Transient Ischemic Attack (TIA)

ORG: M-5360 (RFC)
Link to Codes

MCG Health
Recovery Facility Care
30th Edition

Clinical Indications for Admission to Recovery Facility

- Skilled nursing facility (SNF) or subacute facility care is/was needed for appropriate care of patient because of **ALL** of the following:
  - There are no acute hospital care needs and **1 or more** of the following(1):
    - Patient requires 3-day qualifying hospital stay or applicable waiver, and care is related to hospital condition.[A]
    - Patient does not require a prequalifying stay.
  - The patient has Intense and complex care needs that make recovery facility care safer and more practical than attempting care at a lower level and **ALL** of the following[B](4):
    - These care needs include the multiple components of care that are delivered by skilled professionals at a recovery facility.[C]
    - There is a plan to provide **ALL** of the following(6)(7):
      - Care plan management and evaluation to meet patient needs, achieve treatment goals, and ensure medical safety(2)
      - Observation and assessment of patient's changing condition to evaluate need for treatment modification or for additional procedures until condition stabilized[D]
      - Education services to teach patient self-maintenance or to teach caregiver patient care(9)
      - Skilled care daily (or more frequent), including **1 or more** of the following[E](10)(11):
        - Nursing treatments needed for **1 or more** of the following(6):
          - Oxygen administration, starting or managing changes(12)

- Patient care training and assistance for **1 or more** of the following(13):
  - Exercise program (eg, range of motion, pulmonary, cardiac)(14)
  - Safe performance of ADL (eg, dressing, communicating, eating)
  - Skilled restorative nursing program[F](2)
- Therapy services (PT, OT, or SLP) needed for **1 or more** of the following[G](2):
  - Rehabilitation therapy treatments needed for **1 or more** of the following:
    - Ongoing assessment of rehabilitation needs and potential (eg, range of motion, strength, balance)
    - Supervision of therapeutic exercises or activities to ensure patient safety and treatment effectiveness
    - Gait evaluation and training
    - Restoration of speech or swallowing with services of speech-language pathologist
  - Maintenance therapy treatments needed for **ALL** of the following[H]:
    - Maintain the current condition or prevent/slow further deterioration.
    - Supervision of therapeutic exercises or activities to ensure patient safety and treatment effectiveness

Alternative Levels of Care

- Patient may be candidate for other levels of care, including:
  - Home care. For admission criteria, see Transient Ischemic Attack (TIA) HC.

Length of Stay

Length of stay is displayed as percentiles that are based on the observed utilization of subacute or skilled rehabilitation facility length of stay for this diagnosis. For guidelines with low claims data volume, length of stay statistics that are displayed are from combined categories (eg, major postoperative and major medical). Individual patients may require shorter or longer stays as appropriate for their clinical status and care needs. This table is designed to allow organizations to define their goals for subacute or skilled rehabilitation utilization by choosing from the displayed range.

Subacute or Skilled Nursing Rehabilitation Commercial Length of Stay					Subacute or Skilled Nursing Rehabilitation Medicare Length of Stay				
10%ile	20%ile	30%ile	40%ile	50%ile	10%ile	20%ile	30%ile	40%ile	50%ile
3	7	11	14	15	8	12	15	18	21

Evaluation and Treatment

General Treatment Course

Stage	Clinical Status	Interventions
1	• **Clinical indications for admission met** • Recovery facility comprehensive assessment and initial evaluation complete[I] **QM**(16) • Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment SR complete for evaluation of current level of functioning (eg, Activities of Daily Living (ADL) Scoring Tool Calculator) **QM** • Psychosocial Assessment SR complete **QM**	• Transition of care planning initiated with evaluation for next level of care **QM** • Interdisciplinary care plan established and implemented **QM** • Chronic condition management as indicated(22)(23)

	• Social determinants of health screening complete. See Social Determinants of Health Screening Tool SR for further information. **QM** • Medication reconciliation complete. See Medication Reconciliation Tool SR for more information. **QM**(17)(18) • Hospital readmission risk factor evaluation **QM** [J][K](21) • Rehabilitation or maintenance therapy program initiated with service frequency at patient's maximum participation level without compromising safety or exceeding ability or tolerance[L](2) • Skilled needs identified	• DVT prophylaxis(20)(24) • Education for self-care **QM** (22)(25) • Fall risk management **QM** (26) • Laboratory testing or monitoring, if ordered(27) • Medication management **QM** (24)(28)(29) • Nutrition management(30) • Pressure injury risk management **QM** (31) • Psychosocial issues identified and management initiated, as needed **QM** (32)(33) • Respiratory care[M] • Thromboprophylaxis **QM** (24) • Physical therapy (PT) referral and evaluation • Occupational therapy (OT) referral and evaluation • Speech-language pathology (SLP) referral and evaluation
2	• **Therapeutic response to interventions QM** • **Rehabilitation or maintenance therapy program established and patient participating as able with evaluation of current level of functioning (eg, Activities of Daily Living (ADL) Scoring Tool Calculator) [L] QM(2)** • **Physical therapy (PT) progression** • **Occupational therapy (OT) progression** • **Speech-language pathology (SLP) progression**	• Care plan continues. • Ongoing assessment of clinical needs • Transition of care planning continues with evaluation for next level of care. **QM** • Education continues. **QM**
3	• Medical equipment and supplies available at next level of care, and safe use demonstrated • **Medical status stable for patient's condition and manageable at lower level of care** • **Medication regimen established and reconciliation completed QM** • **Rehabilitation or maintenance therapy program completed for safe transfer to lower level of care, or patient no longer demonstrating significant functional gains (eg, Activities of Daily Living (ADL) Scoring Tool Calculator)[L](2)** • **Skilled services (as needed) and logistical requirements can be met at lower level of care.** • **Transition plans and education understood**	• **Transition of care planning completed QM** • Safe to go home and transition to community or transition to alternative level of care (eg, home care) **QM**

Recovery Milestones are indicated in **bold**.

Extended Stay

Extended recovery facility stay may be: brief (1 to 3 days), moderate (4 to 7 days), or prolonged (more than 7 days).

- Extended recovery facility stay may be indicated when **ALL** of the following exist[N]:
  - Continued absence of acute hospital care needs
  - There are Intense and complex care needs making inpatient care a more efficient option.
  - Skilled care needed **at least daily** for **1 or more** of the following:
    - Deep venous thrombosis (DVT) or pulmonary embolus (PE) management; examples include(35):
      - Pharmacoprophylaxis initiation(36)
      - Hemodynamic measurements outside normal limits
      - Laboratory values outside normal limits
      - Signs of active bleeding
      - Assessment or care unmanageable at lower level of care
      - Expect brief to moderate stay extension.
    - Fall management; examples include(37)(38):
      - Functional status significantly impaired, impacting ability to perform ADL or IADL
      - Evaluation and treatment for underlying medical etiology of fall
      - Treatment of fall injury, and injury regimen not established
      - Assessment or care unmanageable at lower level of care
      - Expect brief to moderate stay extension.
    - Gastrointestinal complications management; examples include(39)(40):
      - Nutrition and oral hydration not tolerated or maintained
      - Stool output inadequate for medical condition or surgical procedure
      - Bowel function impeded by opioids
      - Laboratory values outside normal limits
      - Assessment or care unmanageable at lower level of care
      - Expect brief to moderate stay extension.
    - Mental status changes; examples include(41):
      - Underlying medical etiology of mental status change undetermined, and patient's mental status not improved or at baseline
      - Danger to self or others
      - Behavioral crisis management (eg, physical or chemical restraints) needed(42)
      - Behavioral symptoms (eg, agitation, somnolence, or inappropriate behavior) that interfere with medical care
      - Laboratory values outside normal limits
      - Assessment or care unmanageable at lower level of care
      - Expect brief to moderate stay extension.
    - Respiratory management; examples include(12)(43):
      - Breathing abnormalities and oxygen regimen not established
      - Laboratory values outside normal limits
      - Respiratory status assessment to evaluate patient's response to treatment (eg, suctioning or pulmonary hygiene that requires skilled intervention or monitoring)(16)
      - Assessment or care unmanageable at lower level of care
      - Expect brief to moderate stay extension.
    - Significant comorbid disease exacerbation with need for skilled clinical intervention and monitoring(44)
      - Assessment or care unmanageable at lower level of care
      - Stay extension varies depending on condition.

- PT, OT, or SLP services; examples include(45):
  - Unanticipated functional problems impacting safe completion of therapy
  - Multiple comorbidities or frailty impairing functional improvement
  - Cognitive impairment requiring additional intervention and education(46)
  - Communication impairment requiring additional intervention and education
  - Assessment or care unmanageable at lower level of care
  - Expect brief to moderate stay extension.

Patient Education

- Patient and caregiver education. See Transient Ischemic Attack (TIA): Patient Education for Clinicians SR.

Discharge Planning

- Transition of care planning may include(13):
  - Assessment and early establishment of anticipated discharge destination and plans for care, including(4):
    - Treatment plan development involving multiple providers
    - Premorbid functioning
    - Patient and caregiver preferences and abilities
    - Evaluation for skilled services at next level of care as appropriate for patient's continued needs
    - Psychosocial status. See Psychosocial Assessment SR for further information. **QM**(47)
    - Social determinants of health screening. See Social Determinants of Health Screening Tool SR for further information. **QM**(48)
    - Acceptance for care for patient at next level of care, as appropriate
  - Transition of care plan complete, which may include:
    - Patient and caregiver education complete. See Teach-Back Tool SR for further information.
  - Medication reconciliation completion includes **QM** (49)(50):
    - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
    - Assess each medication for correlation to disease state or medical condition.
    - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
    - Provide reconciled medication list to all treating providers.
    - Confirm that patient or caregiver can acquire medication.
    - Educate patient and caregiver.
      - Provide complete medication list to patient and caregiver.
      - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
      - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(9)(51)
    - Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
    - See Medication Reconciliation Tool SR for further information.
  - Appointments planned or scheduled:
    - Primary care provider(52)(53)
    - Cardiologist(54)(55)
    - Neurologist

- Outpatient imaging, tests, or procedures(29)
- Rehabilitation therapy (eg, PT) at next level of care(14)
- Specialists for management of comorbidities as needed
- Surgeon(29)
- Other

− Referrals made for assistance or support, which may include:

- Alcohol and other drug abuse or dependence treatment, as needed **QM** (56)(57)
- Educational program (eg, chronic condition management, self-management)(9)(53)
- Financial, for follow-up care, medication, and transportation(58)
- Home healthcare(59)(60)
- Tobacco use treatment, as needed **QM** (61)(62)(63)
- Other

− Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), as indicated(64):

- ADL-supportive equipment
- Cardiac care equipment and supplies (eg, compression stockings)(35)
- Medication equipment and supplies
- Respiratory equipment and supplies
- Other

▪ Transition plan communicated to all members of patient's care team **QM**

Quality Measures

- HEDIS® Measures include(65):
  - Medication reconciliation is completed.
  - Transition of care needs are assessed and addressed.
  - Psychosocial status (eg, depression screening) is assessed and addressed.
  - Fall risk is assessed and addressed.
  - Tobacco use is assessed and addressed.
  - Immunization status is assessed and addressed.
  - Readmission risk is assessed and addressed.
  - Alcohol and substance misuse is assessed and addressed.
  - Social needs screening and intervention is completed.
- Nursing Home Compare Quality Measures include(66):
  - ADL status is assessed for improvement.
  - Readmission risk is assessed and addressed.
  - Antipsychotic medication use is assessed.
  - Immunization status is assessed and addressed.
  - Pressure injury risk is assessed and addressed.
  - Medication reconciliation is completed.
  - Discharge to the community is completed.
- Skilled Nursing Facility Quality Reporting Program measures include(67):
  - Pressure injury risk is assessed and addressed.
  - Medication reconciliation is completed.
  - Readmission risk is assessed and addressed.
  - Transfer of health information to patient and provider is completed.

- ADL status is assessed for improvement.
- Immunization status is assessed and addressed.
- Discharge to the community is completed.
- Healthcare-associated infection risk is reduced.

- Skilled Nursing Facility Value-Based Purchasing Program quality measures include(68):
  - Readmission risk is assessed and addressed.
  - Healthcare-associated infection risk is reduced.
- The Joint Commission Nursing Care Center National Patient Safety Goals include(69):
  - Medication reconciliation is completed. Education is provided on medication administration including the importance of bringing up-to-date medication lists to all provider visits.
  - Healthcare-associated infection risk is reduced.
  - Fall risk is assessed and addressed.
  - Pressure injury risk is assessed and addressed.
  - Blood thinning medication-associated risk is reduced.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 3 published peer reviewed articles, 1 specialty society or other evidence-based guideline, and 6 book sections.

Rationale

Use of this MCG care guideline helps the clinician identify patients who, by virtue of their nursing, medical management, and rehabilitation needs, require post-acute care to either improve their current level of functioning or prevent or slow the deterioration of their condition.

Use of these evidence-based clinical criteria benefits the patient by complementing existing CMS regulations and expanding examples of services that meet CMS' definition of a skilled nursing service and/or skilled rehabilitation service. This evidence-based guidance ensures that Medicare and Medicare Advantage patients receive full access to Medicare benefits without risk of delay or decreased access. Additional evidence-based guidance benefits the patient by allowing for continued documentation of the need for skilled services, outlining complicating factors (eg, pain exacerbations, infection, comorbid disease exacerbation) that could extend recovery facility care stays, and providing criteria for transitioning a patient to the next appropriate level of care (eg, acute care, home care). This support can increase consistency in treatment thresholds, leading to less variation in care and promoting equitable treatment among patients.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 409.32(10); 42 CFR 409.33(6); 42 CFR 409.35(70); 42 CFR 409.44(11); 42 CFR 410.38(64)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance(2); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6 - Medical Review of Inpatient Hospital Claims for Part A(71)

Medicare Coverage Determinations: Medicare Coverage Database(72)

Other CMS Guidance: Centers for Medicare and Medicaid Services, "Long-term care facility resident assessment instrument 3.0 user's manual" version 1.20.1v4 2025(16)

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Footnotes

[A] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) may require specific considerations for admission to this level of care, which may include an inpatient hospital stay for a medically necessary condition of at least 3 consecutive calendar days, excluding the day of discharge or time spent in observation. Specific considerations are outlined in the CMS document: Medicare Benefit Policy Manual, Chapter 8.(2) [A in Context Link 1]

[B] **Evidence:** A statistical analysis of 702,304 adults age 65 years or older with pre-existing healthcare-associated infections (excluding respiratory) found that patients discharged to a skilled nursing facility had fewer avoidable readmissions than patients discharged to home or with home healthcare.(3) [B in Context Link 1]

[C] **Evidence:** A retrospective cohort study of 11,380 hospitalized adult patients found predictors for skilled nursing facility transition were functional impairments in mobility and bathing; demographic variables were older age, single, Medicare insurance, living alone, facility dwelling, and home less than 50 miles (80.5 km) from hospital.(5) [C in Context Link 1]

[D] After a transient ischemic attack (TIA), patients are at high risk for myocardial infarction (MI) or stroke. Cardiovascular monitoring and prompt clinical treatment for symptoms of a MI or stroke should be part of the patient's care plan.(8) [D in Context Link 1]

[E] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) defines reasonable and necessary skilled care as a service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel" based on the documented assessment of the patient's individual care needs. In some cases, a service that would originally be considered unskilled may be considered skilled if the patient's underlying conditions or complications require the involvement of licensed personnel to ensure that essential nonskilled care is achieving its purpose.(10)(11) [E in Context Link 1]

[F] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) specifies that skilled restorative nursing services are intended to positively affect the patient's functional well-being, with the expectation that the program be rendered at least 6 days a week. When a patient's skilled status is based on a restorative program, medical evidence must be documented to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.(2) [F in Context Link 1]

[G] **Evidence:** A claims-based study of 1.4 million Medicare beneficiaries discharged from an acute care hospital to a post-acute care setting, including an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or home care (HC), found that more hours of occupational therapy and physical therapy services were associated with greater functional improvements, and fewer hours of occupational therapy and physical therapy services were associated with a higher risk for 30-day hospital readmission across all post-acute care settings.(15) [G in Context Link 1]

[H] **National guidelines:** According to the Centers for Medicare and Medicaid Services (CMS), a maintenance therapy program helps to maintain the patient's current condition or to prevent or slow further deterioration. CMS specifies that skilled therapy services are necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered nonskilled, or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.(2) [H in Context Link 1]

[I] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) uses a data collection system to establish best practice, understand costs, and identify cost-effective systems and procedures. The current data collection system for eligible patients is the Minimum Data Set (MDS). MDS is an assessment tool used to identify patient problems, strengths, and preferences. The MDS used to create an individualized care plan can be found at www.cms.gov by searching Minimum Data Set.(16) [I in Context Link 1]

[J] **Evidence:** A retrospective cohort study evaluated 17,235,854 hospitalized patients who were discharged either to home with home healthcare or to a skilled nursing facility (SNF). The patients studied were those whose need for home healthcare vs SNF was borderline, and either setting would be reasonable. The study found that discharge to a SNF was associated with lower readmission rates than discharge to home with home healthcare. There were no significant differences in 30-day mortality rates or improved functional status.(19) [J in Context Link 1]

[K] **Evidence:** A scientific statement from the American Heart Association states the 90 day stroke risk after transient ischemic attack can be as high as 17.8%, with almost half occuring within 2 days of the index event.(20) [K in Context Link 1]

[L] **National guidelines:** According to the Centers for Medicare and Medicaid Services (CMS), a maintenance therapy program helps to maintain the patient's current condition or to prevent or slow further deterioration.(2) [L in Context Link 1, 2, 3]

[M] Respiratory care services may be provided by a qualified professional (eg, respiratory therapist or nursing staff) in accordance with state laws.(2) [M in Context Link 1]

[N] **Evidence:** A retrospective analysis of 91,113 episodes of care in skilled nursing facilities found that risk factors for prolonged length of stay included functional and cognitive impairment; greater pressure ulcer risk; paralysis; antibiotic-resistant infection; HIV infection; and need for a feeding tube, dialysis, tracheostomy, ventilator or respirator, and psychological therapy.(34) [N in Context Link 1]

Definitions

Custodial care

- Custodial care is personal unskilled care to support the patient's care of activities of daily living (ADL), such as bathing, dressing, and eating.(1)

References

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Intense and complex care needs

- Intense and complex care needs require assessment of the patient's clinical needs, ability, and tolerance for treatment, with an evaluation of logistical requirements of needed services. Care must support positive outcomes and safe transition to the next level of care.(1) Logistical requirements of needed services is the ability to coordinate and transfer the patient from various care settings. Logistical requirements may increase the complexity of the patient's care; for example, conditions requiring extensive assistance (eg, body cast, burns, being bedbound) may create an excessive physical hardship or safety concern for the patient to receive needed care on an outpatient basis. Consideration must be given to the patient's condition, what is the most effective care, and to the availability and feasibility of using more economical alternative facilities and services (eg, daily transportation by ambulance to a facility vs inpatient care).(2)

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Occupational therapy (OT) progression

- OT progression includes **ALL** of the following(1)(2):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A](4)
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals as condition improves

References

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Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, increased ROM/strength, increased balance scores, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, Tinetti, Berg Balance Scale).(3)(4) Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.

Physical therapy (PT) progression

- PT progression includes **ALL** of the following(1)(2)(3)(4):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A]
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals as condition improves

References

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Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, increased ROM/strength, increased balance scores, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, Tinetti, Berg Balance Scale). Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.(4)(5)

Safe to go home

- Patient safe to go home if **ALL** of the following exist(1)(2)(3):
  - Medical condition manageable at home
  - Functional status manageable at home
  - Mental status stable for patient's condition
  - Medication availability confirmed and reconciliation complete
  - Patient/caregiver education complete and written discharge instructions provided
  - Caregiver and community resources identified (as needed)
  - Community resources identified and referrals made, as needed
  - Home care arranged, if indicated
  - Necessary medical equipment delivery arranged or available in home, if indicated
  - Necessary medical supplies ordered, or patient/caregiver can obtain, if indicated

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Skilled care

- Skilled care may be direct (eg, in-person assessment and administration of treatments) or indirect (eg, coordinating care between providers, supervising care aides); examples include(1)(2)(3)(4):
  - Performed or supervised by professional or technical personnel
  - Exceed scope of Custodial care
  - Service is considered skilled as indicated by either of the following:

- Service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel" based on the documented assessment of the patient's individual care needs.
- Service that would originally be considered unskilled may be considered skilled if the patient's underlying conditions or complications require the involvement of licensed personnel to ensure that essential nonskilled care is achieving its purpose.

References

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Speech-language pathology (SLP) progression

- SLP progression includes **ALL** of the following(1)(2)(3)(4):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A](5)
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals as condition improves

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Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in

standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, National Outcomes Measurement System (NOMS)). Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.(1)(5)(6)

Transition of care planning completed

- Transition of care planning completed, including **ALL** of the following(1)(2):
  - Transition plan communicated to all members of patient's healthcare team
  - Summary of care, discharge list of medications, and transition plan communicated to primary care provider
  - Medication reconciliation complete
  - Education on condition management and complications to report provided to patient or caregiver[A]
  - Follow-up appointments scheduled
  - Referrals to continue medical and rehabilitation goals (eg, outpatient) arranged, if needed
  - Services (eg, equipment, environment modifications, transportation) arranged, if needed
  - Psychosocial issues addressed, or plan for management, if needed

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Footnotes

A. Health education materials should be given in patient's and caregiver's native language using trained language interpreters whenever possible.(3)

Codes

ICD-10 Diagnosis: G45.0, G45.1, G45.2, G45.3, G45.8, G45.9, G46.0, G46.1, G46.2, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9 [Hide]

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