

Inpatient Rehabilitation Facilities Reason Codes and Statements

Updated on October 1, 2019

Reason Code	Insufficient Documentation Plan of Care
IRF1A	Documentation does not support the individualized Plan of Care (POC) was completed within 4 days of admission to IRF. Refer to 42 CFR 412.622(a)(4)(iii) as described in paragraph (a)(3)(iv), Medicare Benefit Policy Manual Chapter 1, Section 110.1.3
IRF1B	Documentation does not support the Plan of Care (POC) is individualized. Refer to 42 CFR 412.622(a)(4)(iii), Medicare Benefit Policy Manual Chapter 1, Section 110.1.3
IRF1C	Documentation does not support the individualized Plan of Care (POC) included the estimated length of stay. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.3
IRF1D	Documentation does not support the individualized Plan of Care (POC) included the medical prognosis. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.3
IRF1E	Documentation does not support the individualized Plan of Care (POC) included the anticipated interventions, functional outcomes and discharge plans. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.3
IRF1F	Documentation does not support the individualized Plan of Care (POC) included the expected therapy details i.e. intensity (# hours per day), frequency (# days per week), and duration (total # of days during IRF stay). Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.3
IRF1G	Documentation does not support the individualized Plan of Care (POC) was completed by the IRF physician. Refer to 42 CFR 412.622(a)(4)(iii) as described in paragraph (a)(3)(iv), Medicare Benefit Policy Manual Chapter 1, Section 110.1.3
IRF1H	The Plan of Care (POC) was not included in the submitted documentation. Refer to 42 CFR 412.622(a)(4)(iii) as described in paragraph (a)(3)(iv), Medicare Benefit Policy Manual Chapter 1, Section 110.1.3

Reason Code	Insufficient Documentation Pre-Admission Screening
IRF2A	Documentation does not support the preadmission screen was completed or updated within the 48 hours immediately preceding the IRF admission. Refer to 42 CFR 412.622(a)(4)(i)(A), Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2B	Documentation does not support the preadmission screen was signed and dated with the rehab physician concurrence of the findings in the preadmission screening. Refer to 42 CFR 412.622(a)(4)(i)(D), Medicare Benefit Policy Manual Chapter 1, Section 110.1.1

IRF2C	Documentation does not support the preadmission screen included the patient's prior level of function. Refer to Medicare Benefit Policy Manual Chapter1, Section 110.1.1
IRF2D	Documentation does not support the preadmission screen included the patient's expected length of time to achieve documented expected level of improvement. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2E	Documentation does not support the preadmission screen included the patient's expected level of improvement. Refer to Medicare Benefit Policy Manual Chapter1, Section 110.1.1
IRF2F	Documentation does not support the preadmission screen included the patient's anticipated discharge destination from the IRF stay. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2G	Documentation does not support the preadmission screen included the patient's anticipated post-discharge treatments. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2H	Documentation does not support the preadmission screen included the patient's risks for clinical complications. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2I	Documentation does not support the preadmission screen included the conditions that caused the need for rehabilitation. Refer to 42 CFR 412.622(a)(4)(i)(B), Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2J	Documentation does not support the preadmission screen included the treatments needed (i.e. physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics). Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2K	Documentation does not support the preadmission screen included the expected frequency and duration of the treatments needed (i.e. physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics). Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2L	The preadmission screen was not included in the submitted documentation. Refer to 42 CFR 412.622(a)(4)(i)

Reason Code	Insufficient Documentation Post-Admission Physician Evaluation
IRF3A	The post-admission physician evaluation was not included in the submitted documentation. Refer to 42 CFR 412.622(a)(4)(ii), Medicare Benefit Policy Manual Chapter 1, Section 110.1.2
IRF3B	The post-admission physician evaluation did not support medical necessity of admission. Refer to Social Security Act 1862(a)(1)(A), Medicare Benefit Policy Manual Chapter 1, Section 110.1.2
IRF3C	Documentation does not support the post-admission physician evaluation was completed within twenty-four hours of admission to the IRF. Refer to 42 CFR 412.622(a)(4)(ii)(A), Medicare Benefit Policy Manual Chapter 1, Section 110.1.2

IRF3D	The post-admission physician evaluation was completed prior to admission to the IRF. Refer to 42 CFR 412.622(a)(4)(ii)(B), Medicare Benefit Policy Manual Chapter 1, Section 110.1.2
IRF3E	Documentation does not support the post-admission physician evaluation was performed by a rehabilitation physician. Refer to 42 CFR 412.622(a)(4)(ii)(A), Medicare Benefit Policy Manual Chapter 1, Section 110.1.2
IRF3F	Documentation did not support the post-admission physician evaluation was dated, timed, and authenticated by the rehabilitation provider. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.2; Medicare Program Integrity Manual Chapter 3, Section 3.3.2.4
IRF3G	Documentation does not support the post-admission physician evaluation included a documented history and physical. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.2
IRF3H	Documentation does not support the post-admission physician evaluation included a documented review of the patient's prior and/or current medical and functional conditions/comorbidities. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.2
IRF3I	Documentation does not support that a post-admission physician evaluation was completed to compare the patient's condition at the preadmission screening and identify any relevant changes since the pre-admission screening. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.2

Reason Code	Insufficient Documentation Interdisciplinary Team/Conferences
IRF4A	Documentation does not support the interdisciplinary team conference (ITC) notes were submitted. Refer to 42 CFR 412.622(a)(5); Social Security Act 1862 (a)(1), Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4B	Documentation did not consistently support the minimum intensity requirement was met for Interdisciplinary Team Conference (ITC) meetings. Team conferences were not held every 7 days throughout the stay. Refer to 2 CFR 412.622(a)(5)(B); Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4C	Documentation does not support all required participants attended each interdisciplinary team conference (ITC) throughout the IRF stay. Refer to 42 CFR 412.622(a)(5)(A); Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4D	Documentation does not support that the Interdisciplinary Team Conference (ITC) held on MM/DD/YY was led by a physician/rehab physician. Refer to 42 CFR 412.622(a)(5)(A); Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4E	Documentation does not support that a licensed or certified treating therapist was present at each team conference. A therapy assistant does not meet the requirement for a certified or registered therapist in attendance. Refer to 42 CFR 412.622(a)(5)(A); Medicare Benefit Policy Manual Chapter 1, Section 110.2.5

IRF4F	The team conference had an occupational therapy assistant as the therapist in attendance. A therapy assistant does not meet the requirement for a certified or registered therapist in attendance. Refer to 42 CFR 412.622(a)(5)(A); Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4G	Documentation does not support the progress towards and/or validity of established goals was assessed during weekly team conferences. Refer to 42 CFR 412.622(a)(5)(B); Medicare Benefit Policy Manual Chapter 1, Section 110.2.5

Reason Code	Medical Necessity
IRF5A	Documentation does not support the patient's condition required the close physician supervision, the medical management to support the necessity of an IRF stay. Refer to 42 CFR 412.622(a)(3)(iv), Medicare Benefit Policy Manual Chapter 1, Section 110.2
IRF5B	Documentation does not support that upon admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. Refer to 42 CFR 412.622(a)(3)(i), Medicare Benefit Policy Manual Chapter 1, Section 110.2
IRF5C	Documentation does not support that upon admission to the IRF the patient required multiple therapy disciplines (one of which must be physical therapy or occupational therapy). Refer to 42 CFR 412.622(a)(3)(i), Medicare Benefit Policy Manual Chapter 1, Section 110.2
IRF5D	Documentation does not support that upon admission to the IRF the patient was expected and/or able to actively participate in an intensive rehabilitation program without compromising the patient's safety. Refer to 42 CFR 412.622(a)(3)(iii), Medicare Benefit Policy Manual Chapter 1, Section 110.2
IRF5E	Documentation does not support that upon admission a measurable improvement that will be of practical value was expected in a reasonable period of time. Refer to 42 CFR 412.622(a)(3)(ii), Medicare Benefit Policy Manual Chapter 1, Section 110.2
IRF5F	Documentation does not support the patient was sufficiently stable at discharge from the acute care setting to the point the patient would be able to fully participate in the intense rehabilitative treatment provided in the IRF setting. Refer to 42 CFR 412.622(a)(3)(iii), Medicare Benefit Policy Manual Chapter 1, Section 110.2
IRF5G	Documentation does not support that the intensity requirement for the minimum rehabilitation physician visits were met. The patient must require and receive a minimum of three rehabilitation physician visits each week throughout the stay. The Post-Admission Physician Evaluation (PAPE) counts as one of the rehabilitation physician visits. Refer to 42 CFR 412.622(a)(3)(iv), Medicare Benefit Policy Manual Chapter 1, Section 110.2

Reason Code	Order
--------------------	--------------

IRF6A	Documentation does not support admission orders were written at the time of the patient's admission. Refer to 42 CFR 412.606(a), Medicare Benefit Policy Manual Chapter 1, Section 110.4
IRF6B	Documentation does not support the admission orders were signed, dated. Refer to Medicare Program Integrity Manual Chapter 3, Section 3.3.2.4

Reason Code	Billing and/or Coding
IRF7A	The medical record does not support accuracy of HIPPS code on the claim. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.5
IRF7B	Documentation does not support the discharge status code as billed on the claim. (Not a denial reason, but rather a correct coding statement). Refer to IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 3, Section 140.3.
IRF7C	Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) not submitted. Refer to 42 CFR 412.604(c), Medicare Benefit Policy Manual Chapter 1, Section 110.1.5
IRF7D	Documentation does not support that the Patient Assessment Instrument (IRF-PAI) corresponds with the patient's medical record. Refer to 42 CFR 412.606(c)(2): Medicare Benefit Policy Manual Chapter 1, Section 110.1.5
IRF7E	Documentation does not support that the patient was discharged from the Inpatient Rehabilitation Facility (IRF) within three days of admission when there were relevant changes in the patient's status that deemed the patient to not be an appropriate candidate for IRF level of care. The Health Insurance Prospective Payment System (HIPPS) code was changed to A5001. Refer to Medicare Benefit Policy Manual Chapter 1, Section 110.1.2

Reason Code	Medical Necessity – Therapy Services
IRF8A	Documentation does not support the patient generally requires an intensive rehabilitation therapy program. Refer to 42 CFR 412.622(a)(3), Medicare Benefit Policy Manual Chapter 1, Section 110.2.2
IRF8B	Documentation does not support the patient received intensive rehabilitation therapy services. Refer to 42 CFR 412.622(a)(3), Medicare Benefit Policy Manual Chapter 1, Section 110.2.2
IRF8D	Documentation does not support the treatment plan was monitored and revised as needed to support the consideration of all possible resolutions to any problems impeding the patient's progress towards established goals. Refer to 42 CFR 412.622(a)(5)(B), Medicare Benefit Policy Manual Chapter 1, section 110.2.5
IRF8E	Physical Therapy (PT)/Occupational Therapy (OT) evaluation/notes were not submitted. Refer to Medicare Benefit Policy Manual, Chapter 15, Section 220.3., Social Security Act 1833(e)

IRF8F	Documentation did not support one of the therapy disciplines to be either Physical or Occupational therapy. Refer to 42 CFR 412.622(a)(3)(i); Medicare Benefit Policy Manual Chapter 1, Section 110.2
IRF8G	Documentation does not support that therapy services began within thirty-six hours from midnight of the day of admission. Refer to 42 CFR 412.622(a)(3)(ii), Medicare Benefit Policy Manual Chapter 1, Section 110.2.2

Reason Code	Administrative
IRFXA	The file is corrupt and/or cannot be read
IRFXB	The submission was sent to the incorrect review contractor
IRFXC	A virus was found
IRFXD	Other
IRFXE	The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable.
IRFXF	The documentation submitted is incomplete
IRFXG	This submission is an unsolicited response
IRFXH	The documentation submitted cannot be matched to a case/claim
IRFXI	This is a duplicate of a previously submitted transaction
IRFXJ	The date(s) of service on the cover sheet received is missing or invalid.
IRFXK	The NPI on the cover sheet received is missing or invalid.
IRFXL	The state where services were provided is missing or invalid on the cover sheet received.
IRFXM	The Medicare ID on the cover sheet received is missing or invalid.
IRFXN	The billed amount on the cover sheet received is missing or invalid.
IRFXO	The contact phone number on the cover sheet received is missing or invalid.
IRFXP	The Beneficiary name on the cover sheet received is missing or invalid
IRFXQ	The Claim number on the cover sheet received is missing or invalid
IRFXR	The ACN on the coversheet received is missing or invalid