENSITY '' Measures the level of pain as the patient perceives it (described or manifested by the patient). Use the following scale to indicate the level of pain experienced:

Codes: 0. No pain.

1. Mild pain—Although the patient experiences some (''a little'') pain he or she is usually able to carry on with daily routines, socialization, or sleep.

2. Moderate pain—Patient experiences ''a medium'' amount of pain.

3. Severe pain—Patient experiences intense pain.

4. Times when pain is horrible or excruciating—Worst possible pain the person can imagine.

c. CURRENT PAIN STATUS as compared to pain status prior to precipitating event item (A7a). Patient's experience of pain NOW as compared to pain status prior to precipitating event. Note: If the patient has no pain now and no pain prior to precipitating event (item A7a), code ''0'', same.

Coding: 0. Same.

1. Better.

2. Worse.

8. UNKNOWN—The patient is unable to describe how the pain compares OR there is no available information in the clinical record or via family or professional caregivers.

Section J. Oral/Nutritional Status

1. Oral Problems

Intent: To record any oral or nutritional problems in the last 3 days.

Definition: a. Chewing Problem—Inability to chew regular food easily and without pain or difficulties, regardless of cause (for example, poor mastication, immobile jaw, recent oral surgery, temporomandibular joint pain, decreased sensation/motor control).

b. Dental Problem—Upon exam and interview of the patient, problems with teeth are identified (for example, ill—fitting or lack of dentures, painful tooth, poor dental hygiene).

Process: Examine and interview the patient—this is the crucial part of the process, without this examination, oral problems often go undetected. Review clinical records. Talk to the nurse assistants who have recently helped the patient with his/her ADL's.

Coding: Record the most appropriate response in the box provided. Code ''0'' for No and ''1'' for Yes.

2. Swallowing

Intent: The ability to swallow safely can be affected by many disease processes and functional decline. Alterations in one's ability to swallow can result in choking and aspiration, both of which can cause morbidity and mortality. Often patients with swallowing difficulties require altered consistencies of food and fluids OR may not be able to ingest nutrition by mouth. This item details the diet consistencies and modifications in place to address swallowing difficulties.

Process: Observe patient. Review the patient's clinical record, including MD, dietitian and Speech Language Pathology notes if applicable.

Coding: Using the codes provided, indicate which item best describes the dietary prescriptions to address swallowing difficulties.

0. Normal—Safe and efficient swallowing of all diet consistencies.

1. Requires diet modification to swallow solid foods (mechanical diet or able to ingest specific foods only).

2. Requires modification to swallow solid foods and liquids (puree, thickened liquids).

3. Combined oral and tube feeding [tube feeding (via NGT, GT, JT), and some oral intake]

4. No oral intake (NPO)

3. Height and Weight

Intent: To establish a height and weight in order to monitor nutrition and hydration status over time, to establish a baseline to monitor changes in weight over time.

Process: Base weight on the most recent measure in the last 3 days. Utilize your facility's standard of practice to ensure consistency in measuring weights (for example, in a.m. after voiding, before breakfast, with shoes off and in night clothes).

Coding: Record in ''box a.''—Height in inches and in ''box b''—Weight in pounds.

4. Weight Change

Intent: To assess any presence of weight loss or gain.

Process: Review clinical record, weight records, and dietary notes to assess weight history. Since patient may have only been in your facility a few days, it may be difficult to obtain accurate factual information. Utilize patient and family interview to determine appropriate coding.

a. Weight Loss.

Definition:Weight loss in percentages (for example, 5 percent or more in last 30 days).

Process: New admission '' Ask the patient or family about weight changes over the last 30 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current patient '' Review the clinical records and compare current weight with weights of 30 days ago. Calculate weight loss in percentages during the specified time periods.

Coding: 0. No or unknown.

1. Yes, planned loss.

2. Yes, unplanned loss.

b. Weight Gain.

Definition: Weight gain in percentages (for example, 5 percent or more in last 30 days).

Process: New admissions—Ask the patient or family about weight changes over the last 30 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

Current weight '' Review the clinical records and compare current weight with weights of 30 days ago. Calculate weight gain during the specified time periods.

Coding: 0. No or unknown.

1. Yes, planned gain.

2. Yes, unplanned gain.

5. Parenteral or Enteral Intake

Intent: To record the proportion of all calories received, and the average fluid intake, through parenteral or tube feeding in the last 3 days.

a. The proportion of total calories the patient received through parenteral or tube feedings in last 3 days.

Definition:Proportion of total calories received—the proportion of all calories ingested during the last 3 days that the patient actually received (not just ordered) by parenteral or tube feedings. Determined by calorie count.

Process: Review clinical record, particularly the intake flow sheets. Consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.

Coding: Code for the best response. If the patient took no food or fluids by parenteral or tube feedings, or took just sips of fluid, code ''0'' (None).

0. None.

1. 1 percent to 25 percent.

2. 26 percent to 50 percent.

3. 51 percent to 75 percent.

4. 76 percent to 100 percent.

b. Average fluid intake per day by IV or tube in last 3 days.

Definition: Average fluid intake per day by IV or tube in last 3 days refers to the actual amount of fluid the patient received by these modes (not the amount ordered).

Process: Review the Intake and Output record from the last 3 days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Divide the total fluid intake during this time by 3. This will give you the average of fluid intake per day.

Coding: Code for the average number of cc's of fluid the patient received per day by IV or tube in last 3 days.

Codes: 0. None.

1. to 500 cc/day.

2. 501 to 1000 cc/day.

3. 1001 to 1500 cc/day.

4. 1501 to 2000 cc/day.

5. 2001 or more cc/day.

Section K. Procedures/Services

Intent: To document the service, treatments, procedures and devices the patient received over the last 3 days.

1. Clinical Visits and Orders

Intent: To document the number of physician, nurse practitioner, and physician assistant visits in which the patient was examined and notes written, as well as the number of order changes in the last 3 days.

Process: Review the medical record, including physician, nurse practitioner, and physician assistant orders over the last 3 days. See specific processes under each of the following definitions:

Definition: a. Total number of physician visits (by attending, consultant, etc.) in which the patient was examined and MD notes written—This category also includes any primary care or consulting osteopath, podiatrist or dentist. Review the medical record and add up the total number of physician visits the patient had in the last three days. Count only those where the patient was actually seen and examined/assessed by the physician as indicated by physician notes specifically indicating findings/results of the examination. Examination/assessment may be a partial or full exam that occurs at the facility or physician's office/clinic. This category does not include exams conducted in an emergency room.

b. Number of times physician or nurse practitioner called to bedside for emergency (for example, cardiorespiratory arrest, hemorrhaging, to evaluate change in condition)—Once again the physician category also includes bedside visits for emergencies by MD, osteopath, podiatrist, or dentist.

c. Number of nurse practitioner (NP) visits in which patient examined and notes

written—Review the medical record and add up the total number of NP visits the patient had in the last 3 days. Count only those where the patient was actually seen and examined/assessed as indicated by NP notes specifically indicating findings/results of the examination.

d. Number of physician assistant (PA) visits in which patient examined and notes written—Review the medical record and add up the total number of PA visits the patient had in the last 3 days. Count only those where the patient was actually seen and examined/assessed as indicated by PA notes specifically indicating findings/results of the examination.

e. Number of new or changed orders—Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include admission orders, return admission orders or renewal orders without changes. Does include orders for lab tests. Review the physician order sheet in the medical record and add up the total amount of new or changed orders by M.D., osteopath, podiatrist, dentist, NP or PA.

Coding: For each clinical visit or order, record how often it was provided to the patient in the last 3 days.

2. Treatments and Services

Intent: To document the following:

- Column A—over the last 3 days, code for treatment frequency [either daily (Code 3) or less than daily (Code 2) or ordered, not yet implemented (Code 1)].
- Column B—Record whether patient will receive service after discharge.

Process: *Column A*—Review patient's plan of care with the primary caregiver, and review the current medical record, referral information and hospital discharge summary. Use the following coding instructions to indicate how often each of these services was provided in the last 3 days. Note: These treatments and services must either be ordered by a physician or performed by a licensed professional and documented appropriately.

Column B—This column is to be completed ONLY at the discharge assessment (Item AA3 = 5). Review the patient's plan of care with the primary caregiver, and review the current medical record. Use the coding instructions for Column B (below) to indicate whether the patient will receive the service/treatment after discharge.

Coding: *Column A*—For each treatment or service indicate how often it was provided to the patient in the last 3 days. If none of these treatments were provided, check NONE OF ABOVE (Item K2aiA, located in the bottom right hand corner of Section K2, Treatments and Services). For any activity that did not occur, or was not ordered, leave the box next to that item blank. Code for most intense treatment on any one day using the following codes:

[Leave blank] if treatment did not occur, not ordered.

Code ''1'' If the treatment was ordered, but has not yet been implemented.

Code ''2'' If the treatment occurred less than daily.

Code ''3'' If the treatment occurred daily.

Column B—For each treatment or service (''a'' through ''ah'') indicate whether the patient will receive it after discharge. Leave ''Blank'' for No, Code ''1'' for Yes. This information is obtained on a Discharge Assessment only.

Definition: MEDICATION RELATED

a. Diabetic management—Involves a variety of activities centered around stabilization of blood sugar, including determining sliding scale insulin dosages, and blood sugar monitoring. In order to use codes 1–3 in Column A, there must be documentation of changes in type of insulin, insulin dosing, or reports/documentation of blood sugar levels.

b. Injections—Subcutaneous, intramuscular, or intradermal injections of any type of medication, antigen, or vaccine. Although antigens and vaccines are considered ''biologicals'' and not medication per se, it is important to track when they are given in order to monitor for systemic reactions. This category does not include intravenous fluids or medications. If the patient received IV medications, record in Item K2c. (If the patient received IV fluids, record in Item J5b).

c. IV antibiotics/medications—Administration of antibiotics or other medications by means of infusion therapy. Includes any drug or biological (for example, contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication.

SKIN TREATMENT

d. Application of dressing—Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

e. Application of ointments, topical medications—Includes ointments or medications used to treat a skin condition (for example, cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (for example, nitropaste for chest pain).

f. Debridement (chemical or surgical)—Chemical debridement is the process of removing dirt or dead tissue from a wound or burn using chemical agents or dressing change products to promote wound healing. Surgical debridement is the process of surgically removing dirt or dead tissue from a wound or burn to promote wound healing.

g. Nutritional/hydration intervention to manage skin problems—Any nutritional intervention whose purpose is to promote wound healing (for example, high protein drinks, TPN/PPN).

h. Pressure relieving bed/chair—Pressure relieving devices for the bed include air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category. Pressure relieving devices for the chair include gel, air (for example, Roho) or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

i. Turning and repositioning—Includes a continuous, consistent program for changing the patient's position and realigning the body.

j. Ulcer Care—Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

k. Wound care (surgical)—Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of microbial ointments, dressings of any type, suture removal, and warm soaks or heat application.

MANAGEMENT OF HEALTH PROBLEMS

l. Bladder training—A planned program aimed at assessing and treating bladder incontinence.

m. Scheduled toileting—A plan whereby staff members at scheduled times either take the patient to the toilet room, or give the patient a urinal, or remind the patient to go to the toilet. Includes habit training or prompted voiding.

n. Bowel program—A planned program aimed at treating bowel incontinence. A bowel program also includes a program of planned bowel elimination as with patients with spinal cord injury.

o. Cardiac monitoring/Rehabilitation—Cardiac monitoring includes electrical surveillance of heart rates and patterns either through EKG or telemetry. Rehabilitation is a formalized program focusing on regaining function and endurance that has been limited by either a chronic or acute cardiac disease.

p. Cast(s)—A device used to immobilize limbs or joints to promote healing or as a treatment for various musculoskeletal problems.

q. Continuous or bi-level positive airway pressure (CPAP or BiPAP)—Assistive breathing device which provides the patient with a continuous flow of air throughout the breathing cycle.

r. Drains (cutaneous drains and other drains)—A heavy gauged tube used to remove air, fluid, or exudate from a body cavity or wound (exclude chest tubes).

s. Dialysis (includes hemodialysis and peritoneal dialysis)—Hemodialysis is a method for removing unwanted byproducts from the blood of patients with renal insufficiency or failure through the use of a machine (dialyzer). Peritoneal dialysis (CAPD) is a method of removing unwanted by-products from the body through the instillation of dialysate into the peritoneal cavity and using the abdominal wall as a filter.

t. Enteral Feeding Tube—Any tube inserted into the gastrointestinal tract for the purpose of nutrition, hydration, or medication administration. (This includes, jejunostomy, gastrostomy, and PEG tubes).

u. IV line-Central—A catheter which is placed in the more ''central'' veins such as subclavian, jugular, or superior vena cava, for the purpose of monitoring, and administration of medications and fluids. This item includes the insertion, discontinuation, and maintenance of this IV line, including dressing changes, evaluation for patency, assessment for adverse effects (for example, infection), and flushes.

v. IV line-peripheral—A catheter which is placed in a peripheral vein (usually hand or arm) for administration of medications and fluids. This item includes the insertion, discontinuation, and maintenance of this IV line, including dressing changes, evaluation for patency, assessment for adverse effects (for example, infiltration; infection; cellulitis) and flushes.

w. NG feeding tube—A tube inserted through the nose and extending into the stomach.

x. Oxygen—Either the intermittent or continuous use of oxygen to support, promote or maintain vital functions and comfort.

y. Pain management other than drugs—Any documented non-pharmaceutical intervention designed to decrease or alleviate pain. Examples may include (but are not limited to) acupuncture, relaxation therapy, hypnosis, TENS therapy.

z. Suctioning-oral/nasopharyngeal—Removing secretions or other matter from the respiratory system through the mouth or nose.

aa. Suctioning-tracheal—Removing secretions or other matter from the respiratory system through a tracheostomy.

ab. Tracheostomy care—The process of maintaining a clean and functioning tracheostomy, includes assessing the surrounding skin, changing dressing around tracheostomy tube, cleaning and changing inner cannula, monitoring cuff pressures, and securing the tracheostomy tube.

ac. Transfusion(s)—Giving whole blood or blood component (for example, red blood cells) to replace blood loss through injury, surgery, or disease.

ad. Ventilator or respirator—Assures adequate ventilation in patients who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices.

ae. Ventilator weaning—Any patient who was in the process of being weaned off the ventilator or respirator in the last 3 days should be coded under this definition.

OTHER

af. Family training in assistance to patient in health measures or skills required after return to the community—Any documented family teaching to support the patient's discharge home. Examples include, but are not limited to, observing for signs of declining health (for example, hypoglycemia; cognitive change; new or worsening urinary incontinence); administering medications; observing for drug side effects or adverse drug reactions; providing ostomy care or dressing changes; coaching strength training exercises; assisting in transferring and locomotion; providing appropriate verbal/physical cues for feeding; how to label closets and drawers so patient can retrieve clothes; application of behavioral management techniques; when to report change or request assistance.

ag. Patient training in health maintenance or skills required after return to community—Any documented patient teaching to support the patient's discharge home. Examples include, but are not limited to, recognizing and reporting signs of declining health (for example, hypoglycemia; cognitive change; new or worsening urinary incontinence); self-administration of medications; recognizing and reporting drug side effects or adverse drug reaction; recording adherence to strength training exercises; self-ostomy care; how the Lifeline emergency response system works; how to access help in an emergency.

ah. Design and implementation of discharge plan—Discharge plan developed by the interdisciplinary team; includes making the necessary arrangements and contacts with community services.

ai. NONE OF THE ABOVE—Code if the patient has received NONE of the treatments or services above.

3. Nursing Practice or Restorative Care

Intent: To determine the extent to which the patient receives nursing rehabilitation or restorative services from other than specialized therapy staff (for example, occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the patient's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition: Rehabilitation/restorative care—Included are nursing interventions that assist or promote the patient's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item K4. In addition, to be included in this section, a rehabilitation or restorative practice must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote patient involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes under licensed nurse supervision, other staff and volunteers will be assigned to work with specific patients.
- This category does not include exercise groups with more than four patients per supervising helper or caregiver.

Definition: a. Range of motion (passive)—The extent to which, or the limits between which, a part of the body can be passively moved around a fixed point, or joint. Passive range of motion exercise is a program of movements to maintain flexibility and useful motion in the joints of the body.

b. Range of motion (active)—Exercises performed by a patient, with cuing or supervision by staff, that are planned, scheduled, and documented in the clinical record.

c. Splint or orthotic assistance—Assistance can be of 2 types: (1) where staff provide verbal and physical guidance and direction that teaches the patient how to apply, manipulate, and care for an orthotic device or splint, or (2) where staff have a scheduled program of applying and removing a splint or brace, assess the patient's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

Training and skill practice—Activities including repetition, physical or verbal cuing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

d. Bed mobility—Activities used to improve or maintain the patient's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

e. Bladder/Bowel—Activities used to improve or maintain the patient's self-performance in bladder and bowel evacuation (includes ostomy care).

f. Transfer—Activities used to improve or maintain the patient's self-performance in moving between surfaces or planes either with or without assistive devices.

g. Walking—Activities used to improve or maintain the patient's self-performance in walking, with or without assistive devices.

h. Dressing or grooming—Activities used to improve or maintain the patient's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

i. Eating or swallowing—Activities used to improve or maintain the patient's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the patient's ability to ingest nutrition and hydration by mouth.

j. Amputation/prosthesis care—Activities used to improve or maintain the patient's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (for example, leg stump or eye socket).

k. Communication—Activities used to improve or maintain the patient's self-performance in using newly acquired functional communication skills or assisting the patient in using residual communication skills and adaptive devices.

Process: Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation, restorative care schedule, assignment, and implementation record sheet on the nursing unit.

Coding: For the last three days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during each day (24-hour period). The 15 minutes does not have to occur all at once. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero ''0'' if none, or if the service was provided for less than 15 minutes per day in the last 3 days.

4. Therapy Services

This item involves therapies that occurred after admission to the facility and meet the following criteria: (1) were ordered by a physician, (2) were performed by a qualified therapist (that is, one who meets state credentialing requirements) OR (3) were performed by therapy assistant under the direction of the therapist.

The therapy treatment may occur either inside or outside the facility. Includes only therapies based on a therapist's assessment and treatment plan that is documented in the patient's clinical record.

Intent: To record the (A) total number of days treatment was ordered in the last 3 days, (B) number of days administered (for 15 minutes or more), (C) total number of minutes each of the following therapies was provided in the last 3 days (or ordered if days administered =0 and days ordered >0), and (D) whether the patient will receive the service after discharge. Note: In order for therapy minutes to be recorded in the most precise 15 minute increment, either the physician's order or the therapist's plan of care must indicate minutes of therapy ordered by the physician or recommended in the therapist's plan of care.

Definition: a. Speech-language pathology, audiology services—Services that are provided by a qualified speech-language pathologist.

b. Occupational therapy—Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified occupational therapist.

c. Physical therapy—Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified physical therapist.

d. Respiratory therapy—Included are coughing, deep breathing, administration of heated nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional (that is, trained nurse, respiratory therapist). This item does not include use of hand-held medication dispensers. Count only the time that the qualified professional spends with the patient. For high intensity respiratory patients who receive 24° respiratory care, have a discussion with the therapist to get an estimate of the actual amount of time spent at the bedside providing care.

e. Psychological therapy by any licensed mental health professional—Therapy given by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

f. Therapeutic recreation—Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a state licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The Therapeutic Recreation Assistant must work under the direction of a Therapeutic Recreation Specialist.

Process: Review the patient's clinical record and consult with each of the qualified therapists.

Coding: For Boxes (Columns) A, B and C count only post-admission therapies (given in or outside the facility).

Column A: Days ordered—In the first column, enter the number (#) of days the treatment was ordered during the last three days. Enter ''0'' if none. Maximum code is ''3''.

Column B: Days administered—In the second column, enter the number (#) of days the therapy was administered for at least 15 minutes or more in the last three days. Enter ''0'' if none. Maximum code is ''3''.

Column C: Minutes delivered—In the third column, enter the total number (#) of minutes the particular therapy was provided in the last 3 days. The time should include only the actual treatment time (not time waiting, writing reports, or conducting an evaluation). Enter total number of minutes ordered if days administered (K4B) = 0 and days ordered (K4A) > 0. Enter ''0'' if the therapy was not ordered or administered. [Note—Enter cumulative time over all 3 days even when total time on a day (or days) was less than 15 minutes].

Column D: Post Discharge Therapy—Code at discharge assessment only (A3=5). Record whether the patient will receive the therapy service after discharge. Code ''0'' for No, or ''1'' for Yes. This information is obtained on a Discharge Assessment only.

5. Devices and Restraints

Intent: To record the frequency, over the last three days, with which the patient was restrained by any of the devices listed below at any time during the day or night.

Definition: This category includes the use of any device (for example, physical or mechanical device, material, or equipment attached or adjacent to the patient's body) that the patient cannot easily remove and that restricts freedom of movement or normal access to his or her body. If device is used as an ''enabler,'' you still must code device in this item.

a. Full bed rails—Full rails may be one or more rails along both sides of the patient's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the patient from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). A veil screen (used in pediatric units) or veil bed is included in this category.

b. Other types of side rails used (for example, one-side half rail, one-side full rail, two-sided half rails).

c. Trunk restraint—Includes any device or equipment or material that the patient cannot easily remove (for example, vest or waist restraint).

d. Chair prevents rising—Any type of chair with locked lap board or chair that places patient in a recumbent position that restricts rising or a chair that is soft and low to the floor (for example, bean bag chair). Includes ''comfort cushions'' (for example, lap buddy), ''merry walkers.''

Process: Check the patient's clinical records and restraint device flow sheets. Consult nursing staff. Observe the patient.

Coding: For each device type, enter the code that best describes the pattern of restraint or device use for the last 3 days:

0. Not used in last three days

1. Used, but used less than daily in last three days

2. Daily use—night only in the last three days

3. Daily use—days only in the last three days

4. Night and day use, but not constant use in the last three days

5. Constant use for full 24 hours (with periodic release) during the last three days

Section L. Functional Prognosis

Intent: A major goal of post acute care is to rehabilitate the patient to a level of function and health that enables return to the patient's previous living arrangement or, if not appropriate, to the most independent living arrangement possible. Developing plans of care to achieve this goal and prepare for post-discharge needs requires (1) establishing individualized goals in specific areas of function and health, (2) estimating the degree to which the patient will improve, (3) evaluating the patient's and family's individual needs, values, motivation for participation in rehabilitation, and (4) estimating the rate of patient change (and goal achievement) and length of stay. This section asks the interdisciplinary team to take this information and make some predictions on rehabilitation prognosis. These predictions are essential in planning services needed during the stay as well as upon discharge.

1. Functional Improvement Goals

Intent: This section looks at some key functional areas, and asks staff to make a prediction whether the patient will meet these goals in the indicated time frame.

Definition: ADLs

a. Bed mobility/transfer—Goals that involve how patient moves to and from a lying position, turns side to side, and positions body while in bed. Also includes goals involving how patient moves between surfaces—to or from: bed, chair, wheelchair.

b. Dressing—Goals that involve how the patient dresses and undresses (street clothes and underwear) including prostheses, orthotics, fasteners, pullovers, belts, pants, skirts, and shoes.

c. Eating—Goals centering on how the patient eats and drinks (regardless of skill). This includes intake of nourishment by other means (for example, tube feeding, total parenteral nutrition).

d. Locomotion—Goals involving how the patient moves between locations in his/her room and adjacent corridor on the same floor.

If patient uses a wheelchair, the goals would involve how the patient moves once the patient is in the wheelchair.

e. Toileting—Goals that involve how the patient uses the toilet room (or commode, urinal, bedpan), cleanses himself/herself after toilet use or incontinent episode(s), changes pads, manages ostomy or catheter, and adjusts clothes. This item does include goals centering on transfers on and off the toilet or commode.

OTHER

f. Medication Management—Goals involving how the patient manages medications (remembering to take medications, opening bottles, taking correct drug dosages, filling syringe, giving injections, applying ointments).

g. Pain Control—Goals involving the control (cessation or mitigation) of pain by the patient. Pain control goals could involve both pharmacologic and non-pharmacologic interventions.

h. Managing Finances—In the inpatient environment this includes goals involving financial activities such as paying for the newspaper, paying for TV service. When considering home discharge, this item involves paying bills, managing checking account, or bank account.

Process: Using your best clinical judgment, code each of these functional areas using the scale described below. A review of the physician orders, notes and plans of care would be essential in this process to confirm what goals have been established.

Coding: Choose the response that best reflects the clinical staff's prognosis for goal attainment in each of the specified areas in the last 24 hours. Code for the most aggressive goal in each area. For admission assessment and reassessment, code for clinical staff expectations of patient goals in the areas listed below by time of discharge. For discharge assessments, code for staff expectation of patient functional goal in the post discharge period.

0. No goal exists—There is currently no goal in the patient's plan of care that aims to improve or maintain the patient's current functional performance or health (in the area specified) in the area indicated.

1. Goal—improvement, full recovery to premorbid status anticipated—Goals for improvement in the area specified have been set, and clinical staff project that the patient will improve to the level of function or health (in the area specified) that he or she experienced prior to the precipitating event (Item A7a).

2. Goal—improvement, partial recovery anticipated—Goals for improvement in the specified area have been set, but given the patient's current status and availability of services within the expected length of stay, clinical staff project that the patient will not improve to the level of function or health (in the area specified) he or she experienced prior to the precipitating event (Item A7a).

3. Goal—improvement, recovery uncertain—Goals for improvement in the specified area have been set, but given the patient's current health, functional or emotional status, clinical staff are unable to determine if the patient will partially or fully return to the level of function or health (in the specified area) he or she experienced prior to the precipitating event (Item A7a).

4. Goal—maintenance, prevention of further decline—Goals for maintenance (preservation) of function or health in the specified area have been set, and clinical staff project that the patient will meet maintenance goals as evidenced by NO further deterioration in function or health (in the area specified).

2. Attributes Relevant to Rehabilitation

Intent: The intent of this section is to measure the patient's and his or her family's motivation to participate in the rehabilitation program and goals. This is essential to establish the patient and the patient's support system's participation in the established plan of care. When conflicts arise, the plan of care needs to be modified to reflect efforts to resolve these conflicts. For example, if the patient is in the post-acute setting for rehabilitation after a stroke, but is ''refusing rehabilitation,'' this issue becomes the primary issue to deal with rather than the fact that the patient's mobility is limited.

Definition: a. Patient believes he/she is capable of increased independence—The patient states that he/she has the capacity to improve or be more independent (albeit with therapeutic support) or demonstrates this belief by actively participating in rehabilitative programming.

b. Patient unable to recognize new limitations—The patient lacks insight into the level of his/her altered function; may use poor judgement, thereby placing self at safety risk; may resist participation in therapeutic programming aimed at improving function or compensating for deficits.

c. Patient fails to initiate or to continue to carry out ADLs (once initiated) for which he/she has some demonstrated capability—The patient refrains from participating in self-care in one or more ADL areas in which he/she has shown self-care abilities.

Process: Interview the patient. Get a sense of what his/her goals are from this post-acute admission. Also discuss what the patient's family or support person's perceptions are. Observe the patient's behavior and participation in plan of care. Are there differences in the Care Plan goals established by the team and the patient's and family's goals?

Coding: Indicate ''0'' for No, ''1'' for Yes, or ''8'' for Unknown in the box corresponding to each item, indicating that they have been observed, verbalized or documented in the last 3 days.

3. Change Over the Last 3 Days

Intent: To evaluate and predict the rate in which the patient will progress toward his or her established goals.

Process: Obtain information via review of the medical record, staff and patient interview.

Definition: a. Change in overall functional status over last 3 days.

b. Change in overall health status over last 3 days.

Coding: From the following codes, choose the response that best reflects your best clinical judgement of the patient's rate of overall functional and health status change over the last 3 days.

0. Improved.

1. About the same as at admission (or last assessment if this is not an admission assessment).

2. Worse.

4. Estimated Length of Stay From Date of Admission

Intent: It is essential to put a time frame around established goals in the plan of care. The guiding time frame in this process is the anticipated length of stay. This is established based on a number of factors including but not limited to, diagnosis, functional ability and prognosis, medical complications, support systems, patient motivation, and anticipated living arrangement and payor source. All this information must be taken into consideration when making a prediction.

Process: Use a chart review, patient/support system interview, or obtain interdisciplinary clinical input to code for the anticipated length of stay.

Coding: Starting from (and including) the date entered in AA2b or if AA2b is blank AA2a (Admission Date), using your best clinical judgement, determine the patient's expected length of stay in the current setting prior to returning to a community setting. Choose the response that best reflects the anticipated time frame.

0. 1–6 days.

1. 7–13 days.

2. 14—30 days.

3. 31—90 days.

4. 91 or more days.

5. Discharge to community not expected—It is anticipated that the patient will never return to the community, even if they are transferred to another facility. This category also includes patients who are expected to die during this admission.

6. Expected discharge will be to another health care setting prior to return to community—Examples include transfer to nursing facility with eventual discharge to the community.

Section M. Resources for Discharge

Intent: In this section some key elements related to discharge planning are addressed. Before formulating a discharge plan, the resources available to support the patient's discharge home should be evaluated based on the patient's current needs. In conjunction with previous sections of the assessment, these items lay the ground work for developing a realistic discharge/transition plan.

1. Available Social Supports

Intent: To identify the availability of family or friends to provide support during the post-acute phase and after discharge.

Process: Information should be obtained through patient/family interview and through medical record review. Determine if there is any indication that family or close friends are present and available. Privately employed caregivers would not be coded in this item.

Definition: a. Emotional Support—The provision of encouragement, comfort, attentive listening.

b. Intermittent physical support with ADLs or IADLs—less than daily—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing

housework, shopping etc, on a less than daily basis.

c. Intermittent physical support with ADLs or IADLs—daily—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing housework, shopping etc., on a daily basis (for example, once a day), but not full time.

d. Full time physical support (as needed) with ADLs or IADLs—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing housework, shopping etc., on a daily basis full time.

e. All or most of necessary transportation—Includes providing transportation by driving patient in a car (or other motorized vehicle) OR accompanying patient using bus, subway, or other public transportation.

Coding: Ask if one or more family members/close friends are willing and able to provide support after discharge. Enter the most appropriate response next to the type of support. Enter ''0'' for No, ''1'' for Possibly yes, and ''2'' for Definitely Yes.

2. Caregiver Status

Intent: The following items identify issues with the patient's family or informal caregivers in preparation for discharge. Often, when a family member needs post-acute care, the entire family is affected. It is important to determine how the caregiver(s) is coping, whether he/she requires additional supports, or if he/she is willing and able to provide the patient with extended care in their home.

Process: Interview the patient and family/caregiver, as well as staff who are closely involved with the patient's care. Review medical record, including Social Service notes.

Coding: Enter a ''0'' for ''No'', and a ''1'' for ''Yes'' in the box next to each statement that applies to the patient and their care givers/family.

0. No.

1. Yes.

a. Family (or close friend) overwhelmed by patient's illness.

b. Family relationship(s) require unusual amounts of staff time.

3. Living Arrangement

Intent: The intent of this item is to establish the permanent living arrangement both prior to admission [A] and that which is expected after discharge [B]. If the initial arrangement expected at discharge is different than column M3B—code in column C for Temporary Discharge arrangement (A3 = 5).

Process: Obtain information through patient and family interview. Medical record review may also be helpful.

Definition: a. Type of residence.

0. Unknown.

1. Private home—Any house or condominium in the community whether owned by the patient or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled.

2. Private apartment—Any apartment in the community whether owned by the patient or another person.

3. Rented Room—A rented room either part of a private house or a boarding room establishment.

4. Board and Care/assisted living/group home—An alternative housing option which integrates shared living environment with some degree of supportive services such as home health services, personal care, meal service, transportation.

5. Homeless (with or without shelter)—Person does not have a residence—lives out on streets, woods, etc. or uses a community based shelter for individuals who do not have a residential address.

6. Long Term Care Facility (nursing home)—A residence that provides 24-hour skilled or intermediate nursing care.

7. Post Acute Care SNF—Facility (or designated beds within a SNF) dedicated to the care of patients with intense rehabilitative or clinically complex needs. Most patients are admitted to the post acute care facility from an acute hospital, or rehabilitation hospital. These patients will have a short, intense stay in the post acute care SNF.

8. Hospice—An interdisciplinary program of palliative care and support services that addresses the physical, social, spiritual, and financial needs of terminally ill patients and their families.

9. Acute unit/hospital—A facility licensed as an acute care hospital or unit. Patients in acute care may receive comprehensive and complex diagnostic services, treatments, and surgery.

10. Other—Any other setting not categorized above.

b. Live(d) with.

0. Unknown.

1. Alone—Living with a pet is coded as living alone.

2. Spouse only—If patient is living as married (common law marriage) with another person, use this code.

3. Spouse and others—husband or wife, and other family members, friends, boarders.

4. Child—Lives with child, no spouse present.

5. Other relative(s)—Not spouse or children.

6. Friends.

7. Group setting—An alternative housing option which integrates a shared living environment with some degree of supportive services such as home health services, personal care, meal service, transportation.

8. Personal Care Attendant—A health care worker either hired by an agency or the patient himself. This worker is trained to provide the patient with help in ADL's and other types of assistance.

9. Other—Any other living arrangement not categorized above.

Process: Review the medical record. Consult the patient and family. This is meant to measure permanent placement. If a patient is going to be discharged to a skilled nursing facility for a short period of time, and then discharged back to their home, the permanent living arrangement would be either 1 or 2 depending on home service arrangements.

Coding: a. Type of residence—

- In Column A—indicate the type of residence where the patient permanently resided prior to admission.
- In Column B—indicate the type of residence where the patient is expected to permanently reside after discharge.
- In Column C—indicate the type of residence where the patient is expected to temporarily reside initially after discharge. Code this item only if this arrangement is different than that coded in Column B.

b. Lived with—

- In Column A—indicate with whom the patient permanently resided prior to admission.
- In Column B—indicate with whom the patient is expected to permanently reside after discharge.
- In Column C—indicate with whom the patient is expected to temporarily reside initially after discharge. Code this item only if this arrangement is different than that coded in Column B.

Appendix C: List of Comorbidities

ICD9 code No.	Abbreviated code title
011	Pulmonary tuberculosis*
011.0	TB of lung, infiltrative
011.00	TB lung infiltr-unspec
011.01	TB lung infiltr-no exam
011.02	TB lung infiltr-exm unkn
011.03	TB lung infiltr-micro DX
011.04	TB lung infiltr-cult DX
011.05	TB lung infiltr-histo DX
011.06	TB lung infiltr-oth test
011.1	TB of lung, nodular
011.10	TB lung nodular-unspec
011.11	TB lung nodular-no exam
011.12	TB lung nodul-exam unkn
011.13	TB lung nodular-micro DX
011.14	TB lung nodular-cult DX
011.15	TB lung nodular-histo DX
011.16	TB lung nodular-oth test
011.2	TB of lung w cavitation
011.20	TB lung w cavity-unspec
011.21	TB lung w cavity-no exam
011.22	TB lung cavity-exam unkn
011.23	TB lung w cavit-micro DX
011.24	TB lung w cavity-cult DX
011.25	TB lung w cavit-histo DX
011.26	TB lung w cavit-oth test
011.3	Tuberculosis of bronchus
011.30	TB of bronchus-unspec
011.31	TB of bronchus-no exam
011.32	TB of bronchus-exam unkn
011.33	TB of bronchus-micro DX
011.34	TB of bronchus-cult DX
011.35	TB of bronchus-histo DX
011.36	TB of bronchus-oth test
011.4	TB fibrosis of lung
011.40	TB lung fibrosis-unspec
011.41	TB lung fibrosis-no exam
011.42	TB lung fibros-exam unkn
011.43	TB lung fibros-micro DX
011.44	TB lung fibrosis-cult DX
011.45	TB lung fibros-histo DX
011.46	TB lung fibros-oth test
011.5	TB bronchiectasis
011.50	TB bronchiectasis-unspec
011.51	TB bronchiect-no exam
011.52	TB bronchiect-exam unkn
011.53	TB bronchiect-micro DX
011.54	TB bronchiect-cult DX
011.55	TB bronchiect-histo DX
011.56	TB bronchiect-oth test
011.6	Tuberculous pneumonia
011.60	TB pneumonia-unspec

ICD9 code No.	Abbreviated code title
011.61	TB pneumonia-no exam
011.62	TB pneumonia-exam unkn
011.63	TB pneumonia-micro DX
011.64	TB pneumonia-cult DX
011.65	TB pneumonia-histo DX
011.66	TB pneumonia-oth test
011.7	Tuberculous pneumothorax
011.70	TB pneumothorax-unspec
011.71	TB pneumothorax-no exam
011.72	TB pneumothorx-exam unkn
011.73	TB pneumothorax-micro DX
011.74	TB pneumothorax-cult DX
011.75	TB pneumothorax-histo DX
011.76	TB pneumothorax-oth test
011.8	Pulmonary TB nec
011.80	Pulmonary TB nec-unspec
011.81	Pulmonary TB nec-no exam
011.82	Pulmon TB nec-exam unkn
011.83	Pulmon TB nec-micro DX
011.84	Pulmon TB nec-cult DX
011.85	Pulmon TB nec-histo DX
011.86	Pulmon TB nec-oth test
011.9	Pulmonary TB nos
011.90	Pulmonary TB nos-unspec
011.91	Pulmonary TB nos-no exam
011.92	Pulmon TB nos-exam unkn
011.93	Pulmon TB nos-micro DX
011.94	Pulmon TB nos-cult DX
011.95	Pulmon TB nos-histo DX
011.96	Pulmon TB nos-oth test
012	Other respiratory TB*
012.0	Tuberculous pleurisy
012.00	TB pleurisy-unspec
012.01	TB pleurisy-no exam
012.2	TB pleurisy-exam unkn
012.3	TB pleurisy-micro DX
012.04	TB pleurisy-cult DX
012.5	TB pleurisy-histolog DX
012.6	TB pleurisy-oth test
012.1	TB thoracic lymph nodes
012.10	TB thoracic nodes-unspec
012.11	TB thorax node-no exam
012.12	TB thorax node-exam unkn
012.13	TB thorax node-micro DX
012.14	TB thorax node-cult DX
012.15	TB thorax node-histo DX
012.16	TB thorax node-oth test
012.2	Isolated trach/bronch TB
012.20	Isol tracheal TB-unspec
012.21	Isol tracheal TB-no exam
012.22	Isol trach TB-exam unkn
012.23	Isolat trach TB-micro DX
012.24	Isol tracheal TB-cult DX
012.25	Isolat trach TB-histo DX
012.26	Isolat trach TB-oth test
012.3	Tuberculous laryngitis
012.30	TB laryngitis-unspec
012.31	TB laryngitis-no exam
012.32	TB laryngitis-exam unkn
012.33	TB laryngitis-micro DX
012.34	TB laryngitis-cult DX
012.35	TB laryngitis-histo DX
012.36	TB laryngitis-oth test
012.8	Respiratory TB nec
012.80	Resp TB nec-unspec
012.81	Resp TB nec-no exam
012.82	Resp TB nec-exam unkn
012.83	Resp TB nec-micro DX
012.84	Resp TB nec-cult DX
012.85	Resp TB nec-histo DX
012.86	Resp TB nec-oth test
013	CNS tuberculosis*
013.0	Tuberculous meningitis
013.00	TB meningitis-unspec
013.01	TB meningitis-no exam
013.02	TB meningitis-exam unkn
013.03	TB meningitis-micro DX
013.04	TB meningitis-cult DX
013.05	TB meningitis-histo DX
013.06	TB meningitis-oth test
013.1	Tuberculoma of Meninges
013.10	Tubrclma meninges-unspec
013.11	Tubrclma mening-no exam
013.12	Tubrclma menin-exam unkn
013.13	Tubrclma mening-micro DX
013.14	Tubrclma mening-cult DX
013.15	Tubrclma mening-histo DX
013.16	Tubrclma mening-oth test
013.2	Tuberculoma of brain
013.20	Tuberculoma brain-unspec
013.21	Tubrcloma brain-no exam
013.22	Tubrclma brain-exam unkn
013.23	Tubrcloma brain-micro DX
013.24	Tubrcloma brain-cult DX
013.25	Tubrcloma brain-histo DX
013.26	Tubrcloma brain-oth test
013.3	TB abscess of brain
013.30	TB brain abscess-unspec
013.31	TB brain abscess-no exam
013.32	TB brain absc-exam unkn
013.33	TB brain absc-micro DX
013.34	TB brain abscess-cult DX
013.35	TB brain absc-histo DX
013.36	TB brain absc-oth test
013.4	Tuberculoma spinal cord
013.40	Tubrclma sp cord-unspec
013.41	Tubrclma sp cord-no exam
013.42	Tubrclma sp cd-exam unkn
013.43	Tubrclma sp crd-micro DX
013.44	Tubrclma sp cord-cult DX
013.45	Tubrclma sp crd-histo DX
013.46	Tubrclma sp crd-oth test
013.5	TB abscess spinal cord
013.50	TB sp crd abscess-unspec
013.51	TB sp crd absc-no exam
013.52	TB sp crd absc-exam unkn
013.53	TB sp crd absc-micro DX
013.54	TB sp crd absc-cult DX
013.55	TB sp crd absc-histo DX
013.56	TB sp crd absc-oth test
013.6	TB encephalitis/myelitis
013.60	TB encephalitis-unspec
013.61	TB encephalitis-no exam
013.62	TB encephalit-exam unkn
013.63	TB encephalitis-micro DX
013.64	TB encephalitis-cult DX
013.65	TB encephalitis-histo DX
013.66	TB encephalitis-oth test
013.8	CNS tuberculosis nec
013.80	CNS tb nec-unspec
013.81	CNS tb nec-no exam
013.82	CNS tb nec-exam unkn
013.83	CNS tb nec-micro DX
013.84	CNS tb nec-cult DX
013.85	CNS tb nec-histo DX
013.86	CNS tb nec-oth test
013.9	CNS tuberculosis nos
013.90	CNS tb nos-unspec
013.91	CNS tb nos-no exam
013.92	CNS tb nos-exam unkn
013.93	CNS tb nos-micro DX
013.94	CNS tb nos-cult DX
013.95	CNS tb nos-histo DX
013.96	CNS tb nos-oth test
014	Intestinal tb*
014.0	tuberculous peritonitis
014.00	TB peritonitis-unspec
014.01	TB peritonitis-no exam
014.02	TB peritonitis-exam unkn
014.03	TB peritonitis-micro DX
014.04	TB peritonitis-cult DX
014.05	TB peritonitis-histo DX
014.06	TB peritonitis-oth test
014.8	Intestinal tb nec
014.80	Intestinal tb nec-unspec
014.81	Intestin tb nec-no exam
014.82	Intest tb nec-exam unkn
014.83	Intestin tb nec-micro DX
014.84	Intestin tb nec-cult DX
014.85	Intestin tb nec-histo DX
014.86	Intestin tb nec-oth test
015	TB of bone and joint*
015.0	TB of vertebral column
015.00	TB of vertebra-unspec
015.01	TB of vertebra-no exam
015.02	TB of vertebra-exam unkn
015.03	TB of vertebra-micro DX
015.04	TB of vertebra-cult DX
015.05	TB of vertebra-histo DX
015.06	TB of vertebra-oth test
015.1	TB of hip
015.10	TB of hip-unspec
015.11	TB of hip-no exam
015.12	TB of hip-exam unkn
015.13	TB of hip-micro DX
015.14	TB of hip-cult DX
015.15	TB of hip-histo DX
015.16	TB of hip-oth test
015.2	TB of knee
015.20	TB of knee-unspec
015.21	TB of knee-no exam
015.22	TB of knee-exam unkn
015.23	TB of knee-micro DX
015.24	TB of knee-cult DX
015.25	TB of knee-histo DX
015.26	TB of knee-oth test
015.5	TB of limb bones
015.50	TB of limb bones-unspec
015.51	TB limb bones-no exam
015.52	TB limb bones-exam unkn
015.53	TB limb bones-micro EX
015.54	TB limb bones-cult DX
015.55	TB limb bones-histo DX
015.56	TB Limb bones-oth test
015.6	TB of mastoid
015.60	TB of mastoid-unspec
015.61	TB of mastoid-no exam
015.62	TB of mastoid-exam unkn
015.63	TB of mastoid-micro DX
015.64	TB of mastoid-cult DX
015.65	TB of mastoid-histo DX
015.66	TB of mastoid-oth test
015.7	TB of bone nec
015.70	TB of bone nec-unspec
015.71	TB of bone nec-no exam
015.72	TB of bone nec-exam unkn
015.73	TB of bone nec-micro DX
015.74	TB of bone nec-cult DX
015.75	TB of bone nec-histo DX
015.76	TB of bone nec-oth test
015.8	TB of joint nec
015.80	TB of joint nec-unspec
015.81	TB of joint nec-no exam
015.82	TB joint nec-exam unkn
015.83	TB of joint nec-micro DX
015.84	TB of joint nec-cult DX
015.85	TB of joint nec-histo DX
015.86	TB of joint nec-oth test
015.9	TB of bone & joint nos

ICD9 code No.	Abbreviated code title
015.90	TB bone/joint nos-unspec
015.91	TB bone/jt nos-no exam
015.92	TB bone/jt nos-exam unkn
015.93	TB bone/jt nos-micro DX
015.94	TB bone/jt nos-cult DX
015.95	TB bone/jt nos-histo DX
015.96	TB bone/jt nos-oth test
016	Genitourinary TB*
016.0	TB of kidney
016.00	TB of kidney-unspec
016.01	TB of kidney-no exam
016.02	TB of kidney-exam unkn
016.03	TB of kidney-micro DX
016.04	TB of kidney-cult DX
016.05	TB of kidney-histo DX
016.06	TB of kidney-oth Test
016.1	TB of bladder*
106.10	TB of bladder-unspec
016.11	TB of bladder-no exam
016.12	TB of bladder-exam unkn
016.13	TB of bladder-micro DX
016.14	TB of bladder-cult DX
016.15	TB of bladder-histo DX
016.16	TB of bladder-oth test
106.2	TB of ureter
016.20	TB of ureter-unspec
016.21	TB of ureter-no exam
016.22	TB of ureter-exam unkn
016.23	TB of ureter-micro DX
016.24	TB of ureter-cult DX
016.25	TB of ureter-histo DX
016.26	TB of ureter-oth test
016.3	TB of urinary organ nec
016.30	TB urinary nec-unspec
016.31	TB urinary nec-no exam
016.32	TB urinary nec-exam unkn
016.33	TB urinary nec-micro DX
016.34	TB urinary nec-cult DX
016.35	TB urinary nec-histo DX
016.36	TB urinary nec-oth test
016.4	TB of epididymis
016.40	TB epididymis-unspec
016.41	TB epididymis-no exam
016.42	TB epididymis-exam unkn
016.43	TB epididymis-micro DX
016.44	TB epididymis-cult DX
016.45	TB epididymis-histo DX
016.46	TB epididymis-oth test
016.5	TB male genital org nec
016.50	TB male genit nec-unspec
016.51	TB male gen nec-no exam
016.52	TB male gen nec-ex unkn
016.53	TB male gen nec-micro DX
016.54	TB male gen nec-cult DX
016.55	TB male gen nec-histo DX
016.56	TB male gen nec-oth test
016.6	TB of ovary and tube
016.60	TB ovary & tube-unspec
016.61	TB ovary & tube-no exam
016.62	TB ovary/tube-exam unkn
016.63	TB ovary & tube-micro DX
016.64	TB ovary & tube-cult DX
016.65	TB ovary & tube-histo DX
016.66	TB ovary & tube-oth test
016.7	TB female genit org nec
016.70	TB female gen nec-unspec
016.71	TB fem gen nec-no exam
016.72	TB fem gen nec-exam unkn
016.73	TB fem gen nec-micro DX
016.74	TB fem gen nec-cult DX
016.75	TB fem gen nec-histo DX
016.76	TB fem gen nec-oth test
016.9	Genitourinary TB nos
016.90	GU TB nos-unspec
016.91	GU TB nos-no exam
016.92	GU TB nos-exam unkn
016.93	GU TB nos-micro DX
016.94	GU TB nos-cult DX
016.95	GU TB nos-histo DX
016.96	GU TB nos-oth test
017	Tuberculosis nec*
017.0	TB skin & subcutaneous
017.00	TB skin/subcutan-unspec
017.01	TB skin/subcut-no exam
017.02	TB skin/subcut-exam unkn
017.03	TB skin/subcut-micro DX
017.04	TB skin/subcut-cult DX
017.05	TB skin/subcut-histo DX
017.06	TB skin/subcut-oth Test
017.1	Erythema nodosum in TB
017.10	Erythema nodos TB-unspec
017.11	Erythem nodos TB-no exam
017.12	Erythem nod TB-exam unkn
017.13	Erythem nod TB-micro DX
017.14	Erythem nodos TB-cult DX
017.15	Erythem nod TB-histo DX
017.16	Erythem nod TB-oth test
017.2	TB of periph lymph node
017.20	TB periph lymph-unspec
017.21	TB periph lymph-no exam
017.22	TB periph lymph-exam unk
017.23	TB periph lymph-micro DX
017.24	TB periph lymph-cult DX
017.25	TB periph lymph-histo DX
017.26	TB periph lymph-oth test
017.3	TB of eye
017.30	TB of eye-unspec
017.31	TB of eye-no exam
017.32	TB of eye-exam unkn
017.33	TB of eye-micro DX
017.34	TB of eye-cult DX
017.35	TB of eye-histo DX
017.36	TB of eye-oth test
107.4	TB of ear
017.40	TB of ear-unspec
017.41	TB of ear-no exam
017.42	TB of ear-exam unkn
017.43	TB of ear-micro DX
017.44	TB of ear-cult DX
017.45	TB of ear-histo DX
017.46	TB of ear-oth test
017.5	TB of thyroid gland
017.50	TB of thyroid-unspec
017.51	TB of thyroid-no exam
017.52	TB of thyroid-exam unkn
017.53	TB of thyroid-micro DX
017.54	TB of thyroid-cult DX
017.55	TB of thyroid-histo DX
017.56	TB of thyroid-oth test
017.6	TB of adrenal gland
017.60	TB of adrenal-unspec
017.61	TB of adrenal-no exam
017.62	TB of adrenal-exam unkn
017.63	TB of adrenal-micro DX
017.64	TB of adrenal-cult DX
017.65	TB of adrenal-histo DX
017.66	TB of adrenal-oth test
017.7	TB of spleen
017.70	TB of spleen-unspec
017.71	TB of spleen-no exam
017.72	TB of spleen-exam unkn
017.73	TB of spleen-micro DX
017.74	TB of spleen-cult DX
017.75	TB of spleen-histo DX
017.76	TB of spleen-oth test
017.8	TB of esophagus
017.80	TB esophagus-unspec
017.81	TB esophagus-no exam
017.82	TB esophagus-exam unkn
017.83	TB esophagus-micro DX
017.84	TB esophagus-cult DX
017.85	TB esophagus-histo DX
017.86	TB esophagus-oth test
017.9	TB of organ nec
017.90	TB of organ nec-unspec
017.91	TB of organ nec-no exam
017.92	TB organ nec-exam unkn
017.93	TB of organ nec-micro DX
017.94	TB of organ nec-cult DX
017.95	TB of organ nec-histo DX
017.96	TB of organ nec-oth test
018	Miliary tuberculosis*
018.0	Acute miliary TB
018.00	Acute miliary TB-unspec
018.01	Acute miliary TB-no exam
018.02	AC miliary TB-exam unkn
018.03	AC miliary TB-micro DX
018.04	Acute miliary TB-cult DX
018.05	AC miliary TB-histo DX
018.06	AC miliary TB-oth test
018.8	Miliary TB nec
018.80	Miliary TB nec-unspec
018.81	Miliary TB nec-no exam
018.82	Miliary TB nec-exam unkn
018.83	Miliary TB nec-micro DX
018.84	Miliary TB nec-cult DX
018.85	Miliary TB nec-histo DX
018.86	Miliary TB nec-oth test
018.9	Miliary tuberculosis nos
018.90	Miliary TB nos-unspec
018.91	Miliary TB nos-no exam
018.92	Miliary TB nos-exam unkn
018.93	Miliary TB nos-micro DX
018.94	Miliary TB nos-cult DX
018.95	Miliary TB nos-histo DX
018.96	Miliary TB nos-oth test
027.0	Listeriosis
027.1	Erysipelothrix infection
027.2	Pasteurellosis
027.8	Zoonotic bact dis nec
027.9	Zoonotic bact dis nos
036.0	Meningococcal meningitis
036.2	Meningococcemia
036.3	Meningococc adrenal synd
036.40	Meningococc carditis nos
036.42	Meningococc endocarditis
036.43	Meningococc myocarditis
037	Tetanus
038.0	Streptococcal septicemia
038.1	Staphylococc septicemia
038.10	Staphylcocc septicem nos
038.11	Staph aureus septicemia
038.19	Staphylcocc septicem nec
038.2	Pneumococcal septicemia
038.3	Anaerobic septicemia
038.4	Gram-neg septicemia nec
038.40	Gram-neg septicemia nos
038.41	H. influenae septicemia
038.42	E coli septicemia
038.43	Pseudomonas septicemia
038.44	Serratia septicemia
038.49	Gram-neg septicemia nec
038.8	Septicemia nec
038.9	Septicemia nos
042	Human immuno virus dis
052.0	Postvaricella encephalit
052.1	Varicella pneumonitis
053.0	Herpes zoster meningitis
054.3	Herpetic encephalitis

ICD9 code No.	Abbreviated code title
054.5	Herpetic septicemia
054.72	H Simplex meningitis
054.79	H Simplex Complicat nec
055.0	Postmeasles Encephalitis
055.1	Postmeasles Pneumonia
070.20	Hpt B acte coma wo dlta
070.21	Hpt B acte coma w dlta
070.22	Hpt B chrn coma wo dlta
070.23	Hpt B chrn coma w dlta
070.41	Hpt C acute w hepat coma
070.42	Hpt DLT wo b w hpt coma
070.43	Hpt E w hepat coma
070.44	Chrnc hpt C w hepat coma
070.49	Oth vrl hepat w hpt coma
070.06	Viral hepat nos w coma
072.1	Mumps meningitis
072.2	Mumps encephalitis
072.3	Mumps pancreatitis
079.5	Retrovirus
090.42	Congen syph meningitis
093.20	Syphil endocarditis nos
093.82	Syphilitic myocarditis
094.2	Syphilitic meningitis
094.87	Syph rupt cereb aneurysm
098.89	Gonococcal inf site nec
112.4	Candidiasis of lung
112.5	Disseminated candidiasis
112.81	Candidal endocarditis
112.83	Candidal meningitis
114.2	Coccidioidal meningitis
115	Histoplasmosis*
115.1	Histoplasma capsulatum
115.00	Histoplasma capsulat nos
115.01	Histoplasm capsul mening
115.02	Histoplasm capsul retina
115.03	Histoplasm caps pericard
115.04	Histoplasm caps endocard
115.05	Histoplasm caps pneumon
115.09	Histoplasma capsulat nec
115.1	Histoplasma duboisii
115.10	Histoplasma duboisii nos
115.11	Histoplasm dubois mening
115.12	Histoplasm dubois retina
115.13	Histoplasm dub pericard
115.14	Histoplasm dub endocard
115.15	Histoplasm dub pneumonia
115.19	Histoplasma duboisii nec
115.9	Histoplasmosis, unspec
115.90	Histoplasmosis nos
115.91	Histoplasmosis meningit
115.92	Histoplasmosis retinitis
115.93	Histoplasmosis pericard
115.94	Histoplasmosis endocard
115.95	Histoplasmosis pneumonia
115.99	Histoplasmosis nec
130.0	Toxoplasm meningoenceph
130.3	Toxoplasma myocarditis
130.4	Toxoplasma pneumonitis
136.3	Pneumocystosis
204.00	Act lym leuk w/o rmsion
205.00	Act myl leuk w/o rmsion
206.00	Act mono leuk w/o rmsion
207.00	Act erth/erylk w/o rmson
208.00	Act leuk uns cl w/o rmsn
260	Kwashiorkor
261	Nutritional marasmus
262	Oth severe malnutrition
277.00	Cystic fibros w/o ileus
277.01	Cystic fibrosis w ileus
286.0	Cong factor viii diord
286.1	Cong factor ix disorder
286.6	Defibrination syndrome
320.0	Hemophilus meningitis
320.1	Pneumococcal meningitis
320.2	Streptococcal meningitis
320.3	Staphylococc meningitis
320.7	Mening in oth bact dis
320.81	Anaerobic meningitis
320.82	Mningts gram-neg bct nec
320.89	Meningitis oth spcf bact
320.9	Bacterial meningitis nos
321.0	Cryptococcal meningitis
321.1	Mening in oth fungal dis
321.4	Meningit d/t sarcoidosis
321.8	Mening in oth nonbac dis
324.0	Intracranial abscess
324.1	Intraspinal abscess
324.9	CNS abscess nos
345.11	Gen CNV epil w intr epil
345.3	Grand mal status
348.1	Anoxic brain damage
376.01	Orbital cellulitis
376.02	Orbital periostitis
376.03	Orbital osteomyelitis
398.0	Rheumatic myocarditis
403.01	Mal hyp ren w renal fail
404.01	Mal hyper hrt/ren w chf
404.03	Mal hyp hrt/ren w chf&rf
410.01	Ami anterolateral, init
410.11	Ami anterior wall, init
410.21	Ami inferolateral, init
410.31	Ami inferopost, initial
410.41	Ami inferior wall, init
410.51	Ami lateral nec, initial
410.61	True post infarct, init
410.71	Subendo infarct, initial
410.81	Ami nec, initial
410.91	Ami nos, initial
415.1	Pulmon embolism/infarct
415.11	Iatrogen pulm emb/infarc
415.19	Pulm embol/infarct nec
421.0	AC/subac bact endocard
421.1	AC endocardit in oth dis
421.9	AC/subac endocardit nos
422.0	AC myocardit in oth dis
422.90	Acute myocarditis nos
422.91	Idiopathic myocarditis
422.92	Septic myocarditis
422.93	Toxic myocarditis
422.99	Acute myocarditis nec
427.41	Ventricular fibrillation
427.5	Cardiac arrest
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.0	Nontraum extradural hem
432.1	Subdural hemorrhage
433.01	OCL bslr art w infrct
433.11	OCL crtd art w infrct
433.21	OCL vrtb art w infrct
433.31	OCL mlt bi art w infrct
433.81	OCL spcf art w infrct
433.91	OCL art nos w infrct
434.01	CRBL thrmbs w infrct
434.11	CRBL emblsm w infrct
434.91	CRBL art ocl nos w infrc
436	CVA
440.23	ATH ext ntv art ulcrtion
440.24	ATH ext ntv art gngrene
441.0	Dissecting aneurysm
441.00	DSCT of aorta unsp site
441.01	DSCT of thoracic aorta
441.02	DSCT of abdominal aorta
441.03	DSCT of thoracoabd aorta
441.1	RUPTUR thoracic aneurysm
441.3	RUPT abd aortic aneurysm
441.5	RUPT aortic aneurysm nos
441.6	Thoracoabd aneurysm rupt
446.3	Lethal midline granuloma
451.89	Thrombophlebitis nec
452	Portal vein thrombosis
453	OTH venous thrombosis*
453.0	BUDD-Chiari syndrome
453.1	Thrombophlebitis migrans
453.2	Vena cava thrombosis
453.3	Renal vein thrombosis
464.11	AC tracheitis w obstruct
464.21	AC laryngotrach w obstr
464.31	AC epiglottitis w obstr
466.1	Acute bronchiolitis
480.0	Adenoviral pneumonia
480.1	RESP syncyt viral pneum
480.2	Parinfluenza viral pneum
480.8	Viral pneumonia nec
480.9	Viral pneumonia nos
481	Pneumococcal pneumonia
482	Oth bacterial pneumonia*
482.0	K. pneumoniae pneumonia
482.1	Pseudomonal pneumonia
482.2	H.influenzae pneumonia
482.3	Streptococcal pneumonia
482.30	Streptococcal pneumn nos
482.31	Pneumonia strptococcus A
482.32	Pneumonia strptococcus B
482.39	Pneumonia oth strep
482.4	Staphylococcal pneumonia
482.40	Staphylococcal pneu nos
482.41	Staph aureus pneumonia
482.49	Staph pneumonia nec
482.8	Bacterial pneumonia nec
482.81	Pneumonia anaerobes
482.82	Pneumonia e coli
482.83	Pneumo oth grm-neg bact
482.84	Legionnaires' disease
482.89	Pneumonia oth spcf bact
482.9	Bacterial pneumonia nos
483	Pneumonia: organism nec*
483.0	Pneu mycplsm pneumoniae
483.1	Pneumonia d/t chlamydia
483.8	Pneumon oth spec orgnsm
484	Pneum in oth infec dis*
484.1	Pneum w cytomeg incl dis
484.3	Pneumonia in whoop cough
484.5	Pneumonia in anthrax
484.6	Pneum in aspergillosis
484.7	Pneum in oth sys mycoses
484.8	Pneum in infect dis nec
485	Bronchopneumonia org nos
486	Pneumonia, organism nos
487	Influenza*
487.0	Influenza with pneumonia
506.0	Fum/vapor bronc/pneumon
506.1	Fum/vapor ac pulm edema
507.0	Food/vomit pneumonitis
507.1	Oil/essence pneumonitis
507.8	Solid/liq pneumonit nec
510.0	Empyema with fistula
510.9	Empyema w/o fistula
511.1	Bact pleur/effus not tb
513.0	Abscess of lung
513.1	Abscess of mediastinum
514	Pulm congest/hypostasis
515	Postinflam pulm fibrosis
518.3	Pulmonary eosinophilia
518.5	Post traum pulm insuffic
518.81	Acute respiratry failure
519.2	Mediastinitis
528.3	Cellulitis/abscess mouth
530.4	Perforation of esophagus
530.82	Esophageal hemorrhage

ICD9 code No.	Abbreviated code title
531.00	AC stomach ulcer w hem
531.01	AC stomac ulc w hem-obst
531.10	AC stomach ulcer w perf
531.11	AC stom ulc w perf-obst
531.20	AC stomac ulc w hem/perf
531.21	AC stom ulc hem/perf-obs
531.40	CHR stomach ulc w hem
531.41	CHR stom ulc w hem-obstr
531.50	CHR stomach ulcer w perf
531.51	CHR stom ulc w perf-obst
531.60	CHR stomach ulc hem/perf
531.61	CHR stom ulc hem/perf-ob
532.00	AC duodenal ulcer w hem
532.01	AC duoden ulc w hem-obst
532.10	AC duodenal ulcer w perf
532.11	AC duoden ulc perf-obstr
532.20	AC duoden ulc w hem/perf
532.21	AC duod ulc hem/perf-obs
532.40	CHR duoden ulcer w hem
532.41	CHR duoden ulc hem-obstr
532.50	CHR duoden ulcer w perf
532.51	CHR duoden ulc perf-obst
532.60	CHR duoden ulc hem/perf
532.61	CHR duod ulc hem/perf-ob
533.00	AC peptic ulcer w hemorr
533.01	AC peptic ulc w hem-obst
533.10	AC peptic ulcer w perfor
533.11	AC peptic ulc w perf-obs
533.20	AC peptic ulc w hem/perf
533.21	AC pept ulc hem/perf-obs
533.40	CHR peptic ulcer w hem
533.41	CHR peptic ulc w hem-obs
533.50	CHR peptic ulcer w perf
533.51	CHR peptic ulc perf-obst
533.60	CHR pept ulc w hem/perf
533.61	CHR pept ulc hem/perf-ob
534.00	AC marginal ulcer w hem
534.01	AC margin ulc w hem-obst
534.10	AC marginal ulcer w perf
534.11	AC margin ulc w perf-obs
534.20	AC margin ulc w hem/perf
534.21	AC marg ulc hem/perf-obs
534.40	CHR marginal ulcer w hem
534.41	CHR margin ulc w hem-obs
534.50	CHR marginal ulc w perf
534.51	CHR margin ulc perf-obst
534.60	CHR margin ulc hem/perf
534.61	CHR marg ulc hem/perf-ob
535.01	Acute gastritis w hmrhg
535.11	ATRPH gastritis w hmrhg
535.21	GSTR Mcsl Hyprt w hmrg
535.31	ALCHL Gstritis w hmrhg
535.41	OTH SPF Gastrt w hmrhg
535.51	GSTR/DDNTS NOS w hmrhg
535.61	Duodenitis w hmrhg
537.4	Gastric/Duodenal fistula
537.83	Angio Stm/dudn w hmrhg
540.0	AC Append w peritonitis
557.0	AC VASC insuff intestine
562.02	DVRTCLO SML Int w hmrhg
562.03	DVRTCLI SML Int w hmrhg
562.12	DVRTCLO colon w hmrhg
562.13	DVRTCLI colon w hmrhg
567.0	Peritonitis in infec dis
567.1	Pneumococcal peritonitis
567.2	Suppurat peritonitis nec
567.8	Peritonitis nec
567.9	Peritonitis nos
569.60	Colstomy/enter comp nos
569.61	Colosty/enterost infectn
569.69	Colstmy/enteros comp nec
569.83	Perforation of intestine
569.85	Angio intes w hmrhg
570	Acute necrosis of liver
572.0	Abscess of liver
572.4	Hepatorenal syndrome
573.4	Hepatic infarction
575.4	Perforation gallbladder
576.3	Perforation of bile duct
577.2	Pancreat cyst/pseudocyst
579.3	Intest postop nonabsorb
580.0	AC proliferat nephritis
580.4	AC rapidly progr nephrit
580.81	AC nephritis in oth dis
580.89	Acute nephritis nec
580.9	Acute nephritis nos
583.4	Rapidly prog nephrit nos
584.5	Lower nephron nephrosis
584.6	AC renal fail, cort necr
584.7	AC ren fail, medull necr
584.8	AC renal failure nec
584.9	Acute renal failure nos
590.2	Renal/perirenal abscess
596.6	Bladder rupt, nontraum
659.30	Septicemia in labor-unsp
659.31	Septicem in labor-deliv
665.00	Prelabor rupt uter-unsp
665.01	Prelabor rupt uterus-del
665.03	Prelab rupt uter-antepar
665.10	Rupture uterus nos-unsp
665.11	Rupture uterus nos-deliv
669.10	Obstetric shock-unspec
669.11	Obstetric shock-deliver
669.12	Obstet shock-deliv w p/p
669.13	Obstetric shock-antepar
669.14	Obstetric shock-postpart
669.30	AC ren fail w deliv-unsp
669.32	AC ren fail-deliv w p/p
669.34	AC renal failure-postpar
673.00	OB air embolism-unspec
673.01	OB air embolism-deliver
673.02	OB air embol-deliv w p/p
673.03	OB air embolism-antepart
673.04	OB air embolism-postpart
673.10	Amniotic embolism-unspec
673.11	Amniotic embolism-deliv
673.12	Amniot embol-deliv w p/p
673.13	Amniotic embol-antepart
673.14	Amniotic embol-postpart
673.20	OB pulm embol nos-unspec
673.22	Pulm embol nos-del w p/p
673.23	Pulm embol nos-antepart
673.24	Pulm embol nos-postpart
673.30	OB pyemic embol-unspec
673.31	OB pyemic embol-deliver
673.32	OB pyem embol-del w p/p
673.33	OB pyemic embol-antepart
673.34	OB pyemic embol-postpart
673.80	OB pulmon embol nec-unsp
673.81	Pulmon embol nec-deliver
673.82	Pulm embol nec-del w p/p
673.83	Pulmon embol nec-antepar
673.84	Pulmon embol nec-postpar
674.00	Puerp cerebvasc dis-unsp
682	Other cellulitis/abscess*
682.0	Cellulitis of face
682.1	Cellulitis of neck
682.22	Cellulitis of trunk
682.3	Cellulitis of arm
682.4	Cellulitis of hand
682.5	Cellulitis of buttock
682.6	Cellulitis of leg
682.7	Cellulitis of foot
682.8	Cellulitis, site nec
765.01	Extreme immatur <500G
765.02	Extreme immatur 500–749G
765.03	Extreme immatur 750–999G
781.7	Tetany
785.51	Cardiogenic shock
785.59	Shock w/o trauma nec
799.1	Respiratory arrest
958.0	Air embolism
958.1	Fat embolism
958.5	Traumatic anuria
996.02	Malfunc prosth hrt valve
996.61	React-cardiac dev/graft
996.62	React-oth vasc dev/graft
996.63	React-nerv sys dev/graft
996.64	React-indwell urin cath
996.66	React-inter joint prost
996.67	React-oth int ortho dev
996.69	React-int pros devic nec
997.62	Infection amputat stump
998.0	Postoperative shock
998.3	Postop wound disruption
998.5	Postoperative infection
998.6	Persist postop fistula
999.1	Air embol comp med care
V440	Tracheostomy status
V451	Renal dialysis status
V461	Dependence on respirator

*Denotes this is a category rather than a code.

Appendix D—The IRF Market Basket

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor (for purposes of setting prospective payment system rates) based on a market basket index. The proposed market basket includes both operating and capital costs of rehabilitation facilities (that is, freestanding rehabilitation hospitals and rehabilitation hospital units). The index currently used for operating costs for rehabilitation facilities is the excluded hospital market basket. This market basket is based on 1992 cost report data and includes Medicare participating rehabilitation, long term care, psychiatric, cancer, and children's hospitals. Since freestanding rehabilitation hospitals are a component of the excluded hospital market basket, this index most closely reflects the cost shares of rehabilitation facilities. Because the excluded hospital market basket only includes operating costs, we are proposing to use the excluded hospital market basket with the addition of a capital portion to the index. We provide a brief explanation of the methodology used to develop our proposed index for rehabilitation facilities. We refer to this index as the excluded hospital (with capital) market basket. In the following discussion we describe: the methodology used to determine the operating portion of the market basket, the methodology used to determine the capital portion of the market basket, and additional analyses that help support the extent to which rehabilitation cost shares are reflected in the market basket that we are proposing.

The operating portion of the excluded hospital market basket consists of major cost categories and their respective weights. The major cost categories include wages, benefits, drugs, and a residual. The weights for the major cost categories are developed from the Medicare cost reports for FY 1992. The cost

report data used includes those hospitals excluded from the inpatient hospital prospective payment system where the Medicare average length of stay is within 15 percent (higher or lower) of the total facility average length of stay. Limiting the sample in this way provides a more accurate reflection of the structure of costs for Medicare. The detailed cost categories are derived from the Asset and Expenditure Survey, 1992 Census of Service Industries, by the Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce. This is used in conjunction with the 1992 Input-Output Tables published by the Bureau of Economic Analysis, U.S. Department of Commerce. A more detailed description of the development of this index can be found in our final rule, Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates; published in the **Federal Register** at 62 FR 45965–45996, on August 29, 1997.

As previously stated, the market basket we are proposing needs to reflect both operating and capital costs. Capital costs include depreciation, interest, and other capital-related costs. The cost categories for the capital portion of the market basket that we are proposing is developed in a similar manner as those for the inpatient hospital prospective payment system capital input price index, which is explained in the August 30, 1996 **Federal Register**. We calculated weights for capital costs, using the same set of Medicare cost reports used to develop the operating share for excluded hospitals. The resulting capital weight for the 1992 base year is 9.080 percent.

Because capital is consumed over time, depreciation and interest costs in the current year reflect both current and previous capital purchases. We use vintage weighting of current and previous capital price changes to capture this effect. Vintage weighting, which is explained in the August 30, 1996 **Federal Register** (61 FR 46197 through 46203), is the process of weighting price changes for individual years in proportion to that year's share of total purchases still being consumed.

In order to vintage weight the capital portion of the index as described above, the average useful life of both assets and debt instruments (for example, a loan, bond, or promissory note) needs to be developed. For depreciation expenses, the useful life of fixed and movable assets is calculated from the Medicare cost reports for excluded hospitals, including freestanding rehabilitation hospitals. The average useful life for fixed assets is 21 years and the average useful life for movable assets is 13 years. For interest expenses, we use the same useful life of debt instruments used in the hospital prospective payment system capital input price index. We believe that this useful life is appropriate, because it reflects the average useful life of hospital issuances of commercial and municipal bonds from all hospitals, including rehabilitation facilities. The average useful life of interest expense is determined to be 22 years. After the useful life is determined, a set of weights is calculated by determining the average proportion of depreciation or interest expense incurred during any given year during the useful life. This information is developed using the Medicare cost reports. These calculations are the same as those described for the inpatient hospital prospective payment system capital input price index in the August 30, 1996 **Federal Register**. The price proxies for each of the capital cost categories are the same as those used for the inpatient hospital prospective payment system capital input price index. The cost categories, price proxies, and base-year fiscal year 1992 weights for the excluded hospital (with capital) market basket are presented in Table 1. The vintage weights for the index are presented in Table 2.

TABLE 1.—HCFA EXCLUDED HOSPITAL INPUT PRICE INDEX WITH CAPITAL (FY 1992) STRUCTURE AND WEIGHTS

Cost category	Price/wage variable	Weights (%) Base-year: 1992
TOTAL		100.000
Compensation		57.935
Wages and Salaries	HCFA Prospective payment system Occupational	47.417
Employee Benefits	HCFA Prospective payment system	10.519
Professional fees: Non-Medical	ECI—Compensation: Prof. & Tech	1.908
Utilities		1.523
Electricity	WPI—Commercial Electric Power	0.916
Fuel Oil, Coal, etc	WPI—Commercial Natural Gas	0.365
Water and Sewerage	CPI–U—Water & Sewage	0.243
Professional Liability Insurance	HCFA—Prof. Liab. Prem	0.983
All Other Products and Services		28.572
All Other Products		22.027
Pharmaceuticals	WPI—Prescription Drugs	2.791
Food: Direct Purchase	WPI—Processed Foods	2.155
Food: Contract Service	CPI–U—Food Away fr. Home	0.998
Chemicals	WPI—Industrial Chemicals	3.413
Medical Instruments	WPI—Med. Inst. & Equip	2.868
Photographic Supplies	WPI—Photo Supplies	0.364
Rubber and Plastics	WPI—Rub. & Plast. Products	4.423
Paper Products	WPI—Convert. Paper and Paperboard	1.984
Apparel	WPI—Apparel	0.809
Machinery and Equipment	WPI—Mach. & Equipment	0.193
Miscellaneous Products	WPI—Finished Goods	2.029
All Other Services		6.544
Telephone	CPI–U—Telephone Services	0.574
Postage	CPI–U—Postage	0.268
All Other: Labor Intensive	ECI—Compensation: Service Workers	4.945
All Other: Non-Labor Intensive	CPI–U—All Items (Urban)	0.757
Capital-Related Costs		9.080
Depreciation		5.611
Fixed Assets	Boeckh-Institutional Construction: 21 year useful life	3.570
Movable Equipment	WPI—Machinery & Equipment: 13 year useful life	2.041
Interest Costs		3.212
Non-profit	Avg. Yield Municipal Bonds: 22 year useful life	2.730
For-profit	Avg, Yield AAA Bonds: 22 year useful life	0.482
Other Capital-Related Costs	CPI–U—Residential Rent	0.257

*The wage and benefit proxies are a blend of 10 employment cost indices (ECI). A detailed discussion of the price proxies can be found in the August 30, 1996 FEDERAL REGISTER final rule.

TABLE 2.—HCFA EXCLUDED HOSPITAL INPUT PRICE INDEX WITH CAPITAL (FY 1992) VINTAGE WEIGHTS

Year	Fixed assets (21 year weights)	Movable assets (13 year weights)	Interest: capital-related (22 year weights)
1	0.0201	0.0454	0.0071
2	0.0225	0.0505	0.0082
3	0.0225	0.0562	0.0100
4	0.0285	0.0620	0.0119
5	0.0301	0.0660	0.0139
6	0.0321	0.0710	0.0161
7	0.0336	0.0764	0.0185
8	0.0353	0.0804	0.0207
9	0.0391	0.0860	0.0244
10	0.0431	0.0923	0.0291
11	0.0474	0.0987	0.0350
12	0.0513	0.1047	0.0409
13	0.0538	0.1104	0.0474
14	0.0561	.....	0.0525
15	0.0600	.....	0.0590
16	0.0628	.....	0.0670
17	0.0658	.....	0.0742
18	0.0695	.....	0.0809
19	0.0720	.....	0.0875
20	0.0748	.....	0.0931
21	0.0769	.....	0.0993
22	.....	.....	0.1034
Total	1.0000	1.0000	1.0000

We further analyzed the extent to which the weights in the excluded hospital (with capital) market basket that we are proposing reflects the cost weights in rehabilitation hospitals; particularly since more than 50 percent of excluded hospitals are psychiatric hospitals. For this purpose, we conducted an analysis comparing the cost weights of rehabilitation hospitals to the cost weights for excluded hospitals. We analyzed the variations of major costs, such as wages, drugs, and capital for rehabilitation and excluded hospitals. This analysis showed that while these weights differed slightly between rehabilitation hospitals and excluded hospitals, the difference is very small. When these weights are substituted into the market basket structure for sensitivity analysis, the effect is never more than 0.2 percentage points in any given year. This difference is less than the 0.25 percentage point criteria that determines whether a forecast error adjustment under the inpatient hospital prospective payment system is warranted. We conducted this analysis in both the base year (FY 1992), and for the most recent set of cost reports (FY 1997) to determine if the difference in weights changed over time. Again, the differences were very small. Based on this analysis, we concluded that using the excluded hospital (with capital) market basket for the IRF prospective payment system will provide a reasonable measure of the price changes facing rehabilitation hospitals. We request comments on any other data sources that may be available to provide detailed cost category information on rehabilitation hospitals, or on data sources for cost categories in rehabilitation units.

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