CHAPTER 3: CLARIFICATION OF TERMINOLOGY

Activities of Daily Living (ADL) — Activities performed as part of a person's daily routine such as self-care, bathing, dressing, eating, and toileting.

Activity — The performance of a task or action by an individual (definition from the World Health Organization ICF).

Activity Limitation — A restriction or lack of ability to perform an activity in the manner or within a range considered normal for a person for the same age, culture, and education.

Ancillary Services — Health services other than room and board. These may include x-ray, laboratory, and therapy services.

Another Inpatient Rehabilitation Facility — For the purposes of coding items 15A, 16A, and 44D, this code should be used when a patient is admitted from/transferred to another inpatient rehabilitation facility.

Assessment period — The 3-day assessment period for the admission assessment includes the day of admission and the 2 days following the day of admission, ending at 11:59 pm. The discharge assessment period includes the day of discharge and the 2 calendar days prior to the day of discharge.

Assessment Reference Date — The specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period. For the admission assessment, the Assessment Reference Date is the third calendar day that the patient has been in the inpatient rehabilitation facility. For the discharge assessment, the Assessment Reference Date is the date that the patient is discharged from the inpatient rehabilitation facility, or the date that the patient ceases to receive Medicare Part A fee-for-service inpatient rehabilitation services.

Case Mix Group (CMG) — A patient classification system that groups together inpatient medical rehabilitation patients who are expected to have similar resource utilization needs and outcomes.

CMS — Centers for Medicare and Medicaid Services.

Comorbidity — 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. The patient comorbidity/ies listed in Item 24 of the IRF-PAI should have significant impact on the patients' treatment for their primary diagnosis.

Complication — A specific patient condition that affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category, and which began after the rehabilitation stay started.

Critical Access Hospital — For the purposes of coding items 15A, 16A, and 44D, this code should be used to identify an admission/transfer to a critical access hospital (CAH) for inpatient

care. Admission, discharges, or transfers to a critical access hospital (CAH) swing bed should still be coded with Code 61.

Discharge — A Medicare patient in an inpatient rehabilitation facility is considered discharged when one of the following occurs:

1. The patient is formally released.
2. The patient dies in the inpatient rehabilitation facility.

Etiologic Diagnosis — Enter the ICD code to indicate the etiologic problem that led to the impairment for which the patient is receiving rehabilitation (Item 21 - Impairment Group). Refer to Appendix A of this manual for ICD codes associated with specific Impairment Groups. Commonly used ICD codes are listed, but the list is not exhaustive. Consult with health information management staff and current ICD coding books for exact codes.

Falls — Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (e.g., a patient pushes another patient). An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall.

Home — For the purposes of coding items 15A, 16A, and 44D, this includes home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

Home under care of home health service organization — For the purposes of coding items 15A, 16A, and 44D, this code should be used a patient is:

- Admitted from/discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs)—whether home attendant, nursing aides, certified attendants, etc.
- Admitted from/discharged /transferred to a foster care facility with home care; and
- Admitted from/discharged to home under a home health agency with DME.

This code should not be used for home health services provided by a:

- DME supplier or
- Home IV provider for home IV services.

Hospice (home) — For the purposes of coding items 15A, 16A, and 44D, this code should be used if the patient was admitted from/discharged to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and did/will receive in-home hospice services.

Hospice (institutional facility) — For the purposes of coding items 15A, 16A, and 44D, this code should be used if the patient was admitted from/discharged to an inpatient facility that is qualified and the patient received/will receive the general inpatient hospice level of care, or, if the patient was admitted from/discharged to a facility that is qualified and the patient received/will receive hospice inpatient respite level of care.

Impairment — Any loss or abnormality of psychological, physiological, or anatomical structure or function.

Impairment Group Code — Describes the primary reason that the patient is being admitted to the rehabilitation program, and relates directly to the goals of the rehabilitation program.

Inpatient Psychiatric Facility — For the purposes of coding items 15A, 16A, and 44D, this code should be used when a patient is admitted from/transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

Incomplete stay — Patients who meet the criteria for incomplete stays include patients who are discharged to an acute care setting (such as short-stay acute hospital, critical access hospital, inpatient psychiatric facility, or long-term care hospital), patients who die while in the IRF, patients who leave the IRF against medical advice, and patients with a length of stay less than 3 days. For patients with incomplete stays, the discharge self-care and mobility items are skipped.

Intermediate care — For the purposes of coding items 15A, 16A, and 44D, this code is defined at the state level for specifically designated intermediate care facilities. It is also used:

- To designate patients that are admitted from/discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification, or
- For admissions from/discharges/transfers to state designated Assisted Living Facilities.

International Classification of Diseases, 10th Edition, Clinical Management (ICD-10) — A listing of diagnoses and identifying codes used to report diagnoses for individuals.

Interrupted Stay — A patient that is discharged from the IRF and returns to the same IRF within 3 consecutive calendar days. Since Medicare treats this situation as one combined IRF stay, the IRF would not need to repeat all of the required documentation when the patient returns to the IRF after the interruption. However, we would expect the IRF to update the information in the patient's medical record to make sure that it is current (i.e., update the patient's condition, comorbidities, rehabilitation goals, plan of care, etc.). Of course, the patient must continue to meet the criteria for admission to an IRF, and all of the elements required during the patient's stay (such as the 3 physician visits per week, the weekly interdisciplinary team meetings, etc.) must all continue to take place. If the patient returns to the IRF in 4 or more consecutive days (that is, it is not considered an interrupted stay), then all of the required documentation must be completed as with any "new" IRF patient.

Length of Stay (LOS) — The number of days a patient spends in the inpatient rehabilitation facility. The day of discharge is not counted in the length of stay calculation. It does not include the interrupted stay days. It includes all days that the patient is in the IRF for the midnight census.

Long-Term Care Hospital (LTCH) — For the purposes of coding items 15A, 16A, and 44D, this code should be used when admitting/discharging/transferring a patient to a long-term care hospital.

Major surgery — Generally, for the purposes of the IRF-PAI, major surgery refers to a procedure that meets all the following criteria: 1) the patient was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the inpatient rehabilitation facility (IRF), 2) the surgery carried some degree of risk to the patient's life or the potential for severe disability.

Medicaid — A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.

Medicaid Nursing Facility — For the purposes of coding items 15A, 16A, and 44D, this code should be used when a patient is admitted from/transferred to a nursing facility that has no Medicare certified beds. If any beds at the facility are Medicare certified, then the provider should use either status Code 03 or 04, depending on:

- The level of care the patient is receiving; and
- Whether the bed is Medicare certified or not.

Medicare — A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities.

- **Medicare Part A:** The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, home health agencies, and hospices.
- **Medicare Part B:** The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services.
- **Medicare Part C (Medicare Advantage):** Plans that are offered by private companies approved by Medicare.

Onset Days — The number of days from acute onset of the impairment to admission to the inpatient rehabilitation facility.

Orthosis — An appliance (device) applied over a portion of a limb or the trunk and used to support or immobilize body parts, correct or prevent deformity, or assist or restore function. Anti-embolic (and other) stockings, abdominal binders, and elastic wraps are examples of orthoses.

Outlier — Observation outside a certain range differing widely from the rest of the data.

Outlier Payment — An additional payment beyond the standard federal prospective payment for cases with unusually high costs.

Participation — An individual's involvement in life situations in relation to health conditions, body functions, and structures, activities and contextual factors (definition from the World Health Organization's ICF).

Patient Assessment Instrument — A document that contains clinical, demographic, and other information on a patient.

Prospective Payment System (PPS) — A system of payments to a health care facility at a predetermined rate for treatment regardless of the cost of care for a specific patient.

Prosthesis — A device that replaces a body part.

Qualified Clinician — Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

Rehabilitation Impairment Category (RIC) — The highest level of classification for the payment (Case Mix Group) categories. The RIC is not recorded on the IRF-PAI, but is assigned by the software based on the admission impairment group code.

Short-term General Hospital — For the purposes of coding items 15A, 16A, and 44D, refers to a short-term acute care hospital.

Skilled Nursing Facility — For the purposes of coding items 15A, 16A, and 44D, refers to a Medicare certified nursing facility in anticipation of skilled care. For hospitals with an approved swing bed arrangement, use Code 61- Swing Bed. This code should be used regardless of whether or not the patient had/has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay was/will be covered by Medicare.

Swing bed — For the purposes of coding items 15A, 16A, and 44D, this code should be used for patients admitted from/discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement. When a patient is admitted from/discharged from an acute hospital to a Critical Access Hospital (CAH) swing bed, use Code 61.

Transfer (In the case of a short stay transfer policy) — The release of a Medicare inpatient from one inpatient rehabilitation facility to another inpatient rehabilitation facility, an acute care hospital, a long-term care hospital, a skilled nursing facility or a nursing facility that qualifies to receive Medicare or Medicaid payments.

Week — A week is a 7 consecutive calendar day period starting with the day of admission.