SECTION A: ADMINISTRATIVE INFORMATION

Identification Information

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

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

   NOTE: For those patients with a Medicare Advantage (Medicare Part C) Plan, a Medicare number is still needed to complete this section of the IRF-PAI. For additional information regarding how to obtain this number, reference the IRF PPS FY 2010 final rule (74 FR 39799).

   NOTE: In an effort to fight identity theft for Medicare beneficiaries, CMS is replacing the SSN-based Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI).

   April 2019 – December 31, 2019: enter the patient's HICN, or the patient's new MBI. **After December 31, 2019:** Enter the MBI. Do not report the patient's SSN-based HICN.
3. **Patient Medicaid Number:** Enter the patient's Medicaid Number. Verify the number through the business office.

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

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

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

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

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

8. **Gender:** Enter the patient's gender as:
   (1- Male; 2- Female)

9. **Race/Ethnicity:** Check all that apply.
   (A. American Indian or Alaska Native, B. Asian, C. Black or African American, D. Hispanic or Latino, E. Native Hawaiian or Other Pacific Islander, F. White)

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

10. **Marital Status:** Enter the patient's marital status at the time of admission.
    (1- Never Married; 2- Married; 3- Widowed; 4- Separated; 5- Divorced)

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

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

Admission Information

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

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

13. **Assessment Reference Date:** This is the 3rd calendar day of the rehabilitation stay, which represents the last day of the 3-day admission assessment time period. These 3 calendar days are the days during which the patient's clinical condition should be assessed. The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31)*, and *YYYY* is the full year (e.g., *2014*). **Example:** If Admission Date is 07/04/14, then the Assessment Reference Date is 07/06/14.

    NOTE: If the stay is less than 3 calendar days, the admission assessment reference date is the last day of the stay (either day 1 or day 2).

    NOTE: If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days.

Examples

1. Patient was admitted to IRF on 7/4/14. Patient was discharged to Acute Care on 7/6/14. Patient returned to IRF on 7/7/14.

   Coding: The assessment reference date would be 7/7/14. Day 1 would be 7/4/14, Day 2 would be 7/5/14 and Day 3 would be 7/7/14.

2. Patient was admitted to IRF 7/4/14. Patient was discharged to Acute Care on 7/5/14. Patient returned to IRF on 7/6/14.

   Coding: The assessment reference date would be 7/7/14. Day 1 would be 7/4/14, Day 2 would be 7/6/14 and Day 3 would be 7/7/14.

14. **Admission Class:** Enter the admission classification of the patient, as defined below:
   1- Initial Rehab: This is the patient's first admission to any inpatient rehabilitation facility for this impairment.
   2- THIS CODE IS NO LONGER VALID
   *3- Readmission: This is a stay in which the patient was previously admitted to an inpatient rehabilitation facility for this impairment, but is **NOT** admitted to the current rehabilitation program DIRECTLY from another rehabilitation program.*
   4- Unplanned Discharge: This is a stay that lasts less than 3 calendar days because of an unplanned discharge (e.g., due to a medical complication). If the patient stays less than 3 calendar days, see the first page of Section II for item completion instructions.
   5- Continuing Rehabilitation: This is part of a rehabilitation stay that began in another rehabilitation program. The patient was admitted directly from another inpatient rehabilitation facility.

15. **Admit From:** Enter the setting from which the patient was admitted to rehabilitation.
   01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
   02- Short-term General Hospital
   03- Skilled Nursing Facility (SNF)
   04- Intermediate Care
   06- Home under care of organized home health service organization
   50- Hospice (home)
   51- Hospice (institutional facility)
   61- Swing Bed
   62- Another Inpatient Rehabilitation Facility
   63- Long-Term Care Hospital (LTCH)
   64- Medicaid Nursing Facility (NF)
   65- Inpatient Psychiatric Facility
   66- Critical Access Hospital (CAH)
   99- Not Listed

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

16. **Pre-Hospital Living Setting:** Enter the setting where the patient was living prior to being hospitalized.
   01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
   02- Short-term General Hospital
   03- Skilled Nursing Facility (SNF)
   04- Intermediate Care
   06- Home under care of organized home health service organization
   50- Hospice (home)
   51- Hospice (institutional facility)
   61- Swing Bed
   62- Another Inpatient Rehabilitation Facility

63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

17. **Pre-Hospital Living With:** Enter the relationship of any individuals who resided with the patient prior to the patient's hospitalization. If more than one person qualifies, enter the first appropriate category on the list.
    ** Complete this item *only* if you selected code 01 (Home) in Item 16 (Prehospital Living Setting).
    (01- Alone; 02- Family/Relative; 03- Friends; 04- Attendant; 05- Other)

Payer Information

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

20. **Payment Source:** Enter the source of payment for inpatient rehabilitation services. Enter the appropriate category for both primary and secondary source of payment.
    (02- Medicare Fee For Service; 51- Medicare-Medicare Advantage; 99- Not Listed)
    A. **Primary Source**
    B. **Secondary Source**

Examples and Specific Coding Tips for Change in Payer Source

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

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

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

   Coding and Rationale: According to Chapter 1, Section 90 of the Medicare Claims Processing Manual (Pub. 100-04 located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html), whichever payer the patient is enrolled in at the time of admission continues to be the payer for the patient's entire stay. Thus, the Medicare Advantage Plan would continue to be the payer

for the patient's entire IRF stay and the facility would not complete another IRF-PAI. The IRF stay would continue as planned under the Medicare Advantage Plan.

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

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

Medical Information

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

21. **Impairment Group:** For the admission assessment, enter the code that best describes the primary reason for admission to the rehabilitation program (Codes for this item are listed in the table listed Impairment Group Codes).
22. **Etiologic Diagnosis:** Enter the ICD code(s) to indicate the etiologic problem that led to the impairment for which the patient is receiving rehabilitation (Item 21 - Impairment Group). Refer to Section 6 of this manual for ICD codes associated with specific Impairment Groups. Commonly used ICD codes are listed, but the list is not exhaustive. Consult with health information management staff and current ICD coding books for exact codes.
23. **Date of Onset of Impairment:** Enter the onset date of the impairment that was coded in Item 21 (Impairment Group). The date should take the form *MM/DD/YYYY*, where *MM* is a 2-digit code for the month (e.g., *01* for January, *12* for December), *DD* is the day of the month (e.g., from *01* to *31),* and *YYYY* is the full year (e.g., *2014*).

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

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

Coding Tips

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

Impairment group	Date of Onset
Stroke**	Date of admission to acute hospital. If this is not the patient's first stroke, enter the date of the most recent stroke
Brain Dysfunction	
Traumatic	Date of Injury
Non-traumatic	More recent date: date of surgery (e.g., removal of brain tumor) or date of diagnosis
Neurological Conditions	
Multiple Sclerosis	Date of exacerbation
All Remaining Neurological Conditions	Date of diagnosis
Spinal Cord Dysfunction	
Traumatic	Date of injury
Non-traumatic	More recent date: date of surgery (e.g., tumor) or date of diagnosis
Orthopaedic Conditions	
Fractures	Date of fracture
Replacement	Date of surgery
Pulmonary Disorders	
COPD	Date of initial diagnosis (not exacerbation)
Pulmonary Transplant	Date of surgery
Medically Complex Conditions**	
Infections	Date of admission to acute hospital
Neoplasms	Date of admission to acute hospital
Nutrition	Date of admission to acute hospital
Circulatory	Date of admission to acute hospital
Respiratory	Date of admission to acute hospital
Terminal Care	Date of admission to acute hospital
Skin Disorders	Date of admission to acute hospital
Medical/Surgical	Date of admission to acute hospital
Other Medically Complex Conditions	Date of admission to acute hospital
Other Impairment Groups	
Amputation	Date of most recent surgery
Arthritis	Date of diagnosis (if arthroplasty, see impairment group "Orthopaedic Conditions")
Pain Syndromes	Date of onset related to cause (e.g., fall, injury)
Cardiac Disorders	More recent date: Date of diagnosis (event) or date of surgery (e.g., bypass, transplant)
Burns	Date of burn(s)
Congenital Deformities	Date of birth

Impairment group	Date of Onset
Other Disabling Impairment	Date of diagnosis
Major Multiple Trauma	Date of trauma
Developmental Disabilities	Date of birth
Debility**	Date of acute hospital admission

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

24**. Comorbid Conditions:** Enter up to twenty-five (25) ICD codes for comorbid conditions. A patient comorbidity is defined as a secondary condition a patient may have in addition to the primary diagnosis for which the patient was admitted to the IRF. Enter ICD codes which identify comorbid conditions that are not already included in the Impairment Group Code (IGC).

General coding tips:

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

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

  Example: The patient has 15 comorbid conditions. The provider should complete 15 spaces for this item.

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

(0- No; 1- Yes)

General coding tips:

- If the code 0- No is entered into this item, then that means that either the patient does not have any arthritis conditions recorded in items #21, #22, or #24 of the IRF-PAI or that the arthritis conditions recorded in #21, #22, or #24 of the IRF-PAI fail to meet the

applicable regulatory requirements for IRF classification (in 42 Code of Federal Regulations 412.29(b)(2)(x), (xi), and (xii)).

- If the code 1- Yes is entered into this item, then this claim may be selected by the MAC for review of the documentation in the IRF medical record to assure that the patient has met all of the applicable regulatory requirements, including that the patient has completed an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the IRF admission. CMS expects that the IRF will obtain copies of the therapy notes from the outpatient therapy or from the therapy services provided in other less intensive settings and include these in the patient's medical record at the IRF (in a section for prior records). These prior records will be available to the MAC staff who reviews the medical records for compliance with the applicable regulatory requirements.

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

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

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

or services in other less intensive rehabilitation services" in these regulations means the following:

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

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

Coding Instructions

- Measure the patient's height in accordance with the facility's policies and procedures, which should reflect current standards of practice (shoes off, etc.)
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.

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

Coding Instructions

- Measure the patient's weight consistently, according to standard facility practice (e.g., in a.m. after voiding, with shoes off, etc.).

- If the patient has been weighed multiple times during the assessment period, use the first weight.
- Use mathematical rounding (e.g., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.
- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code ("-") and document the rationale on the patient's medical record.

Discharge Information

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

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

41. **Patient discharged against medical advice?** Enter one of the following codes:
    (0- No; 1- Yes)

42. **Program Interruptions:** A program interruption is defined as the situation where a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the 3rd calendar day. Use the following codes to indicate that a program interruption occurred:
    0- No, there were no program interruptions
    1- Yes, there was one or more program interruption(s)

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

43C. 2nd Interruption Date
43D. 2nd Return Date

43E. 3rd Interruption Date
43F. 3rd Return Date

44C. **Was patient discharged alive?**
(0- No; 1- Yes)

44D. **Patient's discharge destination/living setting, using codes below:**
(answer only if 44C= 1; if 44C= 0, skip to item 46)
01- Home (Private home/apt., board/care, assisted living, group home, transitional living)
02- Short-term General Hospital
03- Skilled Nursing Facility (SNF)
04- Intermediate Care
06- Home under care of organized home health service organization
50- Hospice (home)
51- Hospice (institutional facility)
61- Swing Bed
62- Another Inpatient Rehabilitation Facility
63- Long-Term Care Hospital (LTCH)
64- Medicaid Nursing Facility (NF)
65- Inpatient Psychiatric Facility
66- Critical Access Hospital (CAH)
99- Not Listed

NOTE: The IRF-PAI discharge date must be the same as the claim date.

45. **Discharge to Living With:**
(Code only if item 44C is 1- Yes and 44D is 01- Home; Code using 1- Alone; 2- Family/Relatives; 3- Friends; 4- Attendant; 5-Other)

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

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

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

Therapy Information

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

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

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

Examples for O0401

1. Mr. W is admitted to the IRF on 11/1/2015 and is discharged on 11/5/2015.

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

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

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

Examples for O0402

1. Mrs. C is admitted to the IRF on 11/1/2015 and is discharged on 11/14/2015.

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

2. Mr. T is admitted to the IRF on 11/1/2015 and is discharged on 11/11/2015.

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

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

Helpful Terminology and Information

- **Individual Therapy**: The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) to one patient at a time (this is sometimes referred to as "one-on-one" therapy).
- **Concurrent Therapy**: The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating 2 patients at the same time who are performing different activities.

  NOTE: When conducting concurrent and group therapy sessions, start and end times do not need to be the same for all patients participating. The exact time spent for each patient participating in a concurrent or group therapy session should be reported as such. Any additional time either prior to or following participation in a group or concurrent therapy session that a patient receives one-on-one therapy should be recorded as individual therapy. We believe that providers will be able to accurately and effectively document the amount of time that the patient is receiving therapy, as well as the correct mode.
- **Group Therapy**: The provision of therapy services by one licensed/certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating 2-6 patients at the same time who are performing the same or similar activities.

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

  NOTE: The therapist may only provide therapy to one group at a time. Example: One therapist is not allowed to provide therapy to two groups of 6 patients. This will NOT meet the definition stated above.
- **Co-Treatment Therapy**: The provision of therapy services by more than one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed therapist) from different therapy disciplines to 1 patient at the same time.

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

Examples of Modes of Therapy

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

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

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

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

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

   Coding: Patient A- Total minutes of Group therapy: 44 minutes (2:00 pm to 2:12 pm, 2:28 pm to 3:00 pm)

   Patient B- Total minutes of Group therapy: 37 minutes (2:00 pm to 2:37 pm)
   Patient C- Total minutes of Group therapy: 60 minutes (2:00 pm to 3:00 pm)
   Patient D- Total minutes of Group therapy: 60 minutes (2:00 pm to 3:00 pm)

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

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

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

Coding Examples for Therapy Information

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

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

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

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

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

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

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

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

5. On 10/23/2015, Ms. F. was seen for a one-on-one (individual therapy) PT session for endurance training for 65 minutes. She then attended an OT cooking group for 45 minutes along with 4 other patients. Ms. F. was then seen for a one-on-one (individual therapy) SLP session for 30 minutes to do oral motor exercises and another one-on-one (individual therapy) SLP session 40 minutes during lunch for swallowing therapy.

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

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

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

7. On 10/25/2015, PT treated Ms. F for 65 minutes in a group of 6 people and they worked on upper and lower extremity strengthening. Ms. F. was seen for a one-on-one (individual therapy) OT session to work on ADL training for 45 minutes and SLP then saw her at the same time as one other person while she worked on oral motor exercises and the other patient was doing a cognitive exercise for 30 minutes.

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

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

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

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

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

Coding tips for Therapy Information:

- Therapy minutes cannot be rounded for the purposes of documenting therapy provided in an IRF.
- Therapy evaluations do count as the initiation of therapy services.
- The time spent in family conferences does not count towards counting therapy minutes on the IRF-PAI.
- "Therapy time" is time spent in direct contact with the patient. Time spent documenting in the patient's medical record, unsupervised modalities, and significant periods of rest are examples of time not spent in direct contact with the patient and, therefore, may not be documented in this section of the IRF-PAI.

- If the patient has an interrupted stay, record the total number of minutes of therapy the patient received in the IRF for that week the same as if the interrupted stay did not occur. As long as the IRF records the interrupted stay in items 42 and 43 of the IRF-PAI, we will account for the presence of the interrupted stay in analyzing the data.