Inpatient Rehabilitation Facilities Reason Codes and Statements
December 8, 2022

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)(ii), 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)(ii), Medicare Benefit Policy Manual Chapter 1, Section 110.1.3
IRF1G	Documentation does not support the individualized Plan of Care (POC) was developed by the rehabilitation physician with input from the interdisciplinary team. Refer to 42 CFR 412.622(a)(4)(ii), Medicare Benefit Policy Manual Chapter 1, Section 110.1.3.
IRF1H	The documentation did not include an individualized overall Plan of Care (POC) for the patient. Refer to 42 CFR 412.622(a)(4)(ii).

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 rehabilitation physician concurred with the findings and results of the preadmission screening. Refer to 42 CFR 412.622(a)(4)(i)(D), Medicare Benefit Policy Manual Chapter 1, Section 110.1.1.
IRF2C	The preadmission screening does not include the patient's prior level of function. Refer to 42CFR 412.622(a)(4)(i)(B), Medicare Benefit Policy Manual Chapter1, Section 110.1.1
IRF2D	The preadmission screen does not include expected length of time necessary to achieve the expected level of improvement. Refer to 42 CFR 412.622(a)(4)(i)(B), Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2E	The preadmission screening does not include expected level of improvement. Refer to 42 CFR 412.622(a)(4)(i)(B) Medicare Benefit Policy Manual Chapter1, Section 110.1.1
IRF2F	The preadmission screening does not include the patient's anticipated discharge location. Refer to 42 CFR 412.622(a)(4)(i)(B), Medicare Benefit Policy Manual Chapter 1, Section 110.1.1

IRF2H	The preadmission screening does not include an evaluation of the patient's risk for clinical complications. Refer to 42 CFR 412.622(a)(4)(i)(B) Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2I	The preadmission screening does not include the conditions that caused the need for rehabilitation. Refer to 42CFR 412.622(a)(4)(i)(B), Medicare Benefit Policy Manual Chapter1, Section 110.1.1.
IRF2J	The preadmission screening does not include the treatments needed (i.e. physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics). Refer to 42 CFR 412.622(a)(4)(i)(B), Medicare Benefit Policy Manual Chapter 1, Section 110.1.1
IRF2L	The documentation does not include a preadmission screening. Refer to 42 CFR 412.622(a)(4)(i)(B), Medicare Benefit Policy Manual Chapter 1, Section 110.1.1.
IRF2M	The documentation supports the preadmission screening was not conducted by a licensed or certified clinician(s) designated by a rehabilitation physician. Refer to 42 CFR 412.622(a)(4)(i) as described in paragraph (a)(3)(iv), Medicare Benefit Policy Manual Chapter 1, Section 110.1.3.

Reason Code	Insufficient Documentation Post-Admission Physician Evaluation
IRF3A	*For discharges occurring prior to October 1, 2020:* The post-admission physician evaluation was not included in the submitted documentation. Refer to 42 CFR 412.622(a)(4)(ii).
IRF3C	*For discharges occurring prior to October 1, 2020:* The documentation does not support the post-admission physician evaluation was completed within twenty-four hours after admission to the IRF. Refer to 42 CFR 412.622(a)(4)(ii).
IRF3E	*For discharges occurring prior to October 1, 2020:* The documentation does not support the post-admission physician evaluation was performed by a rehabilitation physician. Refer to 42 CFR 412.622(a)(4)(ii).

Reason Code	Insufficient Documentation Interdisciplinary Team/ Conferences
IRF4A	The documentation does not include the results and findings of the interdisciplinary team meeting. Refer to 42 CFR 412.622(a)(5), Medicare Benefit Policy Manual Chapter 1, Section 110.2.5.
IRF4B	The documentation did not consistently support the minimum frequency requirement was met for interdisciplinary team meetings. The interdisciplinary team meetings were

	not held at a minimum of once per week. Refer to 42 CFR 412.622(a)(5)(ii), Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4C	The documentation does not support all required participants (rehabilitation physician, rehabilitation registered nurse, social worker and/or case manager, licensed or certified therapist from each therapy discipline) attended the interdisciplinary team meeting. Refer to 42 CFR 412.622(a)(5)(i), Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4D	The documentation does not support the interdisciplinary team meeting was led by a rehabilitation physician. Refer to 42 CFR 412.622(a)(5)(i), Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4E	Documentation does not support that a licensed or certified therapist from each treating discipline 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)(i), Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4G	The interdisciplinary team meeting notes do not address goal progress and/or any problems impeding the goal progress. Refer to 42 CFR 412.622(a)(5)(ii), Medicare Benefit Policy Manual Chapter 1, Section 110.2.5
IRF4H	The documentation does not include the concurrence by the rehabilitation physician with the results and findings of the interdisciplinary team meeting. Refer to 42 CFR 412.622(a)(5), Medicare Benefit Policy Manual Chapter 1, Section 110.2.5.

Reason Code	Medical Necessity
IRF5A	The documentation does not support the beneficiary required supervision by a rehabilitation physician. 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	The Documentation does not support that upon admission to the IRF the patient required active and ongoing 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	The documentation does not support the patient is sufficiently stable at the time of admission to the IRF to be able to actively participate in and benefit significantly from the intensive rehabilitation therapy program. 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
IRF5G	Documentation does not support that the rehabilitation physician conducted a face-to-face visit with the patient a minimum of three days per week. Beginning with the second week of the IRF admission, a qualified non-physician practitioner may conduct 1 of the 3 required face-to-face visits per week, if the patient discharged on/after 10/01/2022. Refer to 42 CFR 412.622(a)(3)(iv), Medicare Benefit Policy Manual Chapter 1, Section 110.2

Reason Code	Billing and/or Coding
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	*Educational note:* The documentation did not contain the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). The IRF-PAI should generally be included in the documentation. Refer to 42 CFR 412.606(b), Medicare Benefit Policy Manual Chapter 1, Section 110.1.5.

Reason Code	Medical Necessity – Therapy Services
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
IRF8G	Documentation does not support that therapy services began within thirty-six hours from midnight of the day of admission to the IRF. Refer to 42 CFR 412.622(a)(3)(ii), Medicare Benefit Policy Manual Chapter 1, Section 110.2.2.

Reason Code	ADMINISTRATIVE/OTHER *(For Transmission via esMD)*
GEX04	Other
GEX05	The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable.
GEX06	The documentation submitted is incomplete

GEX07	This submission is an unsolicited response
GEX08	The documentation submitted cannot be matched to a case/claim
GEX09	This is a duplicate of a previously submitted transaction
GEX10	The date(s) of service on the cover sheet received is missing or invalid.
GEX11	The NPI on the cover sheet received is missing or invalid.
GEX12	The state where services were provided is missing or invalid on the cover sheet received.
GEX13	The Medicare ID on the cover sheet received is missing or invalid.
GEX14	The billed amount on the cover sheet received is missing or invalid.
GEX15	The contact phone number on the cover sheet received is missing or invalid.
GEX16	The Beneficiary name on the cover sheet received is missing or invalid
GEX17	The Claim number on the cover sheet received is missing or invalid
GEX18	The ACN on the coversheet received is missing or invalid
GEX19 (Effective 10/01/2021)	Provider is exempted from submitting this PA request