Rehabilitation Minimum Data Set Manual, February 2016

Module 1: Technical Specifications and Data Submission

Types of care

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Our vision

Better data. Better decisions. Healthier Canadians.

Our mandate

To lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

Our values

Respect, Integrity, Collaboration, Excellence, Innovation

Important notice

UDSMR

The FIM® instrument includes the following data elements:

41. Eating
42. Grooming
43. Bathing
44. Dressing — Upper Body
45. Dressing — Lower Body
46. Toileting
47. Bladder Management
48. Bowel Management
49. Transfers: Bed, Chair, Wheelchair
50. Transfers: Toilet
51. Transfers: Tub or Shower
52. Locomotion: Walk/Wheelchair
53. Locomotion: Stairs
54. Comprehension
55. Expression
56. Social Interaction
57. Problem-Solving
58. Memory

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Introduction

CIHI background information

The Canadian Institute for Health Information (CIHI) is an independent, not-for-profit organization that provides essential data and analysis on Canada's health system and the health of Canadians.

Taking health information further

Committed to safeguarding the privacy and confidentiality of personal health information, CIHI's mandate is to coordinate the development and maintenance of a common approach to health information for Canada.

To this end, CIHI is responsible for providing accurate and timely information that is needed to establish sound health policies, manage the Canadian health system effectively and create public awareness of factors affecting good health.

Collaboration is the key

The key to CIHI's achievements is partnership. CIHI is a focal point for collaboration among major health players — from provincial governments, regional health authorities and hospitals to the federal government, researchers and associations representing health care professionals. The result of this cooperative effort is a strong and responsive health information system.

Governance structure

CIHI is governed by a Board of Directors whose members strike a balance among the health stakeholders, sectors and regions of Canada.

An overview of CIHI's core functions

CIHI's core functions are to

- Identify and promote national health indicators;
- Coordinate and promote the development and maintenance of national health information standards;
- Develop and manage health databases and registries;
- Conduct analyses and special studies and participate in research;
- Publish reports and disseminate health information; and
- Coordinate and conduct education sessions and conferences.

Privacy and confidentiality

CIHI's mandate to provide accurate and timely health information is complemented by its pledge to respect personal privacy, to safeguard the confidentiality of information and to provide secure information systems. To ensure that health data entrusted to CIHI is protected, CIHI has established policies that address data integrity, system security, data access, data linkage and data disclosure. Also, CIHI personnel sign a confidentiality agreement.

CIHI will publish, report or disclose data only when the requirements and restrictions in *Privacy Policy on the Collection, Use, Disclosure and Retention of Personal Health Information and De-Identified Data, 2010* are met. This document is available at www.cihi.ca > About CIHI > Privacy and Security. CIHI will publish, report or disclose information that identifies individuals directly or indirectly only when

- The individuals concerned provide consent; or
- Laws require the disclosure.

How to use this manual

The *Rehabilitation Minimum Data Set Manual* is divided into 2 separate modules that are intended to provide comprehensive information to a broad range of partners and stakeholders who have key roles in the accurate coding and reporting of adult inpatient rehabilitation episodes.

Module 1: Technical Specifications and Data Submission

Provides data and record submission specifications for use by facilities and vendors in the development of data collection software, with further related detail provided in appendices A through G. This module is primarily written for IT and data submission personnel who are responsible for National Rehabilitation Reporting System (NRS) submissions.

Module 2: Clinical Coding and NRS Training

Provides detailed coding and interpretation guidelines for clinical and health records staff at participating facilities involved in the assessment, coding and submission of data to the NRS. Furthermore, this module contains resources for those involved in providing NRS training for staff in their facility and, as such, Module 2 is a primary resource for basic NRS education workshops that are required for all participating facilities.

For ease of reference, recording forms and appendices provided in Module 1 are also found in Module 2.

National Rehabilitation Reporting System

Development of a National Rehabilitation Reporting System

The FIM® instrument and impairment codes referenced herein are the property of Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.

Introduction

In 1995, CIHI initiated a major project to develop and evaluate a minimum data set and grouping methodology for rehabilitation services across service settings in Canada. By September 1998, CIHI had collected and analyzed a large sample of rehabilitation clinical data from more than 30 sites across Canada and had consulted with more than 350 experts and key stakeholders in the rehabilitation field. The pilot data set included the FIM® instrument (Functional Independence Measure) and a number of CIHI data elements developed to enhance the cognitive domain of the FIM® instrument.

The results of the statistical analysis, the pilot site evaluations and external field review provided solid evidence that the data set is reliable and valid for a range of adult rehabilitation client groups in inpatient facilities. The data set was shown to be internally consistent, with high structural integrity. The high reliability estimates showed that differences in client scores were due solely to differences in client function. The composite measure of the FIM® instrument and CIHI data elements demonstrated that the measurement of the cognitive domain was significantly enhanced. The data set was sensitive to change in client functional status in the majority of rehabilitation client groups.[i]

Based on these results, in 1998, the National Rehabilitation Advisory Group (NRAG) recommended that this data set be used to develop a national reporting system for inpatient rehabilitation services.

In 1999, as part of approximately 40 Roadmap initiatives launched at CIHI, a project was established to develop national indicators and output reports for adult inpatient rehabilitation services. This rehabilitation Roadmap project resulted in the implementation of a prototype national rehabilitation reporting system. An expert working group was established to provide CIHI with guidance on this initiative.

i. Canadian Institute for Health Information. *Rehabilitation Data Standards for Canada, Pilot Project Report*. 1999.

National Rehabilitation Expert Working Group

- The National Rehabilitation Expert Working Group (NREWG) included representatives from across Canada with expertise in clinical practice, administration, rehabilitation services management, health services planning, consumer representation and standards development. The first meeting of this group took place October 1999. The work of the NREWG was concluded at the final meeting in February 2001.
- The NREWG provided guidance to CIHI in the identification of information needs, indicator development, comparative reporting and implementation of a national prototype reporting system.

CIHI Roadmap project on rehabilitation services

- The CIHI Roadmap project included the activities for the development of a national prototype reporting system for adult inpatient rehabilitation services.
- The CIHI minimum data set produced by the pilot project was revised to ensure it meets the current information needs of stakeholders.
- National indicators were defined, including clinical outcomes, for comparative reporting of rehabilitation services.
- Standard reports were developed to facilitate the analysis and use of the data that will be collected.
- Data collection software, data specifications, submission guidelines and an educational program for site implementation were developed for the launch of the prototype system.
- The prototype reporting system was reviewed and enhanced with the experience gained during the prototype year (April 2000 to March 2001).
- Revised data collection software, data specifications, submission guidelines and education workshop materials were incorporated into the NRS in September 2001.
- Transition from the prototype system to full production occurred in fall 2001.

CIHI's national pilot project (1996 to 1999) achieved a milestone in the development of rehabilitation data standards for Canada. The results of the pilot study contributed directly to the implementation of the first prototype reporting system in Canada for collecting and tracking this type of data. The implementation of the prototype version of the NRS was a second major milestone for Canada-wide implementation.

The NRS provides comparative indicators and client outcome information that can be used by clinicians, program planners, accreditation surveyors, regulatory and licensing bodies, funders and health policy-makers.

CIHI Rehabilitation National Advisory Committee

CIHI established a National Advisory Committee for the NRS in 2003, and modified the scope of this committee in 2011 to address broader rehabilitation information activities. The purpose of the CIHI Rehabilitation National Advisory Committee is to provide CIHI with information regarding Canada's rehabilitation sector and to provide input and advice on various rehabilitation data initiatives. This includes but is not limited to the implementation, management, modification and further enhancement of the NRS, in order to meet the needs of a broad range of rehabilitation services stakeholders.

Scope of the National Rehabilitation Reporting System for rehabilitation services

Project scope

The NRS is appropriate for client groups receiving rehabilitation services that meet the following working definition of rehabilitation. Rehabilitation is "a goal oriented and often time-limited process which enables an individual with impairments and disabilities to identify and reach his/her optimal mental, physical and/or social functional level. Rehabilitation provides opportunities to the individual through a client-focused partnership with family, providers and the community, to accommodate a limitation or lack of function. Rehabilitation focuses on abilities and aims to facilitate social integration and independence."[ii]

The rehabilitation data set is targeted at adult clients (18 years and older) in the following inpatient service settings:

- Specialty facilities — provide comprehensive rehabilitation services and specialized programs in free-standing rehabilitation hospitals or specialized units within facilities designated for physical rehabilitation; and
- General facilities — provide rehabilitation services in general (acute care) hospitals with rehabilitation units, programs or designated physical rehabilitation beds.

In October 2002, modifications were made to the NRS to allow data collection for clients age 0 to 17 for select data elements, where appropriate. See the table Data Elements by Age Group for details.

Rehabilitation clients receive multi-dimensional (physical, cognitive, psychosocial) diagnostic, assessment, treatment and service planning interventions. These services are commonly inter- or multi-disciplinary in these facility-based inpatient settings. For further information, see data element 1B Facility Type, in Module 2.

The focus is on adult physical rehabilitation clients who have a time-limited episode of service, individualized and documented rehabilitation plans, predicted discharge dates and expected improvements in functional status.

Rehabilitation Client Groups (RCGs) include those with impairments, activity limitations and/or participation restrictions associated with the following types of conditions:

- Stroke
- Brain Dysfunction
- Neurological Conditions
- Spinal Cord Dysfunction
- Amputation of Limb
- Arthritis

ii. Canadian Institute for Health Information. *Rehabilitation Data Standards for Canada, Pilot Project Report*. 1999.

- Pain Syndromes
- Orthopedic Conditions
- Cardiac Conditions
- Pulmonary Conditions
- Burns
- Congenital Deformities
- Other Disabling Impairments
- Major Multiple Trauma
- Developmental Disabilities
- Debility
- Medically Complex

Recording guidelines

1. The rehabilitation data set is recorded at admission and at discharge for each rehabilitation visit, with the option of a follow-up assessment.
2. Assessments include
   a) The FIM® instrument;
   b) CIHI's cognitive assessment; and
   c) CIHI's Instrumental Activities of Daily Living (IADL) assessment (optional).
3. The admission FIM® instrument and CIHI cognitive assessment must be completed within 72 hours after admission.
4. The discharge FIM® instrument and CIHI cognitive assessment must be completed within 72 hours before discharge from the rehabilitation program or the Date Ready for Discharge, whichever occurs first.
5. CIHI's IADL assessments must be completed within 7 days of admission and within 7 days of discharge if the facility is reporting this optional component.
6. If optional data elements are collected on the admission assessment, these data elements are mandatory on the discharge assessment.
7. The follow-up assessment must be completed between 80 and 180 days after discharge from the rehabilitation program, if a facility decides to include this component of the data set.
8. The socio-demographic and administrative data elements may be derived from a variety of sources, including the chart, other staff, the client or family members.
9. Each person involved in assessing and recording functional elements is required to have CIHI training, either through CIHI's NRS for Trainers program or in-house training, and to achieve a level of competency, based on testing.

10. Each team member who completes a portion of the assessment or data set should initial and date the hard copy.
11. Facilities should establish a policy regarding accountability for the completion of the admission, discharge and follow-up assessment records.

Listing of data elements

The original data elements contained in the NRS were recommended by CIHI's National Rehabilitation Advisory Group (September 1998) and by the National Rehabilitation Expert Working Group (October 1999) to support priority indicators for national reporting of inpatient rehabilitation services. Since implementation, the NRS data set has been adjusted based on ongoing consultations with the NRS Advisory Committee and other key stakeholders representing inpatient rehabilitation across Canada.

2016–2017 data elements by type of assessment

The following table outlines the NRS data elements captured on admission, discharge and follow-up records. "X" represents the data collection point and "(X)" indicates the option to modify (revise or add) data. This table provides a high-level overview of all data elements. For specific coding guidelines, please refer to the data element number and name found in the Data elements specifications and definitions section of this document.

Data element number and name	Admission	Discharge	Follow-up (optional)
Facility identifiers			
1A. Facility Number or Code 1B. Facility Type 1C. Facility Size (Approved Beds) 1D. Facility Size (Operating Beds) 1F. Facility/Site Name 1G. Facility/Site Street Address 1H. Facility/Site City 1I. Facility/Site Province 1J. Facility/Site Postal Code 1K. Facility/Site Telephone Number 1L. Facility/Site Fax Number 1M. Facility/Site CEO/Administrator Name 1N. Facility Coordinator Name 1O. Facility Coordinator Telephone Number 1P. Facility Coordinator Fax Number 1Q. Facility Coordinator Email Address	Submit to CIHI prior to start of data collection		

Data element number and name	Admission	Discharge	Follow-up (optional)
Facility identifiers			
1R. Primary Data Submission Contact Name 1S. Primary Data Submission Contact Telephone Number 1T. Primary Data Submission Contact Fax Number 1U. Primary Data Submission Contact Email Address 1V. Facility Corporation/Region Name 1W. Facility Corporation/Region CEO Name 1Y. Facility/Site Telephone Extension 1Z. Facility Coordinator Telephone Extension 1AA. Primary Data Submission Contact Telephone Extension 1AB. Secondary Data Submission Contact Name 1AC. Secondary Data Submission Contact Telephone Number 1AD. Secondary Data Submission Contact Fax Number 1AE. Secondary Data Submission Contact Email Address 1AF. Secondary Data Submission Contact Telephone Extension	Submit to CIHI prior to start of data collection		
Client identifiers			
2. Assessment Type	X	X	X
3. Program Type	X		
4. Chart Number	X	X	X
5. Health Care Number	X		
6. Province/Territory Issuing Health Care Number	X		
Socio-demographic data			
7. Sex	X		
8. Birthdate	X		
9. Estimated Birthdate	X		
10. Primary Language	X		
11A. Country of Residence	X		
11B. Postal Code of Residence	X		
11C. Province/Territory of Residence	X		
11D. Residence Code	X		
12. Pre-Hospital Living Arrangements	X		
13. Post-Discharge Living Arrangements		X	

Data element number and name	Admission	Discharge	Follow-up (optional)
Socio-demographic data			
14. Pre-Hospital Living Setting	X		
15. Post-Discharge Living Setting		X	
16. Informal Support Received	X	X	X
17. Pre-Hospital Vocational Status	X		
18. Post-Discharge Vocational Status		X	
76. Follow-Up Living Arrangements			X
77. Follow-Up Living Setting			X
78. Follow-Up Vocational Status			X
87. Aboriginal Status	X		
Administrative data			
19A. Admission Class	X	(X)	
19B. Readmission Within 1 Month	X		
19C. Readmission Planned or Unplanned	X		
20A. Date Ready for Admission Known	X		
20B. Date Ready for Admission	X		
21. Admission Date	X		
22. Referral Source	X		
23A. Referral Source Province/Territory	X		
23B. Referral Source Facility Number	X		
24. Responsibility for Payment	X	(X)	
25A. Service Interruption Start Date		X	
25B. Service Interruption Return Date		X	
25D. Service Interruption Transfer Status		X	
28A. Provider Type(s)		X	
28B. Provider Type ID Number		X	
29. Date Ready for Discharge		X	
30. Discharge Date *if 19A = 4	X*	X	
31. Reason for Discharge		X	
32. Referred To		X	
33A. Referred to Province/Territory		X	
33B. Referred to Facility Number		X	
72. Follow-Up Assessment Date			X
73A. Hospitalizations Since Discharge			X
73B. Days in Hospital			X

Data element number and name	Admission	Discharge	Follow-up (optional)
Administrative data			
74. Respondent Type			X
90A. Primary Reason for Waiting for Discharge		X	
90B. Secondary Reason for Waiting for Discharge		X	
91A. Rehabilitation Time With an Occupational Therapist (OT)		X	
91B. Rehabilitation Time With a Physiotherapist (PT)		X	
91C. Rehabilitation Time With a Speech–Language Pathologist (SLP)		X	
91D. Rehabilitation Time With an Occupational Therapist Assistant (OTA)		X	
91E. Rehabilitation Time With a Physiotherapist Assistant (PTA)		X	
91F. Rehabilitation Time With a Communicative Disorders Assistant (CDA)		X	
Health characteristics			
34. Rehabilitation Client Group (RCG)	X	(X)	
38. ASIA Impairment (Spinal Cord Injury)	X		
39. Date of Onset	X		
40A. Height	X	X	
40B. Weight	X	X	
80. Most Responsible Health Condition ICD-10-CA	X	(X)	
81. Pre-Admit Comorbid Health Condition ICD-10-CA	X		
82. Post-Admit Comorbid Health Condition ICD-10-CA		X	
83. Transfer or Death Health Condition ICD-10-CA *if 19A = 4	X*	X	
84. Service Interruption Reason ICD-10-CA		X	
85. Health Condition Reason For Hospitalization ICD-10-CA			X
86. Pre-Admit Comorbid Procedure or Intervention CCI	X		
Activities and participation			
41. Eating — FIM® instrument	X	X	X
42. Grooming — FIM® instrument	X	X	X
43. Bathing — FIM® instrument	X	X	X
44. Dressing — Upper Body — FIM® instrument	X	X	X
45. Dressing — Lower Body — FIM® instrument	X	X	X
46. Toileting — FIM® instrument	X	X	X

Data element number and name	Admission	Discharge	Follow-up (optional)
Activities and participation			
47. Bladder Management — FIM® instrument	X	X	X
48. Bowel Management — FIM® instrument	X	X	X
49. Transfers: Bed, Chair, Wheelchair — FIM® instrument	X	X	X
50. Transfers: Toilet — FIM® instrument	X	X	X
51. Transfers: Tub or Shower — FIM® instrument	X	X	X
52. Locomotion: Walk/Wheelchair — FIM® instrument	X	X	X
53. Locomotion: Stairs — FIM® instrument	X	X	X
54. Comprehension — FIM® instrument	X	X	X
55. Expression — FIM® instrument	X	X	X
56. Social Interaction — FIM® instrument	X	X	X
57. Problem-Solving — FIM® instrument	X	X	X
58. Memory — FIM® instrument	X	X	X
59. Impact of Pain	X	X	X
60. Meal Preparation	X	X	X
61. Light Housework	X	X	X
62. Heavy Housework	X	X	X
64. Communication — Verbal/Non-Verbal Expression	X	X	X
65. Communication — Written Expression	X	X	X
66. Communication — Auditory/ Non-Auditory Comprehension	X	X	X
67. Communication — Reading Comprehension	X	X	X
Activities and participation			
68. Financial Management	X	X	X
69. Orientation	X	X	X
70. General Health Status	X	X	X
75. Reintegration to Normal Living			X
79. Glasses/Hearing Aid Flag	X	X	X
Projects fields			
88A. Project Code 1	X	X	X
88B. Project Data 1	X	X	X
89A. Project Code 2	X	X	X
89B. Project Data 2	X	X	X

Data elements by age group

The following table outlines the differences between the Adult Rehabilitation Minimum Data Set and the data subsets for those younger than age 18. Refer to the section Listing of data elements by type of assessment for details on mandatory and optional data collection specific to admission, discharge and follow-up assessments.

Mandatory = mandatory, to be collected for this age group
Optional = optional, may be collected for this age group
N/A = not applicable, not to be collected for this age group

Data element	Age 0–13	Age 14–17	Age 18 and older
Admission and discharge assessments			
Facility identifiers			
1A–1AA	Mandatory	Mandatory	Mandatory
Client identifiers			
2, 4–6	Mandatory	Mandatory	Mandatory
3	Optional	Optional	Optional
Socio-demographic data			
7–15, 17, 18, 87	Mandatory	Mandatory	Mandatory
16	N/A	Mandatory	Mandatory
Administrative data			
19A–25D, 28A, 29–33B, 90A, 90B, 91A–91F[iii]	Mandatory	Mandatory	Mandatory
28B	Optional	Optional	Optional
Health characteristics			
34, 39, 40A, 40B, 80–86	Mandatory	Mandatory	Mandatory
Activities and participation			
41–59, 64–69, 70, 79	N/A	Mandatory	Mandatory
60–62	Optional	Optional	Optional
Projects fields			
88A–89B	Optional	Optional	Optional
Follow-up assessment (optional) *If the follow-up assessment is completed, there are mandatory and optional items.*			
72–74, 76, 77, 78, 85	Mandatory	Mandatory	Mandatory
60–62, 88A–89B	Optional	Optional	Optional
16, 41–58, 59, 64–69, 70, 79	N/A	Mandatory	Mandatory
75	N/A	Optional	Mandatory

iii. Fields are mandatory to complete for admissions under the Stroke RCG in Ontario and optional to complete in other provinces and for any admission under an RCG other than Stroke.

Data submission requirements

General information

Introduction

This module provides data and record submission specifications for use by facilities and vendors in the development of data collection software for the NRS. This section includes the following subsections:

- Detailed submission requirements;
- Technical requirements;
- Submission and transmission protocols;
- Submission file layouts; and
- Data element specifications and definitions.

The term “Element ID” is referenced in the Submission file layouts section and corresponds to the NRS data elements identified in the Data element specifications and definitions section.

This section is provided under an annual vendor subscription license agreement that provides vendors and other data submission systems developers with the information necessary to assemble and submit an electronic data file. If any facility or jurisdiction chooses to collect rehabilitation data, this NRS specification is to be used.

All vendors are required to subscribe to the vendor subscription services and will automatically receive the necessary products upon signing and returning the license agreement to CIHI. This will ensure a comprehensive view of the NRS system, including data collection and editing, as well as submission to CIHI.

Detailed submission requirements

Submission types

NRS data is collected in the form of an admission, discharge and follow-up assessment. The follow-up assessment is optional to record. Each assessment has a unique record format.

In addition to the 3 assessment types, CIHI also provides 2 types of records to correct or delete assessments that were successfully submitted and accepted into the NRS database. An update record corrects specific fields on an admission, discharge or follow-up assessment, while a delete record deletes the entire assessment from the database.

Demographic and administrative data specific to the facility submitting the NRS data is collected in the form of a facility information record.

An initial submission, by means of transmission (through eData Submission Services, or eDSS), of the facility information must be submitted to CIHI prior to the submission of any NRS assessment data.

A data submission control record must be included with each submission. In addition to this record, the types of data allowable for submission to the NRS include the facility information record and NRS assessment information.

Data will be collected and submitted to CIHI on a quarterly basis in an electronic format only. 1 or more submission files may be submitted for a reporting quarter. All data within a submission file must be from the same reporting quarter. Facilities have the option of submitting the admission and discharge assessments as they are completed, that is, submitting admission assessments in the quarter they occur and then discharge assessments in the quarter they occur. Alternatively, both assessments may be submitted together once the discharge assessment has been completed. If the assessments occurred in different quarters, both assessments can be submitted at the time of discharge but must be submitted in separate files corresponding to the quarter in which they occurred.

Updates to the facility information record must be submitted at the time the change occurs to ensure that CIHI maintains the most current information for the facility at all times. This information is maintained for the purposes of tracking data receipt, processing and updates as well as a means of communication with the facility.

The facility information collected for the NRS is maintained separately from other CIHI databases. A change to the facility information collected for other databases is not automatically applied to the NRS, or vice versa.

Data acceptance rules

As a general CIHI policy, enhancements and modifications to validation rules will be implemented at the beginning of a fiscal year. Vendors are notified in advance of any enhancements or changes that must be applied to their software.

CIHI requires that all data be edited at source and that **only** error-free data be submitted.

Facility information data (including the initial profile as well as any updates) must be submitted in a single ASCII file with variable record length formats as follows, plus a carriage control and line feed character for each record:

Data submission control record: 31 characters

Facility information record: 622 characters

A submission file must contain NRS data for 1 quarter only. Updates to assessment data from a previously submitted quarter should result in the submission of a new file applicable to that reporting quarter.

NRS data must be submitted in a single ASCII file with variable record length formats as follows, plus a carriage control and line feed character for each record:

Data submission control record: 31 characters
Admission assessment data: 1,161 characters
Discharge assessment data: 1,681 characters
Follow-up assessment data: 650 characters

An admission assessment must be completed before a discharge assessment. It is optional to record a follow-up assessment once the discharge assessment has been completed.

A discharge assessment must not be deleted without first deleting its associated follow-up assessment (if applicable). Likewise, an admission assessment must not be deleted without first deleting its associated discharge assessment.

The data submission control record serves 2 purposes:

- To ensure that the complete submission has been received by CIHI; and
- To provide CIHI with an indication that the final submission for a reporting quarter has been received.

A partial submission, whereby the record count does not match the total count on the submission control record, will be rejected in its entirety without any further validation.

Record-level data that does not pass CIHI's validation rules will be rejected. Data will be validated as completely as possible.

A notification of acceptance or rejection of all data submissions and all associated errors/ invalid data will be communicated back to the facility. Only those records with no errors will be accepted by CIHI.

Submission timelines

The following table shows timelines for submission of data to CIHI for the NRS. Dates are consistent from year to year.

Note: If a deadline date falls over a weekend or holiday, records that are submitted by the deadline will be processed on the next working day. For the Error Correction Deadline, the data cut is typically taken the morning of the next working day following a date that falls on a weekend or holiday. Any records submitted by the deadline date will be processed prior to taking the data cut.

NRS submission timelines

Quarter	Reporting period	Submission deadline	Error correction deadline	NRS eReports data updated*
Quarter 1	April 1 to June 30	July 31	August 15	2–3 weeks after error correction deadline
Quarter 2	July 1 to September 30	October 31	November 15	
Quarter 3	October 1 to December 31	January 31	February 14	
Quarter 4	January 1 to March 31	April 30	May 15	

Note

* This date may vary slightly according to CIHI's internal production schedule.

Technical requirements

File-naming conventions

File names must be standardized to facilitate the receipt and processing of NRS data. This naming convention will be strongly enforced. This means that files that are not named accordingly will be returned unprocessed to the submitting facility. Within the naming convention is embedded the associated database identifier, facility number, fiscal year and quarter and a unique logical submission sequence ID.

The file name will be in the format

NRSyyyypphhhhhss.txt

Where

NRS = National Rehabilitation Reporting System
yyyy = fiscal year
pp = fiscal quarter: 01 for first quarter
02 for second quarter
03 for third quarter
04 for fourth quarter
FI for facility information

hhhhh = facility number

ss = submission sequence ID (for example, 01, 02, 03, etc. to a maximum of 99)

A file submitted in a zipped format must have a .zip extension on the file name as follows:

NRSyyyypphhhhhss.zip

When this zipped file is unzipped, the file should adhere to the file naming convention of NRSyyyypphhhhhss.txt.

Note: The first 16 characters **must** conform to CIHI's naming convention or files will be deleted unprocessed. The facility will be notified either during the eDSS submission or by telephone to rename the file and resubmit with the appropriate naming convention.

File characteristics

NRS data will be submitted in a single ASCII file with variable record length formats as specified in the Data acceptance rules section.

A separate submission file must be produced for each fiscal quarter of data submitted.

A data submission control record is the first record in the file. The layout for this record is provided in the Submission file layouts section.

In any submission the records must be sorted in the following order:

1. Data submission control record
2. Assessment data (sorted in ascending order by data record type — 1, 2 and 3)

Within data record type 1 (delete), the records must be sorted in **descending order** by assessment type. The layout for this record is provided in the Submission file layouts section.

Within data record type 2 (initial submission), the records must be sorted in **ascending order** by assessment type. The layout for these records is provided in the Submission file layouts section. A record submitted as an initial submission that is rejected for reasons of file-, record- or element-level errors must be resubmitted as an initial submission.

Within data record type 3 (update), the records must be sorted in **ascending order** by assessment type. These records have the same layout as for data record type 2. All data validation rules that currently apply for data record type 2 will apply for data record type 3, and all fields in the record layout will be updated.

In an effort to prevent duplication of records, submissions with data record type = 2 (initial assessment) and assessment type = 1 (admission assessment) will be flagged with a warning message in the submission report if there already exists an admission assessment in the NRS database that has the same Facility Number, Health Care Number and Chart Number but that does not yet have a corresponding discharge assessment/(un)planned discharge assessment in the database. The data submitter will then have to decide whether this is a legitimate new admission or a duplication of an already-submitted record.

Submission and transmission protocols

In order to satisfy national and provincial/territorial privacy legislation, CIHI is offering a single method for transmission of electronic NRS files to CIHI via the internet. A facility must have the ability to connect to the internet using a browser such as Microsoft Internet Explorer. For both hospitals and vendors to understand the scope of choice, and to drill down on CIHI's detailed requirements, the following overview is provided.

This method of transmission (eDSS) replaces all other methods previously in place for submission of data (i.e., diskettes, pcANYWHERE, Entrust). This method provides security that meets corporate and industry standards through the use of

- Secure encrypted protocols during file upload and transfer from the client's machine to CIHI's servers in a secure area (secure area zone, or SAZ); and
- Restriction of system access to only users who have been authorized and authenticated.

This method also includes the provision and verification of the faxed or emailed information previously requested with each submission file (facility number, fiscal year, period, number of abstracts). This information will be checked against the submission file to ensure that there is a match to the file name. The client receives a message indicating that the file was submitted successfully.

Note: Use of the standard naming convention is mandatory and must be adhered to strictly, including sequence numbers.

Transmission of data can occur 24 hours a day, 7 days a week. Once the initial setup has been put into place, facilities can submit data to CIHI at their convenience; there is no requirement to contact CIHI to arrange transmission times.

Vendors will also be provided with application access codes so that they may submit test files using this protocol.

Testing process

Please note that CIHI requires vendors to test each version of their software before it may be used for transmission of data to the NRS database at CIHI. Because CIHI's policy is to accept only pre-edited, error-free data, the facility's vendor must have successfully completed this standard testing process.

Facility testing is done after the facility's licensed vendor has successfully submitted test data and has passed testing requirements. While completing facility testing is optional for 2016–2017, it is strongly recommended for NRS facilities that have never participated in facility testing or that have recently changed NRS software vendors. It is also recommended for facilities that have had staff turnover or changes to methods of completing NRS assessments such that a testing of processes might be valuable.

Vendor test process for NRS submissions (as part of the vendor subscription service)

CIHI expects vendors to submit sufficient test files annually to meet the requirements laid out in the *Vendor Testing Process Document*. Provincial requirements may vary from year to year.

Note: Until a vendor has submitted a successful test, CIHI will not accept hospital test files. (According to CIHI's web page NRS Vendor Testing, the definition of a successful test is a file without any errors, that is, 100% accuracy.) As part of the vendor subscription service, CIHI will accept 3 test submissions annually for each jurisdiction at no charge.

This process tests the control record, file format and file size, as well a full edit test on the file. Submission reports, including rejected files and records, are provided as feedback to the vendors outlining the problem areas where changes are required. CIHI staff performs analysis of the report and supports the vendor throughout the development process.

Vendors' names will be posted on CIHI's website following a successful test. Each test file should contain sufficient test records to enable CIHI to provide good feedback to the vendor (a minimum of 30 records per file is recommended).

During the test phase, vendors are encouraged to direct all queries to the vendor support representative (help@cihi.ca).

Facility test process for NRS submissions

A facility is considered to have complied with testing once a test facility profile and a test assessment file (containing the required types and numbers of accepted records, outlined below) are successfully submitted to CIHI. The NRS team at CIHI will provide information to facilities about testing requirements prior to the testing period each year.

Steps in facility testing process

1. Verify that the vendor being used by the facility for NRS submissions has completed CIHI's testing process by accessing the list of vendors who have completed testing. This list is located on CIHI's website and is updated regularly.
2. Once the facility's vendor has completed vendor testing, facilities intending to complete facility testing should notify the NRS team via email at nrs@cihi.ca when they are ready to submit test data. The test data should then be submitted via eDSS. If live data is submitted before the facility testing is completed, the live data will be deleted and will have to be resubmitted once testing is complete.
3. Facilities should first create a test facility profile and submit it as a TEST via eDSS. If test admission, discharge and follow-up assessment records are submitted before the test facility profile has been accepted into the database, the test admission, discharge and follow-up assessment records will be deleted and need to be resubmitted after the facility profile is accepted.
4. A confirmation email will be sent to the primary and secondary NRS data submission contacts (identified on the TEST facility profile) indicating that the submitted files have been processed and that the submission reports can be accessed through NRS Operational Reports. Rejected records from the test submission must be corrected and resubmitted in order to complete facility testing requirements. Please contact the NRS team at nrs@cihi.ca with any questions about rejected test files.
5. Facilities should review the submission reports for the test facility profile on the Submission — Test page of the NRS Operational Reports website. Each facility should already have access to NRS Operational Reports for its ongoing NRS reports. If the facility does not have access to test submission reports within the NRS Operational Reports client services area, please contact the NRS team at nrs@cihi.ca, and an access code will be provided. Once the facility profile has been accepted, facilities may begin submitting test admission, discharge and follow-up assessment records.

6. Facilities should compile test admission, discharge and follow-up assessment records into submission files using vendor software. The test data submission must contain at least 5 of each record type (admission, discharge and follow-up, if follow-up data is submitted by the facility) and at least 1 update and 1 deletion record in order to be considered compliant. It is recommended that facilities test a maximum of 50 records in total. Actual or false data can be used for the test submission. In the annual communication from the NRS team, vendors and facilities will be notified of the date the production database was cut to create the test database. This date is important in determining admission records that will be in the test database, for which test discharge or update/delete records can be submitted.
7. Once all testing requirements are fulfilled, an email will be sent to the primary and secondary NRS data submission contacts stating that testing is complete. Live data can then be submitted via eDSS. Facilities must submit an updated live facility profile prior to submitting live data. Live admission, discharge and follow-up assessment records will not be accepted until a live facility profile is successfully submitted.

Contact the NRS team at nrs@cihi.ca for further information about facility testing.

Submission reports

The NRS provides designated users at participating facilities with access to NRS submission reports (sometimes referred to as “error reports”). These reports are automatically generated for all data files submitted to the NRS test and NRS production databases and are posted to NRS Operational Reports, a secure application accessible via the Client Services section of CIHI’s website. The facility-designated primary and secondary submission contacts receive email notifications of each posting immediately following the successful processing of a data file. As submission reports are posted to NRS Operational Reports for 45 days only, it is recommended that you download and save them to a secure location prior to their expiry date.

Note: Designated users are identified by each facility’s NRS facility coordinator, who sends an email to nrs@cihi.ca requesting access. The primary and secondary submission contacts are designated on the facility profile, which is sent to the NRS each year prior to the submission of data files.

NRS submission reports — Warning messages explained

For ease of interpreting your NRS submission reports, the following table has been designed to explain all warnings that may be encountered in the reports. **A record with only a warning will still be accepted into the NRS database (assuming that no error messages exist for the same record)**. Warning flags are meant to highlight potential data quality issues that should be addressed by the facility; there is no need to contact CIHI to explain the outcome of this internal review, though submission of updated records may be required.

Warning number	Warning	Reason for warning	How to correct the warning/what next?
100001	Duplicate Comorbid Recorded on Admission and Discharge	The same comorbidity was coded on both admission and discharge. The only comorbidities that should be coded on discharge (data element 82) are those that arise after admission and during the rehabilitation stay that affect the person's health/functional status and resource requirements during the rehabilitation stay. If a comorbidity recorded at admission (data element 81) still exists at discharge, it should not be re-coded on data element 82 unless the comorbidity resolved itself and then recurred during the rehabilitation stay. For example, if a client was admitted with the flu, recovered, and then acquired the flu again during their rehabilitation stay, it would be appropriate to double-code comorbidities on 81 & 82, assuming the comorbidities affected the rehabilitation stay.	If the comorbidity did not arise *after admission and during the rehabilitation stay*, an update record should be submitted to remove the comorbidity from data element 82. If the comorbidity flagged and coded in data element 82 was present at admission, resolved itself during the rehabilitation stay, and then the same comorbidity was acquired again during the client's stay, then no further action is required.
100002	Duplicate Comorbid Recorded on the same Assessment (admission or discharge)	The same comorbidity was coded more than once within either the admission or discharge assessment. While it may be valid in some cases to duplicate diagnostic codes within an assessment, this warning is intended to assist identification of instances in which duplication is an error. Please verify internally that the duplicate entry is intentional and valid.	If the client did not actually have 2 of the same comorbidities at the time of assessment, then an update record should be submitted to remove the duplication. If the comorbidity was actually present more than once at the time of assessment and was correctly recorded, then no further action is required.

Warning number	Warning	Reason for warning	How to correct the warning/what next?
101000	Potential Duplicate Admission Assessment, please check your records to ensure that this is not a duplicate	This warning occurs when an admission is submitted to the NRS with the same Health Care Number (HCN) and chart number as an open assessment (i.e., an admission assessment with no corresponding discharge assessment) that already exists within the NRS. It is meant to have you confirm internally at your facility that this is in fact a new assessment.	If this is a new additional admission for this client, ensure that the discharge for the first admission is submitted and accepted. No further action would be required after that. If this is not a new admission (i.e. it is a duplicate of one already residing in the NRS database), please submit a delete record to remove the desired duplicate admission from the NRS database. If the discharge record for this client's first (open) admission is included in this same file (i.e., in the same file as the second admission record) and is accepted into the database, then this warning can be ignored. It occurs because the admission records within a file are processed ahead of the discharge records in that file.

Warning number	Warning	Reason for warning	How to correct the warning/what next?
102000	Consider coding a more specific RCG subgroup if possible	This warning occurs when a general RCG is coded where a more specific option is available. For example, if an RCG is coded as 08.1 (Status Post Hip Fracture), your record will be flagged, as there are more specific sub-codes available (08.11 (Status Post Unilateral Hip Fracture) or 08.12 (Status Post Bilateral Hip Fracture).	We strongly recommend that you update the record with a more-specific RCG code. For example, if you know the client was admitted post unilateral hip fracture, you should submit an update record in order to change the RCG code to 08.11 instead of 08.1, since a more specific RCG code is known for this client. If you do not have any further specificity available for the client, then no further action is required.
103000	Height has been recorded as <120 cm (3'11"), please check your record to ensure that this is correct	This warning is meant to flag outlier height values as potential data quality issues, (e.g., coding of height in feet rather than in centimetres).	If the client's actual height is below 120 cm and was correctly recorded, then no action is required. If the height was entered incorrectly, please submit an update record with the accurate height.
103001	Height has been recorded as >200 cm (6'6"), please check your record to ensure that this is correct	This warning is meant to flag outlier height values as potential data quality issues, (e.g., coding of height in millimetres rather than in centimetres).	If the client's actual height is above 200 cm and was correctly recorded, then no action is required. If the height was entered incorrectly, please submit an update record with the accurate height.
104000	Weight has been recorded as <35 kg (77 lbs), please check your record to ensure that this is correct	This warning is meant to flag outlier weight values as potential data quality issues.	If the client's actual weight is below 35 kg and was correctly recorded, then no action is required. If the weight was entered incorrectly, please submit an update record with the accurate weight.

Warning number	Warning	Reason for warning	How to correct the warning/what next?
104001	Weight has been recorded as >150 kg (331 Ibs), please check your record to ensure that this is correct	This warning is meant to flag outlier weight values as potential data quality issues, (e.g., coding of weight in pounds rather than in kilograms).	If the client's actual weight is above 150 kg and was correctly recorded, then no action is required. If the weight was entered incorrectly, please submit an update record with the accurate weight.
105000	RCG probably inconsistent with MRHC	This warning occurs when the ICD-10-CA code used for data element 80 Most Responsible Health Condition is probably inconsistent with the RCG on the assessment record and should likely be double-checked.	If the MRHC and RCG on the assessment record are accurate, no further action is required. If the MRHC and RCG on the assessment record are inconsistent, then an updated record should be submitted.
106000	Duplicate procedure/ intervention recorded on assessment record	This warning occurs when the same pre-admit comorbid procedure or intervention is recorded more than once for the same client on the same admission assessment.	If the duplication represents that the procedure/ intervention was performed in more than 1 location of the body, such as on different sides, then no further action is required. If the procedure/intervention was not performed in more than 1 location of the body, then an update record should be submitted to remove the duplication.

NRS Operational Reports submission reports are available in both PDF and ASCII formats. They identify the total number of records received, accepted and rejected for each data file submitted to the NRS. Records may be accepted outright or flagged with warning messages designed to highlight potential errors. Outright rejections may occur because of file-level errors, record-level errors or element-level errors. Each submission report provides appropriate error messages to aid in trouble-shooting, fixing and resubmitting the affected files/records.

The ASCII-formatted submission reports, should you choose to use them, have the following layouts:

Record layout: File-level rejection

Data element	Start byte	Length	Format
Facility Number	1	5	Char
Fiscal Year	6	4	YYYY
Fiscal Period	10	1	Int
Row Number	11	4	Int
Error Type Code	15	1	Char
Error Code	16	6	Char
Error Message	22	105	Char

The file-level rejection portion of the report is a fixed record length of 126 characters.

Record layout: Record-level rejection

Data element	Start byte	Length	Format
Facility Number	1	5	Char
Fiscal Year	6	4	YYYY
Fiscal Period	10	1	Int
Row Number	11	4	Int
Assessment Type	15	1	Int
Chart Number	16	10	Char
Admission Date	26	8	YYYYMMDD
Error Type Code	34	1	Char
Error Code	35	6	Char
Error Message	41	105	Char

The record-level rejection portion of the report is a fixed record length of 145 characters.

Record layout: Element-level rejection

Data element	Start byte	Length	Format
Facility Number	1	5	Char
Fiscal Year	6	4	YYYY
Fiscal Period	10	1	Int
Row Number	11	4	Int
Assessment Type	15	1	Int
Chart Number	16	10	Char
Admission Date	26	8	YYYYMMDD
Element Number	34	8	Char
Element Name	42	100	Char
Submitted Value	142	50	Char
Error Type Code	192	1	Char
Error Code	193	6	Char
Error Message	199	105	Char

The element-level rejection portion of the report is a fixed record length of 303 characters.

Submission file layouts

Records submitted to the NRS must conform to the specific file layouts listed below. The submission file layouts detail the start byte, length, format and valid code(s) for each data element specific to a particular record. Participating NRS facilities must adhere to these file layouts in order to have files accepted into the NRS database.

Data submission control record

Data element	Start byte	Length	Format	Valid codes
Data Record Type	1	1	Int	0
Submitting Facility or Code	2	5	Char	Must not be spaces
Vendor Number	7	5	Char	Must not be spaces Valid vendor number as assigned and recognized by CIHI to submit adult inpatient rehabilitation data
Fiscal Year of Submission	12	4	YYYY	The reporting fiscal year
Fiscal Quarter for This Submission	16	1	Int	1 — first quarter (April 1 to June 30) 2 — second quarter (July 1 to September 30) 3 — third quarter (October 1 to December 31) 4 — fourth quarter (January 1 to March 31) I — facility information
Number of Data Records in Transmission File	17	6	Int	Record count excluding control record
Date of Submission	23	8	YYYYMMDD	
Last Submission for This Quarter?	31	1	Int	0 — no 1 — yes (if this is the last submission for the quarter) Please note that once Last Submission for This Quarter? is recorded as 1 (yes) for a particular quarter, insert, update or deletion records are still allowable for submission to CIHI.

The data submission control data file is a fixed record length of 31 characters.

Facility information

Element ID	Data element	Start byte	Length	Format	Valid codes
	Data Record Type	1	1	Char	I
1A	Facility Number or Code	2	5	Char	Must not be spaces
1B	Type of Facility	7	1	Int	1, 2
1C	Facility Size (Approved Beds)	8	3	Int	001–999
1D	Facility Size (Operating Beds)	11	3	Int	001–999
1E	Facility per Diem Hospital Charge	14	6	Int Implied Decimal NNNNVNN	Must be spaces Removed from data set as of 2008–2009
1F	Facility/Site Name	20	80	Char	Must not be spaces
1G	Facility/Site Street Address	100	35	Char	Must not be spaces
1H	Facility/Site City	135	15	Char	Must not be spaces
1I	Facility/Site Province	150	2	Char	Valid province/territory code
1J	Facility/Site Postal Code	152	6	ANANAN	Valid postal code for facility
1K	Facility/Site Telephone Number	158	10	Int	Must be numeric
1L	Facility/Site Fax Number	168	10	Int	Must be numeric
1M	Facility/Site CEO/ Administrator Name	178	35	Char	
1N	Facility Coordinator Name	213	35	Char	Must not be spaces
1O	Facility Coordinator Telephone Number	248	10	Int	Must be numeric
1P	Facility Coordinator Fax Number	258	10	Int	Must be numeric
1Q	Facility Coordinator Email Address	268	50	Char	Must not be spaces
1R	Primary Data Submission Contact Name	318	35	Char	

Element ID	Data element	Start byte	Length	Format	Valid codes
1S	Primary Data Submission Contact Telephone Number	353	10	Int	Must be numeric
1T	Primary Data Submission Contact Fax Number	363	10	Int	Must be numeric
1U	Primary Data Submission Contact Email Address	373	50	Char	Must not be spaces
1V	Facility Corporation/ Region Name (if Applicable)	423	35	Char	
1W	Facility Corporation/ Region CEO Name (if Applicable)	458	35	Char	
1X	Report Media (How Do You Wish to Receive Your Reports?)	493	1	Char	Must be space Removed from data set as of 2008–2009
1Y	Facility/Site Telephone Extension	494	6	Int	Must be numeric
1Z	Facility Coordinator Telephone Extension	500	6	Int	Must be numeric
1AA	Primary Data Submission Contact Telephone Extension	506	6	Int	Must be numeric
1AB	Secondary Data Submission Contact Name	512	35	Char	
1AC	Secondary Data Submission Contact Telephone Number	547	10	Int	Must be numeric

Element ID	Data element	Start byte	Length	Format	Valid codes
1AD	Secondary Data Submission Contact Fax Number	557	10	Int	Must be numeric
1AE	Secondary Data Submission Contact Email Address	567	50	Char	Must not be spaces
1AF	Secondary Data Submission Contact Telephone Extension	617	6	Int	Must be numeric

The facility information data record is a fixed length of 622 characters.

Admission assessment data

Element ID	Data element	Start byte	Length	Format	Valid codes
	Data Record Type	1	1	Int	2, 3
1A	Facility Number or Code	2	5	Char	Must not be spaces
2	Assessment Type	7	1	Int	1
3	Program Type	8	2	Char	
4	Chart Number	10	10	Char	
5	Health Care Number	20	12	Char	Valid HCN or –50, –70, –90
6	Province/Territory Issuing Health Care Number	32	3	Char	Valid province/ territory code or –50, –70, –90
7	Sex	35	1	Char	M, F, O
8	Birthdate	36	8	YYYYMMDD	
9	Estimated Birthdate	44	1	Int	0, 1
10	Primary Language	45	3	Char	Valid code from CIHI's standard language pick-list
11A	Country of Residence	48	1	Int	1, 2, 3
11B	Postal Code of Residence	49	6	ANANAN or ANA	Valid postal code or FSA of client or –50, –70, –90
11C	Province/Territory of Residence	55	3	Char	Valid province/ territory code or –50, –70, –90
12–a	Pre-Hospital Living Arrangements — Living With Spouse/Partner	58	3	Int	0, 1, –50, –70
12–b	Pre-Hospital Living Arrangements — Living With Family (Includes Extended)	61	3	Int	0, 1, –50, –70
12–c	Pre-Hospital Living Arrangements — Living With Non-Family, Unpaid (Includes Friends)	64	3	Int	0, 1, –50, –70
12–d	Pre-Hospital Living Arrangements — Living With Paid Attendant	67	3	Int	0, 1, –50, –70

Element ID	Data element	Start byte	Length	Format	Valid codes
12–e	Pre-Hospital Living Arrangements — Living Alone	70	3	Int	0, 1, –50, –70
12–f	Pre-Hospital Living Arrangements — Living in Hospital/Long-Term Care/Residential Care Facility/Nursing Home	73	3	Int	0, 1, –50, –70
12–g	Pre-Hospital Living Arrangements — Other	76	3	Int	0, 1, –50, –70
	For Future CIHI Use	79	4	Int	Must be spaces
14	Pre-Hospital Living Setting	83	3	Int	1–8, –50, –70
16	Informal Support Received	86	1	Int	1–4
17–a	Pre-Hospital Vocational Status — Paid Employment — Full Time	87	3	Int	0, 1, –50, –70
17–b	Pre-Hospital Vocational Status — Paid Employment — Part Time	90	3	Int	0, 1, –50, –70
17–c	Pre-Hospital Vocational Status — Paid Employment — Adjusted/Modified Work	93	3	Int	0, 1, –50, –70
17–d	Pre-Hospital Vocational Status — Unpaid Employment — Full Time	96	3	Int	0, 1, –50, –70
17–e	Pre-Hospital Vocational Status — Unpaid Employment — Part Time	99	3	Int	0, 1, –50, –70
17–f	Pre-Hospital Vocational Status — Unpaid Employment — Adjusted/Modified Work	102	3	Int	0, 1, –50, –70
17–g	Pre-Hospital Vocational Status — Student — Full Time	105	3	Int	0, 1, –50, –70
17–h	Pre-Hospital Vocational Status — Student — Part Time	108	3	Int	0, 1, –50, –70

Element ID	Data element	Start byte	Length	Format	Valid codes
17–i	Pre-Hospital Vocational Status — Student — Adjusted/Modified Work	111	3	Int	0, 1, –50, –70
17–j	Pre-Hospital Vocational Status — Unemployed	114	3	Int	0, 1, –50, –70
17–k	Pre-Hospital Vocational Status — Retired — for Age	117	3	Int	0, 1, –50, –70
17–l	Pre-Hospital Vocational Status — Retired — for Disability	120	3	Int	0, 1, –50, –70
17–m	Pre-Hospital Vocational Status — None of the Above	123	3	Int	0, 1, –50, –70
	For Future CIHI Use	126	5	Int	Must be spaces
19A	Admission Class	131	1	Int	1–5
19B	Readmission Within 1 Month	132	1	Int	0, 1
19C	Readmission Planned	133	1	Int	0, 1
20A	Date Ready for Admission Known	134	1	Int	0, 1
20B	Date Ready for Admission	135	8	YYYYMMDD	
21	Admission Date	143	8	YYYYMMDD	
22	Referral Source	151	3	Int	01–13, 97, –50, –70
23A	Referral Source — Province/Territory	154	3	Char	Valid province/ territory code or –50, –70, –90
23B	Referral Source — Facility Number	157	5	Char	
24–a	Responsibility for Payment — Provincial/ Territorial Responsibility	162	3	Int	0, 1, –50, –70
24–b	Responsibility for Payment — WCB/WSIB	165	3	Int	0, 1, –50, –70
24–c	Responsibility for Payment — Other Province/Territory (Resident of Canada)	168	3	Int	0, 1, –50, –70
24–d	Responsibility for Payment — Federal Government — Veterans Affairs Canada	171	3	Int	0, 1, –50, –70
24–e	Responsibility for Payment — Federal Government — FNIHB	174	3	Int	0, 1, –50, –70

Element ID	Data element	Start byte	Length	Format	Valid codes
24–f	Responsibility for Payment — Other Federal Government	177	3	Int	0, 1, –50, –70
24–g	Responsibility for Payment — Canadian Resident, Self-Pay	180	3	Int	0, 1, –50, –70
24–h	Responsibility for Payment — Canadian Resident, Insurance Pay	183	3	Int	0, 1, –50, –70
24–i	Responsibility for Payment — Other Country Resident, Self-Pay	186	3	Int	0, 1, –50, –70
24–j	Responsibility for Payment — Provincial Definition	189	3	Int	0, 1, –50, –70
	For Future CIHI Use	192	3	Int	Must be spaces
26	Therapy Start Date	195	8	YYYYMMDD	Must be spaces Removed from data set as of 2008–2009
30	Discharge Date	203	8	YYYYMMDD	
34	Rehabilitation Client Group (RCG)	211	6	Int Implied Decimal NNVNNNN	Valid Rehabilitation Client Group
35–1	Most Responsible Health Condition	217	4	Char	Must be spaces Removed from data set as of 2008–2009
35–2	Most Responsible Health Condition — Other	221	50	Char	Must be spaces Removed from data set as of 2008–2009
36A–1	Pre-Admit Comorbid Health Condition (1st Occurrence)	271	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–2	Pre-Admit Comorbid Health Condition (2nd Occurrence)	275	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–3	Pre-Admit Comorbid Health Condition (3rd Occurrence)	279	4	Char	Must be spaces Removed from data set as of 2008–2009

Element ID	Data element	Start byte	Length	Format	Valid codes
36A–4	Pre-Admit Comorbid Health Condition (4th Occurrence)	283	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–5	Pre-Admit Comorbid Heath Condition (5th Occurrence)	287	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–6	Pre-Admit Comorbid Health Condition (6th Occurrence)	291	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–7	Pre-Admit Comorbid Health Condition (7th Occurrence)	295	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–8	Pre-Admit Comorbid Health Condition (8th Occurrence)	299	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–9	Pre-Admit Comorbid Health Condition (9th Occurrence)	303	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–10	Pre-Admit Comorbid Health Condition (10th Occurrence)	307	4	Char	Must be spaces Removed from data set as of 2008–2009
36A–11	Pre-Admit Comorbid Health Condition — Other (1st Occurrence)	311	50	Char	Must be spaces Removed from data set as of 2008–2009
36A–12	Pre-Admit Comorbid Health Condition — Other (2nd Occurrence)	361	50	Char	Must be spaces Removed from data set as of 2008–2009
36A–13	Pre-Admit Comorbid Health Condition — Other (3rd Occurrence)	411	50	Char	Must be spaces Removed from data set as of 2008–2009
37–1	Transfer or Death Health Condition	461	4	Char	Valid ICD-10-CA diagnostic health condition
37–2	Transfer or Death Health Condition — Other	465	50	Char	Must be spaces Removed from data set as of 2008–2009
38	ASIA Impairment Scale	515	1	Int	1–5
39	Date of Onset	516	8	YYYYMMDD	

Element ID	Data element	Start byte	Length	Format	Valid codes
40A	Height (in Centimetres)	524	6	Int Implied Decimal NNNVNNN	000.000–999.999 (where decimal place is implied)
40B	Weight (in Kilograms)	530	6	Int Implied Decimal NNNVNNN	000.000–999.999 (where decimal place is implied)
The 18-item FIM® instrument referenced herein is a trademark of Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.					
41	Eating — FIM® instrument	536	1	Int	1–7
42	Grooming — FIM® instrument	537	1	Int	1–7
43	Bathing — FIM® instrument	538	1	Int	1–7
44	Dressing — Upper Body — FIM® instrument	539	1	Int	1–7
45	Dressing — Lower Body — FIM® instrument	540	1	Int	1–7
46	Toileting — FIM® instrument	541	1	Int	1–7
47	Bladder Management — FIM® instrument	542	1	Int	1–7
48	Bowel Management — FIM® instrument	543	1	Int	1–7
49	Transfers: Bed, Chair, Wheelchair — FIM® instrument	544	1	Int	1–7
50	Transfers: Toilet — FIM® instrument	545	1	Int	1–7
51	Transfers: Tub or Shower — FIM® instrument	546	1	Int	1–7
52A	Locomotion: Walk/Wheelchair — FIM® instrument — mode	547	1	Int	1, 2, 3
52B	Locomotion: Walk/Wheelchair — FIM® instrument	548	1	Int	1–7
53	Locomotion: Stairs — FIM® instrument	549	1	Int	1–7
54A	Comprehension — FIM® instrument — mode	550	1	Int	1, 2, 3

Element ID	Data element	Start byte	Length	Format	Valid codes
54B	Comprehension — FIM® instrument	551	1	Int	1–7
55A	Expression — FIM® instrument — mode	552	1	Int	1, 2, 3
55B	Expression — FIM® instrument	553	1	Int	1–7
56	Social Interaction — FIM® instrument	554	1	Int	1–7
57	Problem-Solving — FIM® instrument	555	1	Int	1–7
58	Memory — FIM® instrument	556	1	Int	1–7
59A	Impact of Pain — Part A	557	1	Int	1, 5, 8
59B	Impact of Pain — Part B	558	1	Int	2, 3, 4
59C	Impact of Pain — Part C	559	1	Int	2–5
60	Meal Preparation	560	1	Int	2–5
61	Light Housework	561	1	Int	2–5
62	Heavy Housework	562	1	Int	2–5
63	Presence of Cognitive and/or Communication Impairment(s) or Activity Limitations	563	1	Int	Must be space Removed from data set as of 2009–2010
64	Communication — Verbal/ Non-Verbal Expression	564	1	Int	1–5, 8
65	Communication — Written Expression	565	1	Int	1–5, 8
66	Communication — Auditory/Non-Auditory Comprehension	566	1	Int	1–5, 8
67	Communication — Reading Comprehension	567	1	Int	1–5, 8
68	Financial Management	568	1	Int	2–5, 8
69	Orientation	569	1	Int	1, 3, 5
70A	General Health Status — Part A — Respondent	570	1	Int	1–3, 8
70B	General Health Status — Part B	571	1	Int	1–5
79	Glasses/Hearing Aid Flag	572	1	Int	0, 1, space

Element ID	Data element	Start byte	Length	Format	Valid codes
80	Most Responsible Health Condition ICD-10-CA	573	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–1	Pre-Admit Comorbid Health Condition ICD-10-CA (1st Occurrence)	580	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–2	Pre-Admit Comorbid Health Condition ICD-10-CA (2nd Occurrence)	587	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–3	Pre-Admit Comorbid Health Condition ICD-10-CA (3rd Occurrence)	594	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–4	Pre-Admit Comorbid Health Condition ICD-10-CA (4th Occurrence)	601	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–5	Pre-Admit Comorbid Health Condition ICD-10-CA (5th Occurrence)	608	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–6	Pre-Admit Comorbid Health Condition ICD-10-CA (6th Occurrence)	615	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–7	Pre-Admit Comorbid Health Condition ICD-10-CA (7th Occurrence)	622	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–8	Pre-Admit Comorbid Health Condition ICD-10-CA (8th Occurrence)	629	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–9	Pre-Admit Comorbid Health Condition ICD-10-CA (9th Occurrence)	636	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–10	Pre-Admit Comorbid Health Condition ICD-10-CA (10th Occurrence)	643	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list

Element ID	Data element	Start byte	Length	Format	Valid codes
81–11	Pre-Admit Comorbid Health Condition ICD-10-CA (11th Occurrence)	650	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–12	Pre-Admit Comorbid Health Condition ICD-10-CA (12th Occurrence)	657	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–13	Pre-Admit Comorbid Health Condition ICD-10-CA (13th Occurrence)	664	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–14	Pre-Admit Comorbid Health Condition ICD-10-CA (14th Occurrence)	671	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
81–15	Pre-Admit Comorbid Health Condition ICD 10-CA (15th Occurrence)	678	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
83	Transfer or Death Health Condition ICD-10-CA	685	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
86–1	Pre-Admit Comorbid Procedure or Intervention CCI (1st Occurrence)	692	10	Char	Valid CCI code from NRS pick-list
86–2	Pre-Admit Comorbid Procedure or Intervention CCI (2nd Occurrence)	702	10	Char	Valid CCI code from NRS pick-list
86–3	Pre-Admit Comorbid Procedure or Intervention CCI (3rd Occurrence)	712	10	Char	Valid CCI code from NRS pick-list
87	Aboriginal Status	722	1	Char	0, 1, 8
88A	Project Code 1	723	6	Char	
88B	Project Data 1	729	200	Char	
89A	Project Code 2	929	6	Char	
89B	Project Data 2	935	200	Char	

Element ID	Data element	Start byte	Length	Format	Valid codes
86–4	Pre-Admit Comorbid Procedure or Intervention CCI (4th Occurrence)	1,135	10	Char	Valid CCI code from NRS pick-list
86–5	Pre-Admit Comorbid Procedure or Intervention CCI (5th Occurrence)	1,145	10	Char	Valid CCI code from NRS pick-list
11D	Residence Code	1,155	7	Char	Blanks or alphanumeric codes provided by the provincial ministries of health.

The admission assessment data file is a fixed record length of 1,161 characters.

Discharge assessment data

Element ID	Data element	Start byte	Length	Format	Valid codes
	Data Record Type	1	1	Int	2, 3
1A	Facility Number or Code	2	5	Char	Must not be spaces
2	Assessment Type	7	1	Int	2
4	Chart Number	8	10	Char	
5	Health Care Number	18	12	Char	Valid HCN or –50, –70, –90
8	Birthdate	30	8	YYYYMMDD	
9	Estimated Birthdate	38	1	Int	0, 1
13–a	Post-Discharge Living Arrangements — Living With Spouse/Partner	39	3	Int	0, 1, –50, –70
13–b	Post-Discharge Living Arrangements — Living With Family (Includes Extended)	42	3	Int	0, 1, –50, –70
13–c	Post-Discharge Living Arrangements — Living With Non-Family, Unpaid (Includes Friends)	45	3	Int	0, 1, –50, –70
13–d	Post-Discharge Living Arrangements — Living With Paid Attendant	48	3	Int	0, 1, –50, –70
13–e	Post-Discharge Living Arrangements — Living Alone	51	3	Int	0, 1, –50, –70
13–f	Post-Discharge Living Arrangements — Living in Hospital/Long-Term Care/Residential Care Facility/Nursing Home	54	3	Int	0, 1, –50, –70
13–g	Post-Discharge Living Arrangements — Other	57	3	Int	0, 1, –50, –70
13–h	Post-Discharge Living Arrangements — Transitional/Temporary	60	3		0, 1, –50, –70
13–i	Post-Discharge Living Arrangements — Living in Acute Care	63	3	Int	0, 1, –50, –70
	For Future CIHI Use	66	2	Int	Must be spaces

Element ID	Data element	Start byte	Length	Format	Valid codes
15	Post-Discharge Living Setting	68	3	Int	1–9, –50, –70
16	Informal Support Received	71	1	Int	1–4
18–a	Post-Discharge Vocational Status — Paid Employment — Full Time	72	3	Int	0, 1, –50, –70
18–b	Post-Discharge Vocational Status — Paid Employment — Part Time	75	3	Int	0, 1, –50, –70
18–c	Post-Discharge Vocational Status — Paid Employment — Adjusted/Modified Work	78	3	Int	0, 1, –50, –70
18–d	Post-Discharge Vocational Status — Unpaid Employment — Full Time	81	3	Int	0, 1, –50, –70
18–e	Post-Discharge Vocational Status — Unpaid Employment — Part Time	84	3	Int	0, 1, –50, –70
18–f	Post-Discharge Vocational Status — Unpaid Employment — Adjusted/Modified Work	87	3	Int	0, 1, –50, –70
18–g	Post-Discharge Vocational Status — Student — Full Time	90	3	Int	0, 1, –50, –70
18–h	Post-Discharge Vocational Status — Student — Part Time	93	3	Int	0, 1, –50, –70
18–i	Post-Discharge Vocational Status — Student — Adjusted/ Modified Work	96	3	Int	0, 1, –50, –70
18–j	Post-Discharge Vocational Status — Unemployed	99	3	Int	0, 1, –50, –70
18–k	Post-Discharge Vocational Status — Retired — for Age	102	3	Int	0, 1, –50, –70

Element ID	Data element	Start byte	Length	Format	Valid codes
18–l	Post-Discharge Vocational Status — Retired — for Disability	105	3	Int	0, 1, –50, –70
18–m	Post-Discharge Vocational Status — None of the Above	108	3	Int	0, 1, –50, –70
	For Future CIHI Use	111	5	Int	Must be spaces
19A	Admission Class	116	1	Int	1–5
21	Admission Date	117	8	YYYYMMDD	
24–a	Responsibility for Payment — Provincial/ Territorial Responsibility	125	3	Int	0, 1, –50, –70
24–b	Responsibility for Payment — WCB/WSIB	128	3	Int	0, 1, –50, –70
24–c	Responsibility for Payment — Other Province/Territory (Resident of Canada)	131	3	Int	0, 1, –50, –70
24–d	Responsibility for Payment — Federal Government — DVA	134	3	Int	0, 1, –50, –70
24–e	Responsibility for Payment — Federal Government — FNIHB	137	3	Int	0, 1, –50, –70
24f	Responsibility for Payment — Other Federal Government	140	3	Int	0, 1, –50, –70
24–g	Responsibility for Payment — Canadian Resident, Self-Pay	143	3	Int	0, 1, –50, –70
24–h	Responsibility for Payment — Canadian Resident, Insurance Pay	146	3	Int	0, 1, –50, –70
24–i	Responsibility for Payment — Other Country Resident, Self-Pay	149	3	Int	0, 1, –50, –70
24–j	Responsibility for Payment — Provincial Definition	152	3	Int	0, 1, –50, –70
	For Future CIHI Use	155	6	Int	Must be spaces
25A–1	1st Service Interruption — Start Date	161	8	YYYYMMDD	

Element ID	Data element	Start byte	Length	Format	Valid codes
25B–1	1st Service Interruption — Return Date	169	8	YYYYMMDD	
25C–1	1st Service Interruption — Reason	177	4	Char	Must be spaces Removed from data set as of 2008–2009
25D–1	1st Service Interruption — Transfer Status	181	1	Int	0, 1
25A–2	2nd Service Interruption — Start Date	182	8	YYYYMMDD	
25B–2	2nd Service Interruption — Return Date	190	8	YYYYMMDD	
25C–2	2nd Service Interruption — Reason	198	4	Char	Must be spaces Removed from data set as of 2008–2009
25D–2	2nd Service Interruption — Transfer Status	202	1	Int	0, 1
25A–3	3rd Service Interruption — Start Date	203	8	YYYYMMDD	
25B–3	3rd Service Interruption — Return Date	211	8	YYYYMMDD	
25C–3	3rd Service Interruption — Reason	219	4	Char	Must be spaces Removed from data set as of 2008–2009
25D–3	3rd Service Interruption — Transfer Status	223	1	Int	0, 1
27	Therapy End Date	224	8	YYYYMMDD	Must be spaces Removed from data set as of 2008–2009
28A–1	Provider Type (1st Occurrence)	232	5	Int	Valid provider type
28B–1	Provider Identification (1st Occurrence)	237	15	Int	
28A–2	Provider Type (2nd Occurrence)	252	5	Int	Valid provider type
28B–2	Provider Identification (2nd Occurrence)	257	15	Int	
28A–3	Provider Type (3rd Occurrence)	272	5	Int	Valid provider type
28B–3	Provider Identification (3rd Occurrence)	277	15	Int	

Element ID	Data element	Start byte	Length	Format	Valid codes
28A–4	Provider Type (4th Occurrence)	292	5	Int	Valid provider type
28B–4	Provider Identification (4th Occurrence)	297	15	Int	
28A–5	Provider Type (5th Occurrence)	312	5	Int	Valid provider type
28B–5	Provider Identification (5th Occurrence)	317	15	Int	
28A–6	Provider Type (6th Occurrence)	332	5	Int	Valid provider type
28B–6	Provider Identification (6th Occurrence)	337	15	Int	
28A–7	Provider Type (7th Occurrence)	352	5	Int	Valid provider type
28B–7	Provider Identification (7th Occurrence)	357	15	Int	
28A–8	Provider Type (8th Occurrence)	372	5	Int	Valid provider type
28B–8	Provider Identification (8th Occurrence)	377	15	Int	
28A–9	Provider Type (9th Occurrence)	392	5	Int	Valid provider type
28B–9	Provider Identification (9th Occurrence)	397	15	Int	
28A–10	Provider Type (10th Occurrence)	412	5	Int	Valid provider type
28B–10	Provider Identification (10th Occurrence)	417	15	Int	
28A–11	Provider Type (11th Occurrence)	432	5	Int	Valid provider type
28B–11	Provider Identification (11th Occurrence)	437	15	Int	
28A–12	Provider Type (12th Occurrence)	452	5	Int	Valid provider type
28B–12	Provider Identification (12th Occurrence)	457	15	Int	
28A–13	Provider Type (13th Occurrence)	472	5	Int	Valid provider type
28B–13	Provider Identification (13th Occurrence)	477	15	Int	

Element ID	Data element	Start byte	Length	Format	Valid codes
28A–14	Provider Type (14th Occurrence)	492	5	Int	Valid provider type
28B–14	Provider Identification (14th Occurrence)	497	15	Int	
28A–15	Provider Type (15th Occurrence)	512	5	Int	Valid provider type
28B–15	Provider Identification (15th Occurrence)	517	15	Int	
28A–16	Provider Type (16th Occurrence)	532	5	Int	Valid provider type
28B–16	Provider Identification (16th Occurrence)	537	15	Int	
28A–17	Provider Type (17th Occurrence)	552	5	Int	Valid provider type
28B–17	Provider Identification (17th Occurrence)	557	15	Int	
28A–18	Provider Type (18th Occurrence)	572	5	Int	Valid provider type
28B–18	Provider Identification (18th Occurrence)	577	15	Int	
28A–19	Provider Type (19th Occurrence)	592	5	Int	Valid provider type
28B–19	Provider Identification (19th Occurrence)	597	15	Int	
28A–20	Provider Type (20th Occurrence)	612	5	Int	Valid provider type
28B–20	Provider Identification (20th Occurrence)	617	15	Int	
29	Date Ready for Discharge	632	8	YYYYMMDD	
30	Discharge Date	640	8	YYYYMMDD	
31	Reason for Discharge	648	1	Int	1–8
32	Referred To	649	3	Int	02–13, 97, –50, –70, –90
33A	Referred to — Province/Territory	652	3	Char	Valid province/ territory code or –50, –70, –90
33B	Referred to — Facility Number	655	5	Char	

Element ID	Data element	Start byte	Length	Format	Valid codes
34	Rehabilitation Client Group (RCG)	660	6	Int Implied Decimal NNVNNNN	Valid Rehabilitation Client Group
35–1	Most Responsible Health Condition	666	4	Char	Must be spaces Removed from data set as of 2008–2009
35–2	Most Responsible Health Condition — Other	670	50	Char	Must be spaces Removed from data set as of 2008–2009
36B–1	Post-Admit Comorbid Health Condition (1st Occurrence)	720	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–2	Post-Admit Comorbid Health Condition (2nd Occurrence)	724	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–3	Post-Admit Comorbid Health Condition (3rd Occurrence)	728	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–4	Post-Admit Comorbid Health Condition (4th Occurrence)	732	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–5	Post-Admit Comorbid Health Condition (5th Occurrence)	736	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–6	Post-Admit Comorbid Health Condition (6th Occurrence)	740	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–7	Post-Admit Comorbid Health Condition (7th Occurrence)	744	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–8	Post-Admit Comorbid Health Condition (8th Occurrence)	748	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–9	Post-Admit Comorbid Health Condition (9th Occurrence	752	4	Char	Must be spaces Removed from data set as of 2008–2009

Element ID	Data element	Start byte	Length	Format	Valid codes
36B–10	Post-Admit Comorbid Health Condition (10th Occurrence)	756	4	Char	Must be spaces Removed from data set as of 2008–2009
36B–11	Post-Admit Comorbid Health Condition — Other (1st Occurrence)	760	50	Char	Must be spaces Removed from data set as of 2008–2009
36B–12	Post-Admit Comorbid Health Condition — Other (2nd Occurrence)	810	50	Char	Must be spaces Removed from data set as of 2008–2009
36B–13	Post-Admit Comorbid Health Condition — Other (3rd Occurrence)	860	50	Char	Must be spaces Removed from data set as of 2008–2009
37–1	Transfer or Death Health Condition	910	4	Char	Must be spaces Removed from data set as of 2008–2009
37–2	Transfer or Death Health Condition — Other	914	50	Char	Must be spaces Removed from data set as of 2008–2009
40A	Height (in Centimetres)	964	6	Int Implied Decimal NNNVNNN	020.000–300.000 (where decimal place is implied)
40B	Weight (in Kilograms)	970	6	Int Implied Decimal NNNVNNN	005.000–500.000 (where decimal place is implied)

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41	Eating — FIM® instrument	976	1	Int	1–7
42	Grooming — FIM® instrument	977	1	Int	1–7
43	Bathing — FIM® instrument	978	1	Int	1–7
44	Dressing — Upper Body — FIM® instrument	979	1	Int	1–7
45	Dressing — Lower Body — FIM® instrument	980	1	Int	1–7
46	Toileting — FIM® instrument	981	1	Int	1–7

Element ID	Data element	Start byte	Length	Format	Valid codes
47	Bladder Management — FIM® instrument	982	1	Int	1–7
48	Bowel Management — FIM® instrument	983	1	Int	1–7
49	Transfers: Bed, Chair, Wheelchair — FIM® instrument	984	1	Int	1–7
50	Transfers: Toilet — FIM® instrument	985	1	Int	1–7
51	Transfers: Tub or Shower — FIM® instrument	986	1	Int	1–7
52B	Locomotion: Walk/Wheelchair — FIM® instrument	987	1	Int	1–7
53	Locomotion: Stairs — FIM® instrument	988	1	Int	1–7
54B	Comprehension — FIM® instrument	989	1	Int	1–7
55B	Expression — FIM® instrument	990	1	Int	1–7
56	Social Interaction — FIM® instrument	991	1	Int	1–7
57	Problem-Solving — FIM® instrument	992	1	Int	1–7
58	Memory — FIM® instrument	993	1	Int	1–7
59A	Impact of Pain — Part A	994	1	Int	1, 5, 8
59B	Impact of Pain — Part B	995	1	Int	2, 3, 4
59C	Impact of Pain — Part C	996	1	Int	2–5
60	Meal Preparation	997	1	Int	2–5
61	Light Housework	998	1	Int	2–5
62	Heavy Housework	999	1	Int	2–5
64	Communication — Verbal/ Non-Verbal Expression	1,000	1	Int	1–5, 8
65	Communication — Written Expression	1,001	1	Int	1–5, 8
66	Communication — Auditory/Non-Auditory Comprehension	1,002	1	Int	1–5, 8

Element ID	Data element	Start byte	Length	Format	Valid codes
67	Communication — Reading Comprehension	1,003	1	Int	1–5, 8
68	Financial Management	1,004	1	Int	2–5, 8
69	Orientation	1,005	1	Int	1, 3, 5
70A	General Health Status — Part A — Respondent	1,006	1	Int	1–3, 8
70B	General Health Status — Part B	1,007	1	Int	1–5
71A–a	Screening Assessment — Service Type	1,008	1	Int	Must be space Removed from data set as of 2008–2009
71B–a	Screening Assessment — Service Discipline	1,009	1	Int	Must be space Removed from data set as of 2008–2009
71A–b	Initial Assessment — Service Type	1,010	1	Int	Must be space Removed from data set as of 2008–2009
71B–b	Initial Assessment — Service Discipline	1,011	1	Int	Must be space Removed from data set as of 2008–2009
71A–c	Reassessment — Service Type	1,012	1	Int	Must be space Removed from data set as of 2008–2009
71B–c	Reassessment — Service Discipline	1,013	1	Int	Must be space Removed from data set as of 2008–2009
71A–d	Service Planning and Coordination — Service Type	1,014	1	Int	Must be space Removed from data set as of 2008–2009
71B–d	Service Planning and Coordination — Service Discipline	1,015	1	Int	Must be space Removed from data set as of 2008–2009
71A–e	Functional Activities — Cognitive — Service Type	1,016	1	Int	Must be space Removed from data set as of 2008–2009
71B–e	Functional Activities — Cognitive — Service Discipline	1,017	1	Int	Must be space Removed from data set as of 2008–2009

Element ID	Data element	Start byte	Length	Format	Valid codes
71A–f	Functional Activities — Communication/ Linguistics — Service Type	1,018	1	Int	Must be space Removed from data set as of 2008–2009
71B–f	Functional Activities — Communication/ Linguistics — Service Discipline	1,019	1	Int	Must be space Removed from data set as of 2008–2009
71A–g	Functional Activities — Physical — Service Type	1.020	1	Int	Must be space Removed from data set as of 2008–2009
71B–g	Functional Activities — Physical — Service Discipline	1,021	1	Int	Must be space Removed from data set as of 2008–2009
71A–h	Functional Activities — Nutritional — Service Type	1,022	1	Int	Must be space Removed from data set as of 2008–2009
71B–h	Functional Activities Nutritional — Service Discipline	1,023	1	Int	Must be space Removed from data set as of 2008–2009
71A–i	Functional Activities — Psychosocial — Service Type	1,024	1	Int	Must be space Removed from data set as of 2008–2009
71B–i	Functional Activities — Psychosocial — Service Discipline	1,025	1	Int	Must be space Removed from data set as of 2008–2009
71A–j	Functional Activities — Vocational — Service Type	1,026	1	Int	Must be space Removed from data set as of 2008–2009
71B–j	Functional Activities — Vocational — Service Discipline	1,027	1	Int	Must be space Removed from data set as of 2008–2009
71A–k	Manual Techniques — Service Type	1,028	1	Int	Must be space Removed from data set as of 2008–2009
71B–k	Manual Techniques — Service Discipline	1,029	1	Int	Must be space Removed from data set as of 2008–2009

Element ID	Data element	Start byte	Length	Format	Valid codes
71A–l	Physical Modalities — Service Type	1,030	1	Int	Must be space Removed from data set as of 2008–2009
71B–l	Physical Modalities — Service Discipline	1,031	1	Int	Must be space Removed from data set as of 2008–2009
71A–m	Injections and Aspirations — Service Type	1,032	1	Int	Must be space Removed from data set as of 2008–2009
71B–m	Injections and Aspirations — Service Discipline	1,033	1	Int	Must be space Removed from data set as of 2008–2009
71A–n	Social Participation Interventions — Service Type	1,034	1	Int	Must be space Removed from data set as of 2008–2009
71B–n	Social Participation Interventions — Service Discipline	1,035	1	Int	Must be space Removed from data set as of 2008–2009
71A–o	Equipment/Assistive Technology — Service Type	1,036	1	Int	Must be space Removed from data set as of 2008–2009
71B–o	Equipment/Assistive Technology — Service Discipline	1,037	1	Int	Must be space Removed from data set as of 2008–2009
71A–p	Education — Service Type	1,038	1	Int	Must be space Removed from data set as of 2008–2009
71B–p	Education — Service Discipline	1,039	1	Int	Must be space Removed from data set as of 2008–2009
71A–q	Consultation — Service Type	1,040	1	Int	Must be space Removed from data set as of 2008–2009
71B–q	Consultation — Service Discipline	1,041	1	Int	Must be space Removed from data set as of 2008–2009

Element ID	Data element	Start byte	Length	Format	Valid codes
79	Glasses/Hearing Aid Flag	1,042	1	Int	0, 1, space
80	Most Responsible Health Condition ICD-10-CA	1,043	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–1	Post-Admit Comorbid Health Condition ICD-10-CA (1st Occurrence)	1,050	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–2	Post-Admit Comorbid Health Condition ICD-10-CA (2nd Occurrence)	1,057	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–3	Post-Admit Comorbid Health Condition ICD-10-CA (3rd Occurrence)	1,064	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–4	Post-Admit Comorbid Health Condition ICD-10-CA (4th Occurrence)	1,071	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–5	Post-Admit Comorbid Health Condition ICD-10-CA (5th Occurrence)	1,078	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–6	Post-Admit Comorbid Health Condition ICD-10-CA (6th Occurrence)	1,085	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–7	Post-Admit Comorbid Health Condition ICD-10-CA (7th Occurrence)	1,092	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–8	Post-Admit Comorbid Health Condition ICD-10-CA (8th Occurrence)	1,099	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–9	Post-Admit Comorbid Health Condition ICD-10-CA (9th Occurrence)	1,106	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list

Element ID	Data element	Start byte	Length	Format	Valid codes
82–10	Post-Admit Comorbid Health Condition ICD-10-CA (10th Occurrence)	1,113	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–11	Post-Admit Comorbid Health Condition ICD-10-CA (11th Occurrence)	1,120	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–12	Post-Admit Comorbid Health Condition ICD-10-CA (12th Occurrence)	1,127	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–13	Post-Admit Comorbid Health Condition ICD-10-CA (13th Occurrence)	1,134	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–14	Post-Admit Comorbid Health Condition ICD-10-CA (14th Occurrence)	1,141	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
82–15	Post-Admit Comorbid Health Condition ICD-10-CA (15th Occurrence)	1,148	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
83	Transfer or Death Health Condition ICD-10-CA	1,155	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
84–1	Service Interruption Reason ICD-10-CA (1st Occurrence)	1,162	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
84–2	Service Interruption Reason ICD-10-CA (2nd Occurrence)	1,169	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
84–3	Service Interruption Reason ICD-10-CA (3rd Occurrence)	1,176	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
52A	Locomotion: Walk/ Wheelchair — FIM® instrument — mode	1,183	1	Int	1, 2
88A	Project Code 1	1,184	6	Char	

Element ID	Data element	Start byte	Length	Format	Valid codes
88B	Project Data 1	1,190	200	Char	
89A	Project Code 2	1,390	6	Char	
89B	Project Data 2	1,396	200	Char	
90A	Reasons for Waiting for Discharge	1,596	3	Char	
90B	Reasons for Waiting for Discharge	1,599	3	Char	
25A–4	4th Service Interruption — Start Date	1,602	8	YYYYMMDD	
25B–4	4th Service Interruption — Return Date	1,610	8	YYYYMMDD	
25D–4	4th Service Interruption — Transfer Status	1,618	1	Int	0, 1
25A–5	5th Service Interruption — Start Date	1,619	8	YYYYMMDD	
25B–5	5th Service Interruption — Return Date	1,627	8	YYYYMMDD	
25D–5	5th Service Interruption — Transfer Status	1,635	1	Int	0, 1
84–4	Service Interruption Reason ICD-10-CA (4th Occurrence)	1,636	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
84–5	Service Interruption Reason ICD-10-CA (5th Occurrence)	1,643	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
54A	Comprehension — FIM® instrument — mode	1,650	1	Int	1, 2, 3
55A	Expression — FIM® instrument — mode	1,651	1	Int	1, 2, 3
91A.	Rehabilitation Time With an Occupational Therapist (OT) (in Minutes)	1,652	5	Int	0–99999
91B.	Rehabilitation Time With a Physiotherapist (PT) (in Minutes)	1,657	5	Int	0–99999
91C.	Rehabilitation Time With a Speech–Language Pathologist (SLP) (in Minutes)	1,662	5	Int	0–99999

Element ID	Data element	Start byte	Length	Format	Valid codes
91D.	Rehabilitation Time With an Occupational Therapist Assistant (OTA) (in Minutes)	1,667	5	Int	0–99999
91E.	Rehabilitation Time With a Physiotherapist Assistant (PTA) (in Minutes)	1,672	5	Int	0–99999
91F.	Rehabilitation Time With a Communicative Disorders Assistant (CDA) (in Minutes)	1,677	5	Int	0–99999

The discharge assessment data file is a fixed record length of 1,681 characters.

Follow-up assessment data

Element ID	Data element	Start byte	Length	Format	Valid codes
	Data Record Type	1	1	Int	2, 3
1A	Facility Number or Code	2	5	Char	Must not be spaces
2	Assessment Type	7	1	Int	3
4	Chart Number	8	10	Char	
5	Health Care Number	18	12	Char	Valid HCN or –50, –70, –90
8	Birthdate	30	8	YYYYMMDD	
9	Estimated Birthdate	38	1	Int	0, 1
11B	Postal Code	39	6	ANANAN or ANA Char	Postal code or FSA of client or –50, –70, –90
11C	Province/Territory of Residence	45	3	Char	Valid province/ territory code or –50, –70, –90
21	Admission Date	48	8	YYYYMMDD	
30	Discharge Date	56	8	YYYYMMDD	
72	Follow-Up Assessment Date	64	8	YYYYMMDD	
73A	Hospitalizations Since Discharge	72	3	Int	0, 1, –50, –70
73B	Days in Hospital — for Hospitalization Since Discharge	75	3	Int	001–999 or –50, –70
73C–1	Health Condition Reason (1st Occurrence) — for Hospitalization Since Discharge	78	4	Char	Must be spaces Removed from data set as of 2008–2009
73C–2	Health Condition Reason (2nd Occurrence) — for Hospitalization Since Discharge	82	4	Char	Must be spaces Removed from data set as of 2008–2009
73C–3	Health Condition Reason (3rd Occurrence) — for Hospitalization Since Discharge	86	4	Char	Must be spaces Removed from data set as of 2008–2009

Element ID	Data element	Start byte	Length	Format	Valid codes
34	Rehabilitation Client Group (RCG)	90	6	Int Implied Decimal NNVNNNN	Valid Rehabilitation Client Group
74	Respondent Type	96	1	Int	1, 2, 3
76–a	Follow-Up Living Arrangements — Living With Spouse/Partner	97	3	Int	0, 1, –50, –70
76–b	Follow-Up Living Arrangements — Living With Family (Includes Extended)	100	3	Int	0, 1, –50, –70
76–c	Follow-Up Living Arrangements — Living With Non-Family, Unpaid (Includes Friends)	103	3	Int	0, 1, –50, –70
76–d	Follow-Up Living Arrangements — Living With Paid Attendant	106	3	Int	0, 1, –50, –70
76–e	Follow-Up Living Arrangements — Living Alone	109	3	Int	0, 1, –50, –70
76–f	Follow-Up Living Arrangements — Living in Hospital/Long-Term Care/Residential Care Facility/Nursing Home	112	3	Int	0, 1, –50, –70
76–g	Follow-Up Living Arrangements — Other	115	3	Int	0, 1, –50, –70
	For Future CIHI Use	118	5	Int	Must be spaces
77	Follow-Up Living Setting	123	3	Int	1–8, –50, –70
16	Informal Support Received	126	1	Int	1–4
78–a	Follow-Up Vocational Status — Paid Employment — Full Time	127	3	Int	0, 1, –50, –70
78–b	Follow-Up Vocational Status — Paid Employment — Part Time	130	3	Int	0, 1, –50, –70
78–c	Follow-Up Vocational Status — Paid Employment — Adjusted/ Modified Work	133	3	Int	0, 1, –50, –70

Element ID	Data element	Start byte	Length	Format	Valid codes
78–d	Follow-Up Vocational Status — Unpaid Employment — Full Time	136	3	Int	0, 1, –50, –70
78–e	Follow-Up Vocational Status — Unpaid Employment — Part Time	139	3	Int	0, 1, –50, –70
78–f	Follow-Up Vocational Status — Unpaid Employment — Adjusted/ Modified Work	142	3	Int	0, 1, –50, –70
78–g	Follow-Up Vocational Status — Student — Full Time	145	3	Int	0, 1, –50, –70
78–h	Follow-Up Vocational Status — Student — Part Time	148	3	Int	0, 1, –50, –70
78–i	Follow-Up Vocational Status — Student — Adjusted/ Modified Work	151	3	Int	0, 1, –50, –70
78–j	Follow-Up Vocational Status — Unemployed	154	3	Int	0, 1, –50, –70
78–k	Follow-Up Vocational Status — Retired — for Age	157	3	Int	0, 1, –50, –70
78–l	Follow-Up Vocational Status — Retired — for Disability	160	3	Int	0, 1, –50, –70
78–m	Follow-Up Vocational Status — None of the Above	163	3	Int	0, 1, –50, –70
	For Future CIHI Use	166	5	Int	Must be spaces

The 18-item FIM® instrument referenced herein is a trademark of Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.

41	Eating — FIM® instrument	171	1	Int	1–7
42	Grooming — FIM® instrument	172	1	Int	1–7
43	Bathing — FIM® instrument	173	1	Int	1–7
44	Dressing — Upper Body — FIM® instrument	174	1	Int	1–7
45	Dressing — Lower Body — FIM® instrument	175	1	Int	1–7
46	Toileting — FIM® instrument	176	1	Int	1–7

Element ID	Data element	Start byte	Length	Format	Valid codes
47	Bladder Management — FIM® instrument	177	1	Int	1–7
48	Bowel Management — FIM® instrument	178	1	Int	1–7
49	Transfers: Bed, Chair, Wheelchair — FIM® instrument	179	1	Int	1–7
50	Transfers: Toilet — FIM® instrument	180	1	Int	1–7
51	Transfers: Tub or Shower — FIM® instrument	181	1	Int	1–7
52B	Locomotion: Walk/ Wheelchair — FIM® instrument	182	1	Int	1–7
53	Locomotion: Stairs — FIM® instrument	183	1	Int	1–7
54B	Comprehension — FIM® instrument	184	1	Int	1–7
55B	Expression — FIM® instrument	185	1	Int	1–7
56	Social Interaction — FIM® instrument	186	1	Int	1–7
57	Problem-Solving — FIM® instrument	187	1	Int	1–7
58	Memory — FIM® instrument	188	1	Int	1–7
59A	Impact of Pain — Part A	189	1	Int	1, 5, 8
59B	Impact of Pain — Part B	190	1	Int	2, 3, 4
59C	Impact of Pain — Part C	191	1	Int	2–5
60	Meal Preparation	192	1	Int	2–5
61	Light Housework	193	1	Int	2–5
62	Heavy Housework	194	1	Int	2–5
64	Communication — Verbal/ Non-Verbal Expression	195	1	Int	1–5, 8
65	Communication — Written Expression	196	1	Int	1–5, 8
66	Communication — Auditory/Non-Auditory Comprehension	197	1	Int	1–5, 8
67	Communication — Reading Comprehension	198	1	Int	1 –5, 8

Element ID	Data element	Start byte	Length	Format	Valid codes
68	Financial Management	199	1	Int	2–5, 8
69	Orientation	200	1	Int	1, 3, 5
70A	General Health Status — Part A — Respondent	201	1	Int	1–3, 8
70B	General Health Status — Part B	202	1	Int	1–5
75–a	Reintegration to Normal Living Index — Mobility in Living Quarters	203	1	Int	0, 1, 2, 8
75–b	Reintegration to Normal Living Index — Mobility in Community	204	1	Int	0, 1, 2, 8
75–c	Reintegration to Normal Living Index — Out-of-Town Trips	205	1	Int	0, 1, 2, 8
75–d	Reintegration to Normal Living Index — Self-Care Needs	206	1	Int	0, 1, 2, 8
75–e	Reintegration to Normal Living Index — Work Activity	207	1	Int	0, 1, 2, 8
75–f	Reintegration to Normal Living Index — Recreational Activities	208	1	Int	0, 1, 2, 8
75–g	Reintegration to Normal Living Index — Social Activities	209	1	Int	0, 1, 2, 8
75–h	Reintegration to Normal Living Index — Family Role	210	1	Int	0, 1, 2, 8
75–i	Reintegration to Normal Living Index — Personal Relationships	211	1	Int	0, 1, 2, 8
75–j	Reintegration to Normal Living Index — Personal Comfort With Others	212	1	Int	0, 1, 2, 8
75–k	Reintegration to Normal Living Index — Dealing With Life Events	213	1	Int	0, 1, 2, 8
79	Glasses/Hearing Aid Flag	214	1	Int	0, 1, space
85–1	Health Condition Reason(s) for Hospitalization ICD-10-CA (1st Occurrence)	215	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list

Element ID	Data element	Start byte	Length	Format	Valid codes
85–2	Health Condition Reason(s) for Hospitalization ICD-10-CA (2nd Occurrence)	222	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
85–3	Health Condition Reason(s) for Hospitalization ICD-10-CA (3rd Occurrence)	229	7	Char	Valid ICD-10-CA diagnostic health condition from NRS pick-list
52A	Locomotion: Walk/Wheelchair — FIM® instrument — mode	236	1	Int	1, 2
88A	Project Code 1	237	6	Char	
88B	Project Data 1	243	200	Char	
89A	Project Code 2	443	6	Char	
89B	Project Data 2	449	200	Char	
54A	Comprehension — FIM® instrument — mode	649	1	Int	1, 2, 3
55A	Expression — FIM® instrument — mode	650	1	Int	1, 2, 3

The follow-up assessment data file is a fixed record length of 650 characters.

Delete record

Rehabilitation services data delete record (Record Type 1)

Element ID	Data element	Start byte	Length	Format	Valid codes
	Data Record Type	1	1	Int	1
1A	Facility Number or Code	2	5	Char	Must not be spaces
2	Assessment Type	7	1	Int	1, 2, 3
4	Chart Number	8	10	Char	
5	Health Care Number	18	12	Char	Valid HCN or –50, –70, –90
21	Admission Date	30	8	YYYYMMDD	

The fields that make up the delete record layout must not be subject to change because these fields belong to a unique index. In order to modify them, the record must be deleted and subsequently inserted as a new record.

Update record

Rehabilitation services data update record (Record Type 3)

The fields that make up the update record are dependent on the type of record being updated. An admission record update has the same record layout and validation rules as an admission record, a discharge record update has the same record layout and validation rules as a discharge record and a follow-up record update has the same record layout and validation rules as a follow-up record. Update records are identified as such when the first byte of information within the record (data record type) is listed as 3.

NRS records can be updated at any time. A record update overwrites the existing record in the NRS database.

Note: It is not possible to update a Chart Number, Health Care Number or Admission Date, as these are unique identifiers for each record. If any of these elements needs to be modified, the record in question first needs to be deleted. A new record with the correct information should then be submitted.

Data element specifications and definitions[iv]

Note: Please refer to Appendix G for a summary of specification edit changes from 2015–2016 to 2016–2017.

Facility identifiers

1A. Facility Number or Code

The facility number (including province number) assigned for the rehabilitation facility or program/unit reporting rehabilitation data.

Specifications	
Field length	5
Field status	Mandatory
Field type	Char
Record/assessment	Submission control record, facility profile and admission, discharge and follow-up assessment records
Justification	None
Valid codes	1-digit province number plus 4-digit facility number Province number — 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, N, Y, V Facility number must be in the range of 0001–9999.
Validation	Must not be spaces. The same facility number must be reflected on all records/assessments, as indicated above. Must be uppercase.

iv. Data element definitions in this module have been abbreviated. Refer to Module 2: Clinical Coding and NRS Training for the detailed definitions.

1B. Facility Type

Description of the rehabilitation hospital based on the nature of the services, the type of hospital the service is located in, the provincial or regional designation and/or the self-assignment of the facility.

Specifications	
Field length	1
Field status	Mandatory
Field type	Int
Record/assessment	Facility profile
Justification	None
Valid codes	1 — Specialty/free-standing facility 2 — General/acute facility
Validation	Must not be spaces.

1C. Facility Size — Approved Beds

Number of beds in the rehabilitation facility or unit approved for rehabilitation services. Can be revised annually only.

Specifications	
Field length	3
Field status	Mandatory
Field type	Int
Record/assessment	Facility profile
Justification	Right
Valid codes	001–999
Validation	Must not be spaces.

1D. Facility Size — Operating Beds

Number of operating beds in the rehabilitation facility or unit for which rehabilitation services are provided.

Specifications	
Field length	3
Field status	Mandatory
Field type	Int
Record/assessment	Facility profile
Justification	Right
Valid codes	001–999
Validation	Must not be spaces.

1F. Facility/Site Name

The name of the rehabilitation facility/site reporting rehabilitation data as recognized by the provincial ministry of health.

Specifications	
Field length	80
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid facility/site name
Validation	Must not be spaces.

1G. Facility/Site Street Address

The complete street address of the rehabilitation facility/site reporting rehabilitation data.

Specifications	
Field length	35
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid facility/site street address
Validation	Must not be spaces.

1H. Facility/Site City

The name of the city in which the rehabilitation facility/site reporting rehabilitation data is located.

Specifications	
Field length	15
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid facility/site city
Validation	Must not be spaces.

1I. Facility/Site Province

The name of the province or territory in which the rehabilitation facility/site reporting rehabilitation data is located.

Specifications	
Field length	2
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid province/territory code (see Legend)
Validation	Must not be spaces. Must be uppercase.

Legend	
NL	Newfoundland and Labrador
PE	Prince Edward Island
NS	Nova Scotia
NB	New Brunswick
QC	Quebec
ON	Ontario
MB	Manitoba
SK	Saskatchewan
AB	Alberta
BC	British Columbia
NT	Northwest Territories
YT	Yukon
NU	Nunavut

1J. Facility/Site Postal Code

The postal code (assigned by Canada Post) of the facility/site.

Specifications	
Field length	6
Field status	Mandatory
Field type	ANANAN
Record/assessment	Facility profile
Justification	None
Valid codes	Full postal code of facility/site
Validation	Must not be spaces. Must be in valid format of ANANAN and the first digit must not be recorded as D, F, I, O, Q, U, W or Z. Must be uppercase.

1K. Facility/Site Telephone Number

The main telephone number of the rehabilitation facility/site reporting rehabilitation data.

Specifications	
Field length	10
Field status	Mandatory
Field type	Int
Record/assessment	Facility profile
Justification	None
Valid codes	Valid telephone number
Validation	Must be numeric.

1L. Facility/Site Fax Number

The fax number of the rehabilitation facility/site reporting rehabilitation data.

Specifications	
Field length	10
Field status	Optional
Field type	Int
Record/assessment	Facility profile
Justification	None
Valid codes	Valid telephone number
Validation	Must be numeric.

1M. Facility/Site CEO/Administrator Name

The name of the facility/site chief executive officer or most senior administrator.

Specifications	
Field length	35
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid name
Validation	Must not be spaces.

1N. Facility Coordinator Name

The name of the single person assuming the facility coordinator role for the purpose of NRS reporting.

Specifications	
Field length	35
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid name
Validation	Must not be spaces.

1O. Facility Coordinator Telephone Number

The telephone number of the NRS facility coordinator.

Specifications	
Field length	10
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid telephone number
Validation	Must not be spaces.

1P. Facility Coordinator Fax Number

The fax number of the NRS facility coordinator.

Specifications	
Field length	10
Field status	Optional
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid fax number
Validation	May be spaces.

1Q. Facility Coordinator Email Address

The email address of the NRS facility coordinator.

Specifications	
Field length	50
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid email format
Validation	Must not be spaces.

1R. Primary Data Submission Contact Name

The name of the person assuming the primary NRS data submission role for the purpose of NRS reporting.

Specifications	
Field length	35
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid name
Validation	Must not be spaces.

1S. Primary Data Submission Contact Telephone Number

The telephone number of the primary NRS data submission contact.

Specifications	
Field length	10
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid telephone number
Validation	Must not be spaces.

1T. Primary Data Submission Contact Fax Number

The fax number of the primary NRS data submission contact.

Specifications	
Field length	10
Field status	Optional
Field type	Char
Record/assessment	Facility Profile
Justification	None
Valid codes	Valid fax number
Validation	May be spaces.

1U. Primary Data Submission Contact Email Address

The email address of the primary NRS data submission contact.

Specifications	
Field length	50
Field status	Mandatory
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid email format
Validation	Must not be spaces.

1V. Facility Corporation/Region Name

The name of the facility corporation or region (if applicable).

Specifications	
Field length	35
Field status	Optional
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid facility corporation/region name
Validation	May be spaces.

1W. Facility Corporation/Region CEO Name

The name of the facility corporation or region CEO (if applicable).

Specifications	
Field length	35
Field status	Optional
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid facility corporation/region CEO name
Validation	May be spaces.

1Y. Facility/Site Telephone Extension

The telephone extension number of the facility/site reporting rehabilitation data.

Specifications	
Field length	6
Field status	Optional
Field type	Char
Record/assessment	Facility profile
Justification	Left
Valid codes	Valid telephone extension number
Validation	May be spaces.

1Z. Facility Coordinator Telephone Extension

The telephone extension number of the NRS facility coordinator.

Specifications	
Field length	6
Field status	Optional
Field type	Char
Record/assessment	Facility profile
Justification	Left
Valid codes	Valid telephone extension number
Validation	May be spaces.

1AA. Primary Data Submission Contact Telephone Extension

The telephone extension number of the primary NRS data submission contact.

Specifications	
Field length	6
Field status	Optional
Field type	Char
Record/assessment	Facility profile
Justification	Left
Valid codes	Valid telephone extension number
Validation	May be spaces.

1AB. Secondary Data Submission Contact Name

The name of the secondary person assuming the data submission role for the purpose of NRS reporting.

Specifications	
Field length	35
Field status	Optional
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid name
Validation	May be spaces.

1AC. Secondary Data Submission Contact Telephone Number

The telephone number of the secondary NRS data submission contact.

Specifications	
Field length	10
Field status	Mandatory to record if 1AB Secondary Data Submission Contact name is recorded; otherwise optional to record.
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid telephone number
Validation	May be spaces.

1AD. Secondary Data Submission Contact Fax Number

The fax number of the secondary NRS data submission contact.

Specifications	
Field length	10
Field status	Optional
Field type	Char
Record/assessment	Facility Profile
Justification	None
Valid codes	Valid fax number
Validation	May be spaces.

1AE. Secondary Data Submission Contact Email Address

The email address of the secondary NRS data submission contact.

Specifications	
Field length	50
Field status	Mandatory to record if 1AB Secondary Data Submission Contact name is recorded; otherwise optional to record.
Field type	Char
Record/assessment	Facility profile
Justification	None
Valid codes	Valid email format
Validation	May be spaces.

1AF. Secondary Data Submission Contact Telephone Extension

The telephone extension number of the secondary NRS data submission contact.

Specifications	
Field length	6
Field status	Optional
Field type	Char
Record/assessment	Facility profile
Justification	Left
Valid codes	Valid telephone extension number
Validation	May be spaces.

Client identifiers

2. Assessment Type

The type of assessment record.

Specifications	
Field length	1
Field status	Mandatory
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–3 (see Legend)
Validation	Must not be spaces.

Legend	
1	**Admission assessment** (completed within 72 hours of admission to rehabilitation facility/unit)
2	**Discharge assessment** (completed within 72 hours prior to discharge from rehabilitation facility/unit)
3	**Follow-up assessment** (completed within 80–180 days following discharge from rehabilitation facility/unit)

3. Program Type

The type of program as defined by the rehabilitation facility/unit.

Specifications	
Field length	2
Field status	Optional
Field type	Char
Record/assessment	Admission assessment
Justification	None
Valid codes	Facility defined
Validation	May be spaces.

4. Chart Number

The person's unique identification number as assigned by the provider/delivery organization.

Specifications	
Field length	10
Field status	Mandatory on admission assessment. Must be defaulted on discharge and follow-up assessments. Must not be modified on discharge and follow-up assessments.
Field type	Char
Record/assessment	Admission, discharge and follow-up assessment records
Justification	Right
Valid codes	Facility generated
Validation	Must not be spaces. Must be uppercase.

5. Health Care Number

The person's health (insurance) number as assigned by the provincial/territorial government of residence.

Specifications	
Field length	12
Field status	Mandatory on admission assessment. Must be defaulted on discharge and follow-up assessments. Must not be modified on discharge and follow-up assessments.
Field type	Char
Record/assessment	Admission, discharge and follow-up assessment records
Justification	Left
Valid codes	Valid Health Care Number or –50, –70, –90 (see Legend)
Validation	Must not be spaces. Must be recorded as –50 if (6) Province/Territory Issuing Health Care Number = –50. Must be recorded as –70 if (6) Province/Territory Issuing Health Care Number = –70. Must be recorded as –90 if (6) Province/Territory Issuing Health Care Number = –90. Must be uppercase.

Legend	
–50	Not available, temporarily
–70	Asked, unknown
–90	Not applicable

6. Province/Territory Issuing Health Care Number

The provincial/territorial government from which the health care number was issued.

Specifications	
Field length	3
Field status	Mandatory
Field type	Char
Record/assessment	Admission assessment
Justification	Right
Valid codes	Valid province/territory code or –50, –70, –90 (see Legend)
Validation	Must not be spaces. Must be uppercase. Must be recorded as –90 if (5) Health Care Number = –90.

Legend	
NL	Newfoundland and Labrador
PE	Prince Edward Island
NS	Nova Scotia
NB	New Brunswick
QC	Quebec
ON	Ontario
MB	Manitoba
SK	Saskatchewan
AB	Alberta
BC	British Columbia
NT	Northwest Territories
YT	Yukon
NU	Nunavut
–50	Not available, temporarily
–70	Asked, unknown
–90	Not applicable

Socio-demographic data

7. Sex

The biological sex of the person.

Specifications	
Field length	1
Field status	Mandatory
Field type	Char
Record/assessment	Admission assessment
Justification	None
Valid codes	M, F, O (see Legend)
Validation	Must not be spaces. Must be uppercase.

Legend	
M	Male
F	Female
O	Other (includes hermaphrodite and transsexuals)

8. Birthdate

The person's birthdate in year, month and day order.

Specifications	
Field length	8
Field status	Mandatory on admission assessment. Must be defaulted on discharge and follow-up assessments. Must not be modified on discharge and follow-up assessments.
Field type	YYYYMMDD
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	A valid date
Validation	Admission Date minus Birthdate must be equal to or greater than 0 and less than 130 years. Must not be spaces.

9. Estimated Birthdate

A flag to indicate that the person's birthdate is estimated.

Specifications	
Field length	1
Field status	Mandatory on admission assessment. Must be defaulted on discharge and follow-up assessments. Must not be modified on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	0, 1
Validation	Must not be spaces.

Legend	
0	No, birthdate is known
1	Yes, birthdate is estimated

10. Primary Language

The primary language spoken and/or understood on a regular basis.

Specifications	
Field length	3
Field status	Mandatory unless 19A Admission Class = 4; otherwise optional to record.
Field type	Char
Record/assessment	Admission assessment
Justification	None
Valid codes	Valid code from CIHI's standard language pick-list (see Appendix B)
Validation	May be spaces if 19A Admission Class = 4. If recorded, the following validations apply: Must be recorded with a valid language code. Must be lower case.

11A. Country of Residence

The country in which the person resides.

Specifications	
Field length	1
Field status	Mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, regardless of Admission Class, then 11B Postal Code and 11C Province/Territory of Residence must be recorded.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	1–3 (see Legend)
Validation	May be spaces if 19A Admission Class = 4. If recorded, the following validations apply: If 11B Postal Code is recorded with a valid full postal code or FSA (excluding –50, –70, –90), then must = 1. If 11C Province/Territory of Residence is recorded with a valid province/territory code (excluding –50, –70, –90), then must = 1. If 11B Postal Code and/or 11C Province/Territory of Residence = –90 (not applicable), then must = 2 or 3.

Legend	
1	Canada
2	United States
3	Other

11B. Postal Code of Residence

The postal code (assigned by Canada Post) of the permanent dwelling in which the person lived prior to admission (for the admission assessment) or at the time of the follow-up (for the follow-up assessment). Dwelling can be a home or facility.

Specifications	
Field length	6
Field status	Mandatory on admission unless 19A Admission Class = 4; otherwise optional to record. If recorded, regardless of admission class, then 11A Country of Residence and 11C Province/Territory of Residence must be recorded. Mandatory to record on follow-up.
Field type	ANANAN or ANA
Record/assessment	Admission and follow-up assessments
Justification	None
Valid codes	Full postal code of client or forward sortation area (FSA) if full Postal Code is not known or –50, –70, –90 (see Legend)
Validation	On admission, may be spaces if 19A Admission Class = 4, unless 11A Country of Residence and/or 11C Province/Territory of Residence are recorded; then must not be spaces. If recorded, the following validations apply on admission assessments: If 11A Country of Residence = 2 or 3, then must = –90 (not applicable). If 11A Country of Residence = 1, then must not = –90 (not applicable). On follow-up, must not be spaces. If recorded, the following validations apply to admission assessments and follow-up assessments: Must be in valid format of ANANAN or ANA and the first digit must not be recorded as D, F, I, O, Q, U, W or Z. If 11C Province/Territory of Residence = ON and the first digit of 1A Facility Number = 5 (Ontario facilities), then 3-digit ANA format is not valid. Must be uppercase.

Legend	
–50	Not available, temporarily
–70	Asked, unknown
–90	Not applicable

11C. Province/Territory of Residence

The province or territory in which the person resided prior to admission (for the admission assessment) or at the time of the follow-up (for the follow-up assessment).

Specifications	
Field length	3
Field status	On admission, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, regardless of Admission Class, then 11A Country of Residence and 11B Postal Code must be recorded. Mandatory to record on follow-up.
Field type	Char
Record/assessment	Admission and follow-up assessments
Justification	None
Valid codes	Valid province/territory code or –50, –70, –90 (see Legend)
Validation	On admission, may be spaces if 19A Admission Class = 4, unless 11A Country of Residence and/or 11B Postal Code of Residence are recorded; then must not be spaces. If recorded, the following validations apply: If 11A Country of Residence = 2 or 3, then must = –90 (not applicable). If 11A Country of Residence = 1, then must not = –90 (not applicable). On follow-up, must not be spaces. On admission and follow-up assessments, must be uppercase.

Legend	
NL	Newfoundland and Labrador
PE	Prince Edward Island
NS	Nova Scotia
NB	New Brunswick
QC	Quebec
ON	Ontario
MB	Manitoba
SK	Saskatchewan
AB	Alberta
BC	British Columbia
NT	Northwest Territories
YT	Yukon
NU	Nunavut
–50	Not available, temporarily
–70	Asked, unknown
–90	Not applicable

11D. Residence Code

Code that is used to identify the area in which the patient resided prior to admission. Valid codes are defined by provincial ministries of health.

For transient/homeless patients, use the Residence Code for the facility managing the care/ treatment of the patient. For patients with a temporary residence, use the Residence Code for the patient's temporary address.

Specifications	
Field length	7
Field status	On admission, mandatory if Facility Province = "NB" (New Brunswick); otherwise optional to record.
Field type	Numeric, Alphanumeric, Alpha
Record/assessment	Admission assessment
Justification	Right
Valid codes	Blanks or alphanumeric codes provided by the provincial ministries of health.
Validation	On admission, must not be spaces if Facility Province = "NB"; otherwise, may be spaces. Must be right-justified.

New Brunswick specifications

In New Brunswick the Residence Code is a 4-digit code which is used to identify the area in which the patient resides. There is also a list of out-of-province Residence Codes. 0000 is not a valid entry.

Effective fiscal year 2003–2004, the New Brunswick Department of Health will provide all regional health authorities (RHAs) with a yearly electronic and paper file called *Standard Geographical Classification* whenever there are significant amounts of modifications and additions. Throughout the year, as changes occur, monthly updates will be provided. The RHAs are responsible for keeping their own tables/dictionaries up-to-date based on that file. The Residence Code must be 4 digits.

12. Pre-Hospital Living Arrangements

The individual or individuals that the person was living with prior to admission to the rehabilitation facility/unit. Refers to permanent living arrangements.

Specifications	
Field length	3
Field status	Mandatory unless 19A Admission Class = 4; otherwise optional to record.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	0, 1, –50, –70 (see Legend)
Selections	Record all that apply (see Fields).
Validation	May be spaces if 19A Admission Class = 4. If recorded, the following validations apply: At least 1 selection must = 1 but not all selections can = 1. If –50 or –70 selected, must be defaulted for all selections. If selection (1) = 1, then selection (5) must = 0. If selection (2) or (3) or (4) = 1, then selection (5) and (6) must = 0. If selection (5) = 1, then selection (1), (2), (3), (4) and (6) must = 0. If selection (6) = 1, then selection (2), (3), (4) and (5) must = 0. If 14 Pre-Hospital Living Setting = 1, 2, 3, 6 or 7, then selection (6) must = 0.

Legend	
0	No
1	Yes
–50	Not available, temporarily
–70	Asked, unknown

Fields	
1	Living with spouse/partner
2	Living with family (includes extended)
3	Living with non-family, unpaid (includes friends)
4	Living with paid attendant
5	Living alone
6	Living in facility (includes all levels of care except acute)
7	Other

13. Post-Discharge Living Arrangements

The individual or individuals that the person will be living with after discharge from the rehabilitation facility/unit.

Specifications	
Field length	3
Field status	Mandatory if 31 Reason for Discharge = 1 or 2; otherwise optional to record.
Field type	Int
Record/assessment	Discharge assessment
Justification	None
Valid codes	0, 1, –50, –70 (see Legend)
Selections	Record all that apply (see Fields).
Validation	May be spaces if 31 Reason for Discharge = 3–7. Must be spaces if 31 Reason for Discharge = 8. If recorded, the following validations apply: At least 1 selection must = 1 but not all selections can = 1. If –50 or –70 selected, must be defaulted for all selections. If selection (1) = 1, then selection (5) must = 0. If selection (2) or (3) or (4) = 1, then selection (5) and (6) must = 0. If selection (5) = 1, then selection (1), (2), (3), (4), (6) and (9) must = 0. If selection (6) = 1, then selection (2), (3), (4) and (5) must = 0. If selection (8) = 1, then at least 1 of selection (1), (2), (3), (4), (5), (6), (7) and (9) must = 1. If selection (9) = 1, then selection (1), (2), (3), (4), (5), (6) and/or (7) must = 0. If 15 Post-Discharge Living Setting = 1, 2, 3, 6 or 7, then selection (6) must = 0.

Legend	
0	No
1	Yes
–50	Not available, temporarily
–70	Asked, unknown

Fields	
1	Living with spouse/partner
2	Living with family (includes extended)
3	Living with non-family, unpaid (includes friends)
4	Living with paid attendant
5	Living alone
6	Living in facility (includes all levels of care except acute)
7	Other
8	Living arrangement(s) is/are transitional or temporary
9	Living in acute care

14. Pre-Hospital Living Setting

The type of accommodation that the person lived in prior to admission to the rehabilitation facility/unit. Refers to permanent living setting.

Specifications	
Field length	3
Field status	Mandatory unless 19A Admission Class = 4; otherwise optional to record.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	1–8, –50, –70 (see Legend)
Validation	May be spaces if 19A Admission Class = 4. If recorded, the following validations apply: If 12 Pre-Hospital Living Arrangements — Selection (6) = 1, then must not = 1, 2, 3, 6 or 7.

Legend	
1	Home (private house or apartment) without health services
2	Home (private house or apartment) with paid health services (e.g., home care/support)
3	Boarding house (includes rented room)
4	Assisted living (includes group home, retirement home, supervised living setting)
5	Residential care (includes long-term care facility, continuing care, convalescent care, nursing home, home for the aged)
6	Shelter (includes night shelter, refuges, hostels for homeless)
7	Public place (includes residing in the street, parks and other public spaces)
8	Other
–50	Not available, temporarily
–70	Asked, unknown

15. Post-Discharge Living Setting

The type of accommodation that the person will be living in after discharge from the rehabilitation facility/unit.

Specifications	
Field length	3
Field status	Mandatory if 31 Reason for Discharge = 1 or 2; otherwise optional to record.
Field type	Int
Record/assessment	Discharge assessment
Justification	None
Valid codes	1–9, –50, –70 (see Legend)
Validation	May be spaces if 31 Reason for Discharge = 3–7. Must be spaces if 31 Reason for Discharge = 8. If recorded, the following validations apply: If 13 Post-Discharge Living Arrangements — Selection (6) = 1, then must not = 1, 2, 3, 6 or 7. If 32 Referred To = 02 or 03, then must = 9.

Legend	
1	Home (private house or apartment) without health services
2	Home (private house or apartment) with paid health services (e.g., home care/support)
3	Boarding house (includes rented room)
4	Assisted living (includes group home, retirement home, supervised living setting)
5	Residential care (includes long-term care facility, continuing care, convalescent care, nursing home, home for the aged)
6	Shelter (includes night shelter, refuges, hostels for homeless)
7	Public place (includes residing in the street, parks and other public spaces)
8	Other
9	Acute care
–50	Not available, temporarily
–70	Asked, unknown

16. Informal Support Received

Describes the unpaid assistance (informal support) provided to the person from any individual, including family, friend or neighbour. Informal support excludes formal services or persons arranged by formal service providers, such as volunteers.

Specifications	
Field length	1
Field status	Mandatory on admission assessment unless 19A Admission Class = 4; otherwise optional to record. Mandatory to record on discharge assessment if 31 Reason for Discharge = 1 or 2; otherwise optional to record. Mandatory on follow-up assessment if 31 Reason for Discharge = 1 or 2, for ages greater than 13 years; otherwise optional to record.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–4 (see Legend)
Validation	On admission assessment, if 19A Admission Class = 4, then may be spaces. On discharge assessment, may be spaces if 31 Reason for Discharge = 3–7. On discharge assessment, must be spaces if 31 Reason for Discharge = 8. Mandatory to record on follow-up if 31 Reason for Discharge = 1 or 2 for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
1	Not required
2	Received
3	Received with restrictions
4	Not received

17. Pre-Hospital Vocational Status

The person's vocational status prior to admission to the rehabilitation facility/unit.

Specifications	
Field length	3
Field status	Mandatory unless 19A Admission Class = 4; otherwise optional to record.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	0, 1, –50, –70 (see Legend)
Selections	Record all that apply (see Fields).
Validation	May be spaces if 19A Admission Class = 4. If recorded, the following validations apply: At least 1 selection must = 1 but not all selections can = 1. If –50 or –70 selected, must be defaulted for all selections. If selection (1.1) = 1, then selection (1.2), (4.0), (5.1), (5.2) and/or (6.0) must = 0. If selection (1.2) = 1, then selection (1.1), (4.0) and/or (6.0) must = 0. If selection (1.3) or (2.3) = 1, then selection (4.0) and/or (6.0) must = 0. If selection (2.1) = 1, then selection (2.2), (4.0) and/or (6.0) must = 0. If selection (2.2) = 1, then selection (2.1), (4.0) and/or (6.0) must = 0. If selection (3.1) = 1, then selection (3.2) and/or (6.0) must = 0. If selection (3.2) = 1, then selection (3.1) and/or (6.0) must = 0. If selection (3.3) = 1, then selection (6.0) must = 0. If selection (4.0) = 1, then selection (1.1) to (2.3), (5.1), (5.2) and/or (6.0) must = 0. If selection (5.1) = 1, then selection (1.1), (4.0), (5.2), and/or (6.0) must = 0. If selection (5.2) = 1, then selection (1.1), (4.0), (5.1) and/or (6.0) must = 0. If selection (6.0) = 1, then selection (1.1) to (5.2) must = 0.

Legend	
0	No
1	Yes
–50	Not available, temporarily
–70	Asked, unknown

Fields	
	Paid employment
1.1	Full time
1.2	Part time
1.3	Adjusted/modified work
	Unpaid employment
2.1	Full time
2.2	Part time
2.3	Adjusted/modified work
	Student
3.1	Full time
3.2	Part time
3.3	Adjusted/modified study
4.0	**Unemployed**
	Retired
5.1	Retired for age
5.2	Retired for disability
6.0	**None of the above**

18. Post-Discharge Vocational Status

The person's actual or expected vocational status upon discharge from the rehabilitation facility/unit.

Specifications	
Field length	3
Field status	Mandatory if 31 Reason for Discharge = 1 or 2; otherwise optional to record.
Field type	Int
Record/assessment	Discharge assessment
Justification	None
Valid codes	0, 1, –50, –70 (see Legend)
Selections	Record all that apply (see Fields).
Validation	May be spaces if 31 Reason for Discharge = 3–7. Must be spaces if 31 Reason for Discharge = 8. If recorded, the following validations apply: At least 1 selection must = 1 but not all selections can = 1. If –50 or –70 selected, must be defaulted for all selections. If selection (1.1) = 1, then selection (1.2), (4.0), (5.1), (5.2) and/or (6.0) must = 0. If selection (1.2) = 1, then selection (1.1), (4.0) and/or (6.0) must = 0. If selection (1.3) or (2.3) = 1, then selection (4.0) and/or (6.0) must = 0. If selection (2.1) = 1, then selection (2.2), (4.0) and/or (6.0) must = 0. If selection (2.2) = 1, then selection (2.1), (4.0) and/or (6.0) must = 0. If selection (3.1) = 1, then selection (3.2) and/or (6.0) must = 0. If selection (3.2) = 1, then selection (3.1) and/or (6.0) must = 0. If selection (3.3) = 1, then selection (6.0) must = 0. If selection (4.0) = 1, then selection (1.1) to (2.3), (5.1), (5.2) and/or (6.0) must = 0. If selection (5.1) = 1, then selection (1.1), (4.0), (5.2), and/or (6.0) must = 0. If selection (5.2) = 1, then selection (1.1), (4.0), (5.1) and/or (6.0) must = 0. If selection (6.0) = 1, then selection (1.1) to (5.2) must = 0.

Legend	
0	No
1	Yes
–50	Not available, temporarily
–70	Asked, unknown

Fields	
	Paid employment
1.1	Full time
1.2	Part time
1.3	Adjusted/modified work
	Unpaid employment
2.1	Full time
2.2	Part time
2.3	Adjusted/modified work
	Student
3.1	Full time
3.2	Part time
3.3	Adjusted/modified study
4.0	**Unemployed**
	Retired
5.1	Retired for age
5.2	Retired for disability
6.0	**None of the above**

Administrative data

19A. Admission Class

The type of inpatient rehabilitation admission.

Specifications	
Field length	1
Field status	Mandatory Must be defaulted on discharge assessment, but may be modified if recorded with a value of 1, 2, 3 or 5.
Field type	Int
Record/assessment	Admission and discharge assessment
Justification	None
Valid codes	1–5 (see Legend)
Validation	If = 4 on admission assessment, then invalid to submit a discharge and follow-up assessment. On admission assessment, if = 4, then Discharge Date minus Admission Date must be less than 4 days (0–3 days for a length of stay) including the admission date. Must not = 4 on discharge assessment On discharge assessment, if = 2, then Discharge Date minus Admission Date must be greater than 3 days including the Admission date. Must not be spaces.

Legend	
1	Initial rehabilitation
2	Short stay
3	Readmission
4	(Un)planned discharge without assessment
5	Continuing rehabilitation

19B. Readmission Within 1 Month

Indicates if the readmission occurred 1 month or less since the previous discharge.

Specifications	
Field length	1
Field status	Mandatory, if 19A Admission Class = 3.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	0, 1 (see Legend)
Validation	Must be recorded if 19A Admission Class = 3; else must be spaces.

Legend	
0	No
1	Yes

19C. Readmission Planned

Indicates if the readmission within 1 month or less since the previous discharge was planned.

Specifications	
Field length	1
Field status	Mandatory, if 19B Readmission Within 1 Month = 1.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	0, 1 (see Legend)
Validation	Must be recorded if 19A Admission Class = 3 and 19B Readmission Within 1 Month = 1; else must be spaces.

Legend	
0	No
1	Yes

20A. Date Ready for Admission to Inpatient Rehabilitation Known

A flag to indicate that the date ready for admission is known.

Specifications	
Field length	1
Field status	Mandatory unless 19A Admission Class = 4; otherwise optional to record.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	0, 1 (see Legend)
Validation	May be spaces if 19A Admission Class = 4. If recorded, the following validations apply: If 20B Date Ready for Admission recorded, then must = 1.

Legend	
0	No
1	Yes

20B. Date Ready for Admission to Inpatient Rehabilitation

The calendar date that the person is considered appropriate and ready to start a rehabilitation program.

Specifications	
Field length	8
Field status	Mandatory, if 20A Date Ready for Admission to Inpatient Rehabilitation Known = 1.
Field type	YYYYMMDD
Record/assessment	Admission assessment
Justification	None
Valid codes	A valid date
Validation	Must be less than or equal to the Admission Date. If 20A Date Ready for Admission Known = 1, then must not be spaces.

21. Admission Date

The calendar date that the person was admitted to a facility/agency for services.

Specifications	
Field length	8
Field status	Mandatory on admission assessment. Must be defaulted on discharge and follow-up assessments. Must not be modified on discharge and follow-up assessments.
Field type	YYYYMMDD
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	A valid date
Validation	On the admission assessment only, must be a valid date within the fiscal year and quarter for which the admission submission is being made. Must not be spaces.

22. Referral Source

The facility/agency/individual who initiated the referral.

Specifications	
Field length	3
Field status	Mandatory unless 19A Admission Class = 4; otherwise optional to record.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	01–13, 97, –50, –70 (see Legend)
Validation	May be spaces if 19A Admission Class = 4. If recorded, the following validations apply: If 19A Admission Class = 5, then must = 04 or 05 only.

Legend	
01	Self/family
02	Inpatient acute unit, same facility
03	Inpatient acute unit, different facility
04	Rehabilitation unit, same facility
05	Rehabilitation unit, different facility (specialty or general facility)
06	Ambulatory care service (facility based)
07	Private practice (primary care services, e.g., MD, PT)
08	Drug dependency services
09	Community services (including public health, transportation services)
10	Residential care facility (includes long-term care, continuing care, convalescent care, nursing home, home for the aged)
11	Legal service (police, parole officer, court)
12	Educational agency
13	Home care agency
97	Other (includes rehabilitation outreach services)
–50	Not available, temporarily
–70	Asked, unknown

23A. Referral Source Province/Territory

The province or territory from which the person was referred.

Specifications	
Field length	3
Field status	Mandatory unless 19A Admission Class = 4; otherwise optional to record.
Field type	Char
Record/assessment	Admission assessment
Justification	None
Valid codes	Valid province/territory code or –50, –70, –90 (see Legend)
Validation	May be spaces if 19A Admission Class = 4. Must be uppercase.

Legend	
NL	Newfoundland and Labrador
PE	Prince Edward Island
NS	Nova Scotia
NB	New Brunswick
QC	Quebec
ON	Ontario
MB	Manitoba
SK	Saskatchewan
AB	Alberta
BC	British Columbia
NT	Northwest Territories
YT	Yukon
NU	Nunavut
–50	Not available, temporarily
–70	Asked, unknown
–90	Not applicable

23B. Referral Source Facility Number

A unique facility number (including province number) assigned by the province/territory from which the person was referred. Applies only to hospitals and residential care facilities.

Specifications	
Field length	5
Field status	Mandatory if 22 Referral Source = 02–06 or 10.
Field type	Char
Record/assessment	Admission assessment
Justification	None
Valid codes	1-digit province number plus 4-digit facility number as defined by the province/territory. Province number — 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, N, Y, V — applicable for 1st digit only. Facility number must be in the range of 0001–9999 — applicable for 2nd to 5th digits inclusive. Facility number unknown or has not been issued by the province/territory = 99999
Validation	If 22 Referral Source = 02–06, 10, then must not be spaces. If applicable to record then: If 22 Referral Source = 03 or 05, then must not = (1A) Facility Number or Code. If 23A Referral Source Province/Territory = –50, –70 or –90, then must = 99999 (facility number unknown). If 23A Referral Source Province/Territory = NL, then 1st digit (province code) must = 0; else must = 99999. If 23A Referral Source Province/Territory = PE, then 1st digit (province code) must = 1; else must = 99999. If 23A Referral Source Province/Territory = NS, then 1st digit (province code) must = 2; else must = 99999. If 23A Referral Source Province/Territory = NB, then 1st digit (province code) must = 3; else must = 99999. If 23A Referral Source Province/Territory = QC, then 1st digit (province code) must = 4; else must = 99999. If 23A Referral Source Province/Territory = ON, then 1st digit (province code) must = 5; else must = 99999. If 23A Referral Source Province/Territory = MB, then 1st digit (province code) must = 6; else must = 99999. If 23A Referral Source Province/Territory = SK, then 1st digit (province code) must = 7; else must = 99999.

Specifications	
	If 23A Referral Source Province/Territory = AB, then 1st digit (province code) must = 8; else must = 99999. If 23A Referral Source Province/Territory = BC, then 1st digit (province code) must = 9; else must = 99999. If 23A Referral Source Province/Territory = NT, then 1st digit (province code) must = N; else must = 99999. If 23A Referral Source Province/Territory = YT, then 1st digit (province code) must = Y; else must = 99999. If 23A Referral Source Province/Territory = NU, then 1st digit (province code) must = V; else must = 99999. Must be uppercase.

24. Responsibility for Payment

The payment code(s) that identifies the group(s) responsible for payment of services rendered.

Specifications	
Field length	3
Field status	Mandatory on admission assessment unless 19A Admission Class = 4; otherwise optional to record. Mandatory on discharge assessment if 31 Reason for Discharge = 1 or 2; otherwise optional to record. Must be defaulted on discharge assessment, but may be modified if applicable.
Field type	Int
Record/assessment	Admission and discharge assessment
Justification	None
Valid codes	0, 1, –50, –70 (see Legend)
Selections	Record all that apply (see Fields).
Validation	On admission assessment, may be spaces if 19A Admission Class = 4. On discharge assessment, may be spaces if 31 Reason for Discharge = 3–8. If recorded, the following validations apply: At least 1 selection must = 1 but not all selections can = 1. If –50 or –70 selected, must be defaulted for all selections. If selection (1) or (3) or (7) or (8) or (10) = 1, then selection (9) must not = 1. If selection (9) = 1, then selection (1), (3) (7) (8) and/or (10) must not = 1.

Legend	
0	No
1	Yes
–50	Not available, temporarily
–70	Asked, unknown

Fields	
1	Provincial/territorial government plan (for resident of province)
2	Workers' compensation board (WCB/WSIB)
3	Other province/territory (resident of Canada)
4	Federal government — Veterans Affairs Canada
5	Federal government — First Nations and Inuit Health Branch (FNIHB)
6	Federal government — other
7	Canadian resident, self-pay
8	Canadian resident, insurance pay
9	Other country residents, self-pay
10	Provincial definition

25. Service Interruptions

Service interruptions (30 calendar days or less in duration per service interruption) occur when the service is temporarily suspended by the facility/agency due to a change in the person's health status. If the service interruption is 30 days or less and the person returns for rehabilitation services for the same health condition, it is considered as part of the original rehabilitation admission. If the interruption is more than 30 days or the person returns with a different main health condition, the person is considered discharged. May record up to 5 service interruptions between admission and discharge to a total maximum of 150 days.

25A. Service Interruption Start Date

The calendar date of the person's service interruption start date.

Specifications	
Field length	8
Field status	Mandatory if service interruption(s) occurred and 31 Reason for Discharge = 1 or 2; otherwise optional to record.
Field type	YYYYMMDD
Occurrences	Up to 5
Record/assessment	Discharge assessment
Justification	None
Valid codes	A valid date
Validation	May be spaces if 31 Reason for Discharge = 3–8 or if no service interruption(s) occurred. If recorded, the following validations apply: Must be greater than the Admission Date and less than or equal to the Service Interruption Return Date and the Date Ready for Discharge. If the Date Ready for Discharge is not coded, then the Service Interruption Start Date must be less than or equal to the Discharge Date. If 25B Service Interruption Return Date and 84 Service Interruption Reason ICD-10-CA are recorded, then must not be spaces. Where more than 1 service interruption is recorded, the start date for each occurrence must not fall on or within the Service Interruption Start Date (25A) and Service Interruption Return Date (25B) of the other occurrences.

25B. Service Interruption Return Date

The calendar date the person's service resumed after an interruption.

Specifications	
Field length	8
Field status	Mandatory if service interruption(s) occurred and 31 Reason for Discharge = 1 or 2; otherwise optional to record.
Field type	YYYYMMDD
Occurrences	Up to 5
Record/assessment	Discharge assessment
Justification	None
Valid codes	A valid date
Validation	May be spaces if 31 Reason for Discharge = 3–8 or if no service interruption(s) occurred. If recorded, the following validations apply: Must be greater than or equal to the Service Interruption Start Date (but not more than 30 days greater) and less than or equal to the Date Ready for Discharge. If the Date Ready for Discharge is not coded, then the Service Interruption Return Date must be less than or equal to the Discharge Date. If 25A Service Interruption Start Date and 84 Service Interruption Reason ICD-10-CA are recorded, then must not be spaces. The difference between 25B Service Interruption Return Date and 25A Service Interruption Start Date for each occurrence must not be greater than 30 days. Where more than 1 service interruption is recorded, the return date for each occurrence must not fall on or within the Service Interruption Start Date (25A) and Service Interruption Return Date (25B) of the other occurrences.

25D. Service Interruption Transfer Status

During the service interruption, the person was transferred out of the rehabilitation bed for all or part of the time. The person may have been transferred to an acute care service in another unit or facility.

As of 2008–2009, data element 25C has been replaced by data element 84 Service Interruption Reason ICD-10-CA.

Specifications	
Field length	1
Field status	Mandatory if service interruption(s) recorded.
Field type	Int
Occurrences	Up to 5
Record/assessment	Discharge assessment
Justification	None
Valid codes	0, 1 (see Legend)
Validation	If recorded, the following validations apply: If 25A Service Interruption Start Date, 25B Service Interruption Return Date and 84 Service Interruption Reason ICD-10-CA are recorded, then must not be spaces.

Legend	
0	No
1	Yes

28A. Provider Type(s)

The type(s) of service provider(s) who delivered rehabilitation interventions to the person between the time of admission and discharge and contributed to clients rehabilitation goals/plans. A maximum of 20 provider types can be recorded.

Specifications	
Field length	5
Field status	Mandatory for first occurrence only if 31 Reason for Discharge = 1 or 2; otherwise optional to record.
Field type	Int
Occurrences	Up to 20
Record/assessment	Discharge assessment
Justification	None
Valid codes	Valid Provider Type Code (see Appendix C)
Validation	May be spaces if 31 Reason for Discharge = 3–8. If recorded, the following validations apply: For occurrences 2 through 20, if 28B Provider Type Identification Number is recorded, then must not be spaces. For all occurrences, an individual provider type (as found in Appendix C) must not be recorded more than once for the same client on the same discharge assessment.

28B. Provider Type Identification Number

The facility or provincial/territorial number assigned to an individual service provider, recorded for each provider type. A maximum of 20 provider type identification numbers can be recorded.

Specifications	
Field length	15
Field status	Optional
Field type	Int
Occurrences	Up to 20
Record/assessment	Discharge assessment
Justification	None
Valid codes	As assigned by the facility
Validation	If recorded, the following validations apply: Must be zero filled and a number in the range of 000000000000001–999999999999999.

29. Date Ready for Discharge

The calendar date that the person is considered ready for discharge from the rehabilitation program. Person meets criteria for discharge.

Specifications	
Field length	8
Field status	Mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record.
Field type	YYYYMMDD
Record/assessment	Discharge assessment
Justification	None
Valid codes	A valid date
Validation	May be spaces if 31 Reason for Discharge = 3–8. If recorded, the following validations apply: Must be greater than or equal to the Admission Date and less than or equal to the Discharge Date.

30. Discharge Date

The calendar date on which the person was discharged from the facility/agency.

Specifications	
Field length	8
Field status	Mandatory on admission assessment if 19A Admission Class = 4. Mandatory on discharge assessment. Must be defaulted on follow-up assessment.
Field type	YYYYMMDD
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	A valid date
Validation	On admission assessment, must be spaces if 19A Admission Class = 1, 2, 3 or 5. Must not be spaces on admission assessment if 19A Admission Class = 4. On discharge assessment only, must be a valid date within the fiscal year and quarter for which the discharge submission is being made. Must be greater than the Admission Date. If Admission Class 19A = 4, Discharge Date must be greater than or equal to the Admission Date. On discharge and follow-up assessments, must not be spaces.

31. Reason for Discharge

The reason for the person's discharge from the facility/agency.

Specifications	
Field length	1
Field status	Mandatory
Field type	Int
Record/assessment	Discharge assessment
Justification	None
Valid codes	1–8 (see Legend)
Validation	If = 8, then invalid to submit a follow-up assessment.

Legend	
1	Service goals met and discharged to community (permanent living setting)
2	Service goals met and referral/transfer to other unit/facility
3	Service goals not met and referral/transfer to other unit/facility or discharged to community
4	Facility/agency withdrew services
5	Person withdrew (against professional advice)
6	Person no longer eligible (funding)
7	Person moved
8	Person deceased

32. Referred To

The facility/agency to which the person was referred/transferred for services at the time of discharge. Excludes referral to placement/case management services.

Specifications	
Field length	3
Field status	Mandatory if 31 Reason for Discharge = 1 or 2 or 3; otherwise optional to record.
Field type	Int
Record/assessment	Discharge assessment
Justification	None
Valid codes	02–13, 97, –50, –70, –90 (see Legend)
Validation	May be spaces if 31 Reason for Discharge = 4–8.

Legend	
02	Inpatient acute unit, same facility
03	Inpatient acute unit, different facility
04	Rehabilitation unit, same facility
05	Rehabilitation unit, different facility (specialty or general facility)
06	Ambulatory care service (facility based)
07	Private practice (primary care services, e.g., MD, PT)
08	Drug dependency services
09	Community services (including public health, transportation services)
10	Residential care facility (includes long-term care, continuing care, convalescent care, nursing home, home for the aged)
11	Legal service (police, parole officer, court)
12	Educational agency
13	Home care agency
97	Other (includes rehabilitation outreach services)
–50	Not available, temporarily
–70	Asked, unknown
–90	Not applicable

33A. Referred to Province/Territory

The province or territory to which the person was referred.

Specifications	
Field length	3
Field status	Mandatory if 32 Referred To = 02–13 or 97; otherwise optional to record.
Field type	Char
Record/assessment	Discharge assessment
Justification	None
Valid codes	Valid province/territory code or –50, –70, –90 (see Legend)
Validation	May be spaces if 32 Referred To is not recorded or is –50, –70 or –90. Must be uppercase.

Legend	
NL	Newfoundland and Labrador
PE	Prince Edward Island
NS	Nova Scotia
NB	New Brunswick
QC	Quebec
ON	Ontario
MB	Manitoba
SK	Saskatchewan
AB	Alberta
BC	British Columbia
NT	Northwest Territories
YT	Yukon
NU	Nunavut
–50	Not available, temporarily
–70	Asked, unknown
–90	Not applicable

33B. Referred to Facility Number

A unique facility number (including province number) assigned by the province/territory to which the person was referred. Applies only to hospitals and residential care facilities.

Specifications	
Field length	5
Field status	Mandatory if 32 Referred To = 02–06 or 10.
Field type	Char
Record/assessment	Discharge assessment
Justification	None
Valid codes	1-digit province number plus 4-digit facility number as defined by the province/territory. Province number — 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, N, Y, V — applicable for 1st digit only. Facility number must be in the range of 0001–9999 — applicable for 2nd to 5th digits inclusive. Facility number unknown or has not been issued by the province/territory = 99999
Validation	If 32 Referred To = 02–06 or 10, then must not be spaces. If applicable to record then: If 32 Referral To = 03 or 05, then must not = (1A) Facility Number or Code. If 33A Referred to Province/Territory = –50, –70 or –90, then must = 99999 (facility number unknown). If 33A Referred to Province/Territory = NL, then 1st digit (province code) must = 0; else must = 99999. If 33A Referred to Province/Territory = PE, then 1st digit (province code) must = 1; else must = 99999. If 33A Referred to Province/Territory = NS, then 1st digit (province code) must = 2; else must = 99999. If 33A Referred to Province/Territory = NB, then 1st digit (province code) must = 3; else must = 99999. If 33A Referred to Province/Territory = QC, then 1st digit (province code) must = 4; else must = 99999. If 33A Referred to Province/Territory = ON, then 1st digit (province code) must = 5; else must = 99999. If 33A Referred to Province/Territory = MB, then 1st digit (province code) must = 6; else must = 99999. If 33A Referred to Province/Territory = SK, then 1st digit (province code) must = 7; else must = 99999.

Specifications	
	If 33A Referred to Province/Territory = AB, then 1st digit (province code) must = 8; else must = 99999. If 33A Referred to Province/Territory = BC, then 1st digit (province code) must = 9; else must = 99999. If 33A Referred to Province/Territory = NT, then 1st digit (province code) must = N; else must = 99999. If 33A Referred to Province/Territory = YT, then 1st digit (province code) must = Y; else must = 99999. If 33A Referred to Province/Territory = NU, then 1st digit (province code) must = V; else must = 99999. Must be uppercase.

Health characteristics

34. Rehabilitation Client Group

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The rehabilitation condition that best describes the primary reason for admission to the rehabilitation program.

Specifications	
Field length	6
Field status	Mandatory on admission assessment. Must be defaulted on discharge assessment, but may be modified if necessary. Must be defaulted on follow-up assessment.
Field type	Int (implied decimal NNVNNNN)
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	Valid Rehabilitation Client Group code (see Appendix D)
Validation	Must not be spaces. If the following RCGs are coded, the data element will be accepted, but flagged with a warning message in the submission report, strongly suggesting coding of a more specific subgroup code: 02.1 Non-Traumatic Brain Dysfunction 02.2 Traumatic Brain Dysfunction 04.1 Non-Traumatic Spinal Cord Dysfunction 04.110 Paraplegia, Unspecified 04.120 Quadriplegia, Unspecified 04.2 Traumatic Spinal Cord Dysfunction 04.210 Paraplegia, Unspecified 04.220 Quadriplegia, Unspecified 08.1 Status Post Hip Fracture 08.5 Status Post Hip Replacement 08.6 Status Post Knee Replacement 08.7 Status Post Knee and Hip Replacement

38. ASIA Impairment (Modified Frankel) Scale

A scale that describes the degree of motor or sensory involvement at admission to rehabilitation for traumatic and non-traumatic spinal cord injury. Developed by the American Spinal Injury Association.

Specifications	
Field length	1
Field status	Mandatory if 34 Rehabilitation Client Group=04.2–04.230 or 14.1 and 14.3. Optional to record if 34 Rehabilitation Client Group = 04.1–04.130.
Field type	Int
Record/assessment	Admission assessment
Justification	None
Valid codes	1–5 (see Legend)
Validation	If 34 Rehabilitation Client Group is recorded as *traumatic spinal cord dysfunction* (04.2–04.230 inclusive) or *major multiple trauma* (14.1 and 14.3 only), must not be spaces. Optional to record if 34 Rehabilitation Client Group is recorded as *non-traumatic spinal cord dysfunction* (04.1–04.130); otherwise must not be recorded.

Legend	
1	A — Complete
2	B — Incomplete (sensory preserved)
3	C — Incomplete (motor non-functional)
4	D — Incomplete (motor functional)
5	E — Normal

39. Date of Onset

Date of onset of the main rehabilitation condition that is coded in (34) Rehabilitation Client Group.

Specifications	
Field length	8
Field status	Mandatory to record unless 19A Admission Class = 4; otherwise optional to record.
Field type	YYYYMMDD
Record/assessment	Admission assessment
Justification	None
Valid codes	A valid date
Validation	May be spaces if 19A Admission Class = 4. If recorded, the following validations apply: Must be less than or equal to the Admission Date OR less than or equal to the Date Ready for Admission, if recorded, but greater than or equal to the Birthdate.

40A. Height

The person's height in centimetres.

Specifications	
Field length	6
Field status	Mandatory to record on admission assessment unless 19A Admission Class = 4; otherwise optional to record. Mandatory to record on discharge assessment if 31 Reason for Discharge = 1 or 2 and difference between 30 Discharge Date and 21 Admission Date is greater than 30 days; otherwise optional to record. If unable to code, 999.999 should be entered.
Field type	Int (implied decimal NNNVNNN) Must be zero filled.
Record/assessment	Admission and discharge assessment
Justification	None
Valid codes	020.000–300.000 or 999.999
Validation	May be spaces on admission assessment if 19A Admission Class = 4. On discharge assessment, must not be spaces if 31 Reason for Discharge = 1 or 2 and difference between 30 Discharge Date and 21 Admission Date is greater than 30 days. On discharge assessment, may be spaces if 31 Reason for Discharge = 3–8 or difference between 30 Discharge Date and 21 Admission Date is less than or equal to 30 days. If recorded, must be equal to or greater than 20 cm and equal to or less than 300 cm, unless unable to code, in which case 999.999 should be entered. If Height (40A) < 120 cm or if Height (40A) > 200 cm, the data element will be accepted but flagged with a warning message in the submission report to highlight outliers that may reflect data entry errors.

40B. Weight

The person's weight in kilograms.

Specifications	
Field length	6
Field status	Mandatory to record on admission assessment unless 19A Admission Class = 4; otherwise optional to record. Mandatory to record on discharge assessment if 31 Reason for Discharge = 1 or 2 and difference between 30 Discharge Date and 21 Admission Date is greater than 30 days; otherwise optional to record. If unable to code, 999.999 should be entered.
Field type	Int (implied decimal NNNVNNN) Must be zero filled.
Record/assessment	Admission and discharge assessment
Justification	None
Valid codes	005.000–500.000 or 999.999
Validation	May be spaces on admission assessment if 19A Admission Class = 4. On discharge assessment, must not be spaces if 31 Reason for Discharge = 1 or 2 and difference between 30 Discharge Date and 21 Admission Date is greater than 30 days. On discharge assessment, may be spaces if 31 Reason for Discharge = 3–8 or difference between 30 Discharge Date and 21 Admission Date is less than or equal to 30 days. If recorded, must be equal to or greater than 5 kg and equal to or less than 500 kg, unless unable to code, in which case 999.999 should be entered. If Weight (40B) < 35 kg or if Weight (40B) > 150 kg, the data element will be accepted but flagged with a warning message in the submission report to highlight outliers that may reflect data entry errors.

Activities and participation

For more information on the FIM® instrument, see Module 2: Clinical Coding and NRS Training.

41. Eating — FIM® instrument

Includes the use of suitable utensils to bring food to the mouth, chew and swallow, once the meal is presented on a table or tray.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 42–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 42–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 42–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

42. Grooming — FIM® instrument

Includes oral care, hair grooming, washing the hands, washing the face and either shaving the face or applying make-up.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

43. Bathing — FIM® instrument

Includes bathing the body from the neck down.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/ assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

44. Dressing: Upper Body — FIM® instrument

Includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/ assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

45. Dressing: Lower Body — FIM® instrument

Includes dressing and undressing from the waist down, as well as applying and removing a prosthesis or orthosis when applicable.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

46. Toileting — FIM® instrument

Includes maintaining perineal hygiene and adjusting clothing before and after using toilet, commode or bedpan.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

47. Bladder Management — FIM® instrument

Includes intentional control of urinary bladder and, if necessary, use of equipment or agent for bladder control.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

48. Bowel Management — FIM® Instrument

Includes intentional control of bowel movements and, if necessary, use of equipment or agent for bowel control.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

49. Transfers: Bed, Chair, Wheelchair — FIM® instrument

Includes all aspects of transferring to and from a bed, chair or wheelchair, or coming to or from a standing position (if walking is typical mode of locomotion).

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

50. Transfers: Toilet — FIM® instrument

Includes getting on and off of a toilet.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

51. Transfers: Tub or Shower — FIM® instrument

Includes getting into and out of a tub or shower stall.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision or setup
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

52A. Locomotion: Walk/Wheelchair — FIM® instrument — Mode

The method used for individual locomotion.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment, for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–3 (see Validation and Legend)
Validation	If 52B Locomotion: Walk/Wheelchair — FIM® instrument is recorded on admission assessment, must not be spaces. If 1 on admission assessment, must be 1 on discharge and follow-up assessments. If 2 on admission assessment, must be 2 on discharge and follow-up assessments. If 3 on admission assessment, must be 1 or 2 on discharge and follow-up assessments. Must not be 3 on discharge and follow-up assessments. Must be spaces for ages 0–13 years.

Legend	
1	Walk
2	Wheelchair
3	Both (on admission assessment only)

52B. Locomotion: Walk/Wheelchair — FIM® instrument

Includes walking once in a standing position or, if using a wheelchair, moving forward once in a seated position, on a level surface.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. If 52A Locomotion: Walk/Wheelchair — FIM® instrument — Mode is recorded on admission assessment, must not be spaces. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Exception (household ambulation)
5	Supervision
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

53. Locomotion: Stairs — FIM® instrument

Includes going up and down 12 to 14 stairs (1 flight) indoors.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Exception (household ambulation)
5	Supervision
4	Minimal contact assistance
3	Moderate assistance
2	Maximal assistance
1	Total assistance

54A. Comprehension — FIM® Instrument — Mode

The method used for individual comprehension.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–3 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. If any of data elements 41–58 is recorded, must not be spaces. Must be spaces for ages 0–13 years.

Legend	
1	Auditory
2	Visual
3	Both

54B. Comprehension — FIM® instrument

Includes understanding of either auditory or visual communication (e.g., writing, sign language).

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. If 54A Comprehension — FIM® instrument — Mode is recorded on admission assessment, must not be spaces. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Standby prompting
4	Minimal prompting
3	Moderate prompting
2	Maximal prompting
1	Total assistance

55A. Expression — FIM® instrument — Mode

The method used for individual expression.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–3 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. If any of data elements 41–58 is recorded, must not be spaces. Must be spaces for ages 0–13 years.

Legend	
1	Vocal
2	Non-vocal
3	Both

55B. Expression — FIM® instrument

Includes clear vocal or non-vocal expression of language.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. If 55A Expression — FIM® instrument — Mode is recorded on admission assessment, must not be spaces. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Standby prompting
4	Minimal prompting
3	Moderate prompting
2	Maximal prompting
1	Total assistance

56. Social Interaction — FIM® instrument

Includes skills related to getting along and participating with others in therapeutic and social situations.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision
4	Minimal direction
3	Moderate direction
2	Maximal direction
1	Total assistance

57. Problem-Solving — FIM® instrument

Includes skills related to solving problems of daily living.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–58 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–58 must be recorded. Mandatory on follow-up assessment for ages greater than 13years. If recorded, data elements 41–58 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision
4	Minimal direction
3	Moderate direction
2	Maximal direction
1	Total assistance

58. Memory — FIM® instrument

Includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. If recorded, data elements 41–57 must be recorded. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 41–57 must be recorded. Mandatory on follow-up assessment for ages greater than 13 years. If recorded, data elements 41–57 must be recorded. Must not be defaulted on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–7 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
7	Complete independence
6	Modified independence
5	Supervision
4	Minimal prompting
3	Moderate prompting
2	Maximal prompting
1	Total assistance

59A. Impact of Pain — Part A

The person is asked the following question:

a. “Do you usually have pain or discomfort?”

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory unless 19A Admission Class = 4; otherwise optional to record. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2 and value recorded on admission assessment = 1 or 5 for this data element; otherwise optional to record. Must not default value on discharge and follow-up assessments. Mandatory on follow-up assessment if 31 Reason for Discharge = 1 or 2 and value recorded on discharge assessment = 1 or 5 for this data element for ages greater than 13 years.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1, 5, 8 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 19A Admission Class = 4, then may be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 1 or 2 and if value recorded on admission assessment = 1 or 5 for this data element, then must not be spaces. On discharge assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. On follow-up assessment, for ages greater than 13 years, if 31 Reason for Discharge = 1 or 2 and if value recorded on discharge assessment = 1 or 5 for this data element, then must not be spaces. On follow-up assessment, for ages greater than 13 years, if 31 Reason for Discharge = 3–8, then may be spaces. Must be spaces for ages 0–13 years.

Legend	
8	Client unable to answer
5	No
1	Yes

59B. Impact of Pain — Part B

The person is asked the following question:

b. “How would you describe the usual intensity of your pain or discomfort?”

Specifications	
Field length	1
Field status	Mandatory, for ages greater than 13 years, on admission assessment if 59A Impact of Pain — Part A = 1. Mandatory, for ages greater than 13 years, on discharge assessment if 59A Impact of Pain — Part A = 1. Mandatory, for ages greater than 13 years, on follow-up assessment if 59A Impact of Pain — Part A = 1. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	2, 3, 4 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 59A Impact of Pain — Part A = 5 or 8, then must be spaces. On discharge assessment, for ages greater than 13 years, if 59A Impact of Pain — Part A = 5 or 8, then must be spaces. On follow-up assessment, for ages greater than 13 years, if 59A Impact of Pain — Part A = 5 or 8, then must be spaces. Must be spaces for ages 0–13 years.

Legend	
4	Mild
3	Moderate
2	Severe

59C. Impact of Pain — Part C

The person is asked the following question:

c. “How many activities does your pain or discomfort prevent?”

Specifications	
Field length	1
Field status	Mandatory, for ages greater than 13 years, on admission assessment if 59A Impact of Pain — Part A = 1. Mandatory, for ages greater than 13 years, on discharge assessment if 59A Impact of Pain — Part A = 1. Mandatory, for ages greater than 13 years, on follow-up assessment if 59A Impact of Pain — Part A = 1. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	2–5 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, if 59A Impact of Pain — Part A = 5 or 8, then must be spaces. On discharge assessment, for ages greater than 13 years, if 59A Impact of Pain — Part A = 5 or 8, then must be spaces. On follow-up assessment, for ages greater than 13 years, if 59A Impact of Pain — Part A = 5 or 8, then must be spaces. Must be spaces for ages 0–13 years.

Legend	
5	None
4	A few
3	Some
2	Most

60. Meal Preparation

Includes the ability to perform meal preparation tasks (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils) in their usual routine/environment.

Specifications	
Field length	1
Field status	Optional to record on admission assessment. Mandatory to record on discharge assessment if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. Optional to record on follow-up assessment. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	2–5 (see Legend)
Validation	May be spaces on admission assessment. On discharge assessment, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2. On discharge assessment, may be spaces if 31 Reason for Discharge = 3–8. May be spaces on follow-up assessment.

Legend	
5	Independent
4	Supervision
3	Assistance
2	Dependent

61. Light Housework

Includes the ability to maintain certain aspects of the internal environment of the person's dwelling.

Specifications	
Field length	1
Field status	Optional to record on admission assessment. Mandatory to record on discharge assessment if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. Optional to record on follow-up assessment. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	2–5 (see Legend)
Validation	May be spaces on admission assessment. On discharge assessment, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2. On discharge assessment, may be spaces if 31 Reason for Discharge = 3–8. May be spaces on follow-up assessment.

Legend	
5	Independent
4	Supervision
3	Assistance
2	Dependent

62. Heavy Housework

Includes the ability to maintain certain aspects of the internal/external environment of the person's dwelling.

Specifications	
Field length	1
Field status	Optional to record on admission assessment. Mandatory to record on discharge assessment if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. Optional to record on follow-up assessment. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	2–5 (see Legend)
Validation	May be spaces on admission assessment. On discharge assessment, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2. On discharge assessment, may be spaces if 31 Reason for Discharge = 3–8. May be spaces on follow-up assessment.

Legend	
5	Independent
4	Supervision
3	Assistance
2	Dependent

64. Communication — Verbal or Non-Verbal Expression

A person's ability to express his or her intention in his or her usual language using vocal or non-vocal language (includes sign language) within an appropriate time frame.

Specifications	
Field length	1
Field status	Mandatory to record on admission assessment, for ages greater than 13 years, if 19A Admission Class = 1, 2, 3 or 5 and 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1 or any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/ Hearing Aid Flag = 0 or space; otherwise optional to record. If recorded, data elements 65–69 must be recorded. Mandatory to record on discharge assessment, for ages greater than 13 years, if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 65–69 must be recorded. Mandatory to record on follow-up assessment, for ages greater than 13 years, if recorded on admission assessment and discharge assessment; otherwise optional to record. If recorded, data elements 65–69 must be recorded. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–5, 8 (see Legend)
Validation	For ages greater than 13 years and 19A Admission Class = 1, 2, 3 or 5, must not be space on admission assessment if: a) Any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/Hearing Aid Flag = 0 or space. OR b) 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1. On admission assessment, for ages greater than 13 years, may be spaces if 19A Admission Class = 4. On discharge assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise may be spaces. On follow-up assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and discharge assessment. Must be spaces for ages 0–13 years.

Legend	
5	Independent
4	Supervision
3	Assistance
2	Dependent
1	Non-functional
8	Not able to test

65. Communication — Written Expression

A person's ability to express his or her intention in his or her usual language through written form within an appropriate time frame.

Specifications	
Field length	1
Field status	Mandatory to record on admission assessment, for ages greater than 13 years, if 19A Admission Class = 1, 2, 3 or 5 and 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1 or any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/ Hearing Aid Flag = 0 or space; otherwise optional to record. If recorded, data elements 64 and 66–69 must be recorded. Mandatory to record on discharge assessment, for ages greater than 13 years, if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 64 and 66–69 must be recorded. Mandatory to record on follow-up assessment, for ages greater than 13 years, if recorded on admission assessment and discharge assessment; otherwise optional to record. If recorded, data elements 64 and 66–69 must be recorded. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–5, 8 (see Legend)
Validation	For ages greater than 13 years and 19A Admission Class = 1, 2, 3 or 5, must not be space on admission assessment if a) Any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/Hearing Aid Flag = 0 or space. OR b) 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1. On admission assessment, for ages greater than 13 years, may be spaces if 19A Admission Class = 4. On discharge assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise, may be spaces. On follow-up assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and discharge assessment. Must be spaces for ages 0–13 years.

Legend	
5	Independent
4	Supervision
3	Assistance
2	Dependent
1	Non-functional
8	Not able to test

66. Communication — Auditory or Non-Auditory Comprehension

A person's ability to understand a communicated intention in his or her usual language using vocal and non-vocal language (includes sign language) within an appropriate time frame.

Specifications	
Field length	1
Field status	Mandatory to record on admission assessment, for ages greater than 13 years, if 19A Admission Class = 1, 2, 3 or 5 and 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1 or any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/ Hearing Aid Flag = 0 or space; otherwise optional to record. If recorded, data elements 64, 65 and 67–69 must be recorded. Mandatory to record on discharge assessment, for ages greater than 13 years, if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 64, 65 and 67–69 must be recorded. Mandatory to record on follow-up assessment, for ages greater than 13 years, if recorded on admission assessment and discharge assessment; otherwise optional to record. If recorded, data elements 64, 65 and 67–69 must be recorded. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–5, 8 (see Legend)
Validation	For ages greater than 13 years and 19A Admission Class = 1, 2, 3 or 5, must not be space on admission assessment if a) Any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/Hearing Aid Flag = 0 or space. OR b) 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1. On admission assessment, for ages greater than 13 years, may be spaces if 19A Admission Class = 4. On discharge assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise, may be spaces. On follow-up assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and discharge assessment. Must be spaces for ages 0–13 years.

Legend	
5	Independent
4	Supervision
3	Assistance
2	Dependent
1	Non-functional
8	Not able to test

67. Communication — Reading Comprehension

A person's ability to understand a communicated intention in his or her usual language through written form within an appropriate time frame.

Specifications	
Field length	1
Field status	Mandatory to record on admission assessment, for ages greater than 13 years, if 19A Admission Class = 1, 2, 3 or 5 and 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1 or any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/Hearing Aid Flag = 0 or space; otherwise optional to record. If recorded, data elements 64–66, 68 and 69 must be recorded. Mandatory to record on discharge assessment, for ages greater than 13 years, if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 64–66, 68 and 69 must be recorded. Mandatory to record on follow-up assessment, for ages greater than 13 years, if recorded on admission assessment and discharge assessment; otherwise optional to record. If recorded, data elements 64–66, 68 and 69 must be recorded. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–5, 8 (see Legend)
Validation	For ages greater than 13 years and 19A Admission Class = is 1, 2, 3 or 5, must not be space on admission assessment if a) Any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/Hearing Aid Flag = 0 or space. OR b) 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1. On admission assessment, for ages greater than 13 years, may be spaces if 19A Admission Class = 4. On discharge assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise, may be spaces. On follow-up assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and discharge assessment. Must be spaces for ages 0–13 years.

Legend	
5	Independent
4	Supervision
3	Assistance
2	Dependent
1	Non-functional
8	Not able to test

68. Financial Management

Includes the ability to manage finances (e.g., how bills are paid, checkbook is balanced, household expenses are balanced, purchases are made).

Specifications	
Field length	1
Field status	Mandatory to record on admission assessment, for ages greater than 13 years, if 19A Admission Class = 1, 2, 3 or 5 and 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1 or any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/ Hearing Aid Flag = 0 or space; otherwise optional to record. If recorded, data elements 64–67 and 69 must be recorded. Mandatory to record on discharge assessment, for ages greater than 13 years, if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 64–67 and 69 must be recorded. Mandatory to record on follow-up assessment, for ages greater than 13 years, if recorded on admission assessment and discharge assessment; otherwise optional to record. If recorded, data elements 64–67 and 69 must be recorded. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	2–5, 8 (see Legend)
Validation	For ages greater than 13 years and 19A Admission Class = 1, 2, 3 or 5, must not be space on admission assessment if a) Any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/Hearing Aid Flag = 0 or space. OR b) 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1. On admission assessment, for ages greater than 13 years, may be spaces if 19A Admission Class = 4. On discharge assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise, may be spaces. On follow-up assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and discharge assessment. Must be spaces for ages 0–13 years.

Legend	
5	Independent
4	Supervision
3	Assistance
2	Dependent
8	Not able to test

69. Orientation

Includes person's awareness of time, place and self.

Specifications	
Field length	1
Field status	Mandatory to record on admission assessment, for ages greater than 13 years, if 19A Admission Class = 1, 2, 3 or 5 and 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1 or any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/ Hearing Aid Flag = 0 or space; otherwise optional to record. If recorded, data elements 64–68 must be recorded. Mandatory to record on discharge assessment, for ages greater than 13 years, if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise optional to record. If recorded, data elements 64–68 must be recorded. Mandatory to record on follow-up assessment, for ages greater than 13 years, if recorded on admission assessment and discharge assessment; otherwise optional to record. If recorded, data elements 64–68 must be recorded. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1, 3, 5 (see Legend)
Validation	For ages greater than 13 years and 19A Admission Class = 1, 2, 3 or 5, must not be space on admission assessment if a) Any of data elements 54, 55, 56, 57 or 58 is scored 1–6 and 79 Glasses/Hearing Aid Flag = 0 or space. OR b) 34 Rehabilitation Client Group = 01.1–01.9, 02.1–02.9, 14.1, 14.2 or 15.1. On admission assessment, for ages greater than 13 years, may be spaces if 19A Admission Class = 4. On discharge assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and 31 Reason for Discharge = 1 or 2; otherwise, may be spaces. On follow-up assessment, for ages greater than 13 years, must not be spaces if recorded on admission assessment and discharge assessment. Must be spaces for ages 0–13 years.

Legend	
5	Oriented to time, place and self
3	Oriented to 1 or 2 items
1	Oriented to none of the items

70A. General Health Status — Part A — Respondent

Includes the person or proxy report of general health status.

Specifications	
Field length	1
Field status	On admission assessment, for ages greater than 13 years, mandatory to record unless 19A Admission Class = 4; otherwise optional to record. On discharge assessment, for ages greater than 13 years, mandatory to record if 31 Reason for Discharge = 1 or 2; otherwise optional to record. Mandatory to record on follow-up assessment for ages greater than 13 years. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–3, 8 (see Legend)
Validation	On admission assessment, for ages greater than 13 years, may be spaces if 19A Admission Class = 4. On discharge assessment, for ages greater than 13 years, may be spaces if 31 Reason for Discharge = 3–8. Must not be spaces on follow-up assessment for ages greater than 13 years. Must be spaces for ages 0–13 years.

Legend	
3	Client
2	Family/friend
1	Service provider
8	Not able to test

70B. General Health Status — Part B

Specifications	
Field length	1
Field status	Mandatory to record, for ages greater than 13 years, if 70A General Health Status — Part A = 1, 2 or 3. Must not default value on discharge and follow-up assessments.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	1–5 (see Legend)
Validation	For ages greater than 13 years, if 70A General Health Status — Part A — Respondent = 1, 2 or 3, then must not be spaces. For ages greater than 13 years, must be spaces if 70A General Health Status — Part A — Respondent = 8. Must be spaces for ages 0–13 years.

Legend	
5	Excellent
4	Very good
3	Good
2	Fair
1	Poor

72. Follow-Up Assessment Date

The calendar date that the follow-up assessment is completed.

Specifications	
Field length	8
Field status	Mandatory if follow-up assessment completed.
Field type	YYYYMMDD
Record/assessment	Follow-up assessment
Justification	None
Valid codes	A valid date
Validation	Must be valid date within the fiscal year and quarter for which the follow-up submission is being made that must be greater than the Discharge Date. Must not be spaces.

73A. Hospitalizations Since Discharge

Any hospitalization for health conditions that are related or unrelated to person's rehabilitation health condition (Rehabilitation Client Group).

Specifications	
Field length	3
Field status	Mandatory if follow-up assessment completed.
Field type	Int
Record/assessment	Follow-up assessment
Justification	None
Valid codes	0, 1, –50, –70 (see Legend)
Validation	Must not be spaces.

Legend	
0	No
1	Yes
–50	Not available, temporarily
–70	Asked, unknown

73B. Days in Hospital

Specifications	
Field length	3
Field status	Mandatory if 73A Hospitalization Since Discharge = 1.
Field type	Int
Record/assessment	Follow-up assessment
Justification	None
Valid codes	001–999, –50, –70 (see Legend)
Validation	If 73A Hospitalization Since Discharge = 0, –50 or –70, then must be spaces. The result (number of days) of the Follow-Up Date — Discharge Date must be greater than the value recorded for this data element.

Legend	
–50	Not available, temporarily
–70	Asked, unknown

74. Respondent Type

The person who responds to the majority of questions for follow-up assessment.

Specifications	
Field length	1
Field status	Mandatory if follow-up assessment completed.
Field type	Int
Record/assessment	Follow-up assessment
Justification	None
Valid codes	1–3 (see Legend)
Validation	Must not be spaces.

Legend	
3	Client
2	Family/friend
1	Service provider

75. Reintegration to Normal Living Index

The degree of a person's achievement in a life situation by that person or proxy. This measure has been used as a proxy for quality of life and has been validated in post-discharge Rehabilitation Client Groups.

Specifications	
Field length	1
Field status	Mandatory, for ages greater than 17 years, if follow-up assessment completed. Optional for ages 14–17 years.
Field type	Int
Selections	See Fields
Record/assessment	Follow-up assessment
Justification	None
Valid codes	0, 1, 2, 8 (see Legend)
Validation	Must be spaces for ages 0–13 years. May be spaces for ages 14–17 years. Must not be spaces for ages greater than 17 years.

Legend	
0	Does not describe my situation
1	Partially describes my situation
2	Fully describes my situation
8	Not able to test/unable to answer

Fields	
a	Mobility in living quarters
b	Mobility in community
c	Out-of-town trips
d	Self-care needs
e	Work activity
f	Recreational activities
g	Social activities
h	Family role
i	Personal relationships
j	Personal comfort with others
k	Dealing with life events

76. Follow-Up Living Arrangements

The individual or individuals that the person is living with after discharge from the rehabilitation facility/unit, at time of follow-up assessment.

Specifications	
Field length	3
Field status	Mandatory if follow-up assessment completed.
Field type	Int
Selections	Record all that apply (see Fields).
Record/assessment	Follow-up assessment
Justification	None
Valid codes	0, 1, –50, –70 (see Legend)
Validation	At least 1 selection must = 1 but not all selections can = 1. If –50 or –70 selected, must be defaulted for all selections. If selection (1) = 1, then selection (5) must = 0. If selection (2) or (3) or (4) = 1, then selection (5) and (6) must = 0. If selection (5) = 1, then selection (1), (2), (3), (4) and (6) must = 0. If selection (6) = 1, then selection (2), (3), (4) and (5) must = 0.

Legend	
0	No
1	Yes
–50	Not available, temporarily
–70	Asked, unknown

Fields	
1	Living with spouse/partner
2	Living with family (includes extended)
3	Living with non-family, unpaid (includes friends)
4	Living with paid attendant
5	Living alone
6	Living in facility (includes all levels of care except acute)
7	Other

77. Follow-Up Living Setting

The type of accommodation that the person is living in at the time of the follow-up assessment.

Specifications	
Field length	3
Field status	Mandatory if follow-up assessment completed.
Field type	Int
Record/assessment	Follow-up assessment
Justification	None
Valid codes	1–8, –50, –70 (see Legend)
Validation	Must not be spaces. If 76 Follow-Up Living Arrangements (6) = 1, then must not = 1, 2, 3, 6 or 7.

Legend	
1	Home (private house or apartment) without health services
2	Home (private house or apartment) with paid health services (e.g., home care/support)
3	Boarding house (includes rented room)
4	Assisted living (includes group home, retirement home, supervised living setting)
5	Residential care (long-term care facility, convalescent care, nursing home, home for the aged)
6	Shelter (includes night shelter, refuges, hostels for homeless)
7	Public place (includes residing in the street, parks and other public spaces)
8	Other
–50	Not available, temporarily
–70	Asked, unknown

78. Follow-Up Vocational Status

The person's actual vocational status at follow-up assessment.

Specifications	
Field length	3
Field status	Mandatory if follow-up assessment completed.
Field type	Int
Selections	Record all that apply (see Fields).
Record/assessment	Follow-up assessment
Justification	None
Valid codes	0, 1, –50, –70 (see Legend)
Validation	At least 1 selection must = 1 but not all selections can = 1. If –50 or –70 selected, must be defaulted for all selections. If selection (1.1) = 1, then selection (1.2), (4.0), (5.1), (5.2) and/or (6.0) must = 0. If selection (1.2) = 1, then selection (1.1), (4.0) and/or (6.0) must = 0. If selection (1.3) or (2.3) = 1, then selection (4.0) and/or (6.0) must = 0. If selection (2.1) = 1, then selection (2.2), (4.0) and/or (6.0) must = 0. If selection (2.2) = 1, then selection (2.1), (4.0) and/or (6.0) must = 0. If selection (3.1) = 1, then selection (3.2) and/or (6.0) must = 0. If selection (3.2) = 1, then selection (3.1) and/or (6.0) must = 0. If selection (3.3) = 1, then selection (6.0) must = 0. If selection (4.0) = 1, then selection (1.1)–(2.3), (5.1), (5.2) and/or (6.0) must = 0. If selection (5.1) = 1, then selection (1.1), (4.0), (5.2) and/or (6.0) must = 0. If selection (5.2) = 1, then selection (1.1), (4.0), (5.1) and/or (6.0) must = 0. If selection (6.0) = 1, then selection (1.1) to (5.2) must = 0.

Legend	
0	No
1	Yes
–50	Not available, temporarily
–70	Asked, unknown

Fields	
	Paid employment
1.1	Full time — work of 30 hours or more per week
1.2	Part time — work of less than 30 hours per week
1.3	Adjusted/modified work — modified work based on functional status
	Unpaid employment
2.1	Full time — work of 30 hours or more per week
2.2	Part time — work of less than 30 hours per week
2.3	Adjusted/modified work — modified work based on functional status
	Student
3.1	Full time — study of 30 hours or more per week
3.2	Part time — study of less than 30 hours per week
3.3	Adjusted/modified study — modified study based on functional status
4.0	**Unemployed**
	Retired
5.1	Retired for age — persons who are retired and are receiving retirement benefits
5.2	Retired for disability — persons who are receiving disability benefits
6.0	**None of the above**

79. Glasses/Hearing Aid Flag

A flag to indicate that a score of 6 on 1 or more of the FIM® instrument cognitive items is due solely to the use of glasses and/or a hearing aid.

Specifications	
Field length	1
Field status	Mandatory on admission, discharge and follow-up assessments when 1 of the following conditions are met: At least 1 value of 54B, 55B, 56, 57 or 58 = 6 and all other values of 54B, 55B, 56, 57 or 58 = 6 or 7. AND 34 Rehabilitation Client Group (RCG) not = 01.1–01.9, 02.1–02.9, 15.1, 14.1 or 14.2. Otherwise must be spaces.
Field type	Int
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	0, 1 (see Legend)
Validation	If at least 1 value of 54B, 55B, 56, 57 or 58 ≤5 then must be spaces. If all values of 54B, 55B, 56, 57 or 58 = 7, then must be spaces. If 34 Rehabilitation Client Group (RCG) = 01.1–01.9, 02.1–02.9, 15.1, 14.1 or 14.2, then must be spaces.

Legend	
0	No, FIM® instrument cognitive items score(s) of 6 is/are NOT due solely to the use of glasses and/or a hearing aid.
1	Yes, FIM® instrument cognitive items score(s) of 6 is/are due solely to the use of glasses and/or a hearing aid.

80. Most Responsible Health Condition ICD-10-CA

The 1 etiological diagnosis that describes the most significant condition that causes the rehabilitation stay in hospital and is directly related to the Rehabilitation Client Group.

Specifications	
Field length	7
Field status	Mandatory on admission assessment. Must be defaulted on discharge assessment, but may be modified if necessary.
Field type	Char
Record/assessment	Admission assessment and discharge assessment
Justification	Right with implied decimal place
Valid codes	Valid NRS ICD-10-CA diagnostic health condition (see Appendix E)
Validation	Must be uppercase.

81. Pre-Admit Comorbid Health Condition ICD-10-CA

Existing health conditions present at the time of admission to facility/unit that affect the person's health/functional status and resource requirements during the rehabilitation program.

Specifications	
Field length	7
Field status	Mandatory if pre-admit comorbid health condition exists; otherwise may be spaces.
Field type	Char
Occurrences	Record all that apply. Up to 15
Record/assessment	Admission assessment
Justification	Right with implied decimal place
Valid codes	Valid NRS ICD-10-CA diagnostic health condition (see Appendix E)
Validation	If any of 81 (1–15) values match any of the other 81 (1–15) values within the same admission record, the data element will be accepted but flagged with a warning message in the submission report to highlight potential duplication. If any of 81 (1–15) values match any of the values recorded in 82 (1–15) Post-Admit Comorbid Health Condition ICD-10-CA, the data element will be accepted but flagged with a warning message in the submission report to highlight potential duplication. Must be uppercase.

82. Post-Admit Comorbid Health Condition ICD-10-CA

Health conditions that arise after admission and during the rehabilitation stay that affect the person's health/functional status and resource requirements during the rehabilitation program.

Specifications	
Field length	7
Field status	Mandatory if post-admit comorbid health condition exists; otherwise may be spaces.
Field type	Char
Occurrences	Record all that apply. Up to 15
Record/assessment	Discharge assessment
Justification	Right with implied decimal place
Valid codes	Valid NRS ICD-10-CA diagnostic health condition (see Appendix E)
Validation	If any of 82 (1–15) values match any of the other 82 (1–15) values within the same discharge record, the data element will be accepted but flagged with a warning message in the submission report to highlight potential duplication. If any of 82 (1–15) values match any of the values recorded in 81 (1–15) Pre-Admit Comorbid Health Condition ICD-10-CA, the data element will be accepted but flagged with a warning message in the submission report to highlight potential duplication. Must be uppercase.

83. Transfer or Death Health Condition ICD-10-CA

The most significant health condition that results in transfer from the rehabilitation program to another unit or facility or that results in death.

Specifications	
Field length	7
Field status	On admission assessment, mandatory if 19A Admission Class = 4 and client transferred from rehabilitation or died. On discharge assessment, mandatory if 31 Reason for Discharge = 8 OR 32 Referred To = 02 or 03.
Field type	Char
Record/assessment	Admission or discharge assessment
Justification	Right with implied decimal place
Valid codes	Valid NRS ICD-10-CA diagnostic health condition (see Appendix E)
Validation	On admission assessment, if 19A Admission Class = 1, 2, 3 or 5, then must be spaces. On admission assessment, if 19A Admission Class = 4, then may be spaces. On discharge assessment, if 31 Reason for Discharge = 8, must not be spaces, or if 32 Referred To = 02 or 03, must not be spaces. On discharge assessment, if 31 Reason for Discharge = 1–7 and 32 Referred To is not = 02 or 03, then 83 Transfer or Death Health Condition must be spaces. Must be uppercase.

84. Service Interruption Reason ICD-10-CA

The health condition that results in service interruption.

Specifications	
Field length	7
Field status	Mandatory if service interruption(s) occurred and 31 Reason for Discharge = 1 or 2; otherwise optional to record.
Field type	Char
Occurrences	Record all that apply. Up to 5
Record/assessment	Discharge assessment
Justification	Right with implied decimal place
Valid codes	Valid NRS ICD-10-CA diagnostic health condition (see Appendix E)
Validation	May be spaces if 31 Reason for Discharge = 3–8 or if no service interruption(s) occurred. If recorded, the following validations apply: If 25A Service Interruption Start Date and 25B Service Interruption Return Date are recorded, then must not be spaces. Must be uppercase.

85. Health Condition Reason(s) for Hospitalization ICD-10-CA

Any hospitalization for health conditions that are related or unrelated to person's rehabilitation health condition (Rehabilitation Client Group).

Specifications	
Field length	7
Field status	Mandatory if 73A Hospitalization Since Discharge = 1.
Field type	Char
Occurrences	Record all that apply. Up to 3
Record/assessment	Follow-up assessment
Justification	Right with implied decimal place
Valid codes	Valid NRS ICD-10-CA diagnostic health condition (see Appendix E)
Validation	If 73A Hospitalizations Since Discharge = 0, –50 or –70, then must be spaces. If 73A Hospitalizations Since Discharge = 1, then at least 1 occurrence must not be spaces. Must be uppercase.

86. Pre-Admit Comorbid Procedure or Intervention CCI

Procedures or interventions performed prior to the rehabilitation stay that affect the client's health/functional status and resource requirements. Includes pre-admit procedures or interventions that delay, interrupt or compromise effectiveness of the rehabilitation program (e.g., joint fixation, amputation).

Specifications	
Field length	10
Field status	Mandatory if pre-admit comorbid procedure or intervention on NRS CCI pick-list exists; otherwise may be spaces.
Field type	Char
Occurrences	Record all that apply. Up to 5
Record/assessment	Admission assessment
Justification	Right
Valid codes	Valid NRS CCI procedure or intervention code (see Appendix F)
Validation	The same pre-admit comorbid procedure or intervention must not be recorded more than once for the same client on the same admission assessment unless the duplication represents that the procedure/intervention was performed in more than 1 location of the body, such as on different sides of the body. Must be uppercase.

87. Aboriginal Status

Aboriginal status refers to client self-identification as a member of an Aboriginal community, including Inuit, Métis or First Nations.

Specifications	
Field length	1
Field status	Mandatory unless 19A Admission Class = 4.
Field type	Char
Record/assessment	Admission assessment
Valid codes	0, 1 or 8 (see Legend)
Validation	May be spaces if 19A Admission Class = 4.

Legend	
0	Does not identify with an Aboriginal community
1	Identifies with an Aboriginal community
8	Did not ask/answer

88A. Projects Code 1

A specific, user-defined code for the special project for which you plan to submit data to CIHI.

Specifications	
Field length	6
Field status	Mandatory to record if 88B Projects Data 1 is recorded; otherwise optional to record.
Field type	Char
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	Any alphanumeric character or spaces
Validation	Any alphanumeric character or spaces

88B. Projects Data 1

Any supplemental data for the project specified in 88A required to meet the information needs of CIHI, the provinces/territories and health care facilities. Special project data can be part of the admission, discharge and/or follow-up records.

Specifications	
Field length	200
Field status	Mandatory to record if 88A Projects Code 1 is recorded; otherwise optional to record.
Field type	Char
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	Any alphanumeric character or spaces
Validation	Any alphanumeric character or spaces

89A. Projects Code 2

A specific, user-defined code for the special project for which you plan to submit data to CIHI.

Specifications	
Field length	6
Field status	Mandatory to record if 89B Projects Data 2 is recorded; otherwise optional to record.
Field type	Char
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	Any alphanumeric character or spaces
Validation	Any alphanumeric character or spaces

89B. Projects Data 2

Any supplemental data for the project specified in 89A required to meet the information needs of CIHI, the provinces/territories and health care facilities. Special project data can be part of the admission, discharge and/or follow-up records.

Specifications	
Field length	200
Field status	Mandatory to record if 89A Projects Code 2 is recorded; otherwise optional to record.
Field type	Char
Record/assessment	Admission, discharge and follow-up assessment records
Justification	None
Valid codes	Any alphanumeric character or spaces
Validation	Any alphanumeric character or spaces

90A. Primary Reason for Waiting for Discharge

The primary reason a person waited to be discharged from a facility/agency.

Specifications	
Field length	3
Field status	Mandatory only if 29 Date Ready for Discharge is not = 30 Discharge Date; otherwise must be blank.
Field type	Char
Record/assessment	Discharge assessment
Justification	None
Valid codes	Valid Reason Waiting for Discharge (see Legend)
Validation	Must be spaces if 29 Date Ready for Discharge is blank or = 30 Discharge Date. Must not be spaces if 29 Date Ready for Discharge is less than 30 Discharge Date.

Legend	
Location	
1.1	Assisted-living/supportive housing
1.2	Residential care (LTC/nursing home)
1.3	Complex continuing care/chronic care
1.4	Acute care
1.5	Transitional care/convalescent care
1.6	Boarding house/rooming house
1.7	Inpatient mental health care
1.8	Palliative care
1.9	Other location
Services	
2.1	Facility-based ambulatory care
2.2	Private-pay therapy/nursing/personal support
2.3	Addiction services
2.4	Community services (includes transportation)
2.5	Home care
2.6	Other services
2.7	Inpatient medical/nursing care
Home modifications/equipment	
3.1	Home modifications
3.2	Equipment (e.g., power wheelchair)
3.3	Other home modifications/equipment
Personal	
4.1	Informal support
4.2	Other personal
–70	Unknown

90B. Secondary Reason for Waiting for Discharge

The secondary (if applicable) reason a person waited to be discharged from a facility/agency.

Specifications	
Field length	3
Field status	Optional to record on discharge assessment.
Field type	Char
Record/assessment	Discharge assessment
Justification	None
Valid codes	Valid Reason Waiting for Discharge (see Legend)
Validation	Must be spaces if 90A Primary Reason Waiting for Discharge is spaces or –70. Must not = 90A Primary Reason Waiting for Discharge unless Primary Reason Waiting for Discharge is spaces.

Legend	
Location	
1.1	Assisted-living/supportive housing
1.2	Residential care (LTC/nursing home)
1.3	Complex continuing care/chronic care
1.4	Acute care
1.5	Transitional care/convalescent care
1.6	Boarding house/rooming house
1.7	Inpatient mental health care
1.8	Palliative care
1.9	Other location
Services	
2.1	Facility-based ambulatory care
2.2	Private-pay therapy/nursing/personal support
2.3	Addiction services
2.4	Community services (includes transportation)
2.5	Home care
2.6	Other services
2.7	Inpatient medical/nursing care
Home modifications/equipment	
3.1	Home modifications
3.2	Equipment (e.g., power wheelchair)
3.3	Other home modifications/equipment
Personal	
4.1	Informal support
4.2	Other personal
–70	Unknown

91A. Rehabilitation Time With an Occupational Therapist (OT)

The total time (in minutes) the client spent in direct/active therapy with an occupational therapist during the rehabilitation stay. Direct therapy refers to individual face-to-face treatment that is guided or monitored by the occupational therapist for the purposes of achieving therapy goals and maximizing recovery within an individualized treatment plan. For more coding guidelines, please see Module 2: Clinical Coding and NRS Training.

Specifications	
Field length	5
Field status	On discharge, mandatory if Facility Province = “ON” (Ontario) and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9 (Stroke); otherwise optional to record.
Field type	Numeric (Minutes)
Record/assessment	Discharge assessment
Justification	Right
Valid codes	0–99999
Validation	On discharge assessment, must not be spaces if Facility Province = “ON” and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9; otherwise, may be spaces. Must be right-justified.

91B. Rehabilitation Time With a Physiotherapist (PT)

The total time (in minutes) the client spent in direct/active therapy with a physiotherapist during the rehabilitation stay. Direct therapy refers to individual face-to-face treatment that is guided or monitored by the physiotherapist for the purposes of achieving therapy goals and maximizing recovery within an individualized treatment plan. For more coding guidelines, please see Module 2: Clinical Coding and NRS Training.

Specifications	
Field length	5
Field status	On discharge, mandatory if Facility Province = “ON” (Ontario) and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9 (Stroke); otherwise optional to record.
Field type	Numeric (Minutes)
Record/assessment	Discharge assessment
Justification	Right
Valid codes	0–99999
Validation	On discharge assessment, must not be spaces if Facility Province = “ON” and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9; otherwise, may be spaces. Must be right-justified.

91C. Rehabilitation Time With a Speech–Language Pathologist (SLP)

The total time (in minutes) the client spent in direct/active therapy with a speech–language pathologist during the rehabilitation stay. Direct therapy refers to individual face-to-face treatment that is guided or monitored by the speech–language pathologist for the purposes of achieving therapy goals and maximizing recovery within an individualized treatment plan. For more coding guidelines, please see Module 2: Clinical Coding and NRS Training.

Specifications	
Field length	5
Field status	On discharge, mandatory if Facility Province = “ON” (Ontario) and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9 (Stroke); otherwise optional to record.
Field type	Numeric (Minutes)
Record/assessment	Discharge assessment
Justification	Right
Valid codes	0–99999
Validation	On discharge assessment, must not be spaces if Facility Province = “ON” and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9; otherwise, may be spaces. Must be right-justified.

91D. Rehabilitation Time With an Occupational Therapist Assistant (OTA)

The total time (in minutes) the client spent in direct/active therapy with an occupational therapist assistant during the rehabilitation stay. Direct therapy refers to individual face-to-face treatment that is guided or monitored by the occupational therapist assistant for the purposes of achieving therapy goals and maximizing recovery within an individualized treatment plan. For more coding guidelines, please see Module 2: Clinical Coding and NRS Training.

Specifications	
Field length	5
Field status	On discharge, mandatory if Facility Province = “ON” (Ontario) and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9 (Stroke); otherwise optional to record.
Field type	Numeric (Minutes)
Record/assessment	Discharge assessment
Justification	Right
Valid codes	0–99999
Validation	On discharge assessment, must not be spaces if Facility Province = “ON” and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9; otherwise, may be spaces. Must be right-justified.

91E. Rehabilitation Time With a Physiotherapist Assistant (PTA)

The total time (in minutes) the client spent in direct/active therapy with a physiotherapist assistant during the rehabilitation stay. Direct therapy refers to individualized face-to-face treatment that is guided or monitored by the physiotherapist assistant for the purposes of achieving therapy goals and maximizing recovery within an individualized treatment plan. For more coding guidelines, please see Module 2: Clinical Coding and NRS Training.

Specifications	
Field length	5
Field status	On discharge, mandatory if Facility Province = “ON” (Ontario) and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9 (Stroke); otherwise optional to record.
Field type	Numeric (Minutes)
Record/assessment	Discharge assessment
Justification	Right
Valid codes	0–99999
Validation	On discharge assessment, must not be spaces if Facility Province = “ON” and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9; otherwise, may be spaces. Must be right-justified.

91F. Rehabilitation Time With a Communicative Disorders Assistant (CDA)

The total time (in minutes) the client spent in direct/active therapy with a communicative disorders assistant during the rehabilitation stay. Direct therapy refers to individual face-to-face treatment that is guided or monitored by the communicative disorders assistant for the purposes of achieving therapy goals and maximizing recovery within an individualized treatment plan. For more coding guidelines, please see Module 2: Clinical Coding and NRS Training.

Specifications	
Field length	5
Field status	On discharge, mandatory if Facility Province = “ON” (Ontario) and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9 (Stroke); otherwise optional to record.
Field type	Numeric (Minutes)
Record/assessment	Discharge assessment
Justification	Right
Valid codes	0–99999
Validation	On discharge assessment, must not be spaces if Facility Province = “ON” and RCG = 01.1, 01.2, 01.3, 01.4 or 01.9; otherwise, may be spaces. Must be right-justified.

Appendix A — Recording forms

The following admission, discharge and follow-up forms include all mandatory and optional data elements in the NRS. Not all response code options are included on the forms for all data elements. Please see module 1 or 2 for the complete list of coding options available, and refer in particular to Module 2 to accurately complete the assessments.

The last page of each recording form has an optional signature sheet with space to enter an initial and date for each data element completed on the form.

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Admission Recording Form

The FIM® instrument and impairment codes referenced herein are the property of Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.

CLIENT IDENTIFIER

3. Program Type (Optional, site defined) [ ][ ]

4. Chart Number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

5. Health Care Number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

6. Province/Territory Issuing Health Care [ ][ ][ ]

SOCIO-DEMOGRAPHIC — 1

87. Aboriginal Status [ ]
0 No, does not self-identify 1 Yes, does self-identify
8 Did not ask/answer

7. Sex [ ]
M Male F Female O Other

8. Birthdate [ ][ ][ ][ ][ ][ ][ ][ ]
Year Month Day

9. Estimated Birthdate [ ]
0 No, birthdate is known 1 Yes, birthdate estimated

10. Primary Language [ ][ ][ ]

11A. Country of Residence [ ]
1 Canada
2 United States
3 Other

11B. Postal Code of Residence [ ][ ][ ] [ ][ ][ ]

11C. Province or Territory of Residence [ ][ ][ ]

11D. Residence Code [ ][ ][ ][ ][ ][ ][ ]

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)

Admission Recording Form

SOCIO-DEMOGRAPHIC — 2

12. Pre-Hospital Living Arrangements (Record all that apply.)

OR

☐ –50 Not available, temporarily
☐ –70 Asked, unknown

☐ 1 Living with spouse/partner
☐ 2 Living with family (includes extended)
☐ 3 Living with non-family, unpaid (includes friends)
☐ 4 Living with paid attendant
☐ 5 Living alone
☐ 6 Living in facility (includes all levels of care except acute)
☐ 7 Other

14. Pre-Hospital Living Setting ☐

1 Home (private house or apartment) without health service
2 Home (private house or apartment) with paid health services (e.g. home care/support; private or public funded)
3 Boarding house (includes rented room)
4 Assisted living (includes group home, retirement home, supervised living setting)
5 Residential care (long-term care facility, convalescent care, nursing home, home for the aged)
6 Shelter (includes night shelter, refuges, hostels for homeless)
7 Public place (includes residing in the street, parks and other public spaces)
8 Other
–50 Not available, temporarily
–70 Asked, unknown

16. Informal Support Received ☐

1 Not required
2 Received
3 Received with restrictions
4 Not received

17. Pre-Hospital Vocational Status (Record all that apply.)

Paid employment
☐ 1.1 Full time
☐ 1.2 Part time
☐ 1.3 Adjusted/modified

Unpaid employment
☐ 2.1 Full time
☐ 2.2 Part time
☐ 2.3 Adjusted/modified

☐ –50 Not available, temporarily

Student
☐ 3.1 Full time
☐ 3.2 Part time
☐ 3.3 Adjusted/modified

Unemployed
☐ 4.0 Unemployed

Retired
☐ 5.1 Retired for age
☐ 5.2 Retired for disability

☐ 6.0 None of the above

☐ –70 Asked, unknown

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Admission Recording Form

ADMINISTRATIVE

19A. Admission Class
- 1 Initial rehabilitation
- 2 Short stay
- 3 Readmission
- 4 (Un)planned discharge without assessment
- 5 Continuing rehabilitation

19B. If code 3 — readmission: Readmission 1 month or less since discharge — 0 No 1 Yes

19C. If yes, was readmission planned? — 0 No 1 Yes

30. If Admission Class 4, (un)planned discharge, record discharge date — Year Month Day

20A. Date Ready for Admission to Inpatient Rehabilitation Known
- 0 No, not known
- 1 Yes, date known (complete 20B)

20B. If known, record Date Ready for Admission — Year Month Day

21. Admission Date — Year Month Day

22. Referral Source

23A. Referral Source Province/Territory

23B. Referral Source Facility Number (If unknown, code 99999.)

24. Responsibility for Payment (Record all that apply.)
- 1 Provincial/territorial plan
- 2 WCB/WSIB
- 3 Other province/territory (resident of Canada)
- 4 Federal gov't — Veterans Affairs Canada
- 5 Federal gov't — FNIHB
- 6 Federal gov't — other
- 7 Canadian resident, self-pay
- 8 Canadian resident, insurance pay
- 9 Other country resident, self-pay
- 10 Provincial definition
- –50 Not available, temporarily
- –70 Asked, unknown

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)

Admission Recording Form

HEALTH CHARACTERISTICS

34. Rehabilitation Client Group
(Record 1 only using numeric code.)

80. Most Responsible Health Condition
(Record 1 only using alphanumeric code from Diagnostic Health Conditions list.)

81. Pre-Admit Comorbid Health Condition(s) (Use ICD-10-CA alphanumeric code[s] from Diagnostic Health Conditions list for complications, comorbidities, high risks and disorders that delay, interrupt or compromise effectiveness.)

(Record all that apply, up to a maximum of 15.)

	Alphanumeric Codes	Health Condition
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Admission Recording Form

HEALTH CHARACTERISTICS (cont'd)

86. Pre-Admit Comorbid Procedure or Intervention (Use CCI alphanumeric code[s] from Appendix E for procedure or interventions occurring prior to rehabilitation admission. If applicable, record up to 5.)

CCI Code

1. | | | | | | | | | | |
2. | | | | | | | | | | |
3. | | | | | | | | | | |
4. | | | | | | | | | | |
5. | | | | | | | | | | |

83. Transfer or Death: Diagnostic Health Condition (Record 1 only using alphanumeric code from Diagnostic Health Conditions list.) | | | | | | | | (Record only if Admission Class 4 — [un]planned Discharge.)

38. ASIA Impairment Scale | |

1A Complete
2B Incomplete — sensory preserved
3C Incomplete — motor non-functional
4D Incomplete — motor functional
5E Normal

39. Date of Onset | | | | | | | | |
Year Month Day

40A. Height | | | | . | | | | cm

40B. Weight | | | | . | | | | kg

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)

Admission Recording Form

ACTIVITIES AND PARTICIPATION

FIM® instrument

		Admission
Self-Care		
41.	Eating	
42.	Grooming	
43.	Bathing	
44.	Dressing — Upper Body	
45.	Dressing — Lower Body	
46.	Toileting	
Sphincter		
47.	Bladder Management	
48.	Bowel Management	
Transfers		
49.	Bed, Chair, Wheelchair	
50.	Toilet	
51.	Tub, Shower	
Locomotion		
52.	Walk/Wheelchair	○ Walk ○ Wheelchair ○ Both
53.	Stairs	
Communication		
54.	Comprehension	○ Auditory ○ Visual ○ Both
55.	Expression	○ Vocal ○ Non-Vocal ○ Both
Social Cognition		
56.	Social Interaction	
57.	Problem-Solving	
58.	Memory	

FIM Levels
NO HELPER
7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)

HELPER
Modified Dependence
5 Supervision
4 Minimal Assistance (Subject = 75%+)
3 Moderate Assistance (Subject = 50%+)
Complete Dependence
2 Maximal Assistance (Subject = 25%+)
1 Total Assistance (Subject = 0%+)

(**Note**: Leave no blanks; enter 1 if not testable due to risk.)

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Admission Recording Form

ACTIVITIES AND PARTICIPATION (cont'd)

CIHI Data Elements

		Admission	
59.	Impact of Pain		
	a. Presence of Pain	☐	8 Client unable to answer (*Do not answer b. and c.*) 5 No *(Do not answer b. and c.)* 1 Yes *(Go to b. and c.)*
	b. Intensity of Pain	☐	4 Mild 3 Moderate 2 Severe
	c. Impact on Activities	☐	5 None 4 A few 3 Some 2 Most
60.	Meal Preparation (optional)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
61.	Light Housework (optional)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
62.	Heavy Housework (optional)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
79.	Glasses/Hearing Aid Flag	☐	0 No 1 Yes
64.	Communication — Verbal or Non-Verbal Expression	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)

Admission Recording Form

ACTIVITIES AND PARTICIPATION (cont'd)

CIHI Data Elements

		Admission	
65.	Communication — Written Expression	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
66.	Communication — Auditory or Non-Auditory Comprehension	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
67.	Communication — Reading Comprehension	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
68.	Financial Management	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent 8 Not able to test
69.	Orientation	☐	5 Oriented to time, place, self 3 Oriented to 1 or 2 items 1 Oriented to none of the items
70.	General Health Status a. Respondent	☐	3 Client 2 Family/significant others 1 Service provider 8 Not able to test
	b. General Health Status	☐	5 Excellent 4 Very good 3 Good 2 Fair 1 Poor

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Admission Recording Form

PROJECTS FIELDS

CIHI Data Elements

88A. Project Code 1	
88B. Project Data 1	
89A. Project Code 2	
89B. Project Data 2	

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

CLIENT IDENTIFIER

4. Chart Number ☐☐☐☐☐☐☐☐☐☐

8. Birthdate ☐☐☐☐☐☐☐☐ (Year Month Day)

21. Admission Date ☐☐☐☐☐☐☐☐ (Year Month Day)

SOCIO-DEMOGRAPHIC — 1

13. Post-Discharge Living Arrangements (Record all that apply.)

OR

☐ –50 Not available, temporarily
☐ –70 Asked, unknown

☐ 1 Living with spouse/partner
☐ 2 Living with family (includes extended)
☐ 3 Living with non-family, unpaid (includes friends)
☐ 4 Living with paid attendant
☐ 5 Living alone
☐ 6 Living in facility (includes all levels of care except acute)
☐ 7 Other
☐ 8 Identified living arrangement(s) is/are transitional or temporary
☐ 9 Living in acute care

15. Post-Discharge Living Setting ☐

1 Home (private house or apartment) without health services
2 Home (private house or apartment) with paid health services (e.g. home care/support; private or public funded)
3 Boarding house (includes rented room)
4 Assisted living (includes group home, retirement home, supervised living setting)
5 Residential care (long-term care facility, convalescent care, nursing home, home for the aged)
6 Shelter (includes night shelter, refuges, hostels for homeless)
7 Public place (includes residing in the street, parks and public spaces)
8 Other
9 Acute care
–50 Not available, temporarily
–70 Asked, unknown

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

SOCIO-DEMOGRAPHIC — 2

16. Informal Support Received ☐
1 Not required
2 Received
3 Received with restrictions
4 Not received

18. Post-Discharge Vocational Status (Record all that apply.)

Paid employment
☐ 1.1 Full time
☐ 1.2 Part time
☐ 1.3 Adjusted/modified

Unpaid employment
☐ 2.1 Full time
☐ 2.2 Part time
☐ 2.3 Adjusted/modified

Student
☐ 3.1 Full time
☐ 3.2 Part time
☐ 3.3 Adjusted/modified

Unemployed
☐ 4.0 Unemployed

Retired
☐ 5.1 Retired for age
☐ 5.2 Retired for disability

☐ 6.0 None of the above

☐ –50 Not available, temporarily

☐ –70 Asked, unknown

ADMINISTRATIVE

19A. Admission Class
(If **different** from admission) ☐
1 Initial rehabilitation
2 Short stay
3 Readmission
4 (Un)planned discharge without assessment
5 Continuing rehabilitation

24. Responsibility for Payment
(If **different** from admission)
(Record all that apply.)
☐ 1 Provincial/territorial plan
☐ 2 WCB/WSIB
☐ 3 Other province/territory (resident of Canada)
☐ 4 Federal gov't — Veterans Affairs Canada
☐ 5 Federal gov't — FNIHB
☐ 6 Federal gov't — other
☐ 7 Canadian resident self-pay
☐ 8 Canadian resident, insurance pay
☐ 9 Other country resident, self-pay
☐ 10 Provincial definition
☐ –50 Not available, temporarily
☐ –70 Asked, unknown

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

ADMINISTRATIVE (cont'd)

25. Service Interruptions

1st Interruption

A. Start Date	B. Return Date	84. Reason	D. Transferred
Year Month Day	Year Month Day	Health Condition Code	0 No 1 Yes

2nd Interruption

A. Start Date	B. Return Date	84. Reason	D. Transferred
Year Month Day	Year Month Day	Health Condition Code	0 No 1 Yes

3rd Interruption

A. Start Date	B. Return Date	84. Reason	D. Transferred
Year Month Day	Year Month Day	Health Condition Code	0 No 1 Yes

4th Interruption

A. Start Date	B. Return Date	84. Reason	D. Transferred
Year Month Day	Year Month Day	Health Condition Code	0 No 1 Yes

5th Interruption

A. Start Date	B. Return Date	84. Reason	D. Transferred
Year Month Day	Year Month Day	Health Condition Code	0 No 1 Yes

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

ADMINISTRATIVE (cont'd)

28A. Provider Types (Record all that apply, up to a maximum of 20.)

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

28B. ID Number (optional)

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

29. Date Ready for Discharge

Year Month Day

30. Discharge Date

Year Month Day

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

ADMINISTRATIVE (cont'd)

90. Reasons for Waiting for Discharge Primary Reason [ ][ ][ ] Secondary Reason [ ][ ][ ]
(Record only if Discharge Date is greater than Date Ready for Discharge. If unknown, code –70.)

Location
- 1.1 Assisted-living/supportive housing
- 1.2 Residential care (LTC/nursing home)
- 1.3 Complex continuing care/chronic care
- 1.4 Acute care
- 1.5 Transitional care/convalescent care
- 1.6 Boarding house/rooming house
- 1.7 Inpatient mental health care
- 1.8 Palliative care
- 1.9 Other Location

Services
- 2.1 Facility-based ambulatory care
- 2.2 Private-pay therapy/nursing/personal support
- 2.3 Addiction services
- 2.4 Community services (includes transportation)
- 2.5 Home care
- 2.6 Other Services
- 2.7 Inpatient Medical/Nursing Care

Home Modifications/Equipment
- 3.1 Home modifications
- 3.2 Equipment (e.g. power wheelchair)
- 3.3 Other Home Modifications/Equipment

Personal
- 4.1 Informal support
- 4.2 Other Personal

31. Reason for Discharge [ ]
- 1 Service goals met and discharged to community
- 2 Service goals met and referral/transfer to other unit/facility
- 3 Service goals not met and referral/transfer to other unit/facility or discharged to community
- 4 Facility/agency withdrew services
- 5 Person withdrew
- 6 Person no longer eligible (funding)
- 7 Person moved
- 8 Person deceased

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

ADMINISTRATIVE (cont'd)

32. Referred To | | | |

33A. Referred to Province/Territory | | | |

33B. Referred to Facility Number | | | | | | |
(If unknown, code 99999.)

91A. Rehabilitation Time With an Occupational Therapist (OT) | | | | | |
(If unknown, code 99999.)

91B. Rehabilitation Time With a Physiotherapist (PT) | | | | | |
(If unknown, code 99999.)

91C. Rehabilitation Time With a Speech-Language Pathologist (SLP) | | | | | |
(If unknown, code 99999.)

91D. Rehabilitation Time With an Occupational Therapist Assistant (OTA) | | | | | |
(If unknown, code 99999.)

91E. Rehabilitation Time With a Physiotherapist Assistant (PTA) | | | | | |
(If unknown, code 99999.)

91F. Rehabilitation Time With a Communicative Disorders Assistant (CDA) | | | | | |
(If unknown, code 99999.)

HEALTH CHARACTERISTICS

34. Rehabilitation Client Group | | . | | | | |
(If **different** from admission record)

80. Most Responsible Health Condition | | | | | | | |
(If **different** from admission record)

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)

Discharge Recording Form

HEALTH CHARACTERISTICS (cont'd)

82. Post-Admit Comorbid Health Conditions(s) (Use alphanumeric code[s] from Diagnostic Health Conditions list for complications, comorbidities, high risks and disorders that delay, interrupt or compromise effectiveness. Record all that apply, up to a maximum of 15.)

	Alphanumeric Codes	Health Condition
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

83. Transfer or Death: Diagnostic Health Condition (Record 1 only using alphanumeric code from Diagnostic Health Conditions list.) _____ (Record only if Reason for Discharge is code 8 or Referred To is code 02 or 03.)

40A. Height ___ . ___ cm

40B. Weight ___ . ___ kg

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

ACTIVITIES AND PARTICIPATION

FIM® instrument

Discharge

Self-Care

41. Eating
42. Grooming
43. Bathing
44. Dressing — Upper Body
45. Dressing — Lower Body
46. Toileting

Sphincter

47. Bladder Management
48. Bowel Management

Transfers

49. Bed, Chair, Wheelchair
50. Toilet
51. Tub, Shower

Locomotion

52. Walk/Wheelchair — ○ Walk ○ Wheelchair

53. Stairs

Communication

54. Comprehension — ○ Auditory ○ Visual ○ Both

55. Expression — ○ Vocal ○ Non-Vocal ○ Both

Social Cognition

56. Social Interaction
57. Problem-Solving
58. Memory

FIM Levels
NO HELPER
7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)

HELPER
Modified Dependence
5 Supervision
4 Minimal Assistance (Subject = 75%+)
3 Moderate Assistance (Subject = 50%+)
Complete Dependence
2 Maximal Assistance (Subject = 25%+)
1 Total Assistance (Subject = 0%+)

(**Note**: Leave no blanks; enter 1 if not testable due to risk.)

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)

Discharge Recording Form

ACTIVITIES AND PARTICIPATION (cont'd)

CIHI Data Elements

		Discharge	
59.	Impact of Pain		
	a. Presence of Pain	☐	8 Client unable to answer (*Do not answer b. and c.*) 5 No *(Do not answer b. and c.)* 1 Yes *(Go to b. and c.)*
	b. Intensity of Pain	☐	4 Mild 3 Moderate 2 Severe
	c. Impact on Activities	☐	5 None 4 A few 3 Some 2 Most

Complete #60–#62 if entered on admission.

60.	Meal Preparation (If entered on admission record)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
61.	Light Housework (If entered on admission record)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
62.	Heavy Housework (If entered on admission record)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
79.	Glasses/Hearing Aid Flag	☐	0 No 1 Yes
64.	Communication — Verbal or Non-Verbal Expression	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

ACTIVITIES AND PARTICIPATION (cont'd)

		Discharge	
65.	Communication — Written Expression	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
66.	Communication — Auditory or Non-Auditory Comprehension	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
67.	Communication — Reading Comprehension	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
68.	Financial Management	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent 8 Not able to test
69.	Orientation	☐	5 Oriented to time, place, self 3 Oriented to 1 or 2 items 1 Oriented to none of the items
70.	General Health Status a. Respondent	☐	3 Client 2 Family/significant others 1 Service provider 8 Not able to test
	b. General Health Status	☐	5 Excellent 4 Very good 3 Good 2 Fair 1 Poor

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Discharge Recording Form

PROJECTS FIELDS

CIHI Data Elements

88A. Project Code 1	
88B. Project Data 1	
89A. Project Code 2	
89B. Project Data 2	

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Follow-Up Recording Form

CLIENT IDENTIFIER

3. Program Type
(If entered on admission record) ☐☐

4. Chart Number ☐☐☐☐☐☐☐☐☐☐

8. Birthdate ☐☐☐☐☐☐☐☐
Year Month Day

30. Discharge Date ☐☐☐☐☐☐☐☐
Year Month Day

72. Follow-Up Assessment Date ☐☐☐☐☐☐☐☐
Year Month Day

74. Respondent Type ☐
- 3 Client
- 2 Family/friend
- 1 Service provider

SOCIO-DEMOGRAPHIC

76. Follow-Up Living Arrangements
(Record all that apply.)

OR

☐ –50 Not available, temporary
☐ –70 Asked, unknown

☐ 1 Living with spouse/partner
☐ 2 Living with family (includes extended)
☐ 3 Living with non-family, unpaid (includes friends)
☐ 4 Living with paid attendant
☐ 5 Living alone
☐ 6 Living in facility (includes all levels of care except acute)
☐ 7 Other

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)

Follow-Up Recording Form

SOCIO-DEMOGRAPHIC (cont'd)

77. Follow-Up Living Setting ☐

1 Home (private house or apartment) without health services
2 Home (private house or apartment) with paid health services (e.g. home care/support; private or public funded)
3 Boarding house (includes rented room)
4 Assisted living (includes group home, retirement home, supervised living setting)
5 Residential care (long-term care facility, convalescent care, nursing home, home for the aged)
6 Shelter (includes night shelter, refuges, hostels for homeless)
7 Public place (includes residing in the street, parks and public spaces)
8 Other
–50 Not available, temporarily
–70 Asked, unknown

16. Informal Support Received (optional) ☐

1 Not required
2 Received
3 Received with restrictions
4 Not received

78. Follow-Up Vocational Status (Record all that apply.)

Paid employment
☐ 1.1 Full time
☐ 1.2 Part time
☐ 1.3 Adjusted/modified

Unpaid employment
☐ 2.1 Full time
☐ 2.2 Part time
☐ 2.3 Adjusted/modified

Student
☐ 3.1 Full time
☐ 3.2 Part time
☐ 3.3 Adjusted/modified

Unemployed
☐ 4.0 Unemployed

Retired
☐ 5.1 Retired for age
☐ 5.2 Retired for disability

☐ 6.0 None of the above

☐ –50 Not available, temporarily
☐ –70 Asked, unknown

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Follow-Up Recording Form

HEALTH CHARACTERISTICS

73A. Hospitalization Since Discharge [ ]
0 No
1 Yes
OR
–50 Not available, temporarily
–70 Asked, unknown

If yes, complete 73B and 85.

73B. Days in Hospital (Total Number) # [ ][ ][ ]
OR
–50 Not available, temporarily
–70 Asked, unknown

85. Health Condition(s) Reason for Hospitalization (Record at least 1 using alphanumeric code from Diagnostic Health Conditions list.) (Record up to 3.)

1. [ ][ ][ ][ ][ ][ ][ ]
2. [ ][ ][ ][ ][ ][ ][ ]
3. [ ][ ][ ][ ][ ][ ][ ]

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Follow-Up Recording Form

ACTIVITIES AND PARTICIPATION

FIM® instrument

		Follow-Up
Self-Care		
41.	Eating	
42.	Grooming	
43.	Bathing	
44.	Dressing — Upper Body	
45.	Dressing — Lower Body	
46.	Toileting	
Sphincter		
47.	Bladder Management	
48.	Bowel Management	
Transfers		
49.	Bed, Chair, Wheelchair	
50.	Toilet	
51.	Tub, Shower	
Locomotion		
52.	Walk/Wheelchair	○ Walk ○ Wheelchair
53.	Stairs	
Communication		
54.	Comprehension	○ Auditory ○ Visual ○ Both
55.	Expression	○ Vocal ○ Non-vocal ○ Both
Social Cognition		
56.	Social Interaction	
57.	Problem-Solving	
58.	Memory	

FIM Levels
NO HELPER
7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)
HELPER
Modified Dependence
5 Supervision
4 Minimal Assistance (Subject = 75%+)
3 Moderate Assistance (Subject = 50%+)
Complete Dependence
2 Maximal Assistance (Subject = 25%+)
1 Total Assistance (Subject = 0%+)

(**Note**: Leave no blanks; enter 1 if not testable due to risk.)

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Follow-Up Recording Form

ACTIVITIES AND PARTICIPATION (cont'd)

CIHI Data Elements

		Follow-Up	
59.	Impact of Pain a. Presence of Pain	☐	8 Client unable to answer (*Do not answer b. and c.*) 5 No *(Do not answer b. and c.)* 1 Yes *(Go to b. and c.)*
	b. Intensity of Pain	☐	4 Mild 3 Moderate 2 Severe
	c. Impact on Activities	☐	5 None 4 A few 3 Some 2 Most
60.	Meal Preparation (optional)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
61.	Light Housework (optional)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
62.	Heavy Housework (optional)	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent
79.	Glasses/Hearing Aid Flag	☐	0 No 1 Yes
64.	Communication — Verbal or Non-Verbal Expression	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)

Follow-Up Recording Form

ACTIVITIES AND PARTICIPATION (cont'd)

		Follow-Up	
65.	Communication — Written Expression	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
66.	Communication — Auditory or Non-Auditory Comprehension	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
67.	Communication — Reading Comprehension	☐	5 Independent 4 Supervision (cueing) 3 Assistance 2 Dependent 1 Non-functional 8 Not able to test
68.	Financial Management	☐	5 Independent 4 Supervision 3 Assistance 2 Dependent 8 Not able to test
69.	Orientation	☐	5 Oriented to time, place, self 3 Oriented to 1 or 2 items 1 Oriented to none of the items
70.	General Health Status a. Respondent	☐	3 Client 2 Family/significant others 1 Service provider 8 Not able to test
	b. General Health Status	☐	5 Excellent 4 Very good 3 Good 2 Fair 1 Poor

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Follow-Up Recording Form

FOLLOW-UP ASSESSMENT

75. Reintegration to Normal Living Index (Record 1 response for each statement.)

Statement	Does not describe my situation 0	Partially describes my situation 1	Fully describes my situation 2	Not able to test 8
I move around my living quarters as I feel is necessary (wheelchairs, other equipment or resources may be used).				
I move around my community as I feel necessary (wheelchairs, other equipment or resources may be used).				
I am able to take trips out of town as I feel are necessary (wheelchairs, other equipment or resources may be used).				
I am comfortable with how my self-care needs (dressing, feeding, toileting, bathing) are met (adaptive equipment, supervision and/or assistance may be used).				
I spend most of my days occupied in a work activity that is necessary or important to me (could be paid employment, housework, volunteer work, school, etc.; adaptive equipment, supervision and/or assistance may be used).				
I am able to participate in recreational activities (hobbies, crafts, sports, reading, television, games, computers, etc.) as I want to (adaptive equipment, supervision and/or assistance may be used).				
I participate in social activities with family, friends and/or business acquaintances as is necessary or desirable to me (adaptive equipment, supervision and/or assistance may be used).				
I assume a role in my family that meets my needs and those of other family members (family means people with whom you live and/or relatives with whom you don't live but see on a regular basis; adaptive equipment, supervision and/or assistance may be used).				
In general, I am comfortable with my personal relationships.				
In general, I am comfortable with myself when I am in the company of others.				
I feel that I can deal with life events as they happen.				

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NATIONAL REHABILITATION REPORTING SYSTEM (NRS)
Follow-Up Recording Form

PROJECTS FIELDS

CIHI Data Elements

88A. Project Code 1	
88B. Project Data 1	
89A. Project Code 2	
89B. Project Data 2	

Appendix B — Primary Language codes validation table

To be used when coding data element 10 Primary Language.

This pick-list is a subset of ISO-639-3 language codes and names for languages spoken in Canada (based on Canadian census data). Vendors have been provided with the language validation table.

Code	Language
eng	English
fra	French
afr	Afrikaans
aka	Akan
sqi	Albanian
alq	Algonquin
ase	American Sign Language
amh	Amharic
ara	Arabic
hye	Armenian
atj	Atikamekw
aze	Azerbaijani
bcr	Babine
bam	Bambara
bea	Beaver
bel	Belarusian
ben	Bengali
bik	Bikol
bos	Bosnian
bul	Bulgarian
mya	Burmese
crx	Carrier
cat	Catalan
cay	Cayuga
ceb	Cebuano
clc	Chilcotin
zho	Chinese
hak	Chinese, Hakka

Code	Language
cmn	Chinese, Mandarin
mnp	Chinese, Min Bei
cdo	Chinese, Min Dong
nan	Chinese, Min Nan
czo	Chinese, Min Zhong
cpx	Chinese, Pu-Xian
wuu	Chinese, Wu
yue	Chinese, Yue
cre	Cree
crk	Cree, Plains
csw	Cree, Swampy
cwd	Cree, Woods
hrv	Croatian
ces	Czech
dak	Dakota
dan	Danish
prs	Dari
chp	Dene Suline
dgr	Dogrib
nld	Dutch
bin	Edo
est	Estonian
ewe	Ewe
fij	Fijian
fin	Finnish
gaa	Ga
gla	Gaelic, Scottish
lug	Ganda
git	Gitxsan
kat	Georgian
deu	German
ell	Greek, Modern (1453–)
guj	Gujarati
gwi	Gwich’in

Code	Language
hai	Haida
has	Haisla
hat	Haitian
hur	Halkomelem
haa	Han
heb	Hebrew
hei	Heiltsuk
hin	Hindi
hun	Hungarian
isl	Icelandic
ibo	Igbo
ilo	Iloko
ikt	Inuinnaqtun
iku	Inuktitut
ita	Italian
jpn	Japanese
kab	Kabyle
kan	Kannada
kkz	Kaska
khm	Khmer, Central
kin	Kinyarwanda
kok	Konkani (macrolanguage)
kor	Korean
kur	Kurdish
kut	Kutenai
kwk	Kwakiutl
lao	Lao
lav	Latvian
lil	Lillooet
lin	Lingala
lit	Lithuanian
mkd	Macedonian
mlg	Malagasy
mal	Malayalam
pqm	Malecite-Passamaquoddy

Code	Language
mlt	Maltese
mar	Marathi
crg	Michif
mic	Micmac
moh	Mohawk
mon	Mongolian
moe	Montagnais
nsk	Naskapi
npi	Nepali (individual language)
ncg	Nisga’a
nor	Norwegian
nuk	Nuu-chah-nulth
oji	Ojibwa
ojs	Ojibwa, Severn
oka	Okanagan
one	Oneida
orm	Oromo
pam	Pampanga
pag	Pangasinan
pan	Panjabi
pus	Pashto
fas	Persian
pol	Polish
por	Portuguese
fcs	Quebec Sign Language
ron	Romanian
run	Rundi
rus	Russian
str	Salish, Straits
srs	Sarsi
sek	Sekani
srp	Serbian
hbs	Serbo-Croatian
sna	Shona
shs	Shuswap

Code	Language
bla	Siksika
snd	Sindhi
sin	Sinhala
den	Slave (Athapascan)
scs	Slavey, North
xsl	Slavey, South
slk	Slovak
slv	Slovenian
som	Somali
spa	Spanish
squ	Squamish
sto	Stoney
swa	Swahili (macrolanguage)
swe	Swedish
tgl	Tagalog
tht	Tahltan
tam	Tamil
tel	Telugu
tha	Thai
thp	Thompson
tir	Tigrinya
tli	Tlingit
tsi	Tsimshian
tur	Turkish
ttm	Tutchone, Northern
tce	Tutchone, Southern
twi	Twi
ukr	Ukrainian
urd	Urdu
vie	Vietnamese
cym	Welsh
wol	Wolof
yid	Yiddish
oth	**Other**
unk	**Unknown**

Appendix C — Provider Types validation table

Provider Types validation table

To be used when coding data element 28 Provider Types.

Code	Service provider
Physician group	
00001	Family Practitioner/General Practitioner
00002	Community Medicine
00003	Emergency Medicine
00010	Internal Medicine
00011	Clinical Immunology and Allergy
00012	Cardiology
00013	Dermatology
00014	Endocrinology and Metabolism
00015	Gastroenterology
00016	Nephrology
00017	Neurology
00018	Respirology
00019	Rheumatology
00020	Pediatrics
00030	General Surgery
00031	Cardiac Surgery
00032	Neurosurgery
00034	Orthopedic Surgery
00035	Plastic Surgery
00036	Thoracic Surgery
00037	Vascular Surgery
00038	Cardiothoracic Surgery
00039	Urology
00040	Pediatric General Surgery
00050	Obstetrics and Gynecology
00051	Gynecologic Reproductive Endocrinology and Infertility

Code	Service provider
Physician group	
00054	Maternal–Fetal Medicine
00055	Critical Care Medicine
00056	Clinical Pharmacology
00057	Anesthesia
00059	Colorectal Surgery
00060	Otolaryngology
00062	Ophthalmology
00064	Psychiatry
00066	Hematology
00070	Physical Medicine and Rehabilitation
00072	Geriatric Medicine
00073	General Surgical Oncology
00074	Medical Oncology
00075	Radiation Oncology
00076	Gynecologic Oncology
00077	General Pathology
00078	Medical Microbiology
00080	Diagnostic Radiology
00082	Medical Genetics
00083	Anatomical Pathology
00085	Hematological Pathology
00086	Neuropathology
00089	Nuclear Medicine
00090	Medical Biochemistry
00092	Pediatric Radiology
00093	Neuroradiology
00096	Infectious Diseases
00097	Neonatal Perinatal Medicine
Dentistry group	
01001	Dentist
01002	Dental Surgeon

Code	Service provider
Dentistry group	
01003	Oral Surgeon
01004	Orthodontist
01005	Pedodontist
01006	Periodontist
01007	Oral Pathologist
01008	Endodontist
01009	Oral Radiologist
01010	Dental Hygienist/Assistant
01011	Dental Mechanic
Podiatry/chiropody in general	
02001	Podiatrist
02002	Chiropodist
Therapist group	
03001	Radiotherapist
03002	Physiotherapist
03003	Occupational Therapist
03004	Respiratory Therapist
03005	Massage Therapist
03006	Psychotherapist
03007	Recreation Therapist
03008	Therapy Assistant
03009	Speech–Language Pathologist
03011	Kinesiologist
03012	Rehabilitation Counsellor
03013	Physiotherapist Assistant
03014	Occupational Therapist Assistant
03015	Rehabilitation Therapist
03016	Rehabilitation Engineer
03017	Orthotist
03018	Prosthetist
03019	Vocational Rehabilitation Counsellor

Code	Service provider
Nursing group	
11001	Registered Nurse
11002	CNA/RNA/LPN/RPN
11003	Nurse Practitioner
11004	Midwife
11005	Nurse Aide/Healthcare Aide
Technician group	
08001	Ophthalmologic Technician
17001	X-ray Technician
17002	Lab Technician
17003	Nuclear Medicine Technician
Other group	
04000	Audiologist
05000	Chiropractor
06000	Dietitian
07000	Osteopath
08000	Optometrist
09000	Orthoptician/Prosthetician
10000	Naturopath
12000	Social Worker
13000	Pharmacist
14000	Physicist in Medicine
15000	Psychologist
16000	Pastor
18000	Alternative Healer
19000	Language Interpreter
20000	Home Support/Home Care Worker

Physician Specialty Codes are based on the Royal College of Physicians and Surgeons of Canada's approved specialties/subspecialties certificate or accreditation programs.

Latest Revision: September 2000

Appendix D — Rehabilitation Client Groups validation table

To be used when coding data element 34 Rehabilitation Client Group.

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Stroke

The Stroke RCG includes cases with a diagnosis of cerebral ischemia due to intracerebral vascular thrombosis, embolism or hemorrhage. Cerebral impairment related to non-vascular causes such as trauma, inflammation, tumour or degenerative changes are excluded.

- 01.1 Left Body Involvement (Right Brain)
- 01.2 Right Body Involvement (Left Brain)
- 01.3 Bilateral Involvement
- 01.4 No Paresis
- 01.9 Other Stroke

Brain Dysfunction

The Brain Dysfunction RCG includes cases with a diagnosis of impairment of traumatic or non-traumatic origin affecting the central nervous system, excluding the spinal cord and/or cranial nerves.

Coding of 02.1 or 02.2 will result in the record being accepted but flagged with an error message upon submission to CIHI. Coding of a more specific subgroup is recommended.

- 02.1 Non-Traumatic

  The Non-Traumatic Brain Dysfunction RCG includes cases with such etiologies as neoplasm, metastases, encephalitis, inflammation, anoxia, metabolic toxicity or degenerative processes.

  - 02.11 Degenerative Processes
  - 02.12 Non Degenerative

- 02.2 Traumatic

  The Traumatic Brain Dysfunction RCG includes cases with motor or cognitive disorders secondary to trauma.

  - 02.21 Open Injury
  - 02.22 Closed Injury

- 02.9 Other Brain

Note: The Degenerative Brain Dysfunction RCG excludes cases of multiple sclerosis (code instead RCG 03.1), amyotrophic lateral sclerosis (code instead 03.8 Neuromuscular Disorders) and parkinsonism (code instead RCG 03.2).

Neurological Conditions

The Neurologic Conditions RCG includes cases with a variety of neurologic and neuromuscular dysfunctions and etiologies.

- 03.1 Multiple Sclerosis
- 03.2 Parkinsonism
- 03.3 Polyneuropathy
- 03.4 Guillain-Barré
- 03.5 Cerebral Palsy
- 03.8 Neuromuscular Disorders
- 03.9 Other Neurologic

Spinal Cord Dysfunction

The Spinal Cord Dysfunction RCG includes cases with various forms of quadriplegia/paresis and paraplegia/paresis, regardless of the etiology, whether traumatic, medical or post-operative. Cases for which spinal cord dysfunction is the major deficit are included, even if the need for treatment is principally related to the urinary tract or skin ulceration.

Coding of 04.1, 04.110, 04.120, 04.2, 04.210 or 04.220 will result in a data element being accepted but flagged with an error message upon submission to CIHI. Coding of a more specific subgroup is recommended.

- 04.1 Non-Traumatic Spinal Cord Dysfunction
  The Non-Traumatic Spinal Cord Dysfunction RCG includes cases with paraplegia or quadriplegia secondary to non-traumatic causes, including post-operative change.
  - 04.110 Paraplegia, Unspecified
    - 04.111 Paraplegia, Incomplete
    - 04.112 Paraplegia, Complete
  - 04.120 Quadriplegia, Unspecified
    - 04.1211 Quadriplegia, Incomplete C1–4
    - 04.1212 Quadriplegia, Incomplete C5–8
    - 04.1221 Quadriplegia, Complete C1–4
    - 04.1222 Quadriplegia, Complete C5–8
  - 04.130 Other Non-Traumatic Spinal Cord
- 04.2 Traumatic Spinal Cord Dysfunction
  The Traumatic Spinal Cord Dysfunction RCG includes cases with paraplegia or quadriplegia secondary to traumatic causes.
  - 04.210 Paraplegia, Unspecified
    - 04.211 Paraplegia, Incomplete
    - 04.212 Paraplegia, Complete
  - 04.220 Quadriplegia, Unspecified
    - 04.2211 Quadriplegia, Incomplete C1–4
    - 04.2212 Quadriplegia, Incomplete C5–8
    - 04.2221 Quadriplegia, Complete C1–4
    - 04.2222 Quadriplegia, Complete C5–8
  - 04.230 Other Traumatic Spinal Cord

Amputation of Limb

The Amputation of Limb RCG includes cases in which the major deficit is absence of a limb. Cases for which limb amputation is the major deficit are included, even if the need for treatment is principally related to wound care or a stump infection.

05.1 Single Upper Extremity Above the Elbow (AE)
05.2 Single Upper Extremity Below the Elbow (BE)
05.3 Single Lower Extremity Above the Knee (AK)
05.4 Single Lower Extremity Below the Knee (BK)
05.5 Double Lower Extremity Above the Knee (AK/AK)
05.6 Double Lower Extremity Above + Below the Knee (AK/BK)
05.7 Double Lower Extremity Below the Knee (BK/BK)
05.9 Other Amputation

Arthritis

The Arthritis RCG includes cases in which the major disorder is arthritis of all etiologies.

06.1 Rheumatoid Arthritis
06.2 Osteoarthritis
06.9 Other Arthritis

Note: The Arthritis RCG should be used for clients entering the rehabilitation program without an immediately preceding orthopedic arthroplastic procedure. Clients entering rehabilitation following an orthopedic arthroplastic procedure for an arthritic condition should be placed in an RCG under Orthopedic Conditions, such as RCG 08.5, 08.6 or 08.9. In these cases, the arthritis diagnosis may be entered as the Most Responsible Health Condition ICD-10-CA (data element 80).

Pain Syndromes

The Pain Syndromes RCG includes cases in which the major disorder is pain, usually chronic and benign, of various etiologies.

07.1 Neck Pain
07.2 Back Pain
07.3 Extremity Pain
07.9 Other Pain

Note: The Pain Syndromes RCG should be used for clients entering the rehabilitation program without a neurologic disorder. Clients entering with a neurologic disorder should be placed in an RCG under Neurological Conditions, such as RCG 03.9 Other Neurologic. In these cases, the neurologic diagnosis should be entered as the Most Responsible Health Condition ICD-10-CA (data element 80), and the pain condition should be coded as a Comorbid Health Condition ICD-10-CA.

Orthopedic Conditions

The Orthopedic Conditions RCG includes, but is not limited to, cases in which the major disorder is post-fracture of bone or post-arthroplasty.

Coding of 08.1, 08.5, 08.6, or 08.7 will result in a data element being accepted but flagged with an error message upon submission to CIHI. Coding of a more specific subgroup is recommended.

- 08.1 Status Post Hip Fracture
  - 08.11 Status Post Unilateral Hip Fracture
  - 08.12 Status Post Bilateral Hip Fracture
- 08.2 Status Post Femur (Shaft) Fracture
- 08.3 Status Post Pelvic Fracture
- 08.4 Status Post Major Multiple Fracture
- 08.5 Status Post Hip Replacement
  - 08.51 Status Post Unilateral Hip Replacement (Primarily Elective Surgery)
  - 08.52 Status Post Bilateral Hip Replacement (Primarily Elective Surgery)
  - 08.53 Status Post Revision of Unilateral Hip Replacement (CIHI Category)
  - 08.54 Status Post Revision of Bilateral Hip Replacement (CIHI Category)
- 08.6 Status Post Knee Replacement
  - 08.61 Status Post Unilateral Knee Replacement (Primarily Elective Surgery)
  - 08.62 Status Post Bilateral Knee Replacement (Primarily Elective Surgery)
  - 08.63 Status Post Revision of Unilateral Knee Replacement (CIHI Category)
  - 08.64 Status Post Revision of Bilateral Knee Replacement (CIHI Category)
- 08.7 Status Post Knee and Hip Replacement
  - 08.71 Status Post Knee and Hip Replacement (Same Side)
  - 08.72 Status Post Knee and Hip Replacement (Different Sides)
  - 08.73 Status Post Revision of Knee and Hip Replacement (Same Side) (CIHI Category)
  - 08.74 Status Post Revision of Knee and Hip Replacement (Different Sides) (CIHI Category)
- 08.9 Other Orthopedic

Note: Hip fractures that result in joint replacement are to be captured in the Status Post Hip Fracture RCG (for example, 08.11). Knee fractures that result in joint replacement are to be captured in 08.9 Other Orthopedic.

Cardiac Disorders

The Cardiac Disorders RCG includes cases in which the major disorder is poor activity tolerance secondary to cardiac insufficiency or general deconditioning due to a cardiac disorder.

09.1 Cardiac

Pulmonary Disorders

The Pulmonary Disorders RCG includes cases in which the major disorder is poor activity tolerance secondary to pulmonary insufficiency.

10.1 Chronic Obstructive Pulmonary Disease
10.9 Other Pulmonary

Burns

The Burns RCG includes cases in which the major disorder is thermal injury to major areas of the skin and or underlying tissue.

11.1 Burns

Congenital Deformities

The Congenital Deformities RCG includes cases in which the major disorder is associated with prenatal, perinatal or postnatal causes and is within the classification of developmental, learning or behavioural disorders.

12.1 Spina Bifida
12.9 Other Congenital

Other Disabling Impairments

The Other Disabling Impairments RCG includes cases that cannot be classified into a specific RCG.

13.1 Other Disabling Impairments

Major Multiple Trauma

The Major Multiple Trauma RCG includes cases with more complex management due to involvement of multiple systems or sites. Note: If only fractures are present, see Orthopedic Conditions RCG.

14.1 Brain + Spinal Cord Injury
14.2 Brain + Multiple Fracture/Amputation
14.3 Spinal Cord + Multiple Fracture/Amputation
14.9 Other Multiple Trauma

Developmental Disabilities

The Developmental Disabilities RCG includes cases where the major disorder is impaired cognitive and/or motor function resulting in developmental delay.

15.1 Developmental Disability

Debility

The Debility RCG includes cases of generalized deconditioning not attributable directly to another impairment group.

16.1 Debility

Note: Include only clients who are debilitated for reasons other than cardiac (09) or pulmonary (10) conditions.

Medically Complex

The Medically Complex RCG includes cases with multiple medical and functional problems and complications prolonging the recuperation period. Medically complex cases require **medical management** of a principal condition and monitoring of comorbidities and potential complications. **Medical rehabilitation treatments are secondary** to the management of the medical conditions. The Medically Complex RCGs group patients by the program/treatment focus rather than the etiology.

17.1 Infections
17.2 Neoplasms
17.31 Nutrition (Endocrine/Metabolic) With Intubation/Parenteral Nutrition
17.32 Nutrition (Endocrine/Metabolic) Without Intubation/Parenteral Nutrition
17.4 Circulatory Disorders
17.51 Respiratory Disorders — Ventilator Dependent
17.52 Respiratory Disorders — Non-Ventilator Dependent
17.6 Terminal Care
17.7 Skin Disorders
17.8 Medical/Surgical Complications
17.9 Other Medically Complex Conditions

17.1 Infections

DO **NOT** INCLUDE respiratory infections (instead code: RCG 17.5X Respiratory Disorders), meningitis (instead code: RCG 2.1 Non-Traumatic Brain Dysfunction), encephalitis (instead code: RCG 2.1 Non-Traumatic Brain Dysfunction) or post-op infections (instead code: RCG 17.8 Medical/Surgical Complications).

17.2 Neoplasms

The **Neoplasms** RCG includes cases that require continuing care after surgery, chemotherapy, radiation, immunotherapy or hormone therapy as a result of a neoplasm. Care may include management of complication from the illness or the treatment. This group does not include clients in a hospice/terminal care program (see RCG 17.6 Terminal Care). Includes types that may be malignant, benign or of uncertain behaviour/nature.

DO **NOT** INCLUDE neoplasms of brain (instead code: RCG 02.1 Non-Traumatic Brain Dysfunction), neoplasms of spinal cord (instead code RCG 04.1XX Non-Traumatic Spinal Cord Dysfunction) or neoplasms of skeletal system (instead code: RCG 05.X Amputation of Limb or 08.9 Other Orthopedic).

17.3 Nutrition (Endocrine/Metabolic)

17.31 **With** Intubation/Parenteral Nutrition
17.32 **Without** Intubation/Parenteral Nutrition

The **Nutrition** RCG includes cases that require care and monitoring related to fluids and nutrition. Care may include management of complications from endocrine or metabolic disorders as well as neoplasms.

17.4 Circulatory Disorders

The **Circulatory Disorders** RCG includes clients who have complications of the circulatory system (heart, blood vessels) or need continuing management after surgery or treatment for circulatory conditions.

MAY INCLUDE acute myocardial infarction and cerebrovascular disease (stroke) if the time since the onset of the circulatory disorder is greater than 3 months.

DO NOT INCLUDE near-term cardiac rehabilitation (post-myocardial infarction, coronary artery bypass graft, etc.); use RCG 09 Cardiac.

17.5 Respiratory Disorders — Ventilator Dependent

The **Respiratory Disorders — Ventilator Dependent** RCG includes cases who are dependent on a ventilator upon admission, regardless of whether or not a weaning program is planned or is effective.

17.6 Terminal Care

The **Terminal Care** RCG includes, but is not limited to, cases at the end stages of cancer, Alzheimer's disease, renal failure, congestive heart failure, stroke, acquired immunodeficiency syndrome (AIDS), Parkinsonism and emphysema. Care typically focuses on comfort measures and pain relief as desired by the client.

17.7 Skin Disorders

The **Skin Disorders** RCG includes cases with open wounds; pressure-related, circulatory and decubitus ulcers; as well as cases with poorly healing wounds due to surgery, cancer or immune disorders.

DO NOT INCLUDE clients with spinal cord dysfunction or amputations, even if the need for treatment is principally related to skin ulceration (use RCG 04.XXXX for clients with spinal cord dysfunction or 05.X for clients with an amputation).

17.8 Medical/Surgical Complications

The **Medical/Surgical Complications** RCG includes but is not limited to clients experiencing post-operative infections and admitted with this as the primary reason for rehabilitation.

17.9 Other Medically Complex Conditions

The **Other Medically Complex Conditions** RCG includes medically complex cases not classified to a specific Medically Complex impairment group.

Appendix E — ICD-10-CA Diagnostic Health Conditions validation table

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To be used when coding data elements 80, 81, 82, 83, 84 and 85.

Abbreviation note: Not otherwise specified (NOS)
Not elsewhere classified (NEC)

"And" stands for "and/or." For example, in the code A18.0 *Tuberculosis of bones and joints*, "tuberculosis of bones," "tuberculosis of joints" and "tuberculosis of bones and joints" are all classified to this rubric.

Inclusion and exclusion notes are not exhaustive but provide examples and guidance for code selection.

ICD-10-CA Codes	Description
Chapter I — Infectious and Parasitic Conditions	
A04.7	Enterocolitis due to Clostridium difficile [C. dif] (Includes: Foodborne intoxication by Clostridium difficile, Pseudomembranous colitis)
A04.8	Other specified bacterial intestinal infections
A04.9	Bacterial intestinal infection, unspecified (Includes: Bacterial enteritis NOS)
A08	Viral and other specified intestinal infections (Excludes: Norwalk virus (A08.1))
A08.1	Acute gastroenteropathy due to Norwalk agent (Includes: Small round structured virus enteritis)
A09	Other gastroenteritis and colitis of infectious and unspecified origin. (Excludes: noninfective (noninfectious) diarrhoea (K52))
A15	Respiratory tuberculosis, bacteriologically and histologically confirmed (Excludes: Primary respiratory tuberculosis, confirmed bacteriologically and histologically (A15.7))
A15.7	Primary respiratory tuberculosis, confirmed bacteriologically and histologically
A16	Respiratory tuberculosis, not confirmed bacteriologically or histologically (Excludes: Primary respiratory tuberculosis without mention of bacteriological or histological confirmation (A16.7))
A16.7	Primary respiratory tuberculosis without mention of bacteriological or histological confirmation
A17	Tuberculosis of nervous system
A18	Tuberculosis of other organs (Excludes: Tuberculosis of bones and joints (A18.0))
A18.0	Tuberculosis of bones and joints (Note: Code also Tuberculosis arthritis (M01.1) when applicable)
A39.0	Meningococcal meningitis
A40	Streptococcal sepsis
A41	Other sepsis
A49.0	Staphylococcal infection, unspecified
A49.1	Streptococcal infection, unspecified

ICD-10-CA Codes	Description
Chapter I — Infectious and Parasitic Conditions	
A49.8	Other bacterial infections of unspecified site (Includes: Haemophilus influenzae infection unspecified; Mycoplasma infection unspecified)
A49.9	Bacterial infection unspecified (Includes: Bacteraemia/bacteremia NOS)
A52.1	Symptomatic neurosyphilis
A80	Acute poliomyelitis
A86	Unspecified viral encephalitis
A87	Viral meningitis
A92.3	West Nile Virus (Includes: West Nile: encephalitis, encephalomyelitis, fever, meningitis, virus)
B02	Zoster [herpes zoster] (Includes: Shingles, zona) (Excludes: that with nervous system involvement (See B02.2)
B02.2	Zoster with other nervous system involvement.
B15	Acute hepatitis A
B16	Acute hepatitis B
B17	Other acute viral hepatitis
B18	Chronic viral hepatitis
B19	Unspecified viral hepatitis
B24	Human immunodeficiency virus [HIV] disease (Includes: Acquired immunodeficiency syndrome [AIDS] NOS AIDS-related complex [ARC] NOS)
B27	Infectious mononucleosis (Includes: glandular fever, monocytic angina, Pfeiffer's disease)
B90	Sequelae of tuberculosis
B91	Sequelae of poliomyelitis
B94.1	Sequelae of viral encephalitis
B99	Other and unspecified infectious diseases
Chapter II — Neoplasms	
C14	Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx
C15	Malignant neoplasm of oesophagus (Includes: Malignant neoplasm of esophagus)
C16	Malignant neoplasm of stomach
C17	Malignant neoplasm of small intestine (Includes: duodenum, jejunum, ileum)
C18	Malignant neoplasm of colon
C19	Malignant neoplasm of rectosigmoid junction (Includes: Colon with rectum, Pelvic peritoneal reflection, Rectosigmoid (colon))
C20	Malignant neoplasm of rectum (Includes: Rectal ampulla)

ICD-10-CA Codes	Description
Chapter II — Neoplasms	
C21	Malignant neoplasm of anus and anal canal
C22	Malignant neoplasm of liver and intrahepatic bile ducts (Excludes: biliary tract NOS (C24))
C23	Malignant neoplasm of gallbladder
C24	Malignant neoplasm of other and unspecified parts of biliary tract (Excludes: intrahepatic bile duct (C22))
C25	Malignant neoplasm of pancreas
C30	Malignant neoplasm of nasal cavity and middle ear
C31	Malignant neoplasm of accessory sinuses (Includes: Maxillary, ethmoid, frontal and sphenoid sinuses)
C32	Malignant neoplasm of larynx
C33	Malignant neoplasm of trachea
C34	Malignant neoplasm of bronchus and lung
C37	Malignant neoplasm of thymus
C38	Malignant neoplasm of heart, mediastinum and pleura
C40.0	Malignant neoplasm scapula and long bones of upper limb
C40.1	Malignant neoplasm short bones of upper limb
C40.2	Malignant neoplasm long bones of lower limb
C40.3	Malignant neoplasm short bones of lower limb
C40.8	Overlapping malignant lesion of bone and articular cartilage of limbs
C40.9	Malignant neoplasm bone and articular cartilage of limb, unspecified
C41	Malignant neoplasm of bone and articular cartilage of other and unspecified sites (Excludes: Malignant neoplasm of vetebral column (C41.2))
C41.2	Malignant neoplasm of vertebral column
C43	Malignant melanoma of skin
C44	Other malignant neoplasms of skin (Includes: malignant neoplasm of: sebaceous glands, sweat glands)
C49.0	Malignant neoplasm of connective and soft tissue of head, face and neck (Includes: Connective tissue of: ear, eyelid)
C49.1	Malignant neoplasm of connective and soft tissue of upper limb, including shoulder
C49.2	Malignant neoplasm of connective and soft tissue of lower limb, including hip
C49.3	Malignant neoplasm of connective and soft tissue of thorax (Includes: Axilla, Diaphragm, Great vessels)
C49.4	Malignant neoplasm of connective and soft tissue of abdomen (Includes: Abdominal wall, Hypochondrium)

ICD-10-CA Codes	Description
Chapter II — Neoplasms	
C49.5	Malignant neoplasm of connective and soft tissue of pelvis (Includes: Buttock, Groin, Perineum)
C49.6	Malignant neoplasm of connective and soft tissue of trunk, unspecified (Includes: Back NOS)
C49.9	Malignant neoplasm of connective and soft tissue, unspecified
C50	Malignant neoplasm of breast (Includes: connective tissue of breast)
C51	Malignant neoplasm of vulva
C52	Malignant neoplasm of vagina
C53	Malignant neoplasm of cervix uteri (Includes: endocervix, exocervix)
C54	Malignant neoplasm of corpus uteri (Includes: endometrium, myometrium, fundus uteri)
C55	Malignant neoplasm of uterus, part unspecified
C56	Malignant neoplasm of ovary
C57	Malignant neoplasm of other and unspecified female genital organs (Includes: fallopian tube, broad and round ligament, parametrium, uterine adnexa)
C61	Malignant neoplasm of prostate
C63	Malignant neoplasm of other and unspecified male genital organs (Includes: epididymiss, spermatic cord, scrotum, seminal vesicle, tunica vaginalis)
C64	Malignant neoplasm of kidney, except renal pelvis
C65	Malignant neoplasm of renal pelvis
C66	Malignant neoplasm of ureter
C67	Malignant neoplasm of bladder
C68	Malignant neoplasm of other and unspecified urinary organs (Includes: urethra, paraurethral gland)
C70.1	Malignant neoplasm of spinal meninges (cord)
C71	Malignant neoplasm of brain
C72	Malignant neoplasm of spinal cord, cranial nerves and other parts of central nervous system (Includes: cauda equina, olfactory nerve, acoustic nerve, cranial nerve NOS)
C76	Malignant neoplasm of other and ill-defined sites (Includes: head face & neck, thorax, abdomen, pelvis, upper limb, lower limb)
C77.0	Secondary [metastasis] malignant neoplasm lymph nodes of head, face and neck (Includes: Supraclavicular lymph nodes)
C77.1	Secondary [metastasis] malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary [metastasis] malignant neoplasm of intra-abdominal lymph nodes
C77.3	Secondary [metastasis] malignant neoplasm of axillary and upper limb lymph nodes (Includes: Pectoral lymph nodes)

ICD-10-CA Codes	Description
Chapter II — Neoplasms	
C77.4	Secondary [metastasis] malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary [metastasis] malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary [metastasis] malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary [metastasis] malignant neoplasm of lymph node, unspecified
C78.0	Secondary [metastasis] malignant neoplasm of lung
C78.1	Secondary [metastasis] malignant neoplasm of mediastinum
C78.2	Secondary [metastasis] malignant neoplasm of pleura (Includes: Malignant pleural effusion NOS)
C78.3	Secondary [metastasis] malignant neoplasm of other and unspecified respiratory organs
C78.8	Secondary [metastasis] malignant neoplasm of other and unspecified digestive organs (Includes: small intestine, large intestine and rectum, retroperitoneum, peritoneum,malignant ascites NOS, liver and intrahepatic bile duct)
C79.0	Secondary [metastasis] malignant neoplasm of kidney and renal pelvis
C79.1	Secondary [metastasis] malignant neoplasm of bladder and other and unspecified urinary organs
C79.2	Secondary [metastasis] malignant neoplasm of skin
C79.3	Secondary [metastasis] malignant neoplasm of brain and cerebral meninges. (Includes: Brain meninges, cerebral, cranial, intracranial)
C79.4	Secondary [metastasis] malignant neoplasm of other and unspecified parts of nervous system (Includes: Meninges, Spinal Meninges, Spinal Cord, Spinal Dura (mater))
C79.5	Secondary [metastasis] malignant neoplasm of bone and bone marrow
C79.6	Secondary [metastasis] malignant neoplasm of ovary
C79.7	Secondary [metastasis] malignant neoplasm of adrenal gland
C79.80	Secondary [metastasis] malignant neoplasm of breast
C79.88	Secondary [metastasis] malignant neoplasm of other specified sites
C79.9	Secondary malignant neoplasm, unspecified site (Includes: Carcinomatosis (secondary), Generalized (secondary), cancer NOS, Malignancy NOS, and Multiple cancer (secondary) NOS)
C80	Malignant neoplasm without specification of site (Includes: primary cancer NOS or unknown)
C81	Hodgkin lymphoma
C85	Other and unspecified types of non-Hodgkin lymphoma
C88	Malignant immunoproliferative diseases
C90	Multiple myeloma and malignant plasma cell neoplasms (Includes: Kahler's disease, Myelomatosis)

ICD-10-CA Codes	Description
Chapter II — Neoplasms	
C91	Lymphoid leukaemia (Includes: Acute Lymphoblastic Leukaemia [ALL]. Chronic Lymphocytic Leukaemia [CLL], lymphoid leukemia)
C92	Myeloid leukaemia (Includes: Acute Myeloblastic Leukemia [AML], Chronic Myeloid Leukemia [CML], Myeloid leukemia)
C93	Monocytic leukaemia (Includes: Monocytic leukemia)
C94	Other specified leukaemias (Includes: Other specified leukemias)
C95	Leukaemia of unspecified cell type (Includes: Leukemia of unspecified cell type)
D18	Haemangioma and lymphangioma, any site (Includes: angioma NOS, hemangioma)
D20.0	Benign neoplasm of retroperitoneum
D21	Other benign neoplasms of connective and other soft tissue (Includes: blood vessel, bursa, cartilage, fascia, fat ligament, except uterine, lymphatic channel, muscle, synovia, tendon)
D31	Benign neoplasm of eye and adnexa
D32.0	Benign neoplasm of cerebral meninges
D32.1	Benign neoplasm of spinal meninges
D33.2	Benign neoplasm of brain, unspecified
D33.3	Benign neoplasm of cranial nerves
D33.4	Benign neoplasm of spinal cord
D33.9	Benign neoplasm of central nervous system, unspecified (Includes: Nervous system (central) NOS)
D34	Benign neoplasm of thyroid gland
D35	Benign neoplasm of other and unspecified endocrine glands (Includes: adrenal, parathyroid, pituitary, craniopharyngeal, pineal)
D36	Benign neoplasm of other and unspecified sites
D43.2	Neoplasm of uncertain or unknown behaviour of brain, unspecified (Includes: Brain NOS)
D43.4	Neoplasm of uncertain or unknown behaviour of spinal cord
D48	Neoplasm of uncertain or unknown behaviour of other and unspecified sites (Includes: bone and articular cartilage)
Chapter III — Diseases of the blood and blood forming organs	
D64.9	Anaemia, unspecified (Includes: anemia)
D66	Hereditary factor VIII deficiency (Includes: Haemophilia A, Haemophilia/Hemophilia NOS;)
D67	Hereditary factor IX deficiency (Includes: Haemophilia B; Hemophilia B)
D68	Other coagulation defects (Includes: Haemophilia C; Hemophilia C, Von Willebrand's disease)

ICD-10-CA Codes	Description
Chapter III — Diseases of the blood and blood forming organs	
D69.6	Thrombocytopenia, unspecified
D75	Other diseases of blood and blood-forming organs (Includes: familial erythrocytosis, secondary polycythaemia, secondary thrombocytosis, basophilia) (Excludes: leukemia (see codes C91 to C94), Abnormal findings of blood chemistry (R79))
D86	Sarcoidosis (Includes: lung, lymph nodes, skin, other and combined sites)
Chapter IV — Endocrine, nutritional and metabolic diseases	
E03	Other hypothyroidism (Includes: Unspecified hypothyroidism)
E04	Other nontoxic goitre (Includes: Unspecified nontoxic goitre)
E05	Thyrotoxicosis [hyperthyroidism]
E06	Thyroiditis
E07	Other disorders of thyroid (Includes: Unspecified disorders of thyroid)
E10	Type 1 diabetes mellitus
E11	Type 2 diabetes mellitus
E13	Other specified diabetes mellitus
E14	Unspecified diabetes mellitus
E34	Other endocrine disorders (Includes: Unspecified endocrine disorders)
E46	Unspecified protein-energy malnutrition
E63	Other nutritional deficiencies (Includes: Unspecified nutritional deficiencies)
E66	Obesity
E67	Other hyperalimentation (Excludes: hyperalimentation unspecified (R63.2))
E78.5	Hyperlipidaemia, unspecified (Includes: hyperlipidemia)
E84	Cystic fibrosis
E86.0	Dehydration
E87	Other disorders of fluid, electrolyte and acid-base balance (Includes: acidosis, hyponatraemia/hyponatremia, alkalosis, hyperkalaemia/hyperkalemia, fluid overload)
E88	Other metabolic disorders (Includes: Unspecified metabolic disorders)
E89	Postprocedural endocrine and metabolic disorders, not elsewhere classified
Chapter V — Mental and behavioural disorders	
F00	Dementia in Alzheimer’s disease (Includes: Primary degenerative dementia of the Alzheimer’s type, presenile onset) (Excludes: Alzheimer’s disease (see G30)).
F01	Vascular Dementia

ICD-10-CA Codes	Description
Chapter V — Mental and behavioural disorders	
F02	Dementia in other diseases classified elsewhere (Includes: Dementia in Pick's Disease (G31), Dementia in Creutzfeldt-Jakob Disease, Dementia in Huntington's disease (G10), Dementia in Parkinson's Disease (G20) etc.) (Note: Code both codes — (F02) and the neurological involvement (G31, G10 or G20))
F03	Unspecified dementia (Includes: Presenile: dementia NOS, Presenile psychosis NOS, Primary degenerative dementia NOS, Psychosis NOS, Senile dementia NOS and Senile dementia depressed or paranoid type)
F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances (Includes: Korsakov's psychosis or syndrome, nonalcoholic)
F05	Delirium, not induced by alcohol and other psychoactive substances (Includes: Acute or subacute: brain syndrome, confusional state (nonalcoholic), infective psychosis, organic reaction, psycho-organic syndrome)
F06	Other mental disorders due to brain damage and dysfunction and to physical disease
F07	Personality and behavioural disorders due to brain disease, damage and dysfunction (Excludes: Postencephalitic syndrome (F07.1) and Postconcussional sundrome (F07.2))
F07.1	Postencephalitic syndrome
F07.2	Postconcussional syndrome (Includes: Cognitive impairment with head injury, Post-traumatic brain syndrome, nonpsychotic Postcontusional syndrome (encephalopathy))
F10.0	Mental and behavioural disorders due to use of alcohol, acute intoxication (Includes: "Bad trips" (drugs), Acute drunkenness in alcoholism, Drunkenness NOS, Pathological intoxication, Trance and possession disroders in psychoactive substance intoxication)
F10.1	Mental and behavioural disorders due to use of alcohol, harmful use (Includes: Addiction or Dependence on alcohol)
F10.2	Mental and behavioural disorders due to use of alcohol, dependence syndrome (Includes: Chronic alcoholism, Dipsomania, Drug addiction)
F10.5	Mental and behavioural disorders due to use of alcohol, psychotic disorder (Includes: Alcoholic halucinosis, Alcoholic jealousy, alcoholic paranoia, alcoholic psychosis NOS)
F10.6	Mental and behavioural disorders due to use of alcohol, amnesic syndrome (Includes: Amnestic disorder, alcohol-or drug-induced, Korsakov's psychosis or syndrome, alcohol-or other psychoactive substance-induced or unspecified)
F10.7	Mental and behavioural disorders due to use of alcohol, residual and late-onset psychotic disorder (Includes: Alcoholic demenita NOS, Chronic alcoholic brain syndrome, Flashbacks, Late-onset psychoactive substance-induced psychotic disorder, Posthallucinogen perception disorder, Residual affective disorder, Residual disorder of personality and behaviour.)

ICD-10-CA Codes	Description
Chapter V — Mental and behavioural disorders	
F10.8	Mental and behavioural disorders due to use of alcohol, other mental and behavioural disorders (Includes: alcohol withdrawal with and without delirium)
F10.9	Mental and behavioural disorders due to use of alcohol, unspecified mental and behavioural disorder
F11	Mental and behavioural disorders due to use of opioids (Includes disorders that are attributable to the use of opioids. This includes: Acute intoxication, Harmful use, Dependence syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, Other and Unspecified mental and behavioural disorders due to the use of opioids.)
F12	Mental and behavioural disorders due to use of cannabinoids (Includes disorders that are attributable to the use of cannabinoids. This includes: Acute intoxication, Harmful use, Dependence syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, Other and Unspecified mental and behavioural disorders due to the use of cannabinoids.)
F13	Mental and behavioural disorders due to use of sedatives or hypnotics (Includes disorders that are attributable to the use of sedatives or hypnotics. This includes: Acute intoxication, Harmful use, Dependence syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, Other and Unspecified mental and behavioural disorders due to the use of sedativs or hypnotics.)
F14	Mental and behavioural disorders due to use of cocaine (Includes disorders that are attributable to the use of cocaine. This includes: Acute intoxication, Harmful use, Dependence syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, Other and Unspecified mental and behavioural disorders due to the use of cocaine.)
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine (Includes disorders that are attributable to the use of other stimulants, including caffeine. This includes: Acute intoxication, Harmful use, Dependance syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, Other and Unspecified mental and behavioural disorders due to the use of other stimulants, including caffeine).
F16	Mental and behavioural disorders due to use of hallucinogens (Includes disorders that are attributable to the use of hallucinogens. This includes: Acute intoxication, Harmful use, Dependance syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, and Other and Unspecified mental and behavioural disorders due to the use of hallucinogens.)

ICD-10-CA Codes	Description
Chapter V — Mental and behavioural disorders	
F17	Mental and behavioural disorders due to use of tobacco (Includes mental and behavioural disorders due to the use of tobacco. This includes: Acute intoxication, Harmful use, Dependence syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, Other and Unspecified mental and behavioural disorders due to the use of tobacco.)
F17.2	Mental and behavioural disorders due to use of tobacco, dependence syndrome (Includes: Drug addiction)
F18	Mental and behavioural disorders due to use of volatile solvents (Includes mental and behavioural disorders due to the use of volatile solvents. This includes: Acute intoxication, Harmful use, Dependance syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, Other and Unspecified mental and behavioural disorders due to the use of volatile solvents.)
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances (Includes mental and behavioural disorders due to multiple drug use and use of other psychoactive substances. This includes: Acute intoxication, Harmful use, Dependance syndrome (Drug addiction), Withdrawal state with or without delirium, Psychotic disorder, Amnesic syndrome, Residual and late-onset psychotic disorder, Other and Unspecified mental and behavioural disorders due to multiple drug use and use of psychoactive substances.)
F20	Schizophrenia
F21	Schizotypal disorder
F22	Persistent delusional disorders (Includes: Paranoia, Parnoid Psychosis, Paranoid State, Paraphrenia (late), Sensitiver Beziehungswahn, Other and Unspecified persistent delusional disorders)
F23	Acute and transient psychotic disorders
F24	Induced delusional disorder (Includes: Folie à deux, Induced paranoid disorder, Induced psychotic disorder)
F25	Schizoaffective disorders
F28	Other nonorganic psychotic disorders (Includes: Chronic hallucinatory psychosis)
F29	Unspecified nonorganic psychosis (Includes: Psychosis NOS)
F30	Manic episode (Includes: Hypomania, Mania NOS)
F31	Bipolar affective disorder (Includes: manic-depressive: illness, psychosis, reaction and manic depression NOS)
F32	Depressive episode (Includes: single episode of: depressive reaction, psychogenic depression, reactive depression, depression NOS)

ICD-10-CA Codes	Description
Chapter V — Mental and behavioural disorders	
F33	Recurrent depressive disorder (Includes: recurrent episodes of: depressive reaction, psychogenic depression, reactive depression, Seasonal affective disorder, and monopolar depression NOS)
F34	Persistent mood [affective] disorders (Includes: Cyclothymia, Dysthymia)
F38	Other mood [affective] disorders
F39	Unspecified mood [affective] disorder (Includes: Affective psychosis NOS)
F40	Phobic anxiety disorders
F41	Other anxiety disorders (Includes: Unspecified anxiety disorders)
F42	Obsessive-compulsive disorder
F43.0	Acute stress reaction (Includes: Acute crisis reaction, Acute reaction to stress, Combat fatigue, Crisis state, Psychic shock)
F43.1	Post-traumatic stress disorder
F43.2	Adjustment disorders (Includes: Adolescent adjustment reaction, Culture shock, Grief reaction)
F43.9	Reaction to severe stress, unspecified (Includes: Other reactions to severe stress NEC)
F44	Dissociative [conversion] disorders (Includes: conversion: hysteria, reaction, Hysteria, Hysterical psychosis)
F45.3	Somatoform autonomic dysfunction (Includes: Cardiac neurosis, Da Costa's syndrome, Gastric neurosis, Neurocirculatory asthenia, Psychogenic forms of: aerophagy, cough, diarrhoea/diarrhea, dyspepsia, dysuria, flatulence, hiccough, hyperventilation, increased frequency of micturition,irritable bowel syndrome, pylorospasm)
F45.4	Persistent somatoform pain disorder (Includes: Psychalgia, Psychogenic: backache, headache)
F45.9	Somatoform disorder, unspecified (Includes: Psychosomatic disorder NOS, Somatization disorder, Hypochondriacal disorder, Other somatoform disorders, Teeth grinding)
F48.0	Neurasthenia (Includes: Fatigue syndrome)
F48.9	Neurotic disorder, unspecified (Includes: Neurosis NOS, Depersonalization derealization syndrome, Other specified neurotic disorders)
F50	Eating disorders (Includes: Anorexia nervosa, Atypical anorexia nervosa, Bulimia nervosa, Bulimia NOS, Hyperorexia nervosa, Atypical bulimia nervosa, Overeating and Vomiting associated with other psychological disturbances, Other and Unspecified eating disorder.)
F60	Specific personality disorders (Includes the following personality disorders: Paranoid, Schizoid, Dissocial, Emotionally unstable, Histronic, Anankastic, Anxious [avoidant], Dependent, and Other and Unspecified personality disorders).
F61	Mixed and other personality disorders

ICD-10-CA Codes	Description
Chapter V — Mental and behavioural disorders	
F62	Enduring personality changes, not attributable to brain damage and disease
F63	Habit and impulse disorders (Includes: Pathological gambling, fire — setting [pyromania], pathological stealing, [kleptomania], Trichotillomania)
F64	Gender identity disorders
F68	Other disorders of adult personality and behaviour (Includes: Compensation neurosis, Hospital hopper syndrome, Munchhausen's syndrome, Peregrinating patient, Character disorder NOS, Relationship disorder NOS)
F69	Unspecified disorder of adult personality and behaviour
F70	Mild mental retardation (Includes: feeble-mindedness, mild mental subnormality. Approximate IQ range of 50 to 69 (in adults, mental age from 9 to under 12 years))
F71	Moderate mental retardation (Includes: Moderate mental subnormality. Approximate IQ range of 35 to 49 (in adults, mental age from 6 to under 9 years))
F72	Severe mental retardation (Includes: severe mental subnormality. Approximate IQ range of 20 to 34 (in adults, mental age from 3 to under 6 years))
F73	Profound mental retardation (Includes: profound mental subnormality. IQ under 20 (in adults, mental age below 3 years))
F78	Other mental retardation
F79	Unspecified mental retardation (Includes: mental: deficiency NOS, subnormality NOS)
F80	Specific developmental disorders of speech and language
F81	Specific developmental disorders of scholastic skills
F82	Specific developmental disorder of motor function
F83	Mixed specific developmental disorders
F84.0	Childhood autism (Includes: Autistic disorder, Infantile: autism, psychosis, Kanner's syndrome)
F84.2	Rett's syndrome
F84.5	Asperger's syndrome (Includes: Autistic psychopathy, Schizoid disorder of childhood)
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified
F88	Other disorders of psychological development (Includes: Developmental agnosia)
F89	Unspecified disorder of psychological development (Includes: Developmental disorder NOS)
F90	Hyperkinetic disorders (Includes: Attention deficit disorder with hyperactivity, hyperactivity disorder, syndrome with hyperactivity) (Excludes: attention deficit disorder stated without hyperactivity (F98))

ICD-10-CA Codes	Description
Chapter V — Mental and behavioural disorders	
F91	Conduct disorders
F92	Mixed disorders of conduct and emotions
F93	Emotional disorders with onset specific to childhood
F94	Disorders of social functioning with onset specific to childhood and adolescence
F95	Tic disorders (Includes: de la Tourette)
F98	Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence (Includes: Attention deficit disorder without hyperactivity, expressive masturbation, nail-biting, nose-picking, thumb-sucking, Pica of infancy/childhood, stereotyped movement disorders, stuttering, cluttering)
F99	Mental disorder, not otherwise specified (Includes: Mental Illness NOS)
Chapter VI — Diseases of the nervous system	
G00	Bacterial meningitis, not elsewhere classified
G03	Meningitis due to other and unspecified causes
G04	Encephalitis, myelitis and encephalomyelitis (Excludes: West Nile Virus (A92.3), MS (G35))
G06.0	Intracranial abscess and granuloma
G06.1	Intraspinal abscess and granuloma
G08	Intracranial and intraspinal phlebitis and thrombophlebitis
G09	Sequelae of inflammatory diseases of central nervous system (Includes: encephalitis NOS, late effects of intracranial or intraspinal abscess, and pyogenic infection) (Excludes: late effects of viral encephalitis (B94.1))
G10	Huntington's disease
G11.0	Congenital nonprogressive ataxia
G11.1	Early-onset cerebellar ataxia (Includes: Friedreich's ataxia, Spinocerebellar ataxia)
G11.2	Late-onset cerebellar ataxia
G11.3	Cerebellar ataxia with defective DNA repair (Includes: Ataxia telangiectasia [Louis-Bar])
G11.4	Hereditary spastic paraplegia
G11.8	Other hereditary ataxias
G11.9	Hereditary ataxia, unspecified (Includes: Hereditary cerebellar: ataxia NOS, degeneration (primary), disease, syndrome)
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.2	Motor neuron disease (Includes: ALS, progressive bulbar palsy and spinal muscular atrophy)

ICD-10-CA Codes	Description
Chapter VI — Diseases of the nervous system	
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G20	Parkinson's disease
G21	Secondary parkinsonism
G22	Parkinsonism in diseases classified elsewhere (Note: Code also specific infectious code. Code both codes — A52.1 Symptomatic neurosyphilis and G22)
G23	Other degenerative diseases of basal ganglia (Includes: Unspecified degenerative diseases of basal ganglia, Hallervorden-Spatz disease, Progressive supranuceal palsy, striatonigral degeneration)
G24	Dystonia (Includes: Dyskinesia)
G25	Other extrapyramidal and movement disorders (Includes: Unspecified extrapyramidal and movement disorders) (Excludes: Huntington's disease (G10))
G30	Alzheimer's disease (Excludes: Dementia in Alzheimer's disease. (See F00))
G31	Other degenerative diseases of nervous system, not elsewhere classified (Includes: Unspecified degenerative diseases of nervous system)
G35	Multiple sclerosis
G36	Other acute disseminated demyelination (Includes: Unspecified acute disseminated demyelination)
G37	Other demyelinating diseases of central nervous system (Includes: Unspecified demyelinating diseases of central nervous system) (Excludes: Acute transverse myelitis in demyelinating disease of central nervous system (G37.3))
G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
G40	Epilepsy (Includes: a previous history of seizure(s) or recurrent seizures) (Excludes: Status epilepticus (G41); First time, single isolated seizure (no history of previous seizure) see R56)
G41	Status epilepticus
G43	Migraine
G44	Other headache syndromes
G45.9	Transient cerebral ischaemic attack, unspecified (Includes: TIA; transient cerebral ischemic attack)
G47.0	Disorders of initiating and maintaining sleep [insomnias]
G47.1	Disorders of excessive somnolence [hypersomnias]
G47.2	Disorders of the sleep-wake schedule
G47.30	Sleep apnoea, obstructed (Includes: Sleep apnea, obstructed)
G47.31	Sleep apnoea, central (Includes: Sleep apnea, central)
G47.38	Other sleep apnoea (Includes: Other sleep apnea)

ICD-10-CA Codes	Description
Chapter VI — Diseases of the nervous system	
G47.4	Narcolepsy and cataplexy
G47.8	Other sleep disorders
G47.9	Sleep disorder, unspecified
G50	Disorders of trigeminal nerve
G51	Facial nerve disorders (Excludes: Bell's Palsy (G51.0))
G51.0	Bell's palsy
G52	Disorders of other cranial nerves (Includes: cranial nerve disorder unspecified)
G54.0	Brachial plexus disorders (Includes: Thoracic outlet syndrome)
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.5	Neuralgic amyotrophy
G54.6	Phantom limb syndrome with pain
G54.7	Phantom limb syndrome without pain
G54.8	Other nerve root and plexus disorders
G54.9	Nerve root and plexus disorder, unspecified
G56.0	Carpal tunnel syndrome
G56.1	Other lesions of median nerve
G56.2	Lesion of ulnar nerve
G56.3	Lesion of radial nerve
G56.4	Causalgia of upper limb
G56.8	Other mononeuropathies of upper limb
G56.9	Mononeuropathy of upper limb, unspecified (Excludes: Carpal tunnel syndrome (G56.0))
G57.0	Lesion of sciatic nerve (Excludes: Sciatica NOS (See M54.3))
G57.1	Meralgia paraesthetica
G57.2	Lesion of femoral nerve
G57.3	Lesion of lateral popliteal nerve
G57.4	Lesion of medial popliteal nerve
G57.5	Tarsal tunnel syndrome
G57.6	Lesion of plantar nerve
G57.7	Causalgia of lower limb
G57.8	Other mononeuropathies of lower limb
G57.9	Mononeuropathy of lower limb, unspecified

ICD-10-CA Codes	Description
Chapter VI — Diseases of the nervous system	
G58	Other mononeuropathies
G60.0	Hereditary motor and sensory neuropathy (Includes: Charcot-Marie tooth)
G61	Inflammatory polyneuropathy (Excludes: Guillain-Barre syndrome (G61.0))
G61.0	Guillain-Barré syndrome
G62	Other polyneuropathies (Includes: drug-induced polyneuropathy, chronic inflammatory demyelinizing polyneuropathy, Radiation-induced polyneuropathy, and Neuropathy, not otherwise specified)
G64	Other disorders of peripheral nervous system
G70.0	Myasthenia gravis
G70.9	Myoneural disorder, unspecified (Includes: Other specific myoneural disorders; Toxic myoneural disorders; Congenital and developmental myasthenia)
G71	Primary disorders of muscles (Includes: muscular dystrophy, myotonic disorders, congenital myopathies, mitochondrial myopathies)
G72	Other myopathies (Includes: drug-induced myopathy, alcoholic myopathy, inflammatory myopathy)
G73	Disorders of myoneural junction and muscle in diseases classified elsewhere
G80.0	Spastic quadriplegic cerebral palsy (Includes: Congenital spastic paralysis (cerebral), and Spastic tetraplegic cerebral palsy)
G80.1	Spastic diplegic cerebral palsy (Includes: Spastic cerebral palsy NOS)
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Dyskinetic cerebral palsy (Includes: Athetoid cerebral palsy, and Dystonic cerebral palsy)
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy (Includes: Mixed cerebral palsy syndromes)
G80.9	Cerebral palsy, unspecified (Includes: Cerebral palsy NOS)
G81.00	Flaccid hemiplegia of dominant side
G81.01	Flaccid hemiplegia of non-dominant side
G81.09	Flaccid hemiplegia of unspecified [unilateral] side
G81.10	Spastic hemiplegia of dominant side
G81.11	Spastic hemiplegia of non-dominant side
G81.19	Spastic hemiplegia of unspecified [unilateral] side
G81.90	Hemiplegia of unspecified type of dominant side
G81.91	Hemiplegia of unspecified type of non-dominant side
G81.99	Hemiplegia of unspecified type of unspecified [unilateral] side (Includes: hemiplegia, NOS)
G82.0	Flaccid paraplegia
G82.1	Spastic paraplegia

ICD-10-CA Codes	Description
Chapter VI — Diseases of the nervous system	
G82.2	Paraplegia, unspecified (Includes: diplegia of lower limbs, Paraplegia NOS)
G82.310	Flaccid quadriplegia, complete at cervical spine level C1 to C4
G82.311	Flaccid quadriplegia, complete at cervical spine level C5 to C7 (Includes: level unspecified)
G82.320	Flaccid quadriplegia, incomplete at cervical spine level C1 to C4
G82.321	Flaccid quadriplegia, incomplete at cervical spine level C5 to C7 (Includes: level unspecified)
G82.390	Flaccid quadriplegia, unspecified at cervical spine level C1 to C4
G82.391	Flaccid quadriplegia, unspecified at cervical spine level C5 to C7 (Includes: level unspecified)
G82.410	Spastic quadriplegia, complete at cervical spine level C1 to C4
G82.411	Spastic quadriplegia, complete at cervical spine level C5 to C7 (Includes: level unspecified)
G82.420	Spastic quadriplegia, incomplete at cervical spine level C1 to C4
G82.421	Spastic quadriplegia, incomplete at cervical spine level C5 to C7 (Includes: level unspecified)
G82.490	Spastic quadriplegia, unspecified at cervical spine level C1 to C4
G82.491	Spastic quadriplegia, unspecified at cervical spine level C5 to C7 (Includes: level unspecified)
G82.510	Quadriplegia, unspecified type, complete at cervical spine level C1 to C4
G82.511	Quadriplegia, unspecified type, complete at cervical spine level C5 to C7 (Includes: level unspecified)
G82.520	Quadriplegia, unspecified type, incomplete at cervical spine level C1 to C4
G82.521	Quadriplegia, unspecified type, incomplete at cervical spine level C5 to C7 (Includes: level unspecified)
G82.590	Quadriplegia, unspecified type, unspecified at cervical spine level C1 to C4
G82.591	Quadriplegia, unspecified type, unspecified at cervical spine level C5 to C7 (Includes: level unspecified)
G83.0	Diplegia of upper limbs (Includes: Paralysis of both upper limbs, paresis of both upper limbs)
G83.1	Monoplegia of lower limb (Includes: Paralysis of lower limb, paresis of lower limb)
G83.20	Monoplegia of upper limb on dominant side (Includes: Paresis of upper limb on dominant side)
G83.21	Monoplegia of upper limb on non-dominant side (Includes: Paresis of upper limb on non-dominant side)
G83.22	Monoplegia of upper limb on unspecified [unilateral] side (Includes: Paresis of uppler limb on unspecified [unilateral] side)

ICD-10-CA Codes	Description
Chapter VI — Diseases of the nervous system	
G83.4	Cauda equina syndrome
G83.5	Locked-in state
G83.8	Other specified paralytic syndromes
G83.9	Paralytic syndrome, unspecified (Includes paresis, unspecified)
G90.0	Idiopathic peripheral autonomic neuropathy
G90.4	Autonomic dysreflexia
G90.9	Disorder of autonomic nervous system, unspecified (Includes: Other disorders of autonomic nervous system; Familial dysautonomia [Riley-Day], Horner's syndrome; Multi-system degeneration)
G91	Hydrocephalus
G92	Toxic encephalopathy
G93.1	Anoxic brain damage, not elsewhere classified
G93.3	Postviral fatigue syndrome (Includes: benign myalgic encephalopathy and chronic fatigue syndrome)
G93.4	Encephalopathy, unspecified
G93.88	Other specified disorders of brain (Includes: Unspecified disorders of brain) (Excludes: Anoxic brain damage (G93.1), Postviral fatigue syndrome (G93.3), and Encephalopathy, unspecified (G93.4))
G95.0	Syringomyelia and syringobulbia
G95.1	Vascular myelopathies (Includes: acute infarction of spinal cord)
G95.2	Cord compression, unspecified
G95.8	Other specified diseases of spinal cord
G95.9	Disease of spinal cord, unspecified (Includes: myelopathy, not otherwise specified)
G96	Other disorders of central nervous system (Includes: Unspecified disorders of central nervous system, cerebrospinal fluid leak, CSF leak)
G97.1	Other reaction to spinal and lumbar puncture
G97.2	Intracranial hypotension following ventricular shunting
G97.8	Other postprocedural disorders of nervous system
G97.9	Postprocedural disorder of nervous system, unspecified
Chapter VII — Diseases of the eye and adnexa	
H10	Conjunctivitis
H25	Senile cataract
H26	Other Cataract
H33	Retinal detachments and breaks
H35	Other retinal disorders

ICD-10-CA Codes	Description
Chapter VII — Diseases of the eye and adnexa	
H40	Glaucoma
H46	Optic neuritis (Includes: Optic: neuropathy, except ischaemic, papillitis, Retrobulbar neuritis NOS)
H47	Other disorders of optic [2nd] nerve and visual pathways (Includes: Unspecified disorders of optic [2nd] nerve and visual pathways)
H49	Paralytic strabismus
H50	Other strabismus (Includes: Unspecified strabismus)
H53	Visual Disturbance (Excludes: Diplopia (H53.2))
H53.2	Diplopia (Double Vision)
H54.0	Blindness, binocular
H54.1	Severe visual impairment, binocular
H54.2	Moderate visual impairment, binocular
H54.3	Mild or no visual impairment, binocular
H54.4	Blindness, monocular
H54.5	Severe visual impairment, monocular
H54.6	Moderate visual impairment, monocular
H54.9	Unspecified visual impairment (binocular)
H55	Nystagmus and other irregular eye movements (Includes: Nystagmus: NOS, congenital, deprivation, dissociated, latent)
H57	Other disorders of eye and adnexa (Includes: Unspecified disorders of eye and adnexa)
H59	Postprocedural disorders of eye and adnexa, not elsewhere classified (Includes: keratopathy following cataract surgery)
Chapter VIII — Diseases of the ear and mastoid process	
H60	Otitis externa
H61	Other disorders of external ear (Includes: wax in ear)
H65	Nonsuppurative otitis media (Includes: with myringitis)
H66	Suppurative and unspecified otitis media (Includes: with myringitis, otitis media not elsewhere classified)
H72	Perforation of tympanic membrane (Includes: perforation of ear drum: persistent post-traumatic, postinflammatory)
H74	Other disorders of middle ear and mastoid (Includes: Unspecified disorders of middle ear and mastoid)
H80	Otosclerosis (Includes: otospongiosis)
H81.0	Ménière's disease (Includes: Labyrinthine hydrops, ménière's syndrome or vertigo)
H81.1	Benign paroxysmal vertigo

ICD-10-CA Codes	Description
Chapter VIII — Diseases of the ear and mastoid process	
H81.2	Vestibular neuronitis
H81.3	Other peripheral vertigo (Includes: Lermoyez' syndrome, Vertigo aural, Vertigo otogenic, Vertigo peripheral NOS)
H81.4	Vertigo of central origin (Includes: Central positional nystagmus)
H81.8	Other disorders of vestibular function
H81.9	Disorder of vestibular function, unspecified (Includes: Vertiginous syndrome NOS)
H83	Other diseases of inner ear (Includes: labyrinthitis, noise-induced hearing loss)
H90.0	Conductive hearing loss, bilateral
H90.1	Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side
H90.2	Conductive hearing loss, unspecified (Includes: Conductive deafness NOS)
H90.3	Sensorineural hearing loss, bilateral
H90.4	Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side
H90.5	Sensorineural hearing loss, unspecified (Includes: Congenital deafness NOS, Hearing loss: central NOS, neural NOS, perceptive NOS, sensory NOS, Sensorineural deafness NOS)
H90.6	Mixed conductive and sensorineural hearing loss, bilateral
H90.7	Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side
H90.8	Mixed conductive and sensorineural hearing loss, unspecified
H91	Other hearing loss (Includes: Unspecified hearing loss)
H93	Other disorders of ear, not elsewhere classified (Includes: tinnitus and disorders of acoustic nerve, unspecified disorders of ear)
H95	Postprocedural disorders of ear and mastoid process, not elsewhere classified
Chapter IX — Disease of the circulatory system	
I00	Rheumatic fever without mention of heart involvement (Includes: Arthritis, rheumatic, acute or subacute)
I01	Rheumatic fever with heart involvement
I02	Rheumatic chorea (Includes: Sydenham's chorea)
I05	Rheumatic mitral valve diseases (Includes: Mitral stenosis, rheumatic mitral insufficiency, mitral (valve) failure)
I06	Rheumatic aortic valve diseases (Includes: rheumatic aortic stenosis) (Excludes: nonrheumatic aortic (valve)stenosis See I35.0)
I07	Rheumatic tricuspid valve diseases (Includes: whether specified as rheumatic or of unspecified origin)

ICD-10-CA Codes	Description
Chapter IX — Disease of the circulatory system	
I08	Multiple valve diseases
I09	Other rheumatic heart diseases (Includes: Unspecified rheumatic heart diseases)
I10	Essential (primary) hypertension (Includes hypertension NOS, High blood pressure)
I11	Hypertensive heart disease (Includes: Hypertensive heart disease NOS)
I12	Hypertensive renal disease (Includes: Arteriosclerosis of kidney, Arteriosclerotic nephritis (chronic) (interstitial), Hypertensive nephropathy, Hypertensive renal disease NOS, Nephrosclerosis)
I13	Hypertensive heart and renal disease
I15	Secondary hypertension (Includes: hypertension secondary to renal disorders and hypertension secondary to endocrine disorders)
I20	Angina pectoris (Includes: Stable angina, Unstable angina)
I21	Acute myocardial infarction (Includes: myocardial infarction specified as acute or with a stated duration of 4 weeks (28 days) or less from onset)
I22	Subsequent myocardial infarction (Includes: further extension of myocardial infarction, recurrent myocardial infarction) (Note: Code is assigned for infarction of any myocardial site occuring within 4 weeks (28 days) from the onset of a previous infarction).
I23	Certain current complications following acute myocardial infarction
I24	Other acute ischaemic heart diseases (Excludes: angina pectoris (I20)) (Includes: Unspecified acute ischaemic/ischemic heart diseases, coronary thrombosis not resulting in myocardial infarction, Dressler's syndrome)
I25.0	Atherosclerotic cardiovascular disease, so described
I25.1	Atherosclerotic heart disease (Includes: Coronary (artery): atheroma, atherosclerosis, disease, sclerosis, CAD)
I25.2	Old myocardial infarction (Includes: Healed myocardial infarction, Past myocardial infarction by ECG or other special investigation, but currently presenting no symptoms)
I25.3	Aneurysm of heart (Includes: Aneurysm mual, Aneurysm ventricular)
I25.4	Coronary artery aneurysm (Includes: Coronary arteriovenous fistula, acquired)
I25.5	Ischaemic cardiomyopathy (Includes: Ischemic cardiomyopathy)
I25.6	Silent myocardial ischaemia (Includes: Silent myocardial ischemia)
I25.8	Other forms of chronic ischaemic heart disease (Includes: Any condition in (I21-I22) and (I24) specified as chronic or with a stated duration of more than 4 weeks (more than 28 days) from onset. [Old MI])
I25.9	Chronic ischaemic heart disease, unspecified (Includes: Ischaemic/Ischemic heart disease (chronic) NOS)

ICD-10-CA Codes	Description
Chapter IX — Disease of the circulatory system	
I26.0	Pulmonary embolism with mention of acute cor pulmonale (Includes: Acute cor pulmonale NOS)
I26.9	Pulmonary embolism without mention of acute cor pulmonale (Includes: Pulmonary embolism NOS)
I27.0	Primary pulmonary hypertension
I27.1	Kyphoscoliotic heart disease
I27.2	Other secondary pulmonary hypertension
I27.8	Other specified pulmonary heart diseases
I27.9	Pulmonary heart disease, unspecified (Includes: Chronic cardiopulmonary disease, Cor pulmonale (chronic) NOS)
I28	Other diseases of pulmonary vessels (Includes: Arteriovenous fistula of pulmonary vessels, Aneurysm of pulmonary artery, Other (Rupture of pulmonary vessel, stenosis of pulmonary vessel, Stricture of pulmonary vessl) and Unspecified diseases of pulmonary vessels)
I30	Acute pericarditis (Includes: Infective pericarditis)
I31	Other diseases of pericardium (Includes: cardiac tamponade, unspecified diseases of pericardium, Pericarditis (chronic) NOS)
I33	Acute and subacute endocarditis
I34.0	Mitral (valve) insufficiency (Includes: Mitral (valve): incompetence NOS or of specified cause, except rheumatic, regurgitation NOS or of specified cause, except rheumatic)
I34.1	Mitral (valve) prolapse (Includes: Floppy mitral valve syndrome)
I34.2	Nonrheumatic mitral (valve) stenosis
I34.8	Other nonrheumatic mitral valve disorders
I34.9	Nonrheumatic mitral valve disorder, unspecified
I35.0	Aortic (valve) stenosis
I35.1	Aortic (valve) insufficiency (Includes: Aortic (valve): incompetence NOS or of specified cause, except rheumatic, regurgitation NOS or of specified cause, except rheumatic)
I35.2	Aortic (valve) stenosis with insufficiency
I35.8	Other aortic valve disorders (Includes: Aneurysm of aortic valve, Murmur of aortic (valve))
I35.9	Aortic valve disorder, unspecified
I36.1	Nonrheumatic tricuspid (valve) insufficiency (Includes: Tricuspid (valve) incompetence of specified cause, except rheumatic, regurgitation of specified cause, except rheumatic)
I36.9	Nonrheumatic tricuspid valve disorder, unspecified (Includes: Other nonrheumatic tricuspid valve disorders, Nonrheumatic tricuspid (valve) stenosis with or without insufficiency) (Excludes: Specified as rheumatic (See I07)).

ICD-10-CA Codes	Description
Chapter IX — Disease of the circulatory system	
I37	Pulmonary valve disorders (Includes: Stenosis with or without insufficiency, incompetence NOS or specified cause, except rheumatic, regurgitation NOS or of specified cause, except rheumatic, other and unspecified pulmonary valve disorders) (Excludes: Rheumatic pulmonary valve disorder - (See I09))
I38	Endocarditis, valve unspecified (Includes: Endocarditis (chronic) NOS, Valvular, Valvular, incompetence of unspecified valve, NOS or of specified cause, except rheumatic or congenital, insufficiency of unspecified valve, NOS or of specified cause, except rheumatic or congenital,, regurgitation of unspecified valve, NOS or of specified cause, except rheumatic or congenital, stenosis of unspecified valve, NOS or of specified cause, except rheumatic or congenital, Valvulitis (chronic) of unspecified valve, NOS or of specified cause, except rheumatic or congenital)
I40	Acute myocarditis (Includes: Infective myocarditis)
I42	Cardiomyopathy
I44	Atrioventricular and left bundle-branch block (Includes: Complete heart block)
I45	Other conduction disorders
I46.0	Cardiac arrest with successful resuscitation (Excludes: with conduction disorder code (I44–I45), or myocardial infarction code (I21–I22))
I46.1	Sudden cardiac death, so described
I46.9	Cardiac arrest, unspecified (Excludes: Cardiorespiratory failure (See R09.2))
I47.0	Re-entry ventricular arrhythmia
I47.1	Supraventricular tachycardia (Includes: Paroxysmal tachycardia: atrial, atrioventriuclar [AV], junctional, nodal)
I47.2	Ventricular tachycardia
I47.9	Paroxysmal tachycardia, unspecified (Includes: Bouveret(-Hoffman) syndrome)
I48.0	Atrial fibrillation
I48.91	Atrial flutter, unspecified (Includes: typical atrial flutter, atypical atrial flutter)
I49.00	Ventricular fibrillation
I49.01	Ventricular flutter
I49.1	Atrial premature depolarization (Includes: Atrial premature beats)
I49.2	Junctional premature depolarization
I49.3	Ventricular premature depolarization
I49.4	Other and unspecified premature depolarization (Includes: Ectopic beats, Extrasystoles, Extrasystolic arrhythmias, Premature beats NOS, Premature contractions)
I49.5	Sick sinus syndrome (Includes: Tachycardia-bradycardia syndrome)
I49.8	Other specified cardiac arrhythmias (Includes: Long QT syndrome, and Rhythm disorders: Coronary sinus, ectopic, nodal)
I49.9	Cardiac arrhythmia, unspecified (Includes: Arrhythmia (cardiac) NOS)

ICD-10-CA Codes	Description
Chapter IX — Disease of the circulatory system	
I50.0	Congestive heart failure (Includes: Right ventricular failure)
I50.1	Left ventricular failure
I50.9	Heart failure, unspecified
I51.0	Cardiac septal defect, acquired (Includes: Acquired septal defect (old): atrial, auricular, ventricular)
I51.1	Rupture of chordae tendineae, not elsewhere classified
I51.2	Rupture of papillary muscle, not elsewhere classified
I51.3	Intracardiac thrombosis, not elsewhere classified (Includes: Thrombosis (old): apical, atrial, auricular, ventricular)
I51.4	Myocarditis, unspecified (Includes: Myocardial fibrosis, Myocarditis: NOS, chronic (interstitial))
I51.5	Myocardial degeneration (Includes: Degeneration of heart or myocardium: fatty, senile, Myocardial disease)
I51.6	Cardiovascular disease, unspecified (Includes: Cardiovascular accident NOS)
I51.7	Cardiomegaly (Includes: Cardiac: dilatation, hypertrophy, Ventricular dilatation)
I51.8	Other ill-defined heart diseases (Includes: Carditis (acute) (chronic), Pancarditis (acute) (chronic))
I51.9	Heart disease, unspecified
I60	Subarachnoid haemorrhage (Includes: rupture of cerebral arteriovenous malformation, subarachnoid hemorrhage)
I61	Intracerebral haemorrhage (Excludes: sequelae of intracerebral haemorrhage/hemorrhage (I69.1))
I62.0	Subdural haemorrhage (acute)(nontraumatic) (Includes: Subdural hemorrhage)
I62.1	Nontraumatic extradural haemorrhage (Includes: Nontraumatic epidural haemorrhage/hemorrhage)
I62.9	Intracranial haemorrhage (nontraumatic), unspecified (Includes: Intracranial hemorrhage (nontraumatic), unspecified)
I63.0	Cerebral infarction due to thrombosis of precerebral arteries
I63.1	Cerebral infarction due to embolism of precerebral arteries
I63.2	Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries
I63.3	Cerebral infarction due to thrombosis of cerebral arteries
I63.4	Cerebral infarction due to embolism of cerebral arteries
I63.5	Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries
I63.6	Cerebral infarction due to cerebral venous thrombosis, nonpyogenic
I63.8	Other cerebral infarction
I63.9	Cerebral infarction, unspecified

ICD-10-CA Codes	Description
Chapter IX — Disease of the circulatory system	
I64	Stroke, not specified as haemorrhage or infarction (Includes: Cerebrovascular accident (CVA) NOS)
I65	Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction (Includes: embolism, narrowing obstruction (complete) (partial), thrombosis of basilar, carotid or vertebral arteries, not resulting in cerebral infarction)
I66	Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction (Includes: embolism, narrowing, obstruction (complete) (partial), thrombosis of middle, anterior and posterior cerebral arteries, and cerebellar arteries, not resulting in cererbral infarction)
I67.0	Dissection of cerebral arteries, nonruptured
I67.1	Cerebral aneurysm, nonruptured (Includes: Cerebral: aneurysm NOS, arteriovanous fistual, acquired)
I67.2	Cerebral atherosclerosis (Includes: Atheroma of cerebral arteries)
I67.3	Progressive vascular leukoencephalopathy (Includes: Binswanger's disease)
I67.4	Hypertensive encephalopathy
I67.5	Moyamoya disease
I67.6	Nonpyogenic thrombosis of intracranial venous system (Includes: Nonpyogenic thrombosis of: cerebral vein, intracranial venous sinus)
I67.7	Cerebral arteritis, not elsewhere classified
I67.8	Other specified cerebrovascular diseases (Includes: Acute cerebrovascular insufficiency NOS, Cerebral ischaemia (chronic))
I67.9	Cerebrovascular disease, unspecified
I69.0	Sequelae of subarachnoid haemorrhage (Code if present one year or more after onset of the causal condition) (Includes: Sequelae of subarachnoid hemorrhage)
I69.1	Sequelae of intracerebral haemorrhage (Code if present one year or more after onset of the causal condition) (Includes: Sequelae of intracerebral hemorrhage)
I69.2	Sequelae of other nontraumatic intracranial haemorrhage (Code if present one year or more after onset of the causal condition) (Includes: Sequelae of other nontraumatic intracranial hemorrhage)
I69.3	Sequelae of cerebral infarction (Code if present one year or more after onset of the causal condition)
I69.4	Sequelae of stroke, not specified as haemorrhage or infarction (Code if present one year or more after onset of the causal condition)
I70	Atherosclerosis (Includes: Arteriosclerosis)
I71.0	Dissection of aorta [any part] (Includes: Dissecting aneurysm of aorta (ruptured) [any part])
I71.1	Thoracic aortic aneurysm, ruptured

ICD-10-CA Codes	Description
Chapter IX — Disease of the circulatory system	
I71.2	Thoracic aortic aneurysm, without mention of rupture
I71.3	Abdominal aortic aneurysm, ruptured
I71.4	Abdominal aortic aneurysm, without mention of rupture
I71.5	Thoracoabdominal aortic aneurysm, ruptured
I71.6	Thoracoabdominal aortic aneurysm, without mention of rupture
I71.8	Aortic aneurysm of unspecified site, ruptured (Includes: Rupture of aorta NOS)
I71.9	Aortic aneurysm of unspecified site, without mention of rupture (Includes: Aneurysm of aorta, Dilatation of aorta, Hyaline necrosis of aorta)
I72	Other aneurysm and dissection (Includes: aneurysm (cirsoid) (false)(ruptured))
I73.0	Raynaud's syndrome (Includes: Raynaud's disease, Raynaud's gangrene, Raynaud's phenomenon (secondary))
I73.8	Other specified peripheral vascular diseases (Includes: Acrocyanosis, Acroparaesthesia: simple [Schultze's type], or vasomotor [Nothnagel's type], Erythrocyanosis, Erythromelalgia)
I73.9	Peripheral vascular disease, unspecified (Includes: Intermittent claudication, Spasm of artery)
I74	Arterial embolism and thrombosis (Includes: Infarction: embolic, thrombotic, Occlusion: embolic, thrombotic)
I77	Other disorders of arteries and arterioles (Includes: Unspecified disorders of arteries and arterioles)
I80	Phlebitis and thrombophlebitis (Includes: endophlebitis, inflammation, vein, periphlebitis, suppurative phlebitis)
I81	Portal vein thrombosis (Includes: Portal (vein) obstruction)
I82	Other venous embolism and thrombosis (Includes: Embolism and thrombosis of other and unspecified vein, Budd-Chiari Syndrome)
I86	Varicose veins of other sites
I87	Other disorders of veins (Includes: Venous insufficiency (chronic) (peripheral), unspecified disorders of veins)
I88	Nonspecific lymphadenitis
I89	Other noninfective disorders of lymphatic vessels and lymph nodes (Includes: Lymphoedema, not elsewhere classified, Disease of lymphatic vessels NOS, Lymphangitis (NOS, chronic, subacute))
I95.0	Idiopathic hypotension
I95.2	Hypotension due to drugs
I95.8	Other hypotension (Includes: Chronic hypotension)
I95.9	Hypotension, unspecified
I97.0	Postcardiotomy syndrome

ICD-10-CA Codes	Description
Chapter IX — Disease of the circulatory system	
I97.1	Other functional disturbances following cardiac surgery (Includes: Cardiac insufficiency following cardiac surgery or due to presence of cardiac prosthesis, Heart failure cardiac insufficiency following cardiac surgery or due to presence of cardiac prosthesis)
I97.2	Postmastectomy lymphoedema syndrome (Includes: Elephantiasis due to mastectomy, Obliteration of lymphatic vessels due to mastectomy, Postmastectomy lymphedema syndrome)
I97.8	Other postprocedural disorders of circulatory system, not elsewhere classified
I97.9	Postprocedural disorder of circulatory system, unspecified
I99	Other and unspecified disorders of circulatory system
Chapter X — Diseases of the respiratory system	
J00	Acute nasopharyngitis [common cold]
J01	Acute sinusitis
J02	Acute pharyngitis
J03	Acute tonsillitis
J04	Acute laryngitis and tracheitis
J05	Acute obstructive laryngitis [croup] and epiglottitis
J06	Acute upper respiratory infections of multiple and unspecified sites
J09	Influenza due to certain indentified influenza virus (Includes: Influenza A/H1N1 pandemic 2009 [swine flu], Influenza A/H5N1 epidemic [avian influenza])
J10	Influenza due to other identified influenza virus
J11	Influenza, virus not identified
J12.0	Adenoviral pneumonia
J12.1	Respiratory syncytial virus pneumonia
J12.2	Parainfluenza virus pneumonia
J12.3	Human metapneumovirus pneumonia
J12.8	Other viral pneumonia
J12.9	Viral pneumonia, unspecified
J13	Pneumonia due to Streptococcus pneumoniae
J14	Pneumonia due to Haemophilus influenzae
J16	Pneumonia due to other infectious organisms, not elsewhere classified
J18	Pneumonia, organism unspecified (Excludes: Aspiration pneumonia (see J69))
J20	Acute bronchitis
J21	Acute bronchiolitis
J38	Diseases of vocal cords and larynx, not elsewhere classified (Includes: Paralysis of vocal cords and larynx, Nodules of vocal cords, edema of larynx, abscess of vocal cords)

ICD-10-CA Codes	Description
Chapter X — Diseases of the respiratory system	
J39	Other diseases of upper respiratory tract (Includes: Unspecified diseases of upper respiratory tract)
J40	Bronchitis, not specified as acute or chronic
J41	Simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43	Emphysema
J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with acute exacerbation, unspecified
J44.8	Other specified chronic obstructive pulmonary disease
J44.9	Chronic obstructive pulmonary disease, unspecified
J45	Asthma
J47	Bronchiectasis
J61	Pneumoconiosis due to asbestos and other mineral fibres
J62	Pneumoconiosis due to dust containing silica
J63	Pneumoconiosis due to other inorganic dusts
J64	Unspecified pneumoconiosis
J65	Pneumoconiosis associated with tuberculosis
J66	Airway disease due to specific organic dust
J67	Hypersensitivity pneumonitis due to organic dust
J68	Respiratory conditions due to inhalation of chemicals, gases, fumes and vapours
J69	Pneumonitis due to solids and liquids (Includes: Aspiration pneumonia)
J70	Respiratory conditions due to other external agents (Includes: Respiratory conditions due to unspecified external agents)
J81	Pulmonary oedema (Includes: Pulmonary edema)
J82	Pulmonary eosinophilia, not elsewhere classified (Includes: eosinophilic asthma, Loffler's pneumonia, Tropical (pulmonary) eosinophilia, pulmonary eosinophilia NOS.)
J84.1	Other interstitial pulmonary diseases with fibrosis
J84.8	Other specified interstitial pulmonary diseases
J84.9	Interstitial pulmonary disease, unspecified
J85.0	Gangrene and necrosis of lung
J85.1	Abscess of lung with pneumonia
J85.2	Abscess of lung without pneumonia
J85.3	Abscess of mediastinum
J90	Pleural effusion, not elsewhere classified

ICD-10-CA Codes	Description
Chapter X — Diseases of the respiratory system	
J93	Pneumothorax
J94	Other pleural conditions (Includes: Unspecified pleural conditions, hemothorax, hemopneumothorax)
J95.00	Haemorrhage from tracheostomy stoma (Includes: Hemorrhage from tracheostomy stoma)
J95.01	Infection of tracheostomy stoma (Includes: Sepsis of thracheostomy stoma)
J95.02	Malfunction of tracheostomy stoma (Includes: Obstruction of tracheostomy airway)
J95.03	Tracheo-esophageal fistula following tracheostomy
J95.08	Other tracheostomy complication
J95.1	Acute pulmonary insufficiency following thoracic surgery
J95.2	Acute pulmonary insufficiency following nonthoracic surgery
J95.3	Chronic pulmonary insufficiency following surgery
J95.4	Mendelson’s syndrome (Includes: Chemical pneumonitis due to anaesthesia)
J95.5	Postprocedural subglottic stenosis
J95.80	Postprocedural pneumothorax
J95.81	Transfusion related acute lung injury (TRALI)
J95.88	Other postprocedural respiratory disorders (Includes: ventilator-associated pneumonia (VAP))
J95.9	Postprocedural respiratory disorder, unspecified
J96.0	Acute respiratory failure
J96.1	Chronic respiratory failure
J96.9	Respiratory failure, unspecified
J98.0	Diseases of bronchus, not elsewhere classified
J98.10	Atelectasis
J98.18	Other pulmonary collapse (Includes: collapse of lung)
J98.2	Interstitial emphysema
J98.3	Compensatory emphysema
J98.4	Other disorders of lung
J98.5	Diseases of mediastinum, not elsewhere classified
J98.6	Disorders of diaphragm
J98.8	Other specified respiratory disorders
J98.9	Respiratory disorder, unspecified

ICD-10-CA Codes	Description
Chapter XI — Diseases of the digestive system	
K07.6	Temporomandibular joint (TMJ) disorders
K08	Other disorders of teeth and supporting structures (Includes: Unspecified disorders of teeth and supporting structures)
K21	Gastro-oesophageal reflux disease (Includes: GERD, Gastro-esophageal reflux disease, reflux esophagitis)
K25	Gastric ulcer
K26	Duodenal ulcer
K27	Peptic ulcer, site unspecified
K28	Gastrojejunal ulcer
K29	Gastritis and duodenitis
K30	Dyspepsia
K31	Other diseases of stomach and duodenum (Includes: Unspecified diseases of stomach and duodenum)
K35	Acute appendicitis
K40	Inguinal hernia (Includes: Scrotal hernia)
K41	Femoral hernia
K42	Umbilical hernia
K43	Ventral hernia
K44	Diaphragmatic hernia (Includes: Hiatus hernia)
K45	Other abdominal hernia
K46	Unspecified abdominal hernia
K50	Crohn’s disease [regional enteritis]
K51	Ulcerative colitis
K52	Other noninfective gastroenteritis and colitis (Includes: Unspecified noninfective gastroenteritis and colitis). (Excludes: infectious or unspecified origin (A09))
K56	Paralytic ileus and intestinal obstruction without hernia (Includes: Intussusception, volvulus, paralysis of intestine)
K57	Diverticular disease of intestine
K58	Irritable bowel syndrome
K59.0	Constipation
K63	Other diseases of intestine (Includes: Unspecified diseases of intestine, Abscess/perforation/fistula/ulcer of intestine, polyp of colon)
K64	Haemorrhoids and perianal venous thrombosis (Includes: Hemorrhoids and perianal venous thrombosis)
K65	Peritonitis

ICD-10-CA Codes	Description
Chapter XI — Diseases of the digestive system	
K66	Other disorders of peritoneum (Includes: peritoneal adhesions, unspecified disorders of peritoneum)
K70	Alcoholic liver disease (Includes: Alcoholic hepatitis, alcoholic cirrhosis of liver, alcoholic hepatic failure)
K71	Toxic liver disease
K72	Hepatic failure, not elsewhere classified
K73	Chronic hepatitis, not elsewhere classified (Excludes: Alcoholic (chronic) hepatitis (See K70))
K74	Fibrosis and cirrhosis of liver (Excludes: Alcoholic cirrhosis of liver (See K70))
K75	Other inflammatory liver diseases (Includes: Unspecified inflammatory liver diseases, abscess of liver)
K76	Other diseases of liver (Includes: Unspecified diseases of liver, portal hypertension)
K80	Cholelithiasis
K81	Cholecystitis
K82	Other diseases of gallbladder (Includes: Unspecified diseases of gallbladder, cholesterolosis of gallbladder, obstruction of gallbladder)
K83	Other diseases of biliary tract (Includes: Unspecified diseases of biliary tract, cholangitis, obstruction of bile duct without calculus (With calculus see K80))
K85	Acute pancreatitis
K86	Other diseases of pancreas (Includes: Unspecified diseases of pancreas, chronic pancreatitis, alcohol-induced chronic pancreatitis)
K90	Intestinal malabsorption (Includes: Celiac disease, Whipple’s disease)
K91.0	Vomiting following gastrointestinal surgery
K91.1	Postgastric surgery syndromes (Includes: Syndrome: dumping, postgastrectomy, postvagotomy)
K91.2	Postsurgical malabsorption, not elsewhere classified (Includes: Postsurgical blind loop syndrome)
K91.3	Postoperative intestinal obstruction (Includes: postoperative ileus)
K91.42	Malfunction of colostomy stoma, not elsewhere classified
K91.45	Enterostomy malfunction, not elsewhere classified
K91.5	Postcholecystectomy syndrome
K91.62	Gastrostomy malfunction, not elsewhere classified
K91.8	Other postprocedural disorders of digestive system, not elsewhere (Includes: Afferent loop syndrome)
K91.9	Postprocedural disorder of digestive system, unspecified

ICD-10-CA Codes	Description
Chapter XII — Diseases of the skin and subcutaneous tissue	
K92	Other diseases of digestive system (Includes: Unspecified diseases of digestive system, GI haemorrhage/hemorrhage unspecified, melaena/melena, haematemesis/hematemesis)
L01	Impetigo
L02.0	Cutaneous abscess, furuncle and carbuncle of face
L02.1	Cutaneous abscess, furuncle and carbuncle of neck
L02.2	Cutaneous abscess, furuncle and carbuncle of trunk
L02.3	Cutaneous abscess, furuncle and carbuncle of buttock
L02.4	Cutaneous abscess, furuncle and carbuncle of limb
L02.8	Cutaneous abscess, furuncle and carbuncle of other sites
L02.9	Cutaneous abscess, furuncle and carbuncle, unspecified
L03.00	Cellulitis of finger
L03.01	Cellulitis of toe
L03.10	Cellulitis of upper limb
L03.11	Cellulitis of lower limb
L03.2	Cellulitis of face
L03.30	Cellulitis of chest wall
L03.31	Cellulitis of abdominal wall
L03.32	Cellulitis of umbilicus
L03.33	Cellulitis of groin
L03.34	Cellulitis of back [any part except buttock]
L03.35	Cellulitis of buttock
L03.36	Cellulitis of perineum
L03.39	Cellulitis of trunk, unspecified
L03.8	Cellulitis of other sites (Includes: Head [any part, except face], Scalp)
L03.9	Cellulitis, unspecified
L04	Acute lymphadenitis (Includes: abscess (acute))
L05	Pilonidal cyst
L08	Other local infections of skin and subcutaneous tissue (Includes: Unspecified local infections of skin and subcutaneous tissue, pyoderma)
L13	Other bullous disorders (Includes: dermatitis herpetiformis, Duhring’s disease)
L20	Atopic dermatitis
L21	Seborrhoeic dermatitis
L23	Allergic contact dermatitis
L24	Irritant contact dermatitis

ICD-10-CA Codes	Description
Chapter XII — Diseases of the skin and subcutaneous tissue	
L25	Unspecified contact dermatitis
L26	Exfoliative dermatitis
L27	Dermatitis due to substances taken internally
L28	Lichen simplex chronicus and prurigo
L29	Pruritus (Includes: Itch NOS)
L30	Other dermatitis (Includes: Eczema NOS, unspecified dermatitis)
L40	Psoriasis (Excludes: Arthropathic psoriasis (L40.5))
L40.5	Arthropathic psoriasis (Note: Code also the appropriate M code (M07.0, M07.1, M07.2, M07.3, M09.0) when applicable.
L44	Other papulosquamous disorders (Includes: Unspecified papulosquamous disorder)
L50	Urticaria
L51	Erythema multiforme
L52	Erythema nodosum
L53	Other erythematous conditions (Includes: Unspecified erythematous conditions)
L56	Other acute skin changes due to ultraviolet radiation (Includes: Unspecified acute skin changes due to ultraviolet radiation)
L59	Other disorders of skin and subcutaneous tissue related to radiation (Includes: Unspecified disorders of skin and subcutaneous tissue related to radiation)
L60	Nail disorders (Includes: Ingrown nail)
L81	Other disorders of pigmentation (Includes: Unspecified disorders of pigmentation)
L84	Corns and callosities (Includes: Callus)
L89.0	Stage I decubitus [pressure] ulcer and pressure area (Note: The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss.) (Includes: Decubitus [pressure] ulcer limited to erythema [redness] only, without skin breakdown)
L89.1	Stage II decubitus [pressure] ulcer (Includes: Decubitus [pressure] ulcer with: abrasion, blister, partial thickness skin loss involving epidermis and/or dermis, skin loss NOS)
L89.2	Stage III decubitus [pressure] ulcer (Note: Decubitus [pressure] ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue extending to, but not through, underlying fascia.)
L89.3	Stage IV decubitus [pressure] ulcer (Note: Decubitus [pressure] ulcer with necrosis of muscle, bone or supporting structures (i.e. tendon or joint capsule).)

ICD-10-CA Codes	Description
Chapter XII — Diseases of the skin and subcutaneous tissue	
L89.8	Decubitus [pressure] ulcer, unstageable (Note: Decubitus [pressure] ulcer with full thickness tissue loss in which the base of the ulcer is covered by slough/eschar and therefore, cannot be accurately staged. Decubitus ulcer with necrosis involving muscle or bone (Stage X))
L89.9	Decubitus ulcer and pressure area, unspecified (Includes: Decubitus [pressure] ulcer without mention of stage or severity)
L90.5	Scar conditions and fibrosis of skin (Includes: adherent scar, cicatrix, scar NOS) (Excludes: keloid scar (L91))
L91	Hypertrophic disorders of skin (Includes: keloid scar)
L92	Granulomatous disorders of skin and subcutaneous tissue
L93	Lupus erythematosus (Excludes: systemic lupus erythematosus (M32) and scleroderma (M34))
L94	Other localized connective tissue disorders (Includes: Unspecified localized connective tissue disorder)
L95	Vasculitis limited to skin, not elsewhere classified
L97	Ulcer of lower limb, not elsewhere classified (Includes chronic skin ulcer of leg and foot)
L98	Other disorders of skin and subcutaneous tissue, not elsewhere classified (Includes: Unspecified disorders of skin and subcutaneous tissue, chronic ulcer NEC, ulcer of skin NOS)
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M00.0	Staphylococcal arthritis and polyarthritis
M00.8	Arthritis and polyarthritis due to other specified bacterial agents (Includes: Pneumococcal arthritis and polyarthritis, Other streptococcal arthritis and polyarthritis).
M00.9	Pyogenic arthritis, unspecified (Includes: Infective arthritis NOS)
M01.1	Tuberculous arthritis (Note: Code also Tuberculosis of bones and joints (A18.0) when applicable)
M01.8	Arthritis in other infectious and parasitic diseasess classified elsewhere
M02	Reactive arthropathies (Includes: Reiter's disease, other and unspecified reactive arthropathies).
M05	Seropositive rheumatoid arthritis
M06	Other rheumatoid arthritis (Includes: Adult-onset Still's disease, rheumatoid arthritis unspecified)
M07.0	Distal interphalangeal psoriatic arthropathy
M07.1	Arthritis mutilans
M07.2	Psoriatic spondylitis
M07.3	Other psoriatic arthropathies

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M08.0	Juvenile rheumatoid arthritis (Includes: Juvenile rheumatoid arthritis with or without rheumatoid factor. Note: arthritis in children with onset before 16th birthday and lasting longer than 3 months)
M08.1	Juvenile ankylosing spondylitis
M08.9	Juvenile arthritis, unspecified site (Includes: Other juvenille arthritis, Pauciarticular juvenile arthritis, Juvenile arthritis with systemic onset (Still's disease NOS), Juvenile polyarthritis (seronegative), Chronic juvenile polyarthritis).
M09.0	Juvenile arthritis in psoriasis
M10.90	Gout, unspecified, multiple sites (Includes: Specified gout, multiple sites)
M10.91	Gout, unspecified, shoulder region (Includes: Specified gout, shoulder region)
M10.92	Gout, unspecified, upper arm (Includes: Specified gout, upper arm)
M10.93	Gout, unspecified, forearm (Includes: Specified gout, forearm)
M10.94	Gout, unspecified, hand (Includes: Specified gout, hand)
M10.95	Gout, unspecified, pelvic region and thigh (Includes: Specified gout, pelvic region and thigh)
M10.96	Gout, unspecified, lower leg (Includes: Specified gout, lower leg)
M10.97	Gout, unspecified, ankle and foot (Includes: Specified gout, ankle and foot)
M10.98	Gout, unspecified, other site (Includes: Specified gout, other site)
M10.99	Gout, unspecified, unspecified site (Includes: Specified gout, unspecified site)
M11	Other crystal arthropathies (Includes: Hydroxyapatite deposition disease, Familial chondrocalcinosis, Chrondrocalcinosis NOS, Other and unspecified crystal arthropathies)
M12	Other specific arthropathies (Includes: Chronic postrheumatic arthropathy [Jaccoud], Kaschin-Beck disease, Vilonodular synovitis (pigmented), Palindromic rheumatism, intermittent hydrarthrosis (intermittent joint effusions), Traumatic arthropathy, and other athropaties NEC, Transient arthropathy) (Excludes: Arthropathy NOS (see M13.9), Arthrosis (see M15-M19)
M13.0	Polyarthritis, unspecified (Excludes: inflammatory polyarthropathy (M06))
M13.1	Monoarthritis, not elsewhere classified
M13.8	Other specified arthritis (Includes: Allergic arthritis)
M13.9	Arthritis, unspecified (Includes: Arthropathy NOS)
M15.0	Primary generalized (osteo)arthrosis
M15.3	Secondary multiple arthrosis (Includes: Post -traumatic polyarthrosis)
M15.8	Other polyarthrosis (Includes: Polyarthrosis, unspecified)
M16	Coxarthrosis [arthrosis of hip] (Includes: Osteoarthritis of hip)
M17	Gonarthrosis [arthrosis of knee] (Includes: Osteoarthritis of knee)
M19	Other arthrosis of other joints

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M20.1	Hallux valgus (acquired) (Includes: Bunion)
M20.2	Hallux rigidus
M20.3	Other deformity of hallux (acquired) (Includes: Hallux varus)
M20.4	Other hammer toe(s) (acquired)
M20.5	Other deformities of toe(s) (acquired)
M20.6	Acquired deformity of toe(s), unspecified
M21.0	Valgus deformity, not elsewhere classified (Excludes: metatarsus valgus (Q66), talipes calcaneovalgus (Q66))
M21.1	Varus deformity, not elsewhere classified (Excludes: metatarsus varus (Q66), tibia vara (M92))
M21.2	Flexion deformity
M21.3	Wrist or foot drop (acquired)
M21.4	Flat foot [pes planus] (acquired) (Excludes: congenital pes planus (Q66)
M21.5	Acquired clawhand, clubhand, clawfoot and clubfoot (Excludes: clubfoot, not specified as acquired (Q66))
M21.6	Other acquired deformities of ankle and foot (Excludes: deformities of toe (acquired) (M20.1 - M20.6))
M21.7	Unequal limb length (acquired)
M21.8	Other specified acquired deformities of limbs
M21.9	Acquired deformity of limb, unspecified
M22	Disorders of patella (Includes: Recurrent dislocation of patella, Patellofemoral disorders, Chondromalacia of patella) (Excludes: Dislocation of patella (see S83.0))
M23.4	Loose body in knee
M23.5	Chronic instability of knee
M23.6	Other spontaneous disruption of ligament(s) of knee
M24.1	Other articular cartilage disorders (Includes: Degeneration of articular cartilage)
M24.2	Disorder of ligament (Includes: Instability secondary to old ligament injury, Ligamentous laxity NOS)
M24.39	Pathological dislocation and subluxation of joint, not elsewhere classified, unspecified site
M24.4	Recurrent dislocation and subluxation of joint
M24.53	Contracture of joint, forearm
M24.56	Contracture of joint, lower leg
M24.58	Contracture of joint, other site
M24.59	Contracture of joint, unspecified site
M24.62	Ankylosis of joint, upper arm

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M24.65	Ankylosis of joint, pelvic region and thigh
M24.67	Ankylosis of joint, ankle and foot
M24.68	Ankylosis of joint, other site
M24.69	Ankylosis of joint, unspecified site
M24.7	Protrusio acetabuli
M24.8	Other specific joint derangements, not elsewhere classified
M25.1	Fistula of joint
M25.2	Flail joint
M25.3	Other instability of joint (Includes: Unstable joint) (Excludes: Instability of joint secondary to: old ligament injury (M24.2), removal of joint prosthesis (M96.8))
M25.4	Effusion of joint (Includes: Fluid of joint, hydrarthrosis, swelling of joint)
M25.5	Pain in joint
M25.6	Stiffness of joint, not elsewhere classified
M25.7	Osteophyte
M25.8	Other specified joint disorders (Includes: Calcification of joint)
M25.9	Joint disorder, unspecified
M30	Polyarteritis nodosa and related conditions
M31	Other necrotizing vasculopathies (Includes: Aortic arch syndrome [Takayasu], Giant cell arteritis, Wegener's granulomatosis)
M32	Systemic lupus erythematosus
M33.0	Juvenile dermatomyositis
M33.1	Other dermatomyositis
M33.2	Polymyositis
M33.9	Dermatopolymyositis, unspecified
M34	Systemic sclerosis (Includes: scleroderma)
M35.3	Polymyalgia rheumatica (Excludes: polymyalgia rheumatica with giant cell arteritis (M31))
M35.9	Systemic involvement of connective tissue, unspecified site (Includes: Autoimmune disease (systemic) NOS, Collagen (vascular) disease NOS, Other specified systemic involvement of connective tissue, Hypermobility syndrome, Familial ligamentous laxity, Relapsing panniculitis [Weber-Christian], Multifocal fibrosclerosis, Diffuse (eosinophilic) fasciitis, Behçet's disease, Other overlap syndromes, Sicca Syndrome [Sjögren])
M40.0	Postural kyphosis (Excludes: osteochondrosis of spine (M42)
M40.1	Other secondary kyphosis
M40.2	Other and unspecified kyphosis
M40.3	Flatback syndrome

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M40.4	Other lordosis (Includes: Lordosis acquired, postural)
M40.5	Lordosis, unspecified
M41.8	Other forms of scoliosis (Includes: Infantile idiopathic scoliosis, Juvenile idiopathic scoliosis, Other idiopathic scoliosis, Thoracogenic scoliosis, Neuromuscular scoliosis, Scoliosis secondary to cerebral palsy)
M41.9	Scoliosis, unspecified
M42	Spinal osteochondrosis (Includes: Juvenile and adult osteochondrosis of spine, Calvé's disease, Scheuermann's disease, Spinal osteochondrosis unspecified). (Excludes: Postural kyphosis (See M40.0), Other osteochrondropathies (See M93))
M43.0	Spondylolysis
M43.1	Spondylolisthesis
M43.2	Other fusion of spine (Includes: Ankylosis of spinal joint)
M43.5	Other recurrent vertebral subluxation
M43.6	Torticollis
M43.8	Other specified deforming dorsopathies (Excludes: kyphosis and lordosis (M40.-), scoliosis (M41.-))
M43.9	Deforming dorsopathy, unspecified (Includes: Curvature of spine NOS)
M45	Ankylosing Spondylitis
M46	Other inflammatory spondylopathies (Includes: Other infective spondylopathies, Inflammatory spondylopathy unspecified, Spinal enthesopathy, Oteomyelitis of vertebra, Infection of intevertebral disc (pyogenic), Discitis, unspecified)
M47.1	Other spondylosis with myelopathy
M47.2	Other spondylosis with radiculopathy
M47.8	Other spondylosis (Includes: Cervical spondylosis, lumbosacral spondylosis, Thoracic spondylosis without myelopathy or radiculopathy)
M47.9	Spondylosis, unspecified
M48.00	Spinal stenosis, multiple sites in spine
M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.06	Spinal stenosis, lumbar region
M48.07	Spinal stenosis, lumbosacral region
M48.08	Spinal stenosis, sacral and sacrococcygeal region
M48.09	Spinal stenosis, unspecified site

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M48.1	Ankylosing hyperostosis [Forestier] (Includes: Diffuse idiopathic skeletal hyperostosis [DISH])
M48.2	Kissing spine
M48.3	Traumatic spondylopathy
M48.4	Fatigue fracture of vertebra (Includes: Stress fracture of vertebra)
M48.5	Collapsed vertebra, not elsewhere classified (Includes: collapsed vertebra NOS, Wedging of vertebra NOS)
M48.8	Other specified spondylopathies (Includes: ossification of posterior longitudinal ligament)
M48.9	Spondylopathy, unspecified
M49.5	Collapsed vertebra in diseases classified elsewhere (Note: Code also Secondary malignant neoplasm of bone and bone marrow (C79.5), when applicable)
M50	Cervical disc disorder with myelopathy (Includes: cervical disc disorders with cervicalgia, cervicothoracic disc disorders)
M51	Other intervertebral disc disorders (Includes: thoracic, thoracolumbar and lumbosacral disorders)
M53.2	Spinal instabilities
M53	Other dorsopathies, not elsewhere classified (Includes: Coccygodynia, Sacrococcygeal disorders NEC)
M54.1	Radiculopathy (Includes: Neuritis or radiculitis: brachial NOS, lumbar NOS, thoracic NOS, Radiculitis NOS) (Excludes: neuralgia and neuritis NOS (M79.2), radiculopathy with: cervical disc disorder (M50), lumbar and other intervertebral disc disorder (M51), spondylosis (M47.8))
M54.2	Cervicalgia (Includes: Neck Pain cervical)
M54.3	Sciatica (Excludes: Lesion of sciatic nerve (see G57.0))
M54.4	Lumbago with sciatica
M54.5	Low back pain (Includes: Loin pain, Low back strain, Lumbago NOS)
M54.6	Pain in thoracic spine
M54.8	Other dorsalgia
M54.9	Dorsalgia, unspecified site (Includes: Backache NOS)
M60.0	Infective myositis (Includes: Tropical pyomyositis)
M61	Calcification and ossification of muscle (Includes: Myositis ossificans traumatica, Myositis/Fibrodysplasia ossificans progressiva, Paralytic calcification and ossification of muscle, Myositis ossificans associated with quadriplegia or paraplegia, Other and unspecified ossification of muscle) (Excludes: calcific tendinitis (M65.2), of shoulder (M75.3))

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M62	Other disorders of muscle (Includes: Muscle (sheath) hernia, rhabdomyolysis) (Excludes: Traumatic rhabdomyolysis: See T79.6)
M62.0	Diastasis of muscle
M62.1	Other rupture of muscle (nontraumatic) (Excludes: rupture of tendon (M66.0-M66.4), traumatic rupture of muscle - see injury of muscle by body region)
M62.3	Immobility syndrome (paraplegic)
M62.4	Contracture of muscle (Excludes: contracture of joint (M24.53-M24.59))
M62.5	Muscle wasting and atrophy, not elsewhere classified (Includes: Disuse atrophy NEC)
M65.0	Abscess of tendon sheath
M65.1	Other infective (teno)synovitis
M65.2	Calcific tendinitis (Excludes: of shoulder (M75.3))
M65.3	Trigger finger (Includes: Nodular tendinous disease)
M65.8	Other synovitis and tenosynovitis (Includes: Irritable hip, synovitis and tenosynovitis unspecified)
M66.0	Rupture of popliteal cyst
M66.1	Rupture of synovium (Includes: Rupture of synovial cyst)
M66.2	Spontaneous rupture of extensor tendons
M66.4	Spontaneous rupture of other tendons
M67.0	Short Achilles tendon (acquired)
M67.1	Other contracture of tendon (sheath) (Excludes: with contracture of joint (M24.53–M24.59))
M67.2	Synovial hypertrophy, not elsewhere classified
M67.3	Transient synovitis (Includes: Toxic synovitis)
M67.4	Ganglion (Includes: Ganglion of joint or tendon (sheath))
M70.2	Olecranon bursitis
M70.3	Other bursitis of elbow
M70.4	Prepatellar bursitis
M70.6	Trochanteric bursitis (Includes: Trochanteric tendinitis)
M70.7	Other bursitis of hip (Includes: Ischial bursitis)
M70.8	Other soft tissue disorders related to use, overuse and pressure
M71.1	Other infective bursitis
M71.2	Synovial cyst of popliteal space [Baker]
M71.3	Other bursal cyst (Includes: Synovial cyst NOS)
M71.4	Calcium deposit in bursa (Excludes: of shoulder (M75.3))
M71.5	Other bursitis, not elsewhere classified

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M72.0	Palmar fascial fibromatosis [Dupuytren]
M72.1	Knuckle pads
M72.2	Plantar fascial fibromatosis (Includes: Plantar fasciitis)
M72.4	Pseudosarcomatous fibromatosis (Includes: Nodular fasciitis)
M72.60	Necrotizing fasciitis, multiple sites
M72.61	Necrotizing fasciitis, shoulder region
M72.62	Necrotizing fasciitis, upper arm
M72.63	Necrotizing fasciitis, forearm
M72.64	Necrotizing fasciitis, hand
M72.65	Necrotizing fasciitis, pelvic region and thigh
M72.66	Necrotizing fasciitis, lower leg
M72.67	Necrotizing fasciitis, ankle and foot
M72.68	Necrotizing fasciitis, other site
M72.69	Necrotizing fasciitis, unspecified site
M72.8	Other fibroblastic disorders (Includes: Abscess of fascia)
M72.9	Fibroblastic disorder, unspecified (Includes: Fasciitis NOS, Fibromatosis)
M75.0	Adhesive capsulitis of shoulder (Includes: Frozen shoulder, Periarthritis of shoulder)
M75.1	Rotator cuff syndrome
M75.2	Bicipital tendinitis
M75.3	Calcific tendinitis of shoulder (Includes: Calcified bursa of shoulder)
M75.4	Impingement syndrome of shoulder
M75.5	Bursitis of shoulder
M75.8	Other shoulder lesions
M75.9	Shoulder lesion, unspecified site
M76	Enthesopathies of lower limb, excluding foot (Includes: Gluteal tendinitis, Psoas tendinitis, Iliotibial band syndrome, Tibial collateral bursitis [Pellegrini-Stieda], Patellar tendinitis, Peroneal tendinitis, Other enthesopathies of lower limb, excluding foot, Anterior tibial syndrome, Posterior tibial tendinitis)
M77	Other enthesopathies (Includes: Medial and lateral epicondylitis, Tennis elbow, Periarthritis of wrist, Metatarsalgia, Other and unspecified enthesopathies, Bone spur NOS, Capsulitis NOS, Perarthritis NOS, Tendinitis NOS)
M79.1	Myalgia (Excludes: myositis (M60.0))
M79.2	Neuralgia and neuritis, unspecified (Excludes: radiculitis: NOS (M54.1), brachial NOS (M54.1), lumbosacral NOS (M54.1), Sciatica (M54.3 - M54.4))
M79.60	Pain in upper limb
M79.61	Pain in lower limb

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M79.69	Pain in unspecified limb
M79.7	Fibromyalgia (Includes: Fibromyositis, Fibrositis, Myofibrositis)
M80.80	Other osteoporosis with pathological fracture, multiple sites (Includes: Pathological fracture of multiple sites with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, multiple sites)
M80.81	Other osteoporosis with pathological fracture, shoulder region (Includes: Pathological fracture of shoulder region with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, shoulder region)
M80.82	Other osteoporosis with pathological fracture, upper arm (Includes: Pathological fracture of upper arm with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, upper arm)
M80.83	Other osteoporosis with pathological fracture, forearm (Includes: Pathological fracture of forearm with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, forearm)
M80.84	Other osteoporosis with pathological fracture, hand (Includes: Pathological fracture of hand with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, hand)
M80.85	Other osteoporosis with pathological fracture, pelvic region and thigh (Includes: Pathological fracture of pelvic region and thigh with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, pelvic region and thigh)
M80.86	Other osteoporosis with pathological fracture, lower leg (Includes: Pathological fracture of lower leg with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, lower leg)
M80.87	Other osteoporosis with pathological fracture, ankle and foot (Includes: Pathological fracture of ankle and foot with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, ankle and foot)
M80.88	Other osteoporosis with pathological fracture, other site (Includes: Pathological fracture of other site with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, other site)

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M80.89	Other osteoporosis with pathological fracture, unspecified site (Includes: Pathological fracture of unspecified site with postmenopausal/postoophorectomy/postsurgical malabsorption/drug-induced/idiopathic osteoporosis, and osteoporosis of disuse with pathological fracture, unspecified site)
M80.90	Unspecified osteoporosis with pathological fracture, multiple sites
M80.91	Unspecified osteoporosis with pathological fracture, shoulder region
M80.92	Unspecified osteoporosis with pathological fracture, upper arm
M80.93	Unspecified osteoporosis with pathological fracture, forearm
M80.94	Unspecified osteoporosis with pathological fracture, hand
M80.95	Unspecified osteoporosis with pathological fracture, pelvic region and thigh
M80.96	Unspecified osteoporosis with pathological fracture, lower leg
M80.97	Unspecified osteoporosis with pathological fracture, ankle and foot
M80.98	Unspecified osteoporosis with pathological fracture, other site
M80.99	Unspecified osteoporosis with pathological fracture, unspecified site
M81	Osteoporosis without pathological fracture
M83	Adult osteomalacia
M84.0	Malunion of fracture
M84.10	Nonunion of fracture [pseudarthrosis], multiple sites
M84.11	Nonunion of fracture [pseudarthrosis], shoulder region
M84.12	Nonunion of fracture [pseudarthrosis], upper arm
M84.13	Nonunion of fracture [pseudarthrosis], forearm
M84.14	Nonunion of fracture [pseudarthrosis], hand
M84.15	Nonunion of fracture [pseudarthrosis], pelvic region and thigh
M84.16	Nonunion of fracture [pseudarthrosis], lower leg
M84.17	Nonunion of fracture [pseudarthrosis], ankle and foot
M84.18	Nonunion of fracture [pseudarthrosis], other site
M84.19	Nonunion of fracture [pseudarthrosis], unspecified site
M84.2	Delayed union of fracture
M84.3	Stress fracture, not elsewhere classified (Includes: Stress fracture NOS) (Excludes: stress fracture of vertebra (M48.4))
M84.4	Pathological fracture, not elsewhere classified (Includes: Pathological fracture, NOS)
M84.8	Other disorders of continuity of bone
M84.9	Disorder of continuity of bone, unspecified
M86.0	Acute haematogenous osteomyelitis (Includes: Acute hematogenous osteomyelitis)

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M86.1	Other acute osteomyelitis
M86.2	Subacute osteomyelitis
M86.3	Chronic multifocal osteomyelitis
M86.4	Chronic osteomyelitis with draining sinus
M86.5	Other chronic haematogenous osteomyelitis (Includes: Other chronic hematogenous osteomyelitis)
M86.6	Other chronic osteomyelitis
M86.8	Other osteomyelitis
M86.9	Osteomyelitis, unspecified (Includes: Infection of bone NOS, Periostitis without mention of osteomyelitis)
M87	Osteonecrosis
M88	Paget's disease of bone [osteitis deformans]
M89.00	Complex Regional Pain Syndrome I [CRPS I], upper limb (Includes: Sympathetic reflex dystrophy, upper limb, shoulder-hand syndrome, Sudeck's atrophy, upper limb)
M89.01	Complex Regional Pain Syndrome I [CRPS I], lower limb (Includes: Sympathetic reflex dystrophy, lower limb, Sudeck's atrophy)
M89.02	Complex Regional Pain Syndrome I [CRPS I], other and unspecified site
M89.09	Algoneurodystrophy, NOS
M89.2	Other disorders of bone development and growth
M89.3	Hypertrophy of bone
M89.5	Osteolysis
M89.6	Osteopathy after poliomyelitis
M89.9	Disorder of bone, unspecified (Includes: Other specified disorders of bone)
M90.7	Fracture of bone in neoplastic disease (Code also C14-D48 for the neoplasm when known)
M91.0	Juvenile osteochondrosis of pelvis
M92	Other juvenile osteochondrosis
M93	Other osteochondropathies (Includes: Osteochondritis dissecans, Other and unspecified osteochondropathies; Apophysitis, Epiphysitis, Osteochondritis, Osteochondrosis not specified as adult or juvenile of unspecified site) (Excludes: Osteochondrosis of spine (See M42))
M94	Other disorders of cartilage (Includes: Chondrocostal junction syndrome [Tietze], Costochondritis, Relapsing polychondritis, Chondromalcia, Chondrolysis, Other and unspecified disorders of cartilage) (Excludes: Chondromalacia of patella (See M22))
M95	Other acquired deformities of musculoskeletal system and connective tissue
M96.0	Pseudarthrosis after fusion or arthrodesis

ICD-10-CA Codes	Description
Chapter XIII — Diseases of the musculoskeletal system and connective tissue	
M96.1	Postlaminectomy syndrome, not elsewhere classified
M96.2	Postradiation kyphosis
M96.3	Postlaminectomy kyphosis
M96.4	Postsurgical lordosis
M96.5	Postradiation scoliosis
M96.60	Fracture of bone following insertion of joint prosthesis (Use an additional code from Chapter XIX - to identify the site of the fracture) (Note: This code is to be used for periprosthetic fractures that occur at any time while the device is in-situ. A fracture that occurs during the insertion of an implant, joint prosthesis or bone plate is classified to the appropriate fracture code according to the location of the fracture)
M96.68	Fracture of bone following insertion of other and unspecified orthopaedic implant (For example: bone plate) (Use an additional code from Chapter XIX - to identify the site of the fracture) (Note: This code is to be used for periprosthetic fractures that occur at any time while the device is in-situ. A fracture that occurs during the insertion of an implant, joint prosthesis or bone plate is classified to the appropriate fracture code according to the location of the fracture)
M96.8	Other postprocedural musculoskeletal disorders (Includes: instability of joint secondary to removal of joint prosthesis)
M96.9	Postprocedural musculoskeletal disorder, unspecified
M99	Biomechanical lesions, not elsewhere classified
Chapter XIV — Diseases of the genitourinay system	
N17	Acute renal failure
N18.1	Chronic kidney disease, stage 1 (Includes: Kidney damage with normal or increased GFR (>90 mL/min))
N18.2	Chronic kidney disease, stage 2 (Includes: Kidney damage with mild decreased GFR (60–89 mL/min))
N18.3	Chronic kidney disease, stage 3 (Includes: Kidney damage with moderately decreased GFR (30–59 mL/min))
N18.4	Chronic kidney disease, stage 4 (Includes: Kidney damage with severely decreased GFR (15–29 mL/min))
N18.5	Chronic kidney disease, stage 5 (Includes: Chronic uraemia, Chronic uremia, End stage kidney disease: NOS, in allograft failure, on dialysis, without dialysis or transplant)
N18.9	Chronic kidney disease, unspecified
N19	Unspecified renal failure
N20	Calculus of kidney and ureter (Includes: Urinary calculus unspecified)
N21.0	Calculus in bladder

ICD-10-CA Codes	Description
Chapter XIV—Diseases of the genitourinay system	
N21.1	Calculus in urethra
N21.9	Calculus of lower urinary tract, unspecified (Includes: Other lower urinary tract calculus)
N23	Unspecified renal colic
N30	Cystitis (Includes: Other and unspecified cystitis, Interstitial cystitis [chronic], Trigonitis, Irradiation cystitis, acute cystitis, abscess of bladder, cystitis cystica (glandularis))
N31.0	Uninhibited neuropathic bladder, not elsewhere classified (Excludes: cord bladder (G95.8), due to spinal cord injury (G95.8), neurogenic bladder due to cauda equina (G83.4), urinary incontinence (R32, N39.30–N39.4))
N31.1	Reflex neuropathic bladder, not elsewhere classified (Excludes: cord bladder (G95.8), due to spinal cord injury (G95.8), neurogenic bladder due to cauda equina (G83.4), urinary incontinence (R32, N39.30–N39.4))
N31.2	Flaccid neuropathic bladder, not elsewhere classified (Excludes: cord bladder (G95.8), due to spinal cord injury (G95.8), neurogenic bladder due to cauda equina (G83.4), urinary incontinence (R32, N39.30–N39.4))
N31.8	Other neuromuscular dysfunction of bladder (Excludes: cord bladder (G95.8), due to spinal cord injury (G95.8), neurogenic bladder due to cauda equina (G83.4), urinary incontinence (R32, N39.30–N39.4))
N31.9	Neuromuscular dysfunction of bladder, unspecified (Excludes: cord bladder (G95.8), due to spinal cord injury (G95.8), neurogenic bladder due to cauda equina (G83.4), urinary incontinence (R32, N39.30–N39.4))
N32	Other disorders of bladder (Includes: bladder neck obstruction)
N34	Urethritis and urethral syndrome
N36	Other disorders of urethra (Includes: urethral fistula, prolapse of urethra)
N39	Other disorders of urinary system
N39.0	Urinary tract infection, site not specified (Includes: UTI, site not specified)
N39.30	Mixed incontinence (Includes: stress incontinence with urge incontinence)
N39.39	Stress incontinence
N39.4	Other specified urinary incontinence (Includes: Urge incontinence)
N42	Other disorders of prostate
N50	Other disorders of male genital organs
N64	Other disorders of breast (Includes: Fat necrosis of breast, Galactocele, Mastodynia)
N73	Other female pelvic inflammatory diseases
N80	Endometriosis
N94	Pain and other conditions associated with female genital organs and menstrual cycle

ICD-10-CA Codes	Description
Chapter XIV — Diseases of the genitourinay system	
N99	Postprocedural disorders of genitourinary system, not elsewhere classified (Includes: Postprocedural renal failure, Postprocedural urethral stricture, Postprocedural pelvic peritoneal adhesions, Haemorrahge/hemorrhage from external stoma of urinary tract, Infection of external stoma of urinary tract. Other malfunction of external stoma of urinary tract)
N99.8	Other postprocedural disorder of genitourinary system
N99.9	Postprocedural disorder of genitourinary system, unspecified
Chapter XVII — Congenital malformations, deformations and chromosomal abnormalities	
Q03	Congenital hydrocephalus (Excludes: Arnold-Chiari syndrome (Q07.0))
Q04	Other congenital malformations of brain
Q05	Spina bifida (Includes: hydromeningocele (spinal), meningocele (spinal), meningomyelocele, myelocele, myelomeningocele, rachischisis, spina bifida (aperta) (cystica), syringomyelocele)
Q06	Other congenital malformations of spinal cord
Q07.0	Arnold-Chiari syndrome
Q07.8	Other specified congenital malformations of nervous system (Includes: Unspecified congenital malformations of nervous system, Agensis of nerve, Displacement of brachial plexus, Jaw-winking syndrome, Marcus Gunn's syndrome)
Q65.2	Congenital dislocation of hip, unspecified
Q65.5	Congenital subluxation of hip, unspecified
Q65.6	Unstable hip (Includes: Dislocatable hip, Subluxatable hip)
Q65.8	Other congenital deformities of hip (Includes: Anteversion of femoral neck, Congenital: acetabular dysplasia, coxa: valga, vara)
Q65.9	Congenital deformity of hip, unspecified
Q66	Congenital deformities of feet (Includes: Talipes equinovarus, Talipes calcaneovarus, Metatarsus varus, Other congenital varus deformities of feet, Talipes calcaneovalgus, Congenital pes planus, Flat foot (congenital, rigid, spastic), Metatarsus valgus, Clubfoot, Hammer toe, Talipes NOS, Vertical talus, Other and unspecified congenital deformities of feet)
Q67.5	Congenital deformity of spine (Includes: Congenital Scoliosis NOS, Congenital scoliosis postural)
Q67.8	Other congenital deformities of chest (Includes: Congenital deformity of chest wall NOS, Other congenital deformities of skull, face and jaw, Congenital deviation of nasal septum, Pectus excavatum, Congenital funnel chest, Pectus carinatum, Congenital pigeon chest)
Q68.8	Other specified congenital musculoskeletal deformities (Includes: Congenital: deformity of clavicle, elbow, forearm, scapula, or dislocation of elbow or shoulder)

ICD-10-CA Codes	Description
Chapter XVII — Congenital malformations, deformations and chromosomal abnormalities	
Q69.9	Polydactyly, unspecified (Includes: Supernumerary digit (s) NOS)
Q70	Syndactyly
Q71	Reduction defects of upper limb [absence of upper limb] (Includes: Congenital complete absence of upper limb(s), Congenital absence of upper arm and forearm with hand present, Congenital absence of both forearm and hand, Congenital absence of hand and finger(s), Unspecified reduction defiect of upper limb).
Q72	Reduction defects of lower limb [absence of lower limb] (Includes: Congenital complete absence of lower limb(s), Congenital absence of thigh and lower leg with foot present, Congenital absence of both lower leg and foot, Congenital absence of foot and toe(s), Unspecified reduction defect of lower limb).
Q73.0	Congenital absence of unspecified limb(s) (Includes: Amelia NOS)
Q74	Other congenital malformations of limb(s) (Includes: Arthrogryposis multiplex congenita, Unspecified congenital malformation of limb(s))
Q75	Other congenital malformations of skull and face bones
Q76	Congenital malformations of spine and bony thorax
Q77	Osteochondrodysplasia with defects of growth of tubular bones and spine
Q78	Other osteochondrodysplasias
Q79	Congenital malformations of the musculoskeletal system, not elsewhere classified
Q85.0	Neurofibromatosis (nonmalignant) (Includes: Von Recklinghausen's disease)
Q85.1	Tuberous sclerosis (Includes: Bourneville's disease, Epiloia)
Q87	Other specified congenital malformation syndromes affecting multiple systems
Q89	Other congenital malformations, not elsewhere classified
Q90	Down's syndrome
Q99	Other chromosome abnormalities, not elsewhere classified
Chapter XVIII — Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	
R00.0	Tachycardia, unspecified (Includes: Rapid heart beat, Tachycardia sinoauricular NOS, sinus [sinusal] NOS)
R00.1	Bradycardia, unspecified (Includes: Bradycardia: sinoatrial, sinus, vagal, Slow heart beat)
R00.2	Palpitations (Includes: Awareness of heart beat)
R00.8	Other and unspecified abnormalities of heart beat
R01	Cardiac murmurs and other cardiac sounds
R02	Gangrene, not elsewhere classified

ICD-10-CA Codes	Description
Chapter XVIII — Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	
R03	Abnormal blood-pressure reading, without diagnosis (Excludes: Hypotension (See I95.–))
R04.0	Epistaxis (Includes: Haemorrhage/hemorrhage from nose, Nosebleed)
R04.1	Haemorrhage from throat (Includes: Hemorrhage from throat)
R04.2	Haemoptysis (Includes: Blood-stained sputum, Cough with haemorrhage/hemorrhage, hemoptysis)
R04.8	Haemorrhage from other sites in respiratory passages (Includes: Pulmonary haemorrhage/hemorrhage NOS)
R04.9	Haemorrhage from respiratory passages, unspecified (Includes: Hemorrhage from respiratory passages, unspecified)
R05	Cough
R06.0	Dyspnoea (Includes: Orthopnoea/orthopnea, Shortness of breath [SOB], dyspnea)
R06.2	Wheezing
R06.8	Other and unspecified abnormalities of breathing (Includes: Apnoea/apnea NOS, Breath -holding (spells), Choking sensation, Sighing, Stridor, Periodic breathing, Cheynes-Stokes breathing, Hyperventilation, Mouth breathing, Snoring, Hiccough, Sneezing)
R07.0	Pain in throat
R07.1	Chest pain on breathing (Includes: Painful respiration)
R07.2	Precordial pain
R07.3	Other chest pain (Includes: Anterior chest-wall pain NOS)
R07.4	Chest pain, unspecified
R09.0	Asphyxia, unspecified
R09.1	Pleurisy
R09.2	Respiratory arrest (Includes: Cardiorespiratory failure) (Excludes: Cardiorespiratory arrest (See I46.9))
R09.3	Abnormal sputum (Includes: Abnormal: amount, colour, odour of sputum, Excessive)
R09.8	Other specified symptoms and signs involving the circulatory and respiratory systems (Includes: Bruit (arterial), Chest: abnormal percussion, friction sounds, tympany, Rales, Weak pulse)
R10.0	Acute abdomen (Includes: Severe abdominal pain (generalized) (localized) (with abnormal rigidity))
R10.1	Pain localized to upper abdomen
R10.2	Pelvic and perineal pain
R10.3	Pain localized to other parts of lower abdomen

ICD-10-CA Codes	Description
Chapter XVIII — Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	
R10.4	Other and unspecified abdominal pain (Includes: Abdominal tenderness NOS, Colic NOS, Colic infantile)
R11.0	Projectile vomiting
R11.1	Nausea alone
R11.2	Vomiting alone
R11.3	Nausea with vomiting
R12	Heartburn
R13.0	Oropharyngeal dysphagia (Includes: Neurogenic esophageal dysphagia, Obstructive esophageal dysphagia)
R13.2	Esophageal dysphagia (Includes: Neurogenic oropharyngeal dysphagia, Obstructive oropharyngeal dysphagia)
R13.8	Other and unspecified dysphagia
R14	Flatulence and related conditions (Includes: Abdominal distension (gaseous), Bloating, Eructation, Gas pain, Tympanites (abdominal) (intestinal))
R15	Faecal incontinence (Includes: Encopresis NOS; fecal incontinence)
R16	Hepatomegaly and splenomegaly, not elsewhere classified
R17	Unspecified jaundice
R18	Ascites (Includes: Fluid in peritoneal cavity)
R19	Other symptoms and signs involving the digestive system and abdomen
R20	Disturbances of skin sensation
R21	Rash and other nonspecific skin eruption
R22	Localized swelling, mass and lump of skin and subcutaneous tissue
R23	Other skin changes
R25.0	Abnormal head movements
R25.1	Tremor, unspecified
R25.2	Cramp and spasm
R25.3	Fasciculation (Includes: Twitching NOS)
R25.8	Other and unspecified abnormal involuntary movements
R26.0	Ataxic gait (Includes: Staggering gait)
R26.1	Paralytic gait (Includes: Spastic gait)
R26.2	Difficulty in walking, not elsewhere classified
R26.3	Immobility (Includes: Bedfast or Chairfast)
R26.82	Unsteadiness on feet
R26.88	Other and unspecified abnormalities of gait and mobility (Includes: antalgic gait)
R27.0	Ataxia, unspecified

ICD-10-CA Codes	Description
Chapter XVIII — Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	
R27.8	Other and unspecified lack of coordination
R29.6	Tendency to fall, not elsewhere classified (Includes: Tendency to fall because of old age or other unclear health problems) (Excludes: difficulty in walking (R26.2), dizziness and giddiness (R42) falls due to diseases classified elsewhere syncope and collapse (R55))
R29.8	Other and unspecified symptoms and signs involving the nervous and musculoskeletal systems (Includes: Tetany, Carpopedal spasm, Meningismus, Abnormal reflex, Abnormal posture, Clicking hip)
R30	Pain associated with micturition
R31	Unspecified haematuria (Includes: Essential hematuria, Unspecified hematuria)
R32	Unspecified urinary incontinence
R33	Retention of urine
R34	Anuria and oliguria
R35.0	Nocturia
R35.8	Other and unspecified polyuria (Includes: Frequency of micturition NOS)
R36	Urethral discharge (Includes: Penile discharge, Urethrorrhoea, urethrorrhea)
R39	Other symptoms and signs involving the urinary system
R40.0	Somnolence (Includes: Drowsiness)
R40.1	Stupor (Includes: Semicoma)
R40.2	Coma, unspecified
R41.0	Disorientation, unspecified (Includes: Confusion NOS)
R41.1	Anterograde amnesia
R41.2	Retrograde amnesia
R41.3	Other amnesia (Includes: Amnesia NOS)
R41.6	Neurological neglect syndrome (Includes: Asomatognosia, Hemi-akinesia, Hemi-inattention, Hemispatial neglect , Left-sided neglect, Sensory extinction, Sensory neglect, and Visuospatial neglect)
R41.80	Transient alteration of awareness
R41.88	Other and unspecified symptoms and signs involving cognitive functions and awareness
R42	Dizziness and giddiness (Includes: light-headedness, Vertigo NOS)
R44.3	Hallucinations, unspecified
R44.8	Other and unspecified symptoms and signs involving general sensations and perceptions
R45.0	Nervousness (Includes: Nervous tension)
R45.1	Restlessness and agitation

ICD-10-CA Codes	Description
Chapter XVIII — Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	
R45.2	Unhappiness (Includes: Depression, not clinically diagnosed feeling depressed, Sadness, Worries NOS) (Excludes: depression, diagnosis confirmed clinically (See F32)). (Note: Please see Mental Health Chapter)
R45.3	Demoralization and apathy
R45.4	Irritability and anger
R45.5	Hostility
R45.6	Physical violence
R45.7	State of emotional shock and stress, unspecified
R45.8	Other symptoms and signs involving emotional state (Includes: Suicidal ideation (tendencies))
R46.80	Obsessive-compulsive behaviour (Excludes: Obsessive-compulsive disorder (F42))
R46.88	Other symptoms and signs involving appearance and behaviour (Includes: Concern about body image, Difficult patient, Feeling senile, Feeling violent, Hostile behaviour.)
R47.0	Dysphasia and aphasia
R47.1	Dysarthria and anarthria
R47.8	Other and unspecified speech disturbances
R48.0	Dyslexia and alexia
R48.1	Agnosia
R48.2	Apraxia
R48.8	Other and unspecified symbolic dysfunctions (Includes: Acalculia, Agraphia)
R49.0	Dysphonia (Includes: Hoarseness)
R49.1	Aphonia (Includes: Loss of voice)
R49.8	Other and unspecified voice disturbances
R50	Fever of other and unknown origin (Includes: Drug-induced fever, Fever with chills, Fever with rigors, Persistent fever, Hyperpyrexia NOS, Pyrexia)
R51	Headache (Includes: Facial Pain NOS)
R52.0	Acute pain
R52.1	Chronic intractable pain
R52.2	Other chronic pain
R52.9	Pain, unspecified (Includes: Generalized pain NOS)
R53	Malaise and fatigue (Includes: Asthenia NOS, Debility: NOS, chronic, nervous, General physical deterioration, Lethargy, Tiredness)
R54	Senility (Includes: Old age without mention of psychosis, Senescence without mention of psychosis, Senile: asthenia, debility)

ICD-10-CA Codes	Description
Chapter XVIII — Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	
R55	Syncope and collapse (Includes: Blackout, Fainting)
R56	Convulsions, not elsewhere classified (Includes: First time, single isolated seizure (no history of previous seizure)) (Excludes: a previous history of seizure(s) or recurrent seizures, see G40)
R57	Shock, not elsewhere classified
R58	Haemorrhage, not elsewhere classified (Includes: Haemorrhage/hemorrhage NOS, hemorrhage NEC)
R59	Enlarged lymph nodes (Includes: swollen glands)
R60	Oedema, not elsewhere classified (Includes: Edema, NEC)
R63.0	Anorexia (Includes: Aphagia, Loss of appetite)
R63.1	Polydipsia (Includes: Excessive thirst)
R63.2	Polyphagia (Includes: Excessive eating, Hyperalimentation NOS)
R63.3	Feeding difficulties and mismanagement (Includes: Feeding problem NOS)
R63.4	Abnormal weight loss
R63.5	Abnormal weight gain (Excludes: obesity (E66))
R63.6	Insufficient intake of food and water due to self neglect
R63.8	Other symptoms and signs concerning food and fluid intake
R64	Cachexia (Includes: Adult failure to thrive)
R65.0	Systemic inflammatory response syndrome of infectious origin without organ failure
R65.1	Systemic inflammatory response syndrome of infectious origin with acute organ failure (Includes: Severe sepsis)
R65.2	Systemic inflammatory response syndrome of noninfectious origin without organ failure
R65.3	Systemic inflammatory response syndrome of noninfectious origin with acute organ failure
R65.9	Systemic inflammatory response syndrome, unspecified
R68.8	Other specified general symptoms and signs
R69	Unknown and unspecified causes of morbidity (Includes: Illness NOS, Undiagnosed disease, not specified as to the site or system involved)
R79	Other abnormal findings of blood chemistry (Includes: abnormality of RBCs, abnormality of WBCs NEC, elevated blood glucose level, proteinemia, abnormal blood gas level, findings of drugs and other substances not normally found in blood) (Excludes: Other diseases of blood and blood-forming organs (D75))

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S00.2	Other superficial injuries of eyelid and periocular area
S00.5	Superficial injury of lip and oral cavity
S00.7	Multiple superficial injuries of head
S00.8	Superficial injury of other parts of head (Includes: superficial injury of head, part unspecified)
S01	Open wound of head
S02.100	Fracture of base of skull, closed
S02.101	Fracture of base of skull, open
S02.200	Fracture of nasal bones, closed
S02.201	Fracture of nasal bones, open
S02.300	Fracture of orbital floor, closed
S02.301	Fracture of orbital floor, open
S02.4	Fracture of malar and maxillary bones
S02.5	Fracture of tooth
S02.700	Multiple fractures involving skull and facial bones, closed
S02.701	Multiple fractures involving skull and facial bones, open
S02.900	Fracture of skull and facial bones, part unspecified, closed
S02.901	Fracture of skull and facial bones, part unspecified, open
S03.0	Dislocation of jaw
S03.4	Sprain and strain of jaw (Includes: tempero-mandibular joint)
S03.5	Sprain and strain of joints and ligaments of other and unspecified parts of head (Includes: Dislocation of septal cartilage of nose, Dislocation of tooth, Dislocation of other and unspecified parts of head)
S06.0	Concussion
S06.1	Traumatic cerebral oedema (Includes: Traumatic cerebral edema)
S06.2	Diffuse brain injury (Includes: cerebral contusion NOS, cerebral laceration NOS)
S06.3	Focal brain injury
S06.4	Epidural haemorrhage (Includes: traumatic, Epidural hemorrhage)
S06.5	Traumatic subdural haemorrhage (Includes: Traumatic subdural hemorrhage)
S06.6	Traumatic subarachnoid haemorrhage (Includes: Traumatic subarachnoid hemorrhage)
S06.8	Other intracranial injuries
S06.9	Intracranial injury, unspecified
S10	Superficial injury of neck
S12.0	Fracture of first cervical vertebra

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S12.1	Fracture of second cervical vertebra
S12.20	Fracture of C3–C4 vertebra
S12.21	Fracture of C5–C7 vertebra
S12.7	Multiple fractures of cervical spine
S12.8	Fracture of other parts of neck (Includes: Hyoid bone, larynx, thyroid cartilage, trachea)
S12.9	Fracture of neck, part unspecified
S13.0	Traumatic rupture of cervical intervertebral disc
S13.1	Dislocation of cervical vertebra
S13.2	Dislocation of other and unspecified parts of neck
S13.3	Multiple dislocations of neck
S13.40	Whiplash associated disorder [WAD1] with complaint of neck pain, stiffness or tenderness only
S13.41	Whiplash associated disorder [WAD2] with complaint of neck pain with musculoskeletal signs
S13.42	Whiplash associated disorder [WAD3] with complaint of neck pain with neurological signs
S13.48	Other sprain and strain of cervical spine
S13.5	Sprain and strain of thyroid region
S13.6	Sprain and strain of joints and ligaments of other and unspecified parts of neck
S14.10	Complete lesion of cervical spinal cord
S14.11	Central cord lesion of cervical spinal cord
S14.12	Anterior cord syndrome of cervical spinal cord
S14.13	Posterior cord syndrome of cervical spinal cord
S14.18	Other injuries of cervical spinal cord (Includes: Incomplete spinal cord lesion)
S14.19	Unspecified lesion of cervical spinal cord
S15	Injury of blood vessels at neck level
S16	Injury of muscle and tendon at neck level
S20.0	Contusion of breast
S21	Open wound of thorax
S22.00	Fracture of thoracic vertebra T1–T6
S22.01	Fracture of thoracic vertebra T7–T12
S22.09	Fracture of unspecified thoracic vertebra
S22.1	Multiple fractures of thoracic spine
S22.2	Fracture of sternum
S22.3	Fracture of rib

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S22.40	Multiple fractures of 2 - 4 ribs
S22.41	Multiple fractures of 5 or more ribs
S22.49	Multiple fractures of unspecified number of ribs
S22.5	Flail chest
S23	Dislocation, sprain and strain of joints and ligaments of thorax (Includes: dislocation of thoracic vertebra, dislocation of other and unspecified parts of thorax, Sprain and strain of ribs and sternum (costal cartilage), sprain and strain of thoracic spine)
S24.10	Complete lesion of thoracic spinal cord
S24.11	Central cord lesion of thoracic spinal cord
S24.12	Anterior cord syndrome of thoracic spinal cord
S24.13	Posterior cord syndrome of thoracic spinal cord
S24.18	Other injuries of thoracic spinal cord (Includes: Incomplete spinal cord lesion)
S24.19	Unspecified lesion of thoracic spinal cord
S25	Injury of blood vessels of thorax
S26	Injury of heart (Includes: Contusion and haematoma/hematoma, Laceration, Puncture)
S27.1	Traumatic haemothorax (Includes: Traumatic hemothorax)
S27.2	Traumatic haemopneumothorax (Includes: Traumatic hemopneumothorax)
S27.31	Laceration and puncture of lung
S27.8	Injury of other specified intrathoracic organs
S27.81	Laceration of oesophagus (Includes: Laceration of esophagus)
S27.84	Laceration of other specified intrathoracic organs
S27.85	Other and unspecified injury of diaphragm
S27.86	Other and unspecified injury of oesophagus (Includes: Other and unspecified injury of esophagus)
S27.9	Injury of unspecified intrathoracic organ
S30.0	Contusion of lower back and pelvis (Includes: Buttock)
S30.1	Contusion of abdominal wall (Includes: Flank and groin)
S31	Open wound of abdomen, lower back and pelvis
S32.00	Fracture of lumbar vertebra, L1 level
S32.01	Fracture of lumbar vertebra, L2 level
S32.02	Fracture of lumbar vertebra, L3 level
S32.03	Fracture of lumbar vertebra, L4 level
S32.04	Fracture of lumbar vertebra, L5 level
S32.09	Fracture of lumbar vertebra, unspecified level

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S32.1	Fracture of sacrum
S32.2	Fracture of coccyx
S32.3	Fracture of ilium
S32.4	Fracture of acetabulum
S32.5	Fracture of pubis
S32.7	Multiple fractures of lumbar spine and pelvis
S32.8	Fracture of other and unspecified parts of lumbar spine and pelvis
S33.1	Dislocation of lumbar vertebra
S33.2	Dislocation of sacroiliac and sacrococcygeal joint
S33.3	Dislocation of other and unspecified parts of lumbar spine and pelvis
S33.5	Sprain and strain of lumbar spine
S33.6	Sprain and strain of sacroiliac joint
S34.10	Complete lesion of lumbar spinal cord
S34.11	Central cord lesion of lumbar spinal cord
S34.12	Anterior cord syndrome of lumbar spinal cord
S34.13	Posterior cord syndrome of lumbar spinal cord
S34.18	Other injuries of lumbar spinal cord (Includes: Incomplete spinal cord lesion)
S34.19	Unspecified lesion of lumbar spinal cord
S34.3	Injury of cauda equina
S34.4	Injury of lumbosacral plexus
S34.5	Injury of lumbar, sacral and pelvic sympathetic nerves (Includes: celiac and mesenteric nerve plexus)
S35	Injury of blood vessels at abdomen, lower back and pelvis level
S36	Injury of intra-abdominal organs
S37	Injury of of urinary and pelvic organs
S38	Crushing injury and traumatic amputation of part of abdomen, lower back and pelvis
S40.7	Multiple superficial injuries of shoulder and upper arm
S41	Open wound of shoulder and upper arm (Excludes: traumatic amputation of shoulder/upper arm (S48))
S42.0	Fracture of clavicle (Includes: Clavicle (acromial end and shaft), collar bone)
S42.1	Fracture of scapula (Includes: acromial process, acromion, shoulder blade)
S42.20	Fracture of surgical neck of humerus
S42.21	Fracture of anatomical neck of humerus
S42.22	Fracture of greater tuberosity of humerus

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S42.28	Fracture of other part of upper end of humerus
S42.29	Fracture of unspecified part of upper end of humerus
S42.30	Fracture of shaft of humerus NOS
S42.39	Fracture of unspecified part of humerus
S42.40	Supracondylar fracture of humerus
S42.41	Fracture of lateral condyle of humerus
S42.42	Fracture of medial condyle of humerus
S42.43	Fracture of unspecified condyle of humerus
S42.48	Fracture of other part of lower end of humerus
S42.49	Fracture of unspecified part of lower part of humerus
S42.7	Multiple fractures of clavicle, scapula and humerus
S43.0	Dislocation of shoulder joint (Includes: Glenohumeral joint)
S43.1	Dislocation of acromioclavicular joint
S43.2	Dislocation of sternoclavicular joint
S43.38	Dislocation of other parts of shoulder girdle
S43.39	Dislocation of unspecified part of shoulder girdle
S43.401	Sprain and strain of shoulder joint, rotator cuff capsule
S43.402	Sprain and strain of shoulder joint, NOS (Includes: glenohumeral joint, shoulder joint NOS)
S43.5	Sprain and strain of acromioclavicular joint
S43.6	Sprain and strain of sternoclavicular joint
S44.0	Injury of ulnar nerve at upper arm level
S44.1	Injury of median nerve at upper arm level
S44.2	Injury of radial nerve at upper arm level
S44.3	Injury of axillary nerve
S44.4	Injury of musculocutaneous nerve
S44.5	Injury of cutaneous sensory nerve at shoulder and upper arm level
S44.7	Injury of multiple nerves at shoulder and upper arm level
S44.8	Injury of other nerves at shoulder and upper arm level
S44.9	Injury of unspecified nerve at shoulder and upper arm level
S45	Injury of blood vessels at shoulder and upper arm level
S46	Injury of muscle and tendon at shoulder and upper arm level (Excludes: injury of muscle and tendon at or below elbow (S56))
S47	Crushing injury of shoulder and upper arm (Excludes: crushing injury of elbow (S57))

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S48.0	Traumatic amputation at shoulder joint
S48.1	Traumatic amputation at level between shoulder and elbow
S49	Other and unspecified injuries of shoulder and upper arm
S50	Superficial injury of forearm
S51.0	Open wound of elbow
S51.7	Open wound of forearm, multiple
S52.0	Fracture of upper end of ulna (Includes: olecranon process, proximal end, elbow NOS)
S52.1	Fracture of upper end of radius (Includes: head, neck, proximal end)
S52.2	Fracture of shaft of ulna
S52.3	Fracture of shaft of radius
S52.4	Fracture of shafts of both ulna and radius
S52.50	Colles' fracture
S52.58	Other fracture of lower end of radius
S52.59	Unspecified fracture of lower end of radius
S52.6	Fracture of lower end of both ulna and radius
S52.7	Multiple fractures of forearm
S52.8	Fracture of other parts of forearm (Includes: Head and lower end of ulna)
S52.9	Fracture of forearm, part unspecified
S53.1	Dislocation of elbow
S53.2	Traumatic rupture of radial collateral ligament
S53.3	Traumatic rupture of ulnar collateral ligament
S54.0	Injury of ulnar nerve at forearm level
S54.1	Injury of median nerve at forearm level
S54.3	Injury of cutaneous sensory nerve at forearm level
S54.7	Injury of multiple nerves at forearm level
S54.8	Injury of other nerves at forearm level
S55	Injury of blood vessels at forearm level
S57	Crushing injury of forearm (Includes: crushing injury of elbow) (Excludes: crushing injury of shoulder and upper arm (S47))
S58	Traumatic amputation of forearm
S59	Other and unspecified injuries of forearm
S60	Superficial injury of wrist and hand (Includes: Multiple superficial injuries of wrist and hand and fingers, Other and Unspecified superficial injuries of wrist and hand and fingers)

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S61	Open wound of wrist and hand (Includes: fingers) (Includes: Multiple open wounds of wrist and hand, Open wound of other and unspecified parts of wrist and hand)
S62.0	Fracture of navicular [scaphoid] bone of hand
S62.1	Fracture of other carpal bone(s) (Includes: capitate, hamate, lunate, pisiform, trapezium, trapezoid, triquetrum)
S62.2	Fracture of first metacarpal bone (Includes: Bennett's fracture)
S62.3	Fracture of other metacarpal bone
S62.4	Multiple fractures of metacarpal bones
S62.5	Fracture of thumb
S62.6	Fracture of other finger
S62.7	Multiple fractures of fingers
S62.8	Fracture of other and unspecified parts of wrist and hand
S63.0	Dislocation of wrist
S63.1	Dislocation of finger
S63.2	Multiple dislocations of fingers
S63.5	Sprain and strain of wrist
S64.0	Injury of ulnar nerve at wrist and hand level
S64.1	Injury of median nerve at wrist and hand level
S64.2	Injury of radial nerve at wrist and hand level
S64.3	Injury of digital nerve of thumb
S64.7	Injury of multiple nerves at wrist and hand level
S64.8	Injury of other nerves at wrist and hand level
S64.9	Injury of unspecified nerve at wrist and hand level
S65	Injury of blood vessels at wrist and hand level
S67	Crushing injury of wrist and hand
S68.0	Traumatic amputation of thumb (complete)(partial)
S68.2	Traumatic amputation of two or more fingers alone (complete)(partial)
S68.3	Combined traumatic amputation of (part of) finger(s) with other parts of wrist and hand
S68.8	Traumatic amputation of other parts of wrist and hand
S69	Other and unspecified injuries of wrist and hand
S70	Superficial injury of hip and thigh
S70.7	Multiple superficial injuries of hip and thigh
S71.0	Open wound of hip
S71.1	Open wound of thigh

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S71.7	Multiple open wounds of hip and thigh
S72.0	Fracture of neck of femur (Includes: fracture of hip NOS, fracture of head of femur, subcapital fracture of femur, intracapsular fracture of femur, transcervical fracture of femur, cervicotrochanteric)
S72.10	Intertrochanteric fracture
S72.19	Unspecified trochanteric fracture
S72.2	Subtrochanteric fracture
S72.3	Fracture of shaft of femur
S72.4	Fracture of lower end of femur
S72.7	Multiple fractures of femur
S72.8	Fractures of other parts of femur
S72.9	Fracture of femur, part unspecified
S73.0	Dislocation of hip
S73.1	Sprain and strain of hip
S74.0	Injury of sciatic nerve at hip and thigh level
S74.1	Injury of femoral nerve at hip and thigh level
S74.2	Injury of cutaneous sensory nerve at hip and thigh level
S74.7	Injury of multiple nerves at hip and thigh level
S74.8	Injury of other nerves at hip and thigh level
S74.9	Injury of unspecified nerve at hip and thigh level
S75	Injury of blood vessels at hip and thigh level
S76	Injury of muscle and tendon at hip and thigh level
S77	Crushing injury of hip and thigh
S78.0	Traumatic amputation at hip joint
S78.1	Traumatic amputation at level between hip and knee
S78.9	Traumatic amputation of hip and thigh, level unspecified
S79	Other and specified injuries of hip and thigh
S81.0	Open wound of knee
S81.7	Multiple open wounds of lower leg
S81.8	Open wounds of other parts of lower leg
S81.9	Open wound of lower leg, part unspecified
S82.0	Fracture of patella
S82.1	Fracture of upper (proximal) end of tibia (with or without fibula) (Includes: condyles, head, proximal end, tuberosity: with or without mention of fracture of fibula)

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S82.2	Fracture of shaft of tibia (with or without fibula) (Includes: With or without mention of fracture of fibula)
S82.3	Fracture of lower (distal) end of tibia (with or without fibula)
S82.4	Fracture of fibula alone
S82.5	Fracture of medial malleolus
S82.6	Fracture of lateral malleolus
S82.7	Multiple fractures of lower leg
S82.8	Fractures of other parts of lower leg
S82.9	Fracture of lower leg, part unspecified
S83.0	Dislocation of patella
S83.1	Dislocation of knee
S83.2	Tear of meniscus, current
S83.3	Tear of articular cartilage(s) of knee, current
S83.5	Sprain and strain involving (anterior) (posterior) cruciate ligament of knee
S83.6	Sprain and strain of other and unspecified parts of knee
S83.7	Injury to multiple structures of knee
S84.0	Injury of (posterior) tibial nerve at lower leg level
S84.1	Injury of peroneal nerve at lower leg level
S84.2	Injury of cutaneous sensory nerve at lower leg level
S84.8	Injury of other nerves at lower leg level
S84.9	Injury of unspecified nerve at lower leg level
S85	Injury of blood vessels at lower leg level (Excludes: Injury of blood vessels at ankle and foot level (S95))
S86	Injury of muscle and tendon at lower leg level (Excludes: Injury of muscle and tendon at or below ankle (S96))
S87.0	Crushing injury of knee
S87.8	Crushing injury of other and unspecified parts of lower leg (Excludes: crushing injury of ankle and foot (S97))
S88.0	Traumatic amputation at knee level
S88.1	Traumatic amputation at level between knee and ankle
S88.9	Traumatic amputation of lower leg, level unspecified
S89	Other and unspecified injuries of lower leg
S90	Superficial injury of ankle and foot (Includes: Contusion, Multiple superficial injuries of ankle and foot and toes, Other and Unspecified superficial injuries of ankle and foot and toes).
S91.0	Open wound of ankle

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
S91.1	Open wound of toe(s) without damage to nail
S91.2	Open wound of toe(s) with damage to nail
S91.7	Multiple open wounds of ankle and foot
S92.0	Fracture of calcaneus
S92.1	Fracture of talus
S92.2	Fracture of other tarsal bone(s)
S92.4	Fracture of great toe
S93.0	Dislocation of ankle joint
S93.1	Dislocation of toe(s)
S93.3	Dislocation of other and unspecified parts of foot
S94.0	Injury of lateral plantar nerve
S94.1	Injury of medial plantar nerve
S94.2	Injury of deep peroneal nerve at ankle and foot level
S94.3	Injury of cutaneous sensory nerve at ankle and foot level
S94.7	Injury of multiple nerves at ankle and foot level
S94.8	Injury of other nerves at ankle and foot level
S94.9	Injury of unspecified nerve at ankle and foot level
S95	Injury of blood vessels at ankle and foot level
S96	Injury of muscle and tendon at ankle and foot level
S97	Crushing injury of ankle and foot
S98.0	Traumatic amputation of foot at ankle level
S98.3	Traumatic amputation of other parts of foot
S99	Other and unspecified injuries of ankle and foot
T00	Superficial injuries involving multiple body regions
T02.0	Fractures involving head with neck
T02.1	Fractures involving thorax with lower back and pelvis
T02.2	Fractures involving multiple regions of one upper limb
T02.3	Fractures involving multiple regions of one lower limb
T02.4	Fractures involving multiple regions of both upper limbs
T02.5	Fractures involving multiple regions of both lower limbs
T02.6	Fractures involving multiple regions of upper limb(s)
T02.7	Fractures involving thorax with lower back and pelvis with limb(s)
T02.8	Fractures involving other combinations of body regions
T02.9	Multiple fractures, unspecified
T03	Dislocations, sprains and strains involving multiple body regions

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
T04.1	Crushing injuries involving thorax with abdomen, lower back and pelvis (Includes: trunk)
T04.4	Crushing injuries involving multiple regions of upper limb(s) with lower limb(s)
T04.8	Crushing injuries involving other combinations of body regions
T05.0	Traumatic amputation of both hands
T05.1	Traumatic amputation of one hand and other arm [any level, except hand]
T05.2	Traumatic amputation of both arms [any level]
T05.3	Traumatic amputation of both feet
T05.4	Traumatic amputation of one foot and other leg [any level, except foot]
T05.5	Traumatic amputation of both legs [any level]
T05.6	Traumatic amputation of upper and lower limbs, any combination [any level]
T05.8	Traumatic amputations involving other combinations of body regions
T05.9	Multiple traumatic amputations, unspecified
T07	Unspecified multiple injuries
T08	Fracture of spine, level unspecified
T09	Other injuries of spine and trunk, level unspecified (Includes: spinal plexus NOS)
T10	Fracture of upper limb, level unspecified
T11.1	Open wound of upper limb, level unspecified
T13.0	Superficial injury of lower limb, level unspecified (Includes: contusion)
T13.1	Open wound of lower limb, level unspecified
T14.0	Superficial injury of unspecified body region
T14.2	Fracture of unspecified body region
T14.3	Dislocation, sprain and strain of unspecified body region
T14.5	Injury of blood vessel(s) of unspecified body region
T20	Burn and corrosion of head and neck
T22	Burn and corrosion of shoulder and upper limb, except wrist and hand
T23	Burn and corrosion of wrist and hand
T24	Burn and corrosion of hip and lower limb, except ankle and foot
T26	Burn and corrosion confined to eye and adnexa
T27	Burn and corrosion of respiratory tract
T28	Burn and corrosion of other internal organs
T29	Burns and corrosions of multiple body regions
T30	Burn and corrosion, body region unspecified
T35	Frostbite involving multiple body regions and unspecified frostbite

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
T68	Hypothermia
T75.1	Drowning and nonfatal submersion
T75.4	Effects of electric current (Includes: Electrocution, Shock from electric current)
T79.2	Traumatic secondary and recurrent haemorrhage (Includes: Traumatic secondary and recurrent hemorrhage)
T79.3	Post-traumatic wound infection, not elsewhere classified
T79.4	Traumatic shock (Includes: Shock (immediate)(delayed) following injury)
T79.6	Traumatic ischaemia of muscle (Includes: Volkmann's ischaemic/ischemic contracture, traumatic ischemia of muscle, Traumatic rhabdomyolysis)
T79.7	Traumatic subcutaneous emphysema
T79.8	Other early complications of trauma
T79.9	Unspecified early complication of trauma
T80	Complications following infusion, transfusion and therapeutic injection (Includes: Perfusion, air embolism, infection, sepsis)
T81	Complications of procedures, not elsewhere classified (Includes: Hemorrhage, hematoma, shock complicating a procedure, wound dehisence, wound infection)
T82	Complications of cardiac and vascular prosthetic devices, implants and grafts
T83	Complications of genitourinary prosthetic devices, implants and grafts
T84	Complications of internal orthopaedic prosthetic devices, implants and grafts (Includes: Complications of internal orthopedic prosthetic devices, implants and grafts (e.g. pain)) (See also T84.0–T84.6)
T84.0	Mechanical complication of internal joint prosthesis (Includes: breakdown, displacement, malposition, protrusion)
T84.2	Mechanical complication of internal fixation device of other bones
T84.5	Infection and inflammatory reaction due to internal joint prosthesis
T84.6	Infection and inflammatory reaction due to internal fixation device [any site]
T85	Complications of other internal prosthetic devices, implants and grafts
T86	Failure and rejection of transplanted organs and tissues
T87.0	Complications of reattached (part of) upper extremity
T87.1	Complications of reattached (part of) lower extremity
T87.2	Complications of other reattached body part
T87.3	Neuroma of amputation stump
T87.4	Infection of amputation stump
T87.5	Necrosis of amputation stump
T87.6	Other and unspecified complications of amputation stump
T88	Other complications of surgical and medical care, not elsewhere classified

ICD-10-CA Codes	Description
Chapter XIX — Injury, poisoning and certain other consequences of external causes	
T88.7	Unspecified adverse effect of drug or medicament
T90.0	Sequelae of superficial injury of head
T90.1	Sequelae of open wound of head
T90.2	Sequelae of fracture of skull and facial bones
T90.3	Sequelae of injury of cranial nerves
T90.4	Sequelae of injury of eye and orbit
T90.5	Sequelae of intracranial injury
T90.8	Sequelae of other specified injuries of head
T90.9	Sequelae of unspecified injury of head
T91.1	Sequelae of fracture of spine
T91.2	Sequelae of other fracture of thorax and pelvis
T91.3	Sequelae of injury of spinal cord
T91.8	Sequelae of other specified injuries of neck and trunk
T92.1	Sequelae of fracture of arm
T92.2	Sequelae of fracture at wrist and hand level
T92.3	Sequelae of dislocation, sprain and strain of upper limb
T92.6	Sequelae of crushing injury and traumatic amputation of upper limb
T93.1	Sequelae of fracture of femur
T93.2	Sequelae of other fractures of lower limb
T93.3	Sequelae of dislocation, sprain and strain of lower limb
T93.6	Sequelae of crushing injury and traumatic amputation of lower limb
T94.1	Sequelae of injuries, not specified by body region
T98.3	Sequelae of complications of surgical and medical care, not elsewhere classified
Chapter XX — External causes of morbidity and mortality	
X44	Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances (prescription) (overdoses). (Includes: medicinal substances used to treat illness). (Note: These medicinal substances can be those prescribed by a physician, but taken incorrectly by the patient, or medicinal substances that are not prescription and are taken incorrectly by the patient)
X49	Accidental poisoning by and exposure to other and unspecified chemicals and noxious substances (Excludes: medicinal substances (X44)) (Includes: all other chemical substances such as soap, paint, glue, cleaning fluids, dyes, etc.)

ICD-10-CA Codes	Description
Chapter XX — External causes of morbidity and mortality	
X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances. Intentional self harm (overdose) or suicide attempt (prescription) (Includes: medicinal substances used to treat illness)
X69	Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances. Intentional self harm (overdose) or suicide (non prescription) (Excludes: medicinal substances (X64)) (Includes: all other chemical substances such as soap, paint, glue, cleaning fluids, dyes, etc.)
Chapter XXIII — Provisional codes for research and temporary assignment	
U04	Severe acute respiratory syndrome [SARS]
U82	Resistance to betalactam antibiotics (Includes: Resistance to: penicillin, methicillin MRSA, ESBL and other betalactam antiobiotics)
U83	Resistance to other antibiotics (Includes: VRE, quinolones)
U83.7	Resistance to multiple antibiotics only
U83.8	Resistance to other single specified antibiotic
U83.9	Resistance to unspecified antibiotic
Chapter XXI — Factors influencing health status and contact with health services	
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status (Includes: HIV positive NOS)
Z22.30	Carrier of drug-resistant micro-organism (Includes: Drug resistant: Staphylococcus, streptococcus, enterococcus, Clostridium difficile, Escherichia coli, other and unspecified)
Z34	Supervision of normal pregnancy
Z39	Postpartum care and examination (Note: the postpartum period is defined as the first 42 days after birth of the infant)
Z43.0	Attention to tracheostomy (Excludes: artificial opening status only, without need for care (Z93.–))
Z43.4	Attention to other artificial openings of digestive tract (Excludes: artificial opening status only, without need for care (Z93.–))
Z43.5	Attention to cystostomy (Excludes: artificial opening status only, without need for care (Z93.–))
Z43.6	Attention to other artificial openings of urinary tract (Includes: nephrostomy, ureterostomy, and urethrostomy) (Excludes: artificial opening status only, without need for care (Z93.–))
Z43.9	Attention to unspecified artificial opening (Includes: Attention to other specified artificial opening NEC, closure, removal of catheter, takedown stoma, toilet or cleansing). (Excludes: artificial opening status only, without need for care (Z93.–))
Z44	Fitting and adjustment of external prosthetic device

ICD-10-CA Codes	Description
Chapter XXI — Factors influencing health status and contact with health services	
Z51.0	Radiotherapy session
Z51.1	Chemotherapy session for neoplasm
Z51.3	Blood transfusion (without reported diagnosis)
Z51.5	Palliative care
Z72.0	Tobacco use
Z72.1	Alcohol use
Z72.2	Drug use
Z89.0	Acquired absence of finger(s) [including thumb], unilateral
Z89.1	Acquired absence of hand and wrist
Z89.2	Acquired absence of upper limb above wrist (Includes: Arm NOS)
Z89.3	Acquired absence of both upper limbs [any level] (Includes: Acquired absence of finger(s), bilateral)
Z89.4	Acquired absence of foot and ankle (Includes: Toe(s))
Z89.5	Acquired absence of leg at or below knee
Z89.6	Acquired absence of leg above knee (Includes: Leg NOS)
Z89.7	Acquired absence of both lower limbs [any level, except toes alone]
Z89.8	Acquired absence of upper and lower limbs [any level]
Z89.9	Acquired absence of limb, unspecified
Z90.2	Acquired absence of lung [part of]
Z90.3	Acquired absence of part of stomach (Includes: postoperative or post-traumatic loss of body part NEC)
Z90.4	Acquired absence of other parts of digestive tract (Includes: postoperative or post-traumatic loss of body part NEC)
Z91.5	Personal history of self-harm (Includes: Parasuicide, Self-poisoning, Suicide attempt)
Z93.0	Tracheostomy status (See also Z43.–)
Z93.1	Gastrostomy status(See also Z43.–)
Z93.2	Ileostomy status (See also Z43.–)
Z93.3	Colostomy status ((See also Z43.–)
Z93.4	Other artificial openings of gastrointestinal tract status (See also Z43.–)
Z93.5	Cystostomy status (See also Z43.–)
Z93.6	Other artificial openings of urinary tract status (Includes: Nephrostomy, Ureterostomy, Urethrostomy) (See also Z43.–)
Z93.8	Other artificial opening status (See also Z43.–)
Z93.9	Artificial opening status, unspecified (See also Z43.–)
Z94.0	Kidney transplant status

ICD-10-CA Codes	Description
Chapter XXI — Factors influencing health status and contact with health services	
Z94.1	Heart transplant status
Z94.2	Lung transplant status
Z94.3	Heart and lungs transplant status
Z94.4	Liver transplant status
Z94.9	Transplanted organ and tissue status, unspecified (Includes: Other transplanted organ and tissue status, Bone marrow transplant status, Intestine transplant status, Pancreas transplant status, Stem cell transplant status)
Z95.00	Presence of cardiac pacemaker
Z95.1	Presence of aortocoronary bypass graft
Z95.2	Presence of prosthetic heart valve
Z95.3	Presence of xenogenic heart valve
Z95.4	Presence of other heart-valve replacement
Z95.5	Presence of coronary angioplasty implant and graft (Includes: Presence of coronary artery prosthesis, Status following cornary angioplasty NOS)
Z95.8	Presence of other cardiac and vascular implants and grafts (Includes: Presence of intravascular prosthesis NEC, Status following peripheral angioplasty NOS)
Z95.9	Presence of cardiac and vascular implant and graft, unspecified
Z96.0	Presence of urogenital implants
Z96.1	Presence of intraocular lens (Includes: Pseudophakia)
Z96.2	Presence of otological and audiological implants (Includes: Bone-conduction hearing device, Cochlear implant, eustachian tube stent, Myringotomy tube(s), Stapes replacement)
Z96.3	Presence of artificial larynx
Z96.4	Presence of endocrine implants (Includes: Insulin pump)
Z96.5	Presence of tooth-root and mandibular implants (Includes: Maxillary implant)
Z96.60	Presence of artificial hip (Includes: Hip joint replacement (partial)(total))
Z96.61	Presence of artificial knee
Z96.68	Presence of other orthopaedic joint implants (Includes: Finger-joint replacement, Presence of other orthopedic joint implants)
Z96.69	Presence of orthopaedic joint implants unspecified (Includes: Presence of orthopedic joint implants unspecified)
Z96.7	Presence of other bone and tendon implants (Includes: Skull plate)
Z96.8	Presence of other specified functional implants
Z96.9	Presence of functional implant, unspecified
Z97.0	Presence of artificial eye
Z97.1	Presence of artificial limb (complete)(partial)
Z97.2	Presence of dental prosthetic device (complete) (partial)

ICD-10-CA Codes	Description
Chapter XXI — Factors influencing health status and contact with health services	
Z97.3	Presence of spectacles and contact lenses
Z97.4	Presence of external hearing-aid
Z97.5	Presence of (intrauterine) contraceptive device
Z97.8	Presence of other specified devices
Z98.0	Intestinal bypass and anastomosis status
Z98.1	Arthrodesis status
Z98.2	Presence of cerebrospinal fluid drainage device (Includes: CSF shunt)
Z98.8	Other specified postsurgical states
Z99.0	Dependence on aspirator
Z99.1	Dependence on respirator
Z99.2	Dependence on renal dialysis (Includes: Presence of arteriovenous shunt for dialysis, Renal dialysis status)
Z99.8	Dependence on other enabling machines and devices

Appendix F — CCI procedures and interventions validation table

Coding CCI procedures and interventions

To be used when coding data element 86 Pre-Admit Comorbid Procedure or Intervention CCI.

CCI code	Description
1AA52	Drainage, meninges and dura mater of brain
1AB52	Drainage, subarachnoid
1AB86	Closure of fistula, subarachnoid
1AC52	Drainage, ventricles of brain
1AN52	Drainage, brain
1AW72	Release, spinal cord
1AX73	Reduction, spinal canal and meninges
1BB72	Release, other nerves of head and neck
1BG72	Release, brachial plexus
1BG80	Repair, brachial plexus
1BM72	Release, nerve(s) of upper arm and elbow
1BN72	Release, nerve(s) of forearm and wrist
1BP72	Release, nerve(s) of hand
1GZ31	Ventilation, respiratory system NEC
1GZ32	Oxygenation, respiratory system NEC
1SC74	Fixation, spinal vertebrae
1SC75	Fusion, spinal vertebrae
1SC80	Repair, spinal vertebrae
1SE87	Excision partial, intervertebral disc
1SF80	Repair, sacrum and coccyx
1SG80	Repair, muscles of the back
1SI75	Fusion, sacroiliac joint
1SK80	Repair, sternum
1SL80	Repair, ribs
1SM80	Repair, clavicle

CCI code	Description
1SQ03	Immobilization, pelvis
1SQ53	Implantation of internal device, pelvis
1SQ74	Fixation, pelvis
1SQ80	Repair, pelvis
1SY80	Repair, muscles of the chest and abdomen
1TA53	Implantation of internal device, shoulder joint
1TA74	Fixation, shoulder joint
1TA80	Repair, shoulder joint
1TA93	Amputation, shoulder joint (Includes: Amputation, through shoulder joint)
1TB74	Fixation, acromioclavicular and sternoclavicular joints
1TC80	Repair, rotator cuff
1TK74	Fixation, humerus
1TK93	Amputation, humerus (Includes: Amputation , above the elbow)
1TM53	Implantation of internal device, elbow joint
1TM74	Fixation, elbow joint
1TM75	Fusion, elbow joint
1TM80	Repair, elbow joint
1TM93	Amputation, elbow joint
1TV74	Fixation, radius and ulna
1TV93	Amputation, radius and ulna (Includes: Amputation, below elbow)
1UB74	Fixation, wrist joint
1UB75	Fusion, wrist joint
1UB80	Repair, wrist joint
1UB93	Amputation, wrist joint (Includes: Amputation, through wrist joint)
1UC74	Fixation, distal radioulnar joint and carpal joints and bones
1UC80	Repair, distal radioulnar joint and carpal joints and bones
1UF80	Repair, metacarpal bones
1UG80	Repair, metacarpophalangeal joint(s)
1UJ93	Amputation, phalanx of hand
1US80	Repair, extensor tendons of finger [excludes thumb]
1UT80	Repair, flexor tendons of finger [excludes thumb]
1VA53	Implantation of internal device, hip joint

CCI code	Description
1VA73	Reduction, hip joint
1VA74	Fixation, hip joint
1VA75	Fusion, hip joint
1VA80	Repair, hip joint
1VA93	Amputation, hip joint
1VC74	Fixation, femur
1VC93	Amputation, femur (Includes: Amputation, above knee)
1VG53	Implantation of internal device, knee joint
1VG73	Reduction, knee joint
1VG74	Fixation, knee joint
1VG75	Fusion, knee joint
1VG80	Repair, knee joint
1VG93	Amputation, knee joint (Includes: Amputation, through knee joint)
1VK80	Repair, meniscus of knee
1VK87	Excision partial, meniscus of knee
1VK89	Excision total, meniscus of knee
1VL80	Repair, cruciate ligaments of knee
1VM80	Repair, collateral ligaments of knee
1VN80	Repair, cruciate with collateral ligaments of knee
1VP74	Fixation, patella
1VP80	Repair, patella
1VP89	Excision total, patella
1VQ74	Fixation, tibia and fibula
1VQ80	Repair, tibia and fibula
1VQ93	Amputation, tibia and fibula (Includes: Amputation, below knee)
1VS80	Repair, tendons of lower leg [around knee]
1WA53	Implantation of internal device, ankle joint
1WA74	Fixation, ankle joint
1WA75	Fusion, ankle joint
1WA80	Repair, ankle joint
1WA93	Amputation, ankle joint (Includes: Amputation, Syme’s, Amputation, through ankle joint)

CCI code	Description
1WB80	Repair, foot ligaments
1WE75	Fusion, tarsal bones and intertarsal joints [hindfoot, midfoot]
1WE93	Amputation, tarsal bones and intertarsal joints [hindfoot, midfoot]
1WJ80	Repair, tarsometatarsal joints, metatarsal bones and metatarsophalangeal joints [forefoot]
1WJ93	Amputation, tarsometatarsal joints, metatarsal bones and metatarsophalangeal joints [forefoot]
1WT79	Repair by increasing size, tendons of ankle and foot
1WT80	Repair, tendons of ankle and foot
1.ZZ.35.HA-1C	Pharmacotherapy, total body, using thrombolytic agent, percutaneous approach [intramuscular, intravenous, subcutaneous, intradermal] (Includes: tPA, streptokinase)

Appendix G — Summary of specification changes for 2016–2017

Element	Specification changes from 2015–2016 to 2016–2017
29 Date Ready for Discharge	A change in the validation rule now allows Date Ready for Discharge to be equal to or greater than (21) Admission Date (previously, only greater than).
33B Referred to Facility Number	Expanded the definition of coding option 99999 to include instances in which a facility number has not been issued by the province/territory.
34 Rehabilitation Client Group	The 02.1 Non-Traumatic Brain Dysfunction Rehabilitation Client Group is being subdivided into 02.11 Degenerative Processes and 02.12 Non Degenerative.
34 Rehabilitation Client Group	Cannot code a hip fracture (S72 family of codes) as the (80) Most Responsible Health Condition and also code Status Post Hip Replacement (08.5, 08.51 to 08.54) for the (34) Rehabilitation Client Group. These are inconsistent codes.
39 Onset Date	A change in the validation rule now permits Onset Date to be greater than or equal to (8) Birthdate (previously, only greater than).
68 Financial Management	New option has been added to allow to code as “8 Not able to test.”
75 Reintegration to Normal Living Index	New option has been added to allow to code as “8 Not able to test/unable to answer.”
80 Most Responsible Health Condition ICD-10-CA	New validation rule introduced: If (80) Most Responsible Health Condition is coded using the G81 family of codes (Hemiplegia), then (34) Rehabilitation Client Group cannot be recorded as Stroke (01.1 to 01.9).
80 Most Responsible Health Condition ICD-10-CA	New validation rule introduced: If (80) Most Responsible Health Condition is coded using the G82 family of codes (Paraplegia and quadriplegia), then (34) Rehabilitation Client Group cannot be recorded as Spinal Cord Dysfunction (04.1 or 04.1 sub-codes or 04.2 or 04.2 sub-codes).
80 Most Responsible Health Condition ICD-10-CA	New validation rule introduced: If (80) Most Responsible Health Condition is R29.6 (Tendency to fall, not elsewhere classified), then (34) Rehabilitation Client Group cannot be recorded as Fracture of Lower Extremity (08.1, 08.11, 08.12, 08.2, 08.3, 08.4).

Element	Specification changes from 2015–2016 to 2016–2017
80 Most Responsible Health Condition ICD-10-CA	New validation rule introduced: If (80) Most Responsible Health Condition is from the Z89 family of codes (Acquired absence of . . .), then (34) Rehabilitation Client Group cannot be recorded as Amputation of Limb (05.1 to 05.9).
80 Most Responsible Health Condition ICD-10-CA	New validation rule introduced: If (80) Most Responsible Health Condition is coded using the Z96.6 family of codes (Presence of orthopedic joint implants), then (34) Rehabilitation Client Group cannot be recorded as Orthopedic Condition (08.1 to 08.9 and sub-codes).

Data elements accepted but flagged with new warnings in 2016–2017	
34 Rehabilitation Client Group (RCG)	Added 02.1 Non-Traumatic Brain Dysfunction to the list of Rehabilitation Client Group codes that will trigger warning *102000: Consider coding a more specific RCG subgroup if possible*.
34 Rehabilitation Client Group (RCG)	Data element will be flagged with a warning if the recorded value for data element (80) Most Responsible Health Condition is in the I60 family of codes (Subarachnoid hemorrhage) AND data element (34) RCG is submitted as 02.1 or 02.11 or 02.12 (Non-Traumatic Brain Dysfunction).
34 Rehabilitation Client Group (RCG)	Data element will be flagged with a warning if the recorded value for data element (80) Most Responsible Health Condition is in the I61 family of codes (Intracerebral hemorrhage) AND data element (34) RCG is submitted as Non-Traumatic Brain Dysfunction (02.1, 02.11, 02.12) or Traumatic Brain Dysfunction (02.2, 02.21, 02.22).
34 Rehabilitation Client Group (RCG)	Data element will be flagged with a warning if the recorded value for data element (80) Most Responsible Health Condition is in the I62 family of codes (Other non-traumatic intracranial hemorrhage) AND data element (34) RCG is submitted as Stroke (01.1 to 01.9).
86 Pre-Admit Comorbid Procedure or Intervention CCI	Data element will be flagged with a warning if the same Pre-Admit Comorbid Procedure or Intervention CCI is recorded more than once for the same client on the same admission assessment.

NRS Language Code pick-list changes from 2015–2016 to 2016–2017

No changes were made to the NRS Language Code pick-list from 2015–2016 to 2016–2017.

NRS ICD-10-CA pick-list changes from 2015–2016 to 2016–2017

Slight changes were made to the NRS ICD-10-CA pick-list for 2016–2017. 1 new code was added to the list and further detail was added to 2 coding descriptions to facilitate code selection.

New ICD-10-CA code	Description
Z22.30	Carrier of drug-resistant micro-organism (Includes: Drug resistant: Staphylococcus, streptococcus, enterococcus, Clostridium difficile, Escherichia coli, other and unspecified)

Existing ICD-10-CA code	Description (change in bold)
M96.60	Fracture of bone following insertion of joint prosthesis **(USE AN ADDITIONAL CODE FROM CHAPTER XIX – TO IDENTIFY THE SITE OF THE FRACTURE)** (Note: This code is to be used for periprosthetic fractures that occur at any time while the device is in-situ. A fracture that occurs during the insertion of an implant, joint prosthesis or bone plate is classified to fracture by site)
M96.68	Fracture of bone following insertion of other and unspecified orthopedic implant (For example: bone plate) **(USE AN ADDITIONAL CODE FROM CHAPTER XIX – TO IDENTIFY THE SITE OF THE FRACTURE)** (Note: This code is to be used for periprosthetic fractures that occur at any time while the device is in-situ. A fracture that occurs during the insertion of an implant, joint prosthesis or bone plate is classified to fracture by site)

NRS Comorbid Procedure or Intervention CCI pick-list changes from 2015–2016 to 2016–2017

Code 1SE89 (Excision total, intervertebral disc) has been removed from the CCI pick-list for 2016–2017.

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