

# Additional Information Specification 0003: **Rehabilitation Services Attachment**

(This specification replaces  
*Additional Information Message 0003:  
Rehabilitation Services Attachment*  
May 2004)

Release 3.0  
Based on HL7 CDA Standard Release 2.0,  
with supporting LOINC<sup>®</sup> Tables

*Draft March 2007-post ballot*

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# 1 Introduction

This publication provides the defined data items and their corresponding LOINC®<sup>1</sup> code values specific to a rehabilitation services attachment for the following applications.

- Those codes that identify the attachment or attachment components used in transactions such as those defined by the ASC 277 *Health Care Claim Request for Additional Information* and the ASC X12 275 *Additional Information to Support a Health Care Claim or Encounter* Implementation Guides which are products of the insurance subcommittee, X12N, of Accredited Standards Committee X12.<sup>2,3</sup>
- Those codes used in HL7 Clinical Document Architecture (CDA) documents designed for inclusion in the BIN segment of the 275 transaction as described in the *HL7 Additional Information Specification Implementation Guide*<sup>4</sup>

The format of this document and the methods used to arrive at its contents are prescribed in the *HL7 Additional Information Specification Implementation Guide*.

Section 2 of this document defines the LOINC codes used to request rehabilitation services attachments, and the LOINC codes of each component in an attachment. Section 0 further describes each component of a specific rehabilitation services attachment, the cardinality of the components and their answer parts, and the description, entry types, data types, codes, and units of each answer part.

Section 4 presents coding examples, with a narrative scenario, an XML example, and a display image of each example attachment using a popular browser. Section 5 further describes the code sets used in the response to each answer part of the attachment.

**Note:** All LOINC codes and descriptions are copyrighted by the Regenstrief Institute, with all rights reserved. See <http://www.LOINC.org>.

## **Note to Ballot Reviewers:**

**This is not the official ballot copy; instead, it presents a more recent set of edits, strictly for appearance. Some typos were caught and fixed, but most of the editing deals with horizontal and vertical spacing throughout the document.**

**The ballot version of the document, with change tracking of changes made since January, is included in the zip on the HL7 Ballot Desktop for May2007. Direct link: <http://tinyurl.com/2pmveg>**

## **1.1 Business Purpose:**

Additional Information Specifications (AIS) are used to convey information associated with a specific business purpose. AISs are used to convey clinical and non-clinical additional information to support other health care transactions, such as the ASC X12 837 claims and the ASC X12 Health Care Services Review.

<sup>1</sup> LOINC® is a registered trademark of Regenstrief Institute and the LOINC Committee. The LOINC database and LOINC Users' Guide are copyright 1998-2006 Regenstrief Institute and the LOINC Committee and the LOINC database codes and names are available at no cost from <http://www.LOINC.org>. Email: LOINC@regenstrief.org

<sup>2</sup>Information on this and other X12/HIPAA-related implementation guides is available from the Washington Publishing Company, <http://www.wpc-edi.com/>

<sup>3</sup> Within this Health Level Seven document, references to the transaction defined by these X12 implementation guides will be abbreviated by calling them 275 and 277.

<sup>4</sup> Health Level Seven, Inc. 3300 Washtenaw Ave., Suite 227, Ann Arbor, MI 48104-4250. (<http://www.hl7.org>)

This Rehabilitation Services Attachment is used to convey information about therapy services provided for the primary purpose of assisting in an individual's rehabilitation program.

The items defined for electronic supporting documentation were developed by industry domain specific Work Groups and balloted through HL7. Many of the items described in the attachments are based on an analysis of paper forms that have been used by payers in the past. Each possible attachment item, however, has been reviewed for appropriateness in an electronic format.

When this attachment is used for a HIPAA transaction, please refer to the "definition" sub-section of the Claims Attachment Final Rule in the Federal Register for the HIPAA regulated standard definition of Rehabilitation Services.

## 1.2 LOINC Codes and Structure

LOINC codes are used for several purposes:

- In the 277 transaction set, LOINC codes identify the attachment type or attachment components being requested to support a claim or encounter.
- In the HL7 CDA document, LOINC codes are used to identify the attachment type, the attachment components, and their answer parts. LOINC codes may also identify the type of clinical document, if the provider has created the clinical document in CDA format. The HL7 CDA document is returned in the BIN segment of the 275 transaction set.
- LOINC modifier codes may be used in the 277 transaction to further define the specificity of a request.

For further information on the relationship and use of LOINC Codes with the X12 Transactions, and HL7 CDA Documents, see section 1.5 in the *HL7 Additional Information Specification Implementation Guide*.

## 1.3 Revision History

<i>Date</i>	<i>Purpose</i>
Sep 30, 1998	Initial release as separate document.
Dec 2001	Revised title and date; reconciled HL7 ballot responses
August 2003	CDA Ballot
December 2003	Version 2.0 Publication
December 2003	Release 2.1 Ballot
May 2004	May 2004 - Release 2.1 Publication (referenced by 9-23-2005 HIPAA NPRM)
November 2006	Draft using CDA R2
March 2007	Second Informativ Ballot for Release 3.0 Changes

## 1.4 Privacy Concerns in Examples

The names of natural persons that appear in the examples of this book are intentionally fictional. Any resemblance to actual natural persons, living or deceased is purely coincidental.

## 1.5 HL7 Attachment-CDA Document Variants

As described in the *HL7 Additional Information Specification Implementation Guide*, there are two variants of a CDA document when used as an attachment. These are as follows:

- The **human-decision variant** (HDV) is used solely for information that will be rendered for a person to look at, in order to make a decision. The HDV is not required to have structured or coded answers. The only LOINC value used in a HDV CDA document is the LOINC for the *Attachment Type Identifier*. HL7 provides a non-normative style sheet for this purpose. There are two further alternatives within the human-decision variant.
  - It can be a single <nonXMLBody> element that contains a reference to an external file that provides the content for the body of the document, or
  - It can contain a <structuredBody> element containing free text in XML elements that organize the material into sections, paragraphs, tables and lists as described in the *HL7 Additional Information Specification Implementation Guide*.
- The **computer-decision variant** (CDV) has the same content as the human-decision variant, but additional structured information and LOINC coded data is included so that a computer could provide decision support based on the document. Attachments in the CDV can be rendered for human decisions using the same style sheet that HL7 provides for rendering documents formatted according to the human-decision variant.

These variants do not differ in functional content. All variants of the same attachment have required and optional content as specified in the Additional Information Specification document for that attachment. The variants only differ with regard to whether structured and coded data is mandated.

Both variants place constraints upon what information must be present in the CDA to support the Attachment use case, described in section 1.1. Additional CDA structures (document sections, entries, et cetera), may be present to support use cases other than those defined by this AIS. Anything not explicitly prohibited by this AIS may be present in the CDA document to support use cases other than those defined herein.

## 1.6 Request for Information versus Request for Service

This attachment specification for rehabilitation services defines a “send-me-what-you-have” attachment. It asks for a set of rehabilitation services attachment components gathered during the rehabilitation services care process. **It is not asking for any additional data capture efforts.** For example, if the request for data is to send the longest term of sobriety and this information was not captured at the time of care, it is **not** asking the provider to obtain additional information if they don’t already have this information.

In any attachment component answer part it may sometimes be impossible to send a required answer and necessary to send, instead, a reason why the information is not available, using a “No Information” indicator. In the human decision variant the sender shall supplement the natural language explanation of why the information is not available. In the computer-decision variant the sender shall supplement the natural language explanation of why the information is not available with appropriate use of the @nullFlavor attribute value, as described in “No Information” indicator under the Representation of Data Types section 3.7.8 of the *HL7 Additional Information Specification Implementation Guide*.

## 2 LOINC Codes

### 2.1 Rehabilitation Services Supporting Documentation

Table 2.1 defines the LOINC codes used to request a complete attachment data set specific to a given rehabilitation treatment plan. The use of any of these codes in the 277 STC segment represents an explicit request for the complete set of data components relevant to the requested rehabilitation treatment plan.

#### Use of the LOINC Report Subject Identifier Codes

- Solicited Model - The use of one of the Rehabilitation Services attachment codes in the 277 request in the STC segment represents an explicit request for the complete set of components relevant to that Rehabilitation discipline.
- Unsolicited Model – The 275 Rehabilitation Services attachment must use the complete attachment data set for a given rehabilitation discipline, using the LOINC code in table 2.1 and including the required data elements in accordance with cardinality.

The provider shall return all data components for which data is available.

The provider may choose to return images of pages that constitute the requested information by using the <nonXMLBody> element of the CDA as described in the *HL7 Additional Information Specification Implementation Guide*.

The set of data components for each rehabilitation service attachment, identified by individual LOINC codes, is defined in Section 2.4.

**Table 2.1 LOINC codes for a complete rehabilitation attachment data set**

<b>LOINC code</b>	<b>Attachment Name</b>
18823-5	Alcohol-substance abuse rehabilitation attachment
18824-3	Cardiac rehabilitation attachment
18825-0	Medical social services rehabilitation attachment
18826-8	Occupational therapy rehabilitation attachment
19002-5	Physical therapy rehabilitation attachment
18594-2	Psychiatric rehabilitation attachment
19003-3	Respiratory therapy rehabilitation attachment
LOINC-TBD	Pulmonary therapy rehabilitation attachment
19004-1	Skilled nursing rehabilitation attachment
29206-0	Speech therapy rehabilitation attachment

Requests for laboratory results and/or non-lab diagnostic studies results related to a given rehabilitation encounter are to be reported individually as defined by CDAR2AIS0005R030 *Additional Information Specification 0005: Laboratory Results Attachment* and CDAR2AIS0004R030 *Additional Information Specification 0004: Clinical Reports Attachment*. The requester may also use the codes presented in those attachment specifications to request laboratory results or non-lab diagnostic study results related to a given rehabilitation encounter.



## 2.2 Scope Modification Codes

The HL7 publication *LOINC Modifier Codes (for use with ASC X12 Implementation Guides when Requesting Additional Information)* provides code values for further defining the specificity of a request for additional information. Both time window and item selection modifier codes are defined. This publication is available from HL7, and is in the download package with the AIS documents.

## 2.3 Special Considerations for Sending Medications

The LOINC codes for rehabilitation plans include some that can be used to request or send medications used as part of a plan. The considerations for sending medications are described in Section 2 of *Additional Information Specification 0006: Medications Attachment*. The sender shall use the instructions in that document for sending medications in rehabilitation plans. The sender does not need to send a unique Medications attachment to send medication information related to the rehabilitation treatment. The components and answer parts to send medications associated to rehabilitation treatments is included in this AIS. If further clarification on the components and answer parts are needed, please reference the *Additional Information Specification 0006: Medications Attachments* for these details.

## 2.4 Attachment Data Components

The questions that these LOINC codes represent are the result of a significant industry outreach project and represent the complete set of rehabilitation services attachment components. Individual LOINC codes are defined for each data component of the attachment specific to the disciplines listed in Table 2.1. These LOINC codes are listed in sections 2.4.1 to 2.4.10 respectively. For example, the data components comprising the cardiac rehabilitation attachment (LOINC 18824-3) appear in Table 0. Each table is headed by the LOINC code defining the complete attachment.

The LOINC codes in Table 2.1 represent requests for complete rehabilitation services attachments. However, the requester also has the option of focusing on a specific component of the attachment through the use of the LOINC codes defined in the following tables. In this case the provider will respond with information, when available, specific to the requested data components.

The attachment content of eight of the disciplines (cardiac rehabilitation, medical social services, occupational therapy, physical therapy, respiratory therapy, pulmonary therapy, skilled nursing and speech therapy) is virtually identical. The data components differ only by the name of the discipline. Psychiatric and alcohol-substance abuse attachments include the same general content with the addition of several data components unique to those disciplines.

The following tables show the specific data components and their LOINC codes for each of the nine rehabilitation disciplines. These LOINC codes may be used in 277 as defined in the associated Implementation Guide and will be mirrored in the corresponding 275 response, in the solicited model. In addition, these LOINC codes are used in the <code> elements of the computer-decision variant of *HL7 Additional Information Specification Implementation Guide*. The questions that these LOINC codes represent are the result of a significant industry outreach project and represent the complete set of rehabilitation services attachment components.

### Use of the component level LOINCs

- Solicited Model – The use of any of the data component level LOINCs in the 277 request in the STC segment represents an explicit request for the associated answer part(s) for that component. The LOINC used in the 277 request must be echoed back in the 275 and the appropriate answer part(s) sent in the HL7 CDA document. The required answer part(s) for the specific component LOINC requested must be sent in accordance with cardinality.

- Unsolicited Model – The 275 Rehabilitation Services attachment must use the LOINC code for the complete Attachment for the given rehabilitation discipline, and its data set, including the required data elements in accordance with cardinality. The complete attachment LOINC code is the first one listed in bold in each table.

For HIPAA covered claims attachment transactions, this AIS explicitly defines all components/questions and their corresponding answer part(s) that can be required by a health plan to support a claim or encounter for any of these specific Rehabilitation Services disciplines. Requirement of any component(s) or answer part(s) outside of this specification would constitute non-compliance with this standard. If additions or modifications to the content (components or answer parts) of this specification are needed, a request must be submitted to the HL7 Attachments Special Interest Group (ASIG), or through the DSMO process (see [www.hipaa-dsmo.org](http://www.hipaa-dsmo.org)). Requests for new or modified content will be considered for inclusion in a future version of this specification.

**2.4.1 Alcohol-Substance Abuse Rehabilitation Attachment****Table 2.4.1 Data Components for Alcohol-Substance Abuse Rehabilitation Attachment**

LOINC Code	Description
<b>18823-5</b>	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION ATTACHMENT</b>
27474-6	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, NEW/REVISED
27515-6	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT
27482-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, VISIT FREQUENCY
27477-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
18672-6	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SYMPTOMS WITH PHYSIOLOGICAL DEPENDENCE INDICATOR
18673-4	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REMISSION STATUS
18674-2	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LONGEST PERIOD OF SOBRIETY FOR ABUSED SUBSTANCE (COMPOSITE)
27478-7	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
27490-2	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
27491-0	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
27495-1	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
27496-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE (COMPOSITE)
27498-5	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED
27499-3	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGNOSIS FOR REHABILITATION
27501-6	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ACTUAL START DATE OF CARE
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
27503-2	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
27504-0	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
27505-7	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
27506-5	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REASON TO CONTINUE
27507-3	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, JUSTIFICATION
18662-7	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, CHIEF COMPLAINT + REASON FOR RELAPSE IF KNOWN

LOINC Code	Description
18663-5	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, HISTORY OF PRESENT ALCOHOL/SUBSTANCE ABUSE
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PAST TREAT ATTEMPTS
18664-3	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, FOLLOWUP APPROACH (COMPOSITE)
18669-2	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LEVEL OF PATIENT PARTICIPATION
18671-8	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, NEXT PLAN OF TREATMENT NARRATIVE
27513-1	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF NEXT PLANNED TREATMENT

**2.4.2 Cardiac Rehabilitation Attachment****Table 2.4.2 Data Components for Cardiac Rehabilitation Attachment**

LOINC Code	Description
<b>18824-3</b>	<b>CARDIAC REHABILITATION ATTACHMENT</b>
27483-7	CARDIAC REHABILITATION TREATMENT PLAN, NEW/REVISED
27457-1	CARDIAC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT
27531-3	CARDIAC REHABILITATION TREATMENT PLAN, VISIT FREQUENCY
27518-0	CARDIAC REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27519-8	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
27536-2	CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
27539-6	CARDIAC REHABILITATION TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
27543-8	CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
27544-6	CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE CARDIAC REHABILITATION PROFESSIONAL ON FILE (COMPOSITE)
27545-3	CARDIAC REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED
27546-1	CARDIAC REHABILITATION TREATMENT PLAN, PROGNOSIS FOR CARDIAC REHABILITATION
27548-7	CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
27445-6	CARDIAC REHABILITATION TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
27446-4	CARDIAC REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
27447-2	CARDIAC REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
27448-0	CARDIAC REHABILITATION TREATMENT PLAN, REASON TO CONTINUE
27449-8	CARDIAC REHABILITATION TREATMENT PLAN, JUSTIFICATION

**2.4.3 Medical Social Services Rehabilitation Attachment****Table 2.4.3 Data Components for Medical Social Services Rehabilitation Attachment**

LOINC Code	Description
<b>18825-0</b>	<b>MEDICAL SOCIAL SERVICES REHABILITATION ATTACHMENT</b>
27750-9	MEDICAL SOCIAL SERVICES TREATMENT PLAN, NEW/REVISED
27791-3	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE OF TREATMENT
27759-0	MEDICAL SOCIAL SERVICES TREATMENT PLAN, VISIT FREQUENCY
27754-1	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27755-8	MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
27764-0	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
27765-7	MEDICAL SOCIAL SERVICES TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
27769-9	MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
27770-7	MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE MEDICAL SOCIAL SERVICES PROFESSIONAL ON FILE (COMPOSITE)
27771-5	MEDICAL SOCIAL SERVICES TREATMENT PLAN, MEDICATION ADMINISTERED
27772-3	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PROGNOSIS FOR MEDICAL SOCIAL SERVICES
27774-9	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, ACTUAL START OF CARE
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
27776-4	MEDICAL SOCIAL SERVICES TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
27777-2	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
27778-0	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
27779-8	MEDICAL SOCIAL SERVICES TREATMENT PLAN, REASON TO CONTINUE
27780-6	MEDICAL SOCIAL SERVICES TREATMENT PLAN, JUSTIFICATION

**2.4.4 Occupational Therapy Rehabilitation Attachment****Table 2.4.4 Data Components for Occupational Therapy Rehabilitation Attachment**

LOINC Code	Description
<b>18826-8</b>	<b>OCCUPATIONAL THERAPY REHABILITATION ATTACHMENT</b>
27597-4	OCCUPATIONAL THERAPY TREATMENT PLAN, NEW/REVISED
27635-2	OCCUPATIONAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT
27606-3	OCCUPATIONAL THERAPY TREATMENT PLAN, VISIT FREQUENCY
27601-4	OCCUPATIONAL THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27602-2	OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
27611-3	OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
27612-1	OCCUPATIONAL THERAPY TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
27616-2	OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
27617-0	OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE OCCUPATIONAL THERAPY PROFESSIONAL ON FILE (COMPOSITE)
27618-8	OCCUPATIONAL THERAPY TREATMENT PLAN, MEDICATION ADMINISTERED
27619-6	OCCUPATIONAL THERAPY TREATMENT PLAN, PROGNOSIS FOR OCCUPATIONAL THERAPY
27621-2	OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
27623-8	OCCUPATIONAL THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
27624-6	OCCUPATIONAL THERAPY TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN INFORMATION (COMPOSITE)
27625-3	OCCUPATIONAL THERAPY TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
27626-1	OCCUPATIONAL THERAPY TREATMENT PLAN, REASON TO CONTINUE
27627-9	OCCUPATIONAL THERAPY TREATMENT PLAN, JUSTIFICATION

**2.4.5 Physical Therapy Rehabilitation Attachment****Table 2.4.5 Data Components for Physical Therapy Rehabilitation Attachment**

LOINC Code	Description
<b>19002-5</b>	<b>PHYSICAL THERAPY REHABILITATION ATTACHMENT</b>
27660-0	PHYSICAL THERAPY TREATMENT PLAN, NEW/REVISED
27698-0	PHYSICAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT
27669-1	PHYSICAL THERAPY TREATMENT PLAN, VISIT FREQUENCY
27664-2	PHYSICAL THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27665-9	PHYSICAL THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
27674-1	PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
27675-8	PHYSICAL THERAPY TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
27679-0	PHYSICAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
27680-8	PHYSICAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE PHYSICAL THERAPY PROFESSIONAL ON FILE (COMPOSITE)
27681-6	PHYSICAL THERAPY TREATMENT PLAN, MEDICATION ADMINISTERED
27682-4	PHYSICAL THERAPY TREATMENT PLAN, PROGNOSIS FOR PHYSICAL THERAPY
27684-0	PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING PLAN OF CARE
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
27686-5	PHYSICAL THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
27687-3	PHYSICAL THERAPY TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN INFORMATION (COMPOSITE)
27688-1	PHYSICAL THERAPY TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
27689-9	PHYSICAL THERAPY TREATMENT PLAN, REASON TO CONTINUE
27690-7	PHYSICAL THERAPY TREATMENT PLAN, JUSTIFICATION



**2.4.6 Psychiatric Rehabilitation Attachment****Table 2.4.6 Data Components for Psychiatric Rehabilitation Attachment**

LOINC Code	Description
<b>18594-2</b>	<b>PSYCHIATRIC REHABILITATION ATTACHMENT</b>
18626-2	PSYCHIATRIC REHABILITATION TREATMENT PLAN, NEW/REVISED
19007-4	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT
18637-9	PSYCHIATRIC REHABILITATION TREATMENT PLAN, VISIT FREQUENCY
18631-2	PSYCHIATRIC REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
18632-0	PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
18642-9	PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
18645-2	PSYCHIATRIC REHABILITATION TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
18649-4	PSYCHIATRIC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
18650-2	PSYCHIATRIC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE (COMPOSITE)
18651-0	PSYCHIATRIC REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED
18652-8	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PROGNOSIS FOR REHABILITATION
18654-4	PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
18656-9	PSYCHIATRIC REHABILITATION TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
18657-7	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PAST TREATMENT ATTEMPTS
18658-5	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
18659-3	PSYCHIATRIC REHABILITATION TREATMENT PLAN, REASON TO CONTINUE
18660-1	PSYCHIATRIC REHABILITATION TREATMENT PLAN, JUSTIFICATION
18661-9	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PSYCHIATRIC SYMPTOMS

**2.4.7 Respiratory Therapy Rehabilitation Attachment****Table 2.4.7 Data Components for Respiratory Therapy Rehabilitation Attachment**

LOINC Code	Description
<b>19003-3</b>	<b>RESPIRATORY THERAPY REHABILITATION ATTACHMENT</b>
27699-8	RESPIRATORY THERAPY TREATMENT PLAN, NEW/REVISED
27740-0	RESPIRATORY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT
27708-7	RESPIRATORY THERAPY TREATMENT PLAN, VISIT FREQUENCY
27703-8	RESPIRATORY THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27704-6	RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
27713-7	RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
27714-5	RESPIRATORY THERAPY TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
27718-6	RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
27719-4	RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE RESPIRATORY THERAPY PROFESSIONAL ON FILE (COMPOSITE)
27720-2	RESPIRATORY THERAPY TREATMENT PLAN, MEDICATION ADMINISTERED
27721-0	RESPIRATORY THERAPY TREATMENT PLAN, PROGNOSIS FOR RESPIRATORY THERAPY
27723-6	RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING PLAN OF CARE
LOINC-TBD	RESPIRATORY THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	RESPIRATORY THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE
LOINC-TBD	RESPIRATORY THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	RESPIRATORY THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
27725-1	RESPIRATORY THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
27726-9	RESPIRATORY THERAPY TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	RESPIRATORY THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
27727-7	RESPIRATORY THERAPY TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
27728-5	RESPIRATORY THERAPY TREATMENT PLAN, REASON TO CONTINUE
27729-3	RESPIRATORY THERAPY TREATMENT PLAN, JUSTIFICATION

**2.4.8 Pulmonary Therapy Rehabilitation Attachment****Table 2.4.8 Data Components for Pulmonary Therapy Rehabilitation Attachment**

LOINC Code	Description
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY REHABILITATION ATTACHMENT</b>
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, NEW/REVISED
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, VISIT FREQUENCY
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE RESPIRATORY THERAPY PROFESSIONAL ON FILE (COMPOSITE)
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, MEDICATION ADMINISTERED
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, PROGNOSIS FOR RESPIRATORY THERAPY
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING PLAN OF CARE
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, REASON TO CONTINUE
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, JUSTIFICATION

**2.4.9 Skilled Nursing Rehabilitation Attachment****Table 2.4.9 Data Components for Skilled Nursing Rehabilitation Attachment**

LOINC Code	Description
<b>19004-1</b>	<b>SKILLED NURSING REHABILITATION ATTACHMENT</b>
27470-4	SKILLED NURSING TREATMENT PLAN, NEW/REVISED
27587-5	SKILLED NURSING TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, DATE RANGE OF TREATMENT
27555-2	SKILLED NURSING TREATMENT PLAN, VISIT FREQUENCY
27550-3	SKILLED NURSING TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27551-1	SKILLED NURSING TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
27560-2	SKILLED NURSING TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
27561-0	SKILLED NURSING TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
27565-1	SKILLED NURSING TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
27566-9	SKILLED NURSING TREATMENT PLAN, SIGNATURE OF RESPONSIBLE SKILLED NURSING PROFESSIONAL ON FILE (COMPOSITE)
27567-7	SKILLED NURSING TREATMENT PLAN, MEDICATION ADMINISTERED
27568-5	SKILLED NURSING TREATMENT PLAN, PROGNOSIS FOR SKILLED NURSING
27570-1	SKILLED NURSING TREATMENT PLAN, DATE RANGE CERTIFYING PLAN OF CARE
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, ACTUAL START OF CARE DATE
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, PAST MEDICAL HISTORY
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
27572-7	SKILLED NURSING TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
27573-5	SKILLED NURSING TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
27574-3	SKILLED NURSING TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
27575-0	SKILLED NURSING TREATMENT PLAN, REASON TO CONTINUE
27576-8	SKILLED NURSING TREATMENT PLAN, JUSTIFICATION

**2.4.10 Speech Therapy Rehabilitation Attachment****Table 2.4.10 Data Components for Speech Therapy Rehabilitation Attachment**

LOINC Code	Description
<b>29206-0</b>	<b>SPEECH THERAPY REHABILITATION ATTACHMENT</b>
29162-5	SPEECH THERAPY TREATMENT PLAN, NEW/REVISED
29166-6	SPEECH THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT
29169-0	SPEECH THERAPY TREATMENT PLAN, VISIT FREQUENCY
29167-4	SPEECH THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
29168-2	SPEECH THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)
29203-7	SPEECH THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
29171-6	SPEECH THERAPY TREATMENT PLAN, CONTINUATION STATUS
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)
29174-0	SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)
29176-5	SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE SPEECH THERAPY PROFESSIONAL ON FILE (COMPOSITE)
29177-3	SPEECH THERAPY TREATMENT PLAN, MEDICATION ADMINISTERED
29178-1	SPEECH THERAPY TREATMENT PLAN, PROGNOSIS FOR THERAPY
29180-7	SPEECH THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING PLAN OF CARE
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY FUNCTION
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)
29182-3	SPEECH THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)
29183-1	SPEECH THERAPY TREATMENT PLAN, PLAN OF TREATMENT
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER NARRATIVE
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN INFORMATION (COMPOSITE)
29184-9	SPEECH THERAPY TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)
29185-6	SPEECH THERAPY TREATMENT PLAN, REASON TO CONTINUE
29186-4	SPEECH THERAPY TREATMENT PLAN, JUSTIFICATION

### 3 Rehabilitation Services Attachment Value Tables

Each of the tables in this section further describes the LOINC components listed in the above corresponding table, along with the expected answer part(s) for each question, including the entry type, data type, cardinality, and codes/units for each answer.

#### Value Table Layout

##### LOINC Code

Component – the LOINC code in **bold** identifies the question or the information being requested

Answer – the LOINC code for the answer part

If there is a single answer part for a LOINC, the LOINC code is on the same line as the Component. If there are multiple answer parts, the LOINC codes are in the next row in the table.

##### Description and Value – LOINC description and explanation.

For the computer decision variant (CDV), the xpath statement is shown.

With the CDV, some answers are placed in the CDA header of the document and are noted as such with the answer. When using the HDV method, those answers may optionally be placed in the CDA header, or they may be included in the CDA body.

Entry Type – CDA Release 2 type. This column describes the type of entry used in the CDA document to record the information.

Data Type – CDA Release 2 data type of the response value. For further information, see the Data Types section of the *HL7 Additional Information Specification Implementation*.

##### Cardinality (Card)

HL7 uses the term Cardinality to refer to the specification of the number of times that a component may or must repeat. When the minimum number of repetitions is zero, the cardinality specification indicates optionality.

Cardinality is described as a pair of numbers, the first is the least number of repetitions that are required, and the second the greatest. The second number can also be “n” which means an unspecified number, more than one. The common patterns are

- |     |  |
|-----|--|
| 1,1 | The attachment component or attachment component answer part is required; only a single occurrence is permitted    |
| 0,1 | The attachment component or attachment component answer part is optional; at most a single occurrence is permitted |
| 1,n | The attachment component or attachment component answer part is required; multiple occurrences are permitted       |
| 0,n | The attachment component or attachment component answer part is optional; multiple occurrences are permitted       |

The Card column describes repetition in the pattern of attachment components and attachment component answer parts. If such a value appears in a row containing a LOINC code for an attachment component, it describes whether the entire component (including one or more answer parts) can repeat. If a repetition value appears in a row containing LOINC code for an attachment component answer part, it indicates that the answer part can repeat within a single occurrence of the complete attachment component.

Response Code/Numeric Units – References to code tables or numeric units. See section 5 for specifics.

**3.1 Alcohol-Substance Abuse Rehabilitation Service Value Table****Table 3.1 Alcohol-Substance Abuse Rehabilitation Service Value Table**

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Card	Code / Numeric Units
<b>27474-6</b> 27474-6	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, NEW/REVISED</b>	<b>REL</b>	<b>CS</b>	<b>1,1</b>	ActRelationship Document
<p>If the treatment plan is revised, then it shall reference the previous treatment plan in the header.</p> <p>/ClinicalDocument/relatedDocument/@typeCode</p> <p>If the typeCode attribute contains the value RPLC then this is a revised treatment plan. If any other value is present (e.g., APND or XFRM), or the relatedDocument element is not present, then this treatment plan is new.</p>					
<b>27515-6</b> 27515-6	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>	<b>OBS</b>		<b>1,1</b>	
<p>The primary diagnosis information (code and date) is carried in an &lt;observation&gt; entry contained within the primary diagnosis section</p> <p>This entry can be located using the following XPath expression.</p> <p>/ClinicalDocument//section[code/@code="27515-6" and code/@codeSystem=\$LOINC]/observation[code/@code="275151-6" and code/@codeSystem=\$LOINC]</p>					
	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS</b>		<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
<p>The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.</p> <p>/ClinicalDocument//section[code/@code="27515-6" and code/@codeSystem=\$LOINC]/observation [code/@code="27515-6" and code/@codeSystem=\$LOINC]/value/@code</p>					
	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>		<b>TS</b>	<b>1,1</b>	
<p>The date of onset or exacerbation of the diagnosis is stored in the &lt;effectiveTime&gt; element of this observation.</p> <p>/ClinicalDocument//section[code/@code="27515-6" and code/@codeSystem=\$LOINC]/observation [code/@code="27515-6" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</p>					

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units
<b>LOINC-TBD</b>	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT</b>	<b>ACT</b>	<b>TS</b>	<b>1,1</b>	
	<p>The rehabilitation plan is documentation of the act of providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.</p> <p>Information about that act is found in the header of the clinical document through use of the &lt;serviceEvent&gt; element describing the act being documented.</p> <p>This element can be identified using the following XPath expression.  <code>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]</code></p> <p>The start date is stored in the &lt;low&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/low/@value</code></p> <p>The estimated end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value</code></p>				
<b>27482-9</b>	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	<b>UCUM</b>
27482-9	<p>The visit frequency is stored in an &lt;observation&gt; element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.</p> <p><code>/ClinicalDocument//section[code/@code="27482-9" and code/@codeSystem=\$LOINC]/observation [code/@code="27482-9" and code/@codeSystem=\$LOINC]/value</code></p>				
<b>27477-9</b>	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>19C 110C</b>
27477-9	<p>The diagnosis information is carried in an &lt;observation&gt; entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath</p>				



LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units
	expression, where "value" is the diagnosis code.				
	<i>/ClinicalDocument//section[code/@code="27477-9" and code/@codeSystem=\$LOINC]//observation [code/@code="27477-9" and code/@codeSystem=\$LOINC]/value/@code</i>				
<b>18672-6</b>	<b>ALCOHOL-SUBSTANCE ABUSE</b>	<b>OBS</b>	<b>BL</b>	<b>1,1</b>	
18672-6	<b>REHABILITATION TREATMENT PLAN, ALCOHOL/SUBSTANCE ABUSE SYMPTOMS WITH PHYSIOLOGICAL DEPENDENCE INDICATOR</b>				
	This is stored as an <observation> further describing the diagnosis addressed by the plan.				
	The <value> element of the <observation> encodes whether symptoms of physiological dependence are present or not.				
	<i>/ClinicalDocument//section[code/@code="18672-6" and code/@codeSystem=\$LOINC]//observation[code/@code="18672-6" and code/@codeSystem=\$LOINC]/value/@value</i>				
<b>18673-4</b>	<b>ALCOHOL-SUBSTANCE ABUSE</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	Subset of
18673-4	<b>REHABILITATION TREATMENT PLAN, REHABILITATION PROBLEM REMISSION STATUS</b>				SNOMED CT
	This information is stored as an <observation> further describing the diagnosis addressed by the plan.				
	The <value> element of the <observation> encodes the remission state of the diagnosis addressed by the plan.				
	<i>/ClinicalDocument//section[code/@code="18672-6" and code/@codeSystem=\$LOINC]//observation[code/@code="18672-6" and code/@codeSystem=\$LOINC]/value/@code</i>				
	416984007 Early Remission				
	417618009 Partial Remission				
	416312007 Full Remission				
<b>18674-2</b>	<b>ALCOHOL-SUBSTANCE ABUSE</b>	<b>OBS</b>		<b>0,n</b>	
	<b>REHABILITATION TREATMENT PLAN, LONGEST PERIOD OF SOBRIETY FOR ABUSED SUBSTANCE (COMPOSITE)</b>				
	This information is stored in an <observation> pertaining to the diagnosis addressed by the plan. The XPath Expression to access this information is:				
	<i>/ClinicalDocument//section[code/@code="18674-2" and code/@codeSystem=\$LOINC]//observation[code/@code="18674-2" and code/@codeSystem=\$LOINC]</i>				
18676-7	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LONGEST PERIOD OF SOBRIETY		PQ	1,1	UCUM
	The <value> element of the <observation> indicates the longest period of sobriety. The @value attribute indicates				

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	the length of the period.				
	<pre> /ClinicalDocument//section[code/@code="18674-2" and code/@codeSystem=\$LOINC]//observation[code/@code="18676-7" and code/@codeSystem=\$LOINC]/value/@value </pre>				
	Include units for the period of sobriety in the @unit attribute:				
	d days				
	mo months				
	wk weeks				
18675-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ABUSED SUBSTANCE		EN	1,1	
	Information about the substance is stored in a <participant> element attached to the sobriety observation.				
	<p>The XPath expression for the name of the substance is<sup>5</sup>:</p> <pre> /ClinicalDocument//section[code/@code="18674-2" and code/@codeSystem=\$LOINC]//observation[code/@code="18674-2" and code/@codeSystem=\$LOINC]/participant [@typeCode="CSM"]/participantRole[@classCode="ADMM"]/playingEntity[ @classCode="MAT"]/name </pre>				
27478-7	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)	PART		1,1	
	The author of the treatment plan is recorded in the header of the CDA Document.				
	It can be found using the following XPath expression.				
	<pre>/ClinicalDocument/author</pre>				
27479-5	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR NAME		PN	1,1	
	The name of the author is stored at the following location.				
	<pre>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</pre>				
27514-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR IDENTIFIER		II	1,1	NPI UPIN or other provider identifier
	Unique identifier for the professional who established the treatment plan. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.				
	This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.				

<sup>5</sup> The semantic meaning of this structure translates to the material entity playing the role of the administrable material participating as the consumable associated with the observation. More simply translated, what substance is being taken.

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	<i>/ClinicalDocument/author/assignedAuthor/id</i>				
27480-3	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR PROFESSION		CD	0,1	PTX
	As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>.				
	<i>/ClinicalDocument/author/assignedAuthor/code/@code</i>				
27490-2	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT	ENC	TS	0,1	
27490-2	The information about the encounter leading to treatment is stored in an <encounter> element in the section describing this encounter. The date range includes the Hospitalization Start Date and the Hospitalization End Date.				
	The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument/section[code/@code="27490-2" and code/@codeSystem=\$LOINC]/encounter[code/@code="27490-2" and code/@codeSystem=\$LOINC]/low/@value</i>				
	The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument/section[code/@code="27490-2" and code/@codeSystem=\$LOINC]/encounter [code/@code="27490-2" and code/@codeSystem=\$LOINC]/high/@value</i>				
27491-0	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, CONTINUATION STATUS	ACT	CS	0,1	ActStatus
27491-0	The continuation status is recorded in the <act> element describing the treatment.				
	This act can be found using the following XPath expression: <i>/ClinicalDocument/section[code/@code="27491-0" and code/@codeSystem=\$LOINC]/act[code/@code="27491-0" and code/@codeSystem=\$LOINC]/statusCode</i>				
	active    The treatment is ongoing. aborted    The treatment has been discontinued.				
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT, REFERRAL INFORMATION (COMPOSITE)	Section		0,1	
	Contains information about the referring person, date of referral and reason for referral.				
Same as Above	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION		ED	0,1	

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units
<p>A narrative description of the reason for the referral.</p> <p><i>/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text</i></p>					
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME		PN	0,1	
<p>The name of the individual who referred the patient for treatment.</p> <p><i>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name</i></p>					
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER		II	0,1	NPI UPIN or other provider identifier
<p>Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.</p> <p>This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.</p> <p><i>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/id</i></p>					
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT		TS	1,1	
<p>The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a &lt;participant&gt; element.</p> <p><i>/ClinicalDocument/participant[@typeCode="REF"]/time</i></p>					
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION – COMMUNICATION TO REFERRING PHYSICIAN INDICATOR		BL	0,1	
<p>An indicator defining if written communication has been sent back to the referring entity.</p> <p>true indicates that written communication has been sent</p> <p>false indicates that it has not been sent.</p> <p><i>/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/observation[code/@code="LOINC-TBD" and @codeSystem=\$LOINC]/value/@value</i></p>					

LOINC code	18823-5				
Component Answer	Alcohol-Substance Abuse Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
27495-1	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)	PART		0,1	
<p>The &lt;legalAuthenticator&gt; element in the CDA Header records information about the signing of the document by the legally responsible party for the content.</p> <p>This element can be found using the following XPath expression:  <a href="#">/ClinicalDocument/legalAuthenticator</a></p>					
27495-1	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE		CS	1,1	ParticipationSignature
<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p> <p><a href="#">/ClinicalDocument/legalAuthenticator/signatureCode/@code</a></p> <p>S            A signature is on file from this participant.  (any other)   A signature is not on file.</p>					
27493-6	ALCOHOL-SUBSTANCE ABUSE REHABILITATION DATE TREATMENT PLAN, AUTHOR SIGNED		TS	1,1	
<p>The &lt;time&gt; element of the &lt;legalAuthenticator&gt; element provides the time at which the document was signed.</p> <p><a href="#">/ClinicalDocument/legalAuthenticator/time/@value</a></p>					
27496-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE (COMPOSITE)	PART		1,1	
<p>The &lt;authenticator&gt; element in the CDA Header records information about the signing of the document by another (not legally responsible<sup>6</sup>) party for the content.</p> <p>This element can be found using the following XPath expression:  <a href="#">/ClinicalDocument/authenticator</a></p>					
27496-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE		CS	1,1	ParticipationSignature
<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p>					

<sup>6</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	18823-5			
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response
Answer	Description and Value	Type	Type	Code /
				Card
				Numeric Units
<i>/ClinicalDocument/authenticator/signatureCode/@code</i>				
S	A signature is on file from this participant.			
(any other)	A signature is not on file.			
27494-4	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE REHAB PROFESSIONAL SIGNED		TS	1,1
The time at which the plan was signed by is stored in the <time> element of the <authenticator> element in the CDA Header.				
<i>/ClinicalDocument/authenticator/time/@value</i>				
<b>27498-5</b>	<b>ALCOHOL-SUBSTANCE ABUSE</b>	<b>SBADM</b>		<b>0,n</b>
27498-5	<b>REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED</b>			
<p><b>Note: This item spans more than one page, below.</b></p> <p>Information about the administration of medication is recorded in an &lt;substanceAdministration&gt; element in the appropriate section.</p> <p>This information can be found using the following XPath expression:  <i>/ClinicalDocument//section[code/@code="27498-5" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27498-5" and code/@codeSystem=\$LOINC]</i></p> <p><b>Repeat the components as needed</b> to report all medications administered as past of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINCs used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 <i>Additional Information Specification 0006: Medications Attachment</i>.</p> <p>To affirmatively document that no medication was administered, include the section, but do not include any &lt;substanceAdministration&gt; elements inside it. Within the section narrative, indicate that no medications were provided.</p> <p>To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the &lt;substanceAdministration&gt; element.</p> <p>Medications uses a single LOINC answer part code that contains multiple components of medication information.</p>				
	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, MEDICATION NAME + IDENTIFIER		MMAT	1,1

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Card Numeric Units
Information about the medication administered is stored in the <manufacturedMaterial> or <manufacturedLabeledDrug> element of the <manufacturedProduct> element of the <consumable> element describing the medication administered. The <manufacturedMaterial> or <manufacturedLabeledDrug> element records the name of the medication in the <name> element, and a code describing the medication in the <code> element.					
NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.					
<code>/ClinicalDocument//section[code/@code="27498-5" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27498-5" and code/@codeSystem=\$LOINC]/manufacturedProduct/*[@classCode="MMAT"]</code>					
The code can be found here:			CD	0,1	NDC RxNorm SCD RxNorm SBD
<code>/ClinicalDocument//section[code/@code="27498-5" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27498-5" and code/@codeSystem=\$LOINC]/manufacturedProduct/*[@classCode="MMAT"]</code>					
The name of the substance can be found here:			ED	1,1	
<code>/ClinicalDocument//section[code/@code="27498-5" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27498-5" and code/@codeSystem=\$LOINC]/manufacturedProduct/*[@classCode="MMAT"]/name</code>					
ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, MEDICATION DOSE			PQ	0,1	UCUM
Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.					
<code>/ClinicalDocument//section[code/@code="27498-5" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27498-5" and code/@codeSystem=\$LOINC]/doseQuantity</code>					
<b>When the dose is specified in "eaches"</b> (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.					
ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, MEDICATION RATE			PQ	0,1	UCUM
Information about the dose rate (e.g., for IV administered medications) is stored in the <rateQuantity> element.					
<code>/ClinicalDocument//section[code/@code="27498-5" and code/@codeSystem=\$LOINC]/substanceAdministration</code>					

LOINC code	18823-5				
Component Answer	Alcohol-Substance Abuse Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>[code/@code="27498-5" and code/@codeSystem=\$LOINC]/rateQuantity</p> <p>The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.</p> <p>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, MEDICATION TIMING</p> <p>The &lt;effectiveTime&gt; element of the &lt;substanceAdministration&gt; element records both the start and end of the administration period, and the frequency of administration.</p> <p>/ClinicalDocument//section[code/@code="27498-5" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27498-5" and code/@codeSystem=\$LOINC]/effectiveTime</p> <p>One or more &lt;effectiveTime&gt; elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.</p>		GTS	1,1	UCUM
	<p>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, MEDICATION ROUTE</p> <p>Information about the medication route is stored in the &lt;routeCode&gt; element of the &lt;substanceAdministration&gt; element.</p> <p>/ClinicalDocument//section[code/@code="27498-5" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27498-5" and code/@codeSystem=\$LOINC]/routeCode/@code</p>		CD	1,1	RouteCode
27499-3	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGNOSIS FOR REHABILITATION	OBS	CD	1,1	Subset of SNOMED CT
27499-3	<p>The prognosis for rehabilitation is stored in an &lt;observation&gt; element in the appropriate section.</p> <p>The XPath Expression for this information is: /ClinicalDocument//section[code/@code="27499-3" and code/@codeSystem=\$LOINC]/observation[code/@code="27499-3" and code/@codeSystem=\$LOINC]</p> <p>The &lt;value&gt; of the &lt;observation&gt; is a code describing the prognosis for rehabilitation.</p> <p>/ClinicalDocument//section[code/@code="27499-3" and code/@codeSystem=\$LOINC]/observation[code/@code="27499-3" and code/@codeSystem=\$LOINC]/value/@code</p> <p>170969009 Poor 67334001 Guarded 65872000 Fair 170968001 Good</p>				
27501-6	ALCOHOL-SUBSTANCE ABUSE	ACT	IVL_TS	0,1	



LOINC code	18823-5				
Component Answer	Alcohol-Substance Abuse Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
27501-6	<b>REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>				
	Identifies the from and through date range that certifies the Plan of Care.				
	This element can be identified using the following XPath expression. /ClinicalDocument//section[code/@code="27501-6"]//act[code/@code="27501-6"]/effectiveTime				
LOINC-TBD	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>	Section	ED	0,1	
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.				
LOINC-TBD	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE</b>	ACT	TS	0,1	
	The begin date of the actual start of care.				
	This element can be identified using the following XPath expression. /ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime				
27502-4	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)</b>	Section	ED	1,1	
27502-4					
May need new LOINC due to change of title.					
LOINC-TBD	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>	OBS		1,1	
	Contains information about the level of function of the patient, both prior and current.				
LOINC-TBD	<b>PRIOR LEVEL OF FUNCTION</b>		CO <sup>7</sup>	1,1	GAF
	Information about the patient's prior level of function based on the Global Area of Functioning levels as defined in the Diagnostic Statistics Manual maintained by the American Psychiatric Association.				
	/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code				
LOINC-TBD	<b>CURRENT LEVEL OF FUNCTION</b>		CO <sup>7</sup>	1,1	GAF

<sup>7</sup> The Coded Ordinal (CO) Data Type is represented exactly as the CD data type. Use of this data type acts as an indicator that the codes are ordered, and can thus be compared to each other in some way. The GAF uses a coding system that describes the patient level of function on a scale, and thus, two code values can be compared to see if the patient function is improving.

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	Information about the patient's current level of function based on the Global Area of Functioning levels as defined in the Diagnostic Statistics Manual maintained by the American Psychiatric Association.				
	/ClinicalDocument//section[code/@code=" Same as question" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code				
27503-2	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)</b>	Section		1,n	
	Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition.				
27503-2	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ASSESSMENT – ASSESSMENT NARRATIVE		ED	1,1	
	/ClinicalDocument//section[code/@code="27503-2" and code/@codeSystem=\$LOINC]/text				
LOINC-TBD	INITIAL ASSESSMENT INDICATOR	OBS	BL	1,1	
	Identifies if this is the initial assessment or a re-evaluation of the patient's condition.				
	true Initial Assessment false Re-evaluation				
	/ClinicalDocument//section[code/@code="27503-2" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code				
27504-0	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)</b>	Section	ED	1,1	
27504-0					
	A narrative of the entire plan of treatment.				
LOINC-TBD	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)</b>	Section	ED	0,1	
	A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.				
27505-7	<b>ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE)</b>	Section		0,n	
	If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.				

LOINC code	18823-5				
Component Answer	Alcohol-Substance Abuse Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS NARRATIVE		ED	1,1	
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS DATE RANGE		TS	1,1	
/ClinicalDocument//section[code/@code="27505-7" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@value					
27506-5 27506-5	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)	Section	ED	0,1	
27507-3 27507-3	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, JUSTIFICATION (NARRATIVE)	Section	ED	0,1	
18662-7 18662-7 May need new LOINC due to title change.	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, CHIEF COMPLAINT +REASON FOR RELAPSE IF KNOWN (NARRATIVE)	Section	ED	0,1	
18663-5 18663-5	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, HISTORY OF PRESENT ALCOHOL/SUBSTANCE ABUSE (NARRATIVE)	Section	ED	1,1	
LOINC-TBD	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PAST TREATMENT ATTEMPTS (NARRATIVE)	Section	ED	0,1	
A narrative description of the past treatment attempts.					
18664-3	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, FOLLOWUP APPROACH (COMPOSITE)	ENC		0,1	
The information about follow-up is stored in an <encounter> element in the appropriate <section>. The XPath expression for this element is:					
/ClinicalDocument//section[code/@code="18664-3" and code/@codeSystem=\$LOINC]/encounter[code/@code="18664-3" and code/@codeSystem=\$LOINC]/					
The @moodCode attribute of the <encounter> is set to INT (or legal children) to indicate that this is intent to do something in the future.					
18665-0	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AGENCY THAT WILL FOLLOW UP		PRF	0,1	
Information about the agency that will follow up is					

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	<p>recorded in the &lt;representedOrganization&gt; element of the &lt;assignedEntity&gt; element, and can be found in the &lt;performer&gt; element associated with the intended &lt;encounter&gt;.</p> <p>/ClinicalDocument//section[code/@code="18664-3" and code/@codeSystem=\$LOINC]/encounter[code/@code="18664-3" and code/@codeSystem=\$LOINC]/performer/assignedEntity/representedOrganization/name</p> <p>Provider may respond with agency or person. If both are sent, the person should be affiliated with the agency.</p>				
18666-8	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PERSON THAT WILL FOLLOW UP		PN		0,1
	<p>Information about the person that will follow up is recorded in the &lt;assignedPerson&gt; element of the &lt;assignedEntity&gt; element, and can be found in the &lt;performer&gt; element associated with the intended &lt;encounter&gt;.</p> <p>/ClinicalDocument//section[code/@code="18664-3" and code/@codeSystem=\$LOINC]/encounter[code/@code="18664-3" and code/@codeSystem=\$LOINC]/performer/assignedEntity/assignedPerson/name</p> <p>Provider may respond with agency or person. If both are sent, the person should be affiliated with the agency.</p>				
18667-6	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, METHODOLOGY FOR FOLLOW UP		ED		1,1
	<p>The methodology for follow-up is stored in the &lt;text&gt; element of the &lt;encounter&gt;.</p> <p>/ClinicalDocument//section[code/@code="18664-3" and code/@codeSystem=\$LOINC]/encounter[code/@code="18664-3" and code/@codeSystem=\$LOINC]/text</p>				
18668-4	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, FREQUENCY OF ASSESSMENTS FOR FOLLOW UP	OBS	GTS		1,1
	<p>The frequency of assessments is stored as an &lt;observation&gt; element attached to the &lt;encounter&gt;.</p> <p>/ClinicalDocument//section[@code="18664-3" and code/@codeSystem=\$LOINC]/encounter[@code="18664-3" and code/@codeSystem=\$LOINC]/observation[@code="18668-4"]/value</p>				
18669-2	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LEVEL OF PATIENT PARTICIPATION	OBS	TX		1,1
18669-2	<p>This information is stored as an &lt;observation&gt;.</p> <p>/ClinicalDocument//section[code/@code="18669-2" and code/@codeSystem=\$LOINC]/observation[code/@code="18669-2" and code/@codeSystem=\$LOINC]/value</p>				

LOINC code	18823-5				
Component	Alcohol-Substance Abuse Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units
<b>18671-8</b>	<b>ALCOHOL-SUBSTANCE ABUSE</b>	<b>OBS</b>	<b>TX</b>	<b>0,1</b>	
18671-8	<b>REHABILITATION TREATMENT PLAN, NEXT PLAN OF TREATMENT TEXT (NARRATIVE)</b>				
<b>27513-1</b>	<b>ALCOHOL-SUBSTANCE ABUSE</b>	<b>ENC</b>	<b>TS</b>	<b>0,1</b>	
27513-1	<b>REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF NEXT PLANNED TREATMENT</b>				

The next planned treatment date range is recorded as an intended <encounter> in the appropriate section. The date range includes the next planned treatment start date and the next planned treatment end date.

The next planned treatment start date is stored in the <low> element of the <effectiveTime> element of the <encounter>. The next planned treatment end date is stored in the <high> element of the <effectiveTime> element of the <encounter>.

The XPath expression for this element is:

`/ClinicalDocument//section[code/@code="27513-1" and code/@codeSystem=$LOINC]//encounter[code/@code="27513-1" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`

`/ClinicalDocument//section[code/@code="27513-1" and code/@codeSystem=$LOINC]//encounter[code/@code="27513-1" and code/@codeSystem=$LOINC]/effectiveTime/high/@value`

## 3.2 Cardiac Rehabilitation Service Value Table

Table 3.2 Cardiac Rehabilitation Service Value Table

LOINC code	18824-3 Cardiac Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
Component Answer	Description and Value				
27483-7 27483-7	<b>CARDIAC REHABILITATION TREATMENT PLAN, NEW/REVISED</b>  If the treatment plan is revised, then it shall reference the previous treatment plan in the header. <i>/ClinicalDocument/relatedDocument/@typeCode</i>  RPLC          Revised any other      New	REL	CS	1,1	ActRelationshipDocument
27457-1 27457-1	<b>CARDIAC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>  The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary diagnosis section.  This entry can be located using the following XPath expression.  <i>/ClinicalDocument//section[code/@code="27457-1" and code/@codeSystem=\$LOINC]//observation[code/@code="27457-1" and code/@codeSystem=\$LOINC]</i>	OBS		1,1	
	<b>CARDIAC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS</b>  The diagnosis code is stored in the <code> element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.  This entry can be located using the following XPath expression, where “value” is the diagnosis code.  <i>/ClinicalDocument//section[code/@code="27457-1" and code/@codeSystem=\$LOINC]//observation [code/@code="27457-1" and code/@codeSystem=\$LOINC]/value/@code</i>		CD	1,1	I9C I10C
	<b>CARDIAC REHABILITATION TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>  The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation.  <i>/ClinicalDocument//section[code/@code="27457-1" and code/@codeSystem=\$LOINC]//observation [code/@code="27457-1" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</i>		TS	1,1	
LOINC-TBD	<b>CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT</b>	ACT	TS	1,1	

LOINC code	18824-3				
Component	Cardiac Rehabilitation Service				Response
Answer	Description and Value	Entry Type	Data Type	Card	Code / Numeric Units

The rehabilitation plan is documentation of the act of providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.

Information about that act is found in the header of the clinical document through use of the <serviceEvent> element describing the act being documented.

This element can be identified using the following XPath expression.

`/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]`

The start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element.

`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/low/@value`

The estimated end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.

`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`

<b>27531-3</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	<b>UCUM</b>
27531-3					

The visit frequency is stored in an <observation> element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.

`/ClinicalDocument//section[code/@code="27531-3" and code/@codeSystem=$LOINC]/observation [code/@code="27531-3" and code/@codeSystem=$LOINC]/value`

<b>27518-0</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
27518-0					

The diagnosis information is carried in an <observation> entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the <code> element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. . When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.

This entry can be located using the following XPath expression, where "value" is the diagnosis code.

`/ClinicalDocument//section[code/@code="27518-0" and code/@codeSystem=$LOINC]/observation [code/@code="27518-0" and code/@codeSystem=$LOINC]/value/@code`

LOINC code	18824-3				
Component Answer	Cardiac Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
27519-8	<b>CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>	PART		1,1	
	The author of the treatment plan is recorded in the header of the CDA Document.				
	It can be found using the following XPath expression. <i>/ClinicalDocument/author</i>				
27520-6	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR NAME		PN	1,1	
	The name of the author is stored at the following location. <i>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</i>				
27456-3	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR IDENTIFIER		II	1,1	NPI UPIN or other provider identifier
	Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.				
	See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.				
	<i>/ClinicalDocument/author/assignedAuthor/id</i>				
27521-4	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR PROFESSION		CD	0,1	PTX
	As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>.				
	<i>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</i>				
27536-2	<b>CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT</b>	ENC	TS	0,1	
27536-2					
	The information about the encounter leading to treatment is stored in an <encounter> element in the section describing this encounter.				
	The date range includes the Hospitalization Start Date and the Hospitalization End Date.				
	The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument/section[code/@code="27536-2" and code/@codeSystem=\$LOINC]/encounter[code/@code="27536-2" and code/@codeSystem=\$LOINC]/low/@value</i>				



LOINC code	18824-3				
Component Answer	Cardiac Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>The plan end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;encounter&gt; element.</p> <p>/ClinicalDocument//section[code/@code="27536-2" and code/@codeSystem=\$LOINC]/encounter [code/@code="27536-2" and code/@codeSystem=\$LOINC]/high/@value</p>				
<b>27539-6</b> 27539-6	<b>CARDIAC REHABILITATION TREATMENT PLAN, CONTINUATION STATUS</b>	<b>ACT</b>	<b>CS</b>	<b>0,1</b>	ActStatus
	<p>The continuation status is recorded in the &lt;act&gt; element describing the treatment. This act can be found using the following XPath expression:</p> <p>/ClinicalDocument//section[code/@code="27539-6" and code/@codeSystem=\$LOINC]/act[code/@code="27539-6" and code/@codeSystem=\$LOINC]/statuscode</p>				
<b>LOINC-TBD</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b>	<b>Section</b>		<b>0,1</b>	
	<p>Contains information about the referring person, date of referral and reason for referral.</p>				
Same as above	CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION		ED	0,1	
	<p>A narrative description of the reason for the referral.</p> <p>/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text</p>				
<b>LOINC-TBD</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME</b>		<b>PN</b>	<b>0,1</b>	
	<p>The name of the individual who referred the patient for treatment.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playing Entity/name</p>				
<b>LOINC-TBD</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER</b>		<b>II</b>	<b>0,1</b>	<b>NPI UPIN or other provider identifier</b>
	<p>Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.</p> <p>This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/id</p>				

LOINC code	18824-3				
Component Answer	Cardiac Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT		TS	1,1	
	<p>The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a &lt;participant&gt; element.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/time</p>				
27543-8	CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)	PART		0,1	
	<p>The &lt;legalAuthenticator&gt; element in the CDA Header records information about the signing of the document by the legally responsible party for the content.</p> <p>This element can be found using the following XPath expression:</p> <p>/ClinicalDocument/legalAuthenticator</p>				
27543-8	CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE		CS	1,1	ParticipationSignature
	<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p> <p>/ClinicalDocument/legalAuthenticator/signatureCode/@code</p> <p>S A signature is on file from this participant. (any other) A signature is not on file.</p>				
27541-2	CARDIAC REHABILITATION DATE TREATMENT PLAN, AUTHOR SIGNED		TS	1,1	
	<p>The &lt;time&gt; element of the &lt;legalAuthenticator&gt; element provides the time at which the document was signed.</p> <p>/ClinicalDocument/legalAuthenticator/time/@value</p>				
27544-6	CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE CARDIAC REHABILITATION PROFESSIONAL ON FILE (COMPOSITE)	PART		1,1	
	<p>The &lt;authenticator&gt; element in the CDA Header records information about the signing of the document by another (not legally responsible<sup>8</sup>) party for the content.</p> <p>This element can be found using the following XPath</p>				

<sup>8</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	18824-3				
Component Answer	Cardiac Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	expression: <i>/ClinicalDocument/authenticator</i>				
27544-6	CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE		CS	1,1	ParticipationSignature
	The <signatureCode> element provides the value indicating the signature status of the document  <i>/ClinicalDocument/authenticator/signatureCode/@code</i>				
	S A signature is on file from this participant. (any other) A signature is not on file.				
27542-0	CARDIAC REHABILITATION TREATMENT PLAN, DATE CARDIAC REHABILITATION PROFESSIONAL SIGNED		TS	1,1	
	The time at which the plan was signed by is stored in the <time> element of the <authenticator> element in the CDA Header.  <i>/ClinicalDocument/authenticator/time/@value</i>				
27545-3	CARDIAC REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED	SBADM		0,n	
27545-3					
Note: This item spans more than one page, below.	Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.  This information can be found using the following XPath expression: <i>/ClinicalDocument//section[code/@code="27545-3" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27545-3" and code/@codeSystem=\$LOINC]</i>  <b>Repeat the components as needed</b> to report all medications administered as past of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINCs used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 <i>Additional Information Specification 0006: Medications Attachment</i> .  To affirmatively document that no medication was administered, include the section, but do not include any <substanceAdministration> elements inside it. Within the section narrative, indicate that no medications were provided.  To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the <substanceAdministration> element.				

LOINC code	18824-3				
Component	Cardiac Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
Card				Numeric	Units
<p>Medications uses a single LOINC answer part code that contains multiple components of medication information.</p>					
CARDIAC REHABILITATION TREATMENT PLAN, MEDICATION NAME + IDENTIFIER		MMAT		1,1	
<p>Information about the medication administered is stored in the &lt;manufacturedMaterial&gt; element of the &lt;manufacturedProduct&gt; element of the &lt;consumable&gt; element describing the medication administered. The &lt;manufacturedMaterial&gt; element records the name of the medication in the &lt;name&gt; element, and a code describing the medication in the &lt;code&gt; element.</p> <p>NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.</p> <p>/ClinicalDocument//section[code/@code="27545-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27545-3" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/</p>					
The code can be found here:		CD		0,1	NDC RxNorm SCD RxNorm SBD
<p>/ClinicalDocument//section[code/@code="27545-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27545-3" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code</p>					
The name of the substance can be found here:		ED		1,1	
<p>/ClinicalDocument//section[code/@code="27545-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27545-3" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name</p>					
CARDIAC REHABILITATION TREATMENT PLAN, MEDICATION DOSE		PQ		1,1	UCUM
<p>Information about the dose amount is stored in the &lt;doseQuantity&gt; element of the &lt;substanceAdministration&gt; element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.</p> <p>/ClinicalDocument//section[code/@code="27545-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27545-3" and code/@codeSystem=\$LOINC]/doseQuantity</p>					
<p><b>When the dose is specified in "eaches"</b> (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.</p>					
CARDIAC REHABILITATION TREATMENT PLAN, MEDICATION RATE		PQ		0,1	UCUM

LOINC code	18824-3				
Component Answer	Cardiac Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>Information about the dose rate (e.g., for IV administered medications) is stored in the &lt;rateQuantity&gt; element.</p> <p>/ClinicalDocument//section[code/@code="27545-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27545-3" and code/@codeSystem=\$LOINC]/rateQuantity</p> <p>The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.</p> <p>CARDIAC REHABILITATION TREATMENT PLAN, MEDICATION TIMING</p> <p>The &lt;effectiveTime&gt; element of the &lt;substanceAdministration&gt; element records both the start and end of the administration period, and the frequency of administration.</p> <p>/ClinicalDocument//section[code/@code="27545-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27545-3" and code/@codeSystem=\$LOINC]/effectiveTime</p> <p>One or more &lt;effectiveTime&gt; elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.</p> <p>CARDIAC REHABILITATION TREATMENT PLAN, MEDICATION ROUTE</p> <p>Information about the medication route is stored in the &lt;routeCode&gt; element of the &lt;substanceAdministration&gt; element.</p> <p>/ClinicalDocument//section[code/@code="27545-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27545-3" and code/@codeSystem=\$LOINC]/routeCode/@code</p>				
			GTS	1,1	UCUM
			CD	1,1	RouteCode
27546-1	CARDIAC REHABILITATION TREATMENT PLAN, PROGNOSIS FOR CARDIAC REHABILITATION	OBS	CD	1,1	Subset of SNOMED CT
27546-1	<p>The prognosis for rehabilitation is stored in an &lt;observation&gt; element in the appropriate section. The XPath Expression for this information is:</p> <p>/ClinicalDocument//section[code/@code="27546-1" and code/@codeSystem=\$LOINC]/observation[code/@code="27546-1" and code/@codeSystem=\$LOINC]</p> <p>The &lt;value&gt; of the &lt;observation&gt; is a code describing the prognosis for rehabilitation.</p> <p>/ClinicalDocument//section[code/@code="27546-1" and code/@codeSystem=\$LOINC]/observation[code/@code="27546-1" and code/@codeSystem=\$LOINC]/value/@code</p> <p>170969009 Poor</p> <p>67334001 Guarded</p> <p>65872000 Fair</p>				

LOINC code	18824-3				
Component Answer	Cardiac Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	170968001 Good				
<b>27548-7</b> 27548-7	<b>CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>	<b>OBS</b>	<b>TS</b>	<b>0,1</b>	
	Identifies the from and through date range that certifies the Plan of Care.				
	This element can be identified using the following XPath expression. <i>/ClinicalDocument//section[code/@code="27548-7"]//act[code/@code="27548-7"]/effectiveTime</i>				
<b>LOINC-TBD</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.				
<b>LOINC-TBD</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE</b>	<b>???</b>	<b>TS</b>	<b>0,1</b>	
	The begin date of the actual start of care.				
	This element can be identified using the following XPath expression. <i>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</i>				
<b>27549-5</b> 27549-5 May need new LOINC due to title change.	<b>CARDIAC REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY(NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
<b>LOINC-TBD</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
	Contains information about the level of function of the patient, both prior and current.				
<b>LOINC-TBD</b>	<b>PRIOR LEVEL OF FUNCTION (NARRATIVE)</b>		<b>ED</b>	<b>1,1</b>	
	Information about the patient's prior level of function in narrative form.  <i>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</i>				
<b>LOINC-TBD</b>	<b>CURRENT LEVEL OF FUNCTION (NARRATIVE)</b>		<b>ED</b>	<b>1,1</b>	
	Information about the patient's current level of function in narrative form.  <i>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and</i>				

LOINC code	18824-3				
Component Answer	Cardiac Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<code>code/@codeSystem=\$LOINC/value</code>				
<b>27445-6</b>	<b>CARDIAC REHABILITATION TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)</b>	<b>Section</b>		<b>1,n</b>	
	Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition. If required to send both the initial assessment and a re-evaluation, send two occurrences of this component. At least one of the assessment narratives must be provided if this component is used.				
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR		<b>CD</b>	1,1	<b>HL97055</b>
	Identifies if this is the initial assessment or a re-evaluation of the patient's condition.				
	true Initial Assessment false Re-evaluation				
	<code>/ClinicalDocument/section[code/@code="27445-6" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code</code>				
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE		ED	0,1	
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE		ED	0,1	
<b>27446-4</b> 27446-4	<b>CARDIAC REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
	A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.				
<b>27447-2</b>	<b>CARDIAC REHABILITATION TREATMENT, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)</b>	<b>Section</b>	<b>ED</b>	<b>0,n</b>	
	If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.				

LOINC code	18824-3				
Component	Cardiac Rehabilitation Service				Response
Answer	Description and Value	Entry Type	Data Type	Card	Code / Numeric Units
LOINC-TBD	CARDIAC REHABILITATION TREATMENT, PROGRESS NOTE + ATTAINMENT OF GOALS DATE RANGE  <i>/ClinicalDocument/section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</i>		IVL_TS	1,1	
27448-0 27448-0	CARDIAC REHABILITATION TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)	Section	ED	0,1	
27449-8 27449-8	CARDIAC REHABILITATION TREATMENT PLAN, JUSTIFICATION (NARRATIVE)	Section	ED	0,1	



### 3.3 Medical Social Services Rehabilitation Value Table

Table 3.3 Medical Social Services Rehabilitation Value Table

LOINC code	18825-0				
Component Answer	Medical Social Services Rehabilitation	Entry Type	Data Type	Card	Response Code / Numeric Units
<b>27750-9</b> 27750-9	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, NEW/REVISED</b>	<b>REL</b>	<b>CS</b>	<b>1,1</b>	ActRelationship Document
	<p>If the treatment plan is revised, then it shall reference the previous treatment plan in the header.</p> <p>/ClinicalDocument/relatedDocument/@typeCode</p> <p>RPLC          Revised any other      New</p>				
<b>27791-3</b> 27791-3	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>	<b>OBS</b>		<b>1,1</b>	
	<p>The primary diagnosis information (code and date) is carried in an &lt;observation&gt; entry contained within the primary diagnosis section.</p> <p>This entry can be located using the following XPath expression. /ClinicalDocument//section[code/@code="27791-3" and code/@codeSystem=\$LOINC]//observation[code/@code="27791-3" and code/@codeSystem=\$LOINC]</p>				
	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PRIMARY DIAGNOSIS		CD	1,1	I9C I10C
	<p>The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use.</p> <p>When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code. /ClinicalDocument//section[code/@code="27791-3" and code/@codeSystem=\$LOINC]//observation [code/@code="27791-3" and code/@codeSystem=\$LOINC]/value/@code</p>				
	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS		TS	1,1	
	<p>The date of onset or exacerbation of the diagnosis is stored in the &lt;effectiveTime&gt; element of this observation.</p> <p>/ClinicalDocument//section[code/@code="27791-3" and code/@codeSystem=\$LOINC]//observation [code/@code="27791-3" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</p>				
<b>LOINC-TBD</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE OF TREATMENT</b>	<b>ACT</b>	<b>TS</b>	<b>1,1</b>	

LOINC code	18825-0				
Component	Medical Social Services Rehabilitation				Response
Answer	Description and Value	Entry Type	Data Type	Card	Code / Numeric Units

The rehabilitation plan is documentation of the act of providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.

Information about that act is found in the header of the clinical document through use of the <serviceEvent> element describing the act being documented.

This element can be identified using the following XPath expression.

`/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]`

The start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element.

`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/low/@value`

The estimated end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.

`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`

<b>27759-0</b> 27759-0	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	<b>UCUM</b>
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The visit frequency is stored in an <observation> element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.

`/ClinicalDocument//section[code/@code="27759-0" and code/@codeSystem=$LOINC]/observation [code/@code="27759-0" and code/@codeSystem=$LOINC]/value`

<b>27754-1</b> 27754-1	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
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The diagnosis information is carried in an <observation> entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the <code> element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use.

When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.

This entry can be located using the following XPath expression, where "value" is the diagnosis code.

`/ClinicalDocument//section[code/@code="27754-1" and code/@codeSystem=$LOINC]/observation [code/@code="27754-1" and`

LOINC code	18825-0				
Component Answer	Medical Social Services Rehabilitation	Entry Type	Data Type	Response Code / Card	Numeric Units
	<i>code/@codeSystem=\$LOINC/value/@code</i>				
<b>27755-8</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>	
	The author of the treatment plan is recorded in the header of the CDA Document.				
	It can be found using the following XPath expression. <i>/ClinicalDocument/author</i>				
27756-6	MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR NAME		PN	1,1	
	The name of the author is stored at the following location. <i>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</i>				
27787-1	MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR IDENTIFIER		II	1,1	NPI UPIN or other provider identifier
	Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.				
	See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.				
	<i>/ClinicalDocument/author/assignedAuthor/id</i>				
27757-4	MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR PROFESSION		CD	0,1	PTX
	The Author profession can be found in the <code> element of the <assignedAuthor>.				
	<i>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</i>				
	As described by the Health Care Provider Taxonomy.				
<b>27764-0</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT</b>	<b>ENC</b>	<b>TS</b>	<b>0,1</b>	
27764-0					
	The date range includes the Hospitalization Start Date and the Hospitalization End Date.				
	The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument/section[code/@code="27764-0" and code/@codeSystem=\$LOINC]/encounter[code/@code="27764-0" and code/@codeSystem=\$LOINC]/low/@value</i>				

LOINC code	18825-0				
Component Answer	Medical Social Services Rehabilitation	Entry Type	Data Type	Card	Response Code / Numeric Units
	<b>Description and Value</b>				
	<p>The plan end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;encounter&gt; element.</p> <p><i>/ClinicalDocument//section[code/@code="27764-0" and code/@codeSystem=\$LOINC]/encounter [code/@code="27760-4" and code/@codeSystem=\$LOINC]/high/@value</i></p>				
<b>27765-7</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, CONTINUATION STATUS</b>	<b>ACT</b>	<b>CS</b>	<b>0,1</b>	ActStatus
27765-7	<p>The continuation status is recorded in the &lt;act&gt; element describing the treatment. This act can be found using the following XPath expression:</p> <p><i>/ClinicalDocument//section[code/@code="27765-7" and code/@codeSystem=\$LOINC]/act[code/@code="27765-7" and code/@codeSystem=\$LOINC]/statuscode</i></p>				
<b>LOINC-TBD</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b>	<b>Section</b>		<b>0,1</b>	
	<p>Contains information about the referring person, date of referral and reason for referral.</p>				
Same as above	MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION – REASON FOR REFERRAL (NARRATIVE)		ED	0,1	
	<p>A narrative description of the reason for the referral.</p> <p><i>/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text</i></p>				
<b>LOINC-TBD</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION – REFERRING PERSON NAME</b>	<b>PART</b>	<b>PN</b>	<b>0,1</b>	
	<p>The name of the individual who referred the patient for treatment.</p> <p><i>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name</i></p>				
<b>LOINC-TBD</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION – REFERRING PERSON IDENTIFIER</b>		<b>II</b>	<b>0,1</b>	NPI UPIN or other provider identifier
	<p>Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.</p> <p>This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.</p>				

LOINC code	18825-0				
Component Answer	Medical Social Services Rehabilitation	Entry Type	Data Type	Card	Response Code / Numeric Units
	/ClinicalDocument/participant[@typeCode="REF"]/participantRole/id				
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION – DATE PATIENT REFERRED FOR TREATMENT		TS	1,1	
	The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a <participant> element.				
	/ClinicalDocument/participant[@typeCode="REF"]/time				
27769-9	MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)	PART		0,1	
	The <legalAuthenticator> element in the CDA Header records information about the signing of the document by the legally responsible party for the content.				
	This element can be found using the following XPath expression:				
	/ClinicalDocument/legalAuthenticator				
27769-9	MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE		CS	1,1	ParticipationSignature
	The <signatureCode> element provides the value indicating the signature status of the document.				
	/ClinicalDocument/legalAuthenticator/signatureCode/@code				
	S A signature is on file from this participant.				
	(any other) A signature is not on file.				
27767-3	MEDICAL SOCIAL SERVICES DATE TREATMENT PLAN, AUTHOR SIGNED		TS	1,1	
	The <time> element of the <legalAuthenticator> element provides the time at which the document was signed.				
	/ClinicalDocument/legalAuthenticator/time/@value				
27770-7	MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE MEDICAL SOCIAL SERVICES PROFESSIONAL ON FILE (COMPOSITE)	PART		1,1	
	The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible <sup>9</sup> ) party for the content.				

<sup>9</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	18825-0				
Component	Medical Social Services Rehabilitation				Response
Answer	Description and Value	Entry Type	Data Type	Card	Code / Numeric Units

This element can be found using the following XPath expression:

[/ClinicalDocument/authenticator](#)

27770-7	MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE	CS	1,1	ParticipationSignature
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The <signatureCode> element provides the value indicating the signature status of the document

[/ClinicalDocument/authenticator/signatureCode/@code](#)

S	A signature is on file from this participant.
(any other)	A signature is not on file.

27768-1	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE MEDICAL SOCIAL SERVICES PROFESSIONAL SIGNED	TS	1,1	
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The time at which the plan was signed by is stored in the <time> element of the <authenticator> element in the CDA Header.

[/ClinicalDocument/authenticator/time/@value](#)

27771-5	MEDICAL SOCIAL SERVICES REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED	SBADM	0,n	
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Note: This item spans more than one page, below.

Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.

This information can be found using the following XPath expression:

[/ClinicalDocument//section\[code/@code="27771-5" and code/@codeSystem=\\$LOINC\]//substanceAdministration\[code/@code="27771-5" and code/@codeSystem=\\$LOINC\]](#)

**Repeat the components as needed** to report all medications administered as part of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINCs used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 *Additional Information Specification 0006: Medications Attachment*.

To affirmatively document that no medication was administered, include the section, but do not include any <substanceAdministration> elements inside it. Within the section narrative, indicate that no medications were provided.

To affirmatively document that a specific medication was

LOINC code	18825-0				
Component Answer	Medical Social Services Rehabilitation	Entry Type	Data Type	Response Code /	Numeric Units
	<b>Description and Value</b>			Card	
	not administered, set the @negationInd attribute to “true” on the <substanceAdministration> element.				
	Medications uses a single LOINC answer part code that contains multiple components of medication information.				
	MEDICAL SOCIAL SERVICES REHABILITATION TREATMENT PLAN, MEDICATION NAME + IDENTIFIER		MMAT	1,1	
	Information about the medication administered is stored in the <manufacturedMaterial> element of the <manufacturedProduct> element of the <consumable> element describing the medication administered. The <manufacturedMaterial> element records the name of the medication in the <name> element, and a code describing the medication in the <code> element.				
	NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.				
	<i>/ClinicalDocument//section[code/@code="27771-5" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27771-5" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/</i>				
	The code can be found here: <i>/ClinicalDocument//section[code/@code="27771-5" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27771-5" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code</i>		CD	0,1	NDC RxNorm SCD RxNorm SBD
	The name of the substance can be found here: <i>/ClinicalDocument//section[code/@code="27771-5" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27771-5" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name</i>		ED	1,1	UCUM
	MEDICAL SOCIAL SERVICES REHABILITATION TREATMENT PLAN, MEDICATION DOSE		PQ	1,1	UCUM
	Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.				
	<i>/ClinicalDocument//section[code/@code="27771-5" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27771-5" and code/@codeSystem=\$LOINC]/doseQuantity</i>				
	<b>When the dose is specified in “eaches”</b> (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.				

LOINC code	18825-0				
Component Answer	Medical Social Services Rehabilitation	Entry Type	Data Type	Card	Response Code / Numeric Units
	<b>DESCRIPTION AND VALUE</b>  MEDICAL SOCIAL SERVICES REHABILITATION TREATMENT PLAN, MEDICATION RATE  Information about the dose rate (e.g., for IV administered medications) is stored in the <rateQuantity> element.  <i>/ClinicalDocument//section[code/@code="27771-5" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27771-5" and code/@codeSystem=\$LOINC]/rateQuantity</i>  The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.		PQ	1,1	UCUM
	<b>DESCRIPTION AND VALUE</b>  MEDICAL SOCIAL SERVICES REHABILITATION TREATMENT PLAN, MEDICATION TIMING  The <effectiveTime> element of the <substanceAdministration> element records both the start and end of the administration period, and the frequency of administration.  <i>/ClinicalDocument//section[code/@code="27771-5" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27771-5" and code/@codeSystem=\$LOINC]/effectiveTime</i>  One or more <effectiveTime> elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.		GTS	1,1	UCUM
	<b>DESCRIPTION AND VALUE</b>  MEDICAL SOCIAL SERVICES REHABILITATION TREATMENT PLAN, MEDICATION ROUTE  Information about the medication route is stored in the <routeCode> element of the <substanceAdministration> element.  <i>/ClinicalDocument//section[code/@code="27771-5" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27771-5" and code/@codeSystem=\$LOINC]/routeCode/@code</i>		CD	1,1	RouteCode
<b>27772-3</b> 27772-3	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, PROGNOSIS FOR MEDICAL SOCIAL SERVICES</b>  The prognosis for rehabilitation is stored in an <observation> element in the appropriate section.  The XPath Expression for this information is: <i>/ClinicalDocument//section[code/@code="27772-3" and code/@codeSystem=\$LOINC]//observation[code/@code="27772-3" and code/@codeSystem=\$LOINC]</i>  The <value> of the <observation> is a code describing the prognosis for rehabilitation.  <i>/ClinicalDocument//section[code/@code="27772-3" and code/@codeSystem=\$LOINC]//observation[code/@code="27772-3" and code/@codeSystem=\$LOINC]/value/@code</i>	OBS	CD	1,1	Subset of SNOMED CT



LOINC code	18825-0				
Component Answer	Medical Social Services Rehabilitation				Response Code /
	Description and Value	Entry Type	Data Type	Card	Numeric Units
	170969009 Poor				
	67334001 Guarded				
	65872000 Fair				
	170968001 Good				
<b>27774-9</b> 27774-9	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>	<b>ACT</b>	<b>IVL_TS</b>	<b>0,1</b>	
	Identifies the from and through date range that certifies the Plan of Care.				
	This element can be identified using the following XPath expression. /ClinicalDocument//section[code/@code="27774-9"]//act[code/@code="27774-9"]/effectiveTime				
<b>LOINC-TBD</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.				
<b>LOINC-TBD</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, ACTUAL START OF CARE DATE</b>	<b>ACT</b>	<b>TS</b>	<b>0,1</b>	
	The begin date of the actual start of care.				
	This element can be identified using the following XPath expression. /ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime				
<b>27775-6</b> 27775-6 May need new LOINC due to title change.	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
<b>LOINC-TBD</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
	Contains information about the level of function of the patient, both prior and current.				
<b>LOINC-TBD</b>	<b>PRIOR LEVEL OF FUNCTION (NARRATIVE)</b> Information about the patient's prior level of function in narrative form.		<b>ED</b>	<b>1,1</b>	
	/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value				
<b>LOINC-TBD</b>	<b>CURRENT LEVEL OF FUNCTION (NARRATIVE)</b> Information about the patient's current level of function in narrative form.		<b>ED</b>	<b>1,1</b>	

LOINC code	18825-0				
Component Answer	Medical Social Services Rehabilitation	Entry Type	Data Type	Card	Response Code / Numeric Units
/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value					
<b>27776-4</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)</b>	<b>Section</b>		<b>1,n</b>	
Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition. If required to send both the initial assessment and a re-evaluation, send two occurrences of this component. At least one of the assessment narratives must be provided if this component is used.					
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR		<b>CD</b>	1,1	<b>HL79055</b>
Identifies if this is the initial assessment or a re-evaluation of the patient's condition.					
true Initial Assessment false Re-evaluation					
/ClinicalDocument//section[code/@code="27776-4" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code					
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE		ED	0,1	
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE		ED	0,1	
<b>27777-2</b> 27777-2	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.					
<b>27778-0</b>	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)</b>	<b>Section</b>	<b>ED</b>	<b>0,n</b>	

LOINC code	18825-0				
Component	Medical Social Services Rehabilitation				Response
Answer	Description and Value	Entry Type	Data Type	Card	Code / Numeric Units
	If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.				
LOINC-TBD	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE		IVL_TS	1,1	
	/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime				
<b>27779-8</b> 27779-8	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
<b>27780-6</b> 27780-6	<b>MEDICAL SOCIAL SERVICES TREATMENT PLAN, JUSTIFICATION (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	

### 3.4 Occupational Therapy Rehabilitation Service Value Table

Table 3.4 Occupational Therapy Rehabilitation Service Value Table

LOINC code	18826-8				
Component Answer	Occupational Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
<b>27597-4</b> 27597-4	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, NEW/REVISED</b>	<b>REL</b>	<b>CS</b>	<b>1,1</b>	ActRelationship Document
	<p>If the treatment plan is revised, then it shall reference the previous treatment plan in the header.</p> <p>/ClinicalDocument/relatedDocument/@typeCode</p> <p>RPLC          Revised any other      New</p>				
<b>27635-2</b> 27635-2	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>	<b>OBS</b>		<b>1,1</b>	
	<p>The primary diagnosis information (code and date) is carried in an &lt;observation&gt; entry contained within the primary diagnosis section.</p> <p>This entry can be located using the following XPath expression. /ClinicalDocument//section[code/@code="27635-2" and code/@codeSystem=\$LOINC]/observation[code/@code="27635-2" and code/@codeSystem=\$LOINC]</p>				
	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS</b>		<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
	<p>The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code. /ClinicalDocument//section[code/@code="27635-2" and code/@codeSystem=\$LOINC]/observation [code/@code="27635-2" and code/@codeSystem=\$LOINC]/value/@code</p>				
	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>		<b>TS</b>	<b>1,1</b>	
	<p>The date of onset or exacerbation of the diagnosis is stored in the &lt;effectiveTime&gt; element of this observation.</p> <p>/ClinicalDocument//section[code/@code="27635-2" and code/@codeSystem=\$LOINC]/observation [code/@code="27635-2" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</p>				
<b>LOINC-TBD</b>	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT</b>	<b>ACT</b>	<b>TS</b>	<b>1,1</b>	
	The rehabilitation plan is documentation of the act of				

LOINC code	18826-8				
Component	Occupational Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units
	<p>providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. Information about that act is found in the header of the clinical document through use of the &lt;serviceEvent&gt; element describing the act being documented. The date range of treatment includes a Start Date and an Estimated Date of Completion.</p> <p>This element can be identified using the following XPath expression.  <code>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]</code></p> <p>The start date is stored in the &lt;low&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/low/@value</code></p> <p>The estimated end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value</code></p>				
<b>27606-3</b> 27606-3	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	<b>UCUM</b>
	<p>The visit frequency is stored in an &lt;observation&gt; element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.</p> <p><code>/ClinicalDocument//section[code/@code="27606-3" and code/@codeSystem=\$LOINC]/observation [code/@code="27606-3" and code/@codeSystem=\$LOINC]/value</code></p>				
<b>27601-4</b> 27601-4	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN (COMPOSITE)</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
	<p>The diagnosis information is carried in an &lt;observation&gt; entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.  <code>/ClinicalDocument//section[code/@code="27601-4" and code/@codeSystem=\$LOINC]/observation [code/@code="27601-4" and code/@codeSystem=\$LOINC]/value/@code</code></p>				
<b>27602-2</b>	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>	

LOINC code	18826-8				
Component	Occupational Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	The author of the treatment plan is recorded in the header of the CDA Document.				
	It can be found using the following XPath expression. <i>/ClinicalDocument/author</i>				
27603-0	OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR NAME		PN	1,1	
	The name of the author is stored at the following location. <i>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</i>				
27634-5	OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR IDENTIFIER		II	1,1	NPI UPIN or other provider identifier
	Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information. <i>/ClinicalDocument/author/assignedAuthor/id</i>				
27604-8	OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR PROFESSION		CD	0,1	PTX
	As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. <i>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</i>				
<b>27611-3</b>	<b>OCCUPATIONAL THERAPY TREATMENT PLAN,</b>	<b>ENC</b>	<b>TS</b>	<b>0,1</b>	
27611-3	<b>DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT</b>				
	The information about the encounter leading to treatment is stored in an <encounter> element in the section describing this encounter. The date range includes the Hospitalization Start Date and the Hospitalization End Date.				
	The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument//section[code/@code="27611-3" and code/@codeSystem=\$LOINC]/encounter[code/@code="27611-3" and code/@codeSystem=\$LOINC]/low/@value</i>				
	The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument//section[code/@code="27611-3" and code/@codeSystem=\$LOINC]/encounter [code/@code="27611-3" and code/@codeSystem=\$LOINC]/high/@value</i>				
<b>27612-1</b>	<b>OCCUPATIONAL THERAPY TREATMENT PLAN,</b>	<b>ACT</b>	<b>CS</b>	<b>0,1</b>	ActStatus

LOINC code	18826-8				
Component Answer	Occupational Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
27612-1	<b>CONTINUATION STATUS</b>				
	<p>The continuation status is recorded in the &lt;act&gt; element describing the treatment.</p> <p>This act can be found using the following XPath expression:  <code>/ClinicalDocument//section[code/@code="27612-1" and code/@codeSystem=\$LOINC]/act[code/@code="27612-1" and code/@codeSystem=\$LOINC]/statusCode</code></p>				
LOINC-TBD	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b>			0,1	
	<p>Contains information about the referring person, date of referral and reason for referral.</p>				
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION		ED	0,1	
	<p>A narrative description of the reason for the referral.</p> <p><code>/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text</code></p>				
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME	PART	PN	0,1	
	<p>The name of the individual who referred the patient for treatment.</p> <p><code>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name</code></p>				
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER		II	0,1	NPI UPIN or other provider identifier
	<p>Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.</p> <p>This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.</p> <p><code>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/id</code></p>				
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT		TS	1,1	
	<p>The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA</p>				

LOINC code	18826-8				
Component Answer	Occupational Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	Description and Value				
	Header in a <participant> element.				
	<a href="#">/ClinicalDocument/participant[@typeCode="REF"]/time</a>				
27616-2	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)</b>	<b>PART</b>		0,1	
	The <legalAuthenticator> element in the CDA Header records information about the signing of the document by the legally responsible party for the content.				
	This element can be found using the following XPath expression:				
	<a href="#">/ClinicalDocument/legalAuthenticator</a>				
27616-2	OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE		CS	1,1	ParticipationSignature
	The <signatureCode> element provides the value indicating the signature status of the document				
	<a href="#">/ClinicalDocument/legalAuthenticator/signatureCode/@code</a>				
	S A signature is on file from this participant.				
	(any other) A signature is not on file.				
27614-7	OCCUPATIONAL THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED		TS	1,1	
	The <time> element of the <legalAuthenticator> element provides the time at which the document was signed.				
	<a href="#">/ClinicalDocument/legalAuthenticator/time/@value</a>				
27617-0	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE OCCUPATIONAL THERAPY PROFESSIONAL ON FILE (COMPOSITE)</b>	<b>PART</b>		1,1	
	The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible <sup>10</sup> ) party for the content.				
	This element can be found using the following XPath expression:				
	<a href="#">/ClinicalDocument/authenticator</a>				
27617-0	OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE OCCUPATIONAL THERAPY PROFESSIONAL ON FILE		CS	1,1	ParticipationSignature
	The <signatureCode> element provides the value indicating				

<sup>10</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.



LOINC code	18826-8			
Component Answer	Occupational Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
	the signature status of the document			
	<i>/ClinicalDocument/authenticator/signatureCode/@code</i>			
	S A signature is on file from this participant.			
	(any other) A signature is not on file.			
27615-4	OCCUPATIONAL THERAPY TREATMENT PLAN, DATE OCCUPATIONAL THERAPY PROFESSIONAL SIGNED		TS	1,1
	The time at which the plan was signed by is stored in the <time> element of the <authenticator> element in the CDA Header.			
	<i>/ClinicalDocument/authenticator/time/@value</i>			
27618-8	OCCUPATIONAL THERAPY REHABILITATION	SBADM		0,n
27618-8	TREATMENT PLAN, MEDICATION ADMINISTERED			
Note: This item spans more than one page, below.	Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.			
	This information can be found using the following XPath expression:			
	<i>/ClinicalDocument//section[code/@code="27618-8" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27618-8" and code/@codeSystem=\$LOINC]</i>			
	<b>Repeat the components as needed</b> to report all medications administered as part of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINC used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 <i>Additional Information Specification 0006: Medications Attachment</i> .			
	To affirmatively document that no medication was administered, include the section, but do not include any <substanceAdministration> elements inside it. Within the section narrative, indicate that no medications were provided.			
	To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the <substanceAdministration> element.			
	Medications uses a single LOINC answer part code that contains multiple components of medication information.			
	OCCUPATIONAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION NAME + IDENTIFIER	MMAT		1,1

LOINC code	18826-8				
Component	Occupational Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units

Information about the medication administered is stored in the <manufacturedMaterial> element of the <manufacturedProduct> element of the <consumable> element describing the medication administered. The <manufacturedMaterial> element records the name of the medication in the <name> element, and a code describing the medication in the <code> element.

NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.

/ClinicalDocument//section[code/@code="27618-8" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27618-8" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/

The code can be found here:

/ClinicalDocument//section[code/@code="27618-8" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27618-8" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code

PQ 0,1 NDC  
RxNorm SCD  
RxNorm SBD

The name of the substance can be found here:

/ClinicalDocument//section[code/@code="27618-8" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27618-8" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name

EN 1,1

#### OCCUPATIONAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION DOSE

PQ 1,1 UCUM

Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.

/ClinicalDocument//section[code/@code="27618-8" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27618-8" and code/@codeSystem=\$LOINC]/doseQuantity

**When the dose is specified in "eaches"** (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.

#### OCCUPATIONAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION RATE

PQ 0,1 UCUM

Information about the dose rate (e.g., for IV administered medications) is stored in the <rateQuantity> element.

/ClinicalDocument//section[code/@code="27618-8" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27618-8" and code/@codeSystem=\$LOINC]/rateQuantity

LOINC code	18826-8				
Component Answer	Occupational Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.</p> <p>OCCUPATIONAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION TIMING</p> <p>The &lt;effectiveTime&gt; element of the &lt;substanceAdministration&gt; element records both the start and end of the administration period, and the frequency of administration.</p> <p>/ClinicalDocument//section[code/@code="27618-8" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27618-8" and code/@codeSystem=\$LOINC]/effectiveTime</p> <p>One or more &lt;effectiveTime&gt; elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.</p> <p>OCCUPATIONAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION ROUTE</p> <p>Information about the medication route is stored in the &lt;routeCode&gt; element of the &lt;substanceAdministration&gt; element.</p> <p>/ClinicalDocument//section[code/@code="27618-8" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27618-8" and code/@codeSystem=\$LOINC]/routeCode/@code</p>		GTS	1,1	UCUM
<b>27619-6</b> 27619-6	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, PROGNOSIS FOR PHYSICAL THERAPY</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	Subset of SNOMED CT
	<p>The prognosis for rehabilitation is stored in an &lt;observation&gt; element in the appropriate section.</p> <p>The XPath Expression for this information is: /ClinicalDocument//section[code/@code="27499-3" and code/@codeSystem=\$LOINC]/observation[code/@code="27499-3" and code/@codeSystem=\$LOINC]</p> <p>The &lt;value&gt; of the &lt;observation&gt; is a code describing the prognosis for rehabilitation.</p> <p>/ClinicalDocument//section[code/@code="27619-6" and code/@codeSystem=\$LOINC]/observation[code/@code="27619-6" and code/@codeSystem=\$LOINC]/value/@code</p> <p>170969009    Poor 67334001    Guarded 65872000    Fair 170968001    Good</p>				
<b>27621-2</b> 27621-2	<b>OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>	<b>ACT</b>	<b>IVL_TS</b>	<b>0,1</b>	
	Identifies the from and through date range that certifies the				

LOINC code	18826-8				
Component Answer	Occupational Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	Plan of Care.				
	This element can be identified using the following XPath expression. <code>/ClinicalDocument//section[code/@code="27621-2"]//act[code/@code="27621-2"]/effectiveTime</code>				
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT	Section	ED	0,1	
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.				
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE	ACT	TS	0,1	
	The begin date of the actual start of care.				
	This element can be identified using the following XPath expression. <code>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</code>				
27622-0 27622-0 May need new LOINC due to title change.	OCCUPATIONAL THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)	Section	ED	1,1	
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)	Section		1,1	
	Contains information about the level of function of the patient, both prior and current.				
LOINC-TBD	PRIOR LEVEL OF FUNCTION (NARRATIVE)		ED	1,1	
	Information about the patient's prior level of function in narrative form.				
	<code>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</code>				
LOINC-TBD	CURRENT LEVEL OF FUNCTION (NARRATIVE)		ED	1,1	
	Information about the patient's current level of function in narrative form.				
	<code>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</code>				
27623-8	OCCUPATIONAL THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)	???		1,n	
	Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's				

LOINC code	18826-8				
Component Answer	Occupational Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>condition. If required to send both the initial assessment and a re-evaluation, send two occurrences of this component. At least one of the assessment narratives must be provided if this component is used.</p>				
LOINC-TBD	<p>OCCUPATIONAL THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR</p> <p>Identifies if this is the initial assessment or a re-evaluation of the patient's condition.</p> <p>true Initial Assessment false Re-evaluation</p> <p><i>/ClinicalDocument//section[code/@code="27623-8" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code</i></p>		CD	1,1	HL79055
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE		ED	0,1	
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE		ED	0,1	
27624-6 27624-6	OCCUPATIONAL THERAPY TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)	Section	ED	1,1	
LOINC-TBD	<p>OCCUPATIONAL THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)</p> <p>A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.</p>	Section	ED	0,1	
LOINC-TBD	<p>OCCUPATIONAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) INFORMATION (COMPOSITE)</p> <p>Information supplied from the Individual Education Plan (IEP) about the patient's treatment or condition.</p>	Section	ED	0,1	
LOINC-TBD	<p>OCCUPATIONAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) – DEFINED SCHOOL YEAR (FROM/THROUGH)</p> <p>The From and Through dates of the school year for the patient.</p> <p><i>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</i></p>		IVL_TS	1,1	

LOINC code	18826-8				
Component	Occupational Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
27625-3	OCCUPATIONAL THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)	Section	ED	0,n	
	If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.				
LOINC-TBD	OCCUPATIONAL THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE		IVL_TS	1,1	
	/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime				
27626-1 27626-1	OCCUPATIONAL THERAPY TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)	Section	ED	0,1	
27627-9 27627-9	OCCUPATIONAL THERAPY TREATMENT PLAN, JUSTIFICATION (NARRATIVE)	Section	ED	0,1	

### 3.5 Physical Therapy Rehabilitation Service Value Table

Table 3.5 Physical Therapy Rehabilitation Service Value Table

LOINC code	19002-5 Physical Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
Component Answer	Description and Value				
<b>27660-0</b> 27660-0	<b>PHYSICAL THERAPY TREATMENT PLAN, NEW/REVISED</b>  If the treatment plan is revised, then it shall reference the previous treatment plan in the header.  <i>/ClinicalDocument/relatedDocument/@typeCode</i>  RPLC            Revised any other        New	<b>REL</b>	<b>CS</b>	<b>1,1</b>	ActRelationship Document
<b>27698-0</b> 27698-0	<b>PHYSICAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>  The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary diagnosis section.  This entry can be located using the following XPath expression. <i>/ClinicalDocument//section[code/@code="27698-0" and code/@codeSystem=\$LOINC]//observation[code/@code="27698-0" and code/@codeSystem=\$LOINC]</i>  PHYSICAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS	<b>OBS</b>		<b>1,1</b>	
			<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
					The diagnosis code is stored in the <code> element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.  This entry can be located using the following XPath expression, where "value" is the diagnosis code. <i>/ClinicalDocument//section[code/@code="27698-0" and code/@codeSystem=\$LOINC]//observation [code/@code="27698-0" and code/@codeSystem=\$LOINC]/value/@code</i>
	<b>PHYSICAL THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>		<b>TS</b>	<b>1,1</b>	
	The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation.  <i>/ClinicalDocument//section[code/@code="27698-0" and code/@codeSystem=\$LOINC]//observation [code/@code="27698-0" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</i>				
<b>LOINC-TBD</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT</b>	<b>ACT</b>	<b>TS</b>	<b>1,1</b>	

LOINC code	19002-5				
Component	Physical Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	<p>The rehabilitation plan is documentation of the act of providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.</p> <p>Information about that act is found in the header of the clinical document through use of the &lt;serviceEvent&gt; element describing the act being documented.</p> <p>This element can be identified using the following XPath expression.</p> <pre>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]</pre> <p>The start date is stored in the &lt;low&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.</p> <pre>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/low/@value</pre> <p>The estimated end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.</p> <pre>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value</pre>				
<b>27669-1</b> 27669-1	<b>PHYSICAL THERAPY TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	<b>UCUM</b>
	<p>The visit frequency is stored in an &lt;observation&gt; element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.</p> <pre>/ClinicalDocument//section[code/@code="27669-1" and code/@codeSystem=\$LOINC]//observation [code/@code="27669-1" and code/@codeSystem=\$LOINC]/value</pre>				
<b>27664-2</b> 27664-2	<b>PHYSICAL THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
	<p>The diagnosis information is carried in an &lt;observation&gt; entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.</p> <pre>/ClinicalDocument//section[code/@code="27477-9" and code/@codeSystem=\$LOINC]//observation [code/@code="27477-9" and code/@codeSystem=\$LOINC]/value/@code</pre>				



LOINC code	19002-5 Physical Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
<b>27665-9</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>
	The author of the treatment plan is recorded in the header of the CDA Document.			
	It can be found using the following XPath expression. <i>/ClinicalDocument/author</i>			
27666-7	PHYSICAL THERAPY TREATMENT PLAN, AUTHOR NAME		PN	1,1
	The name of the author is stored at the following location. <i>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</i>			
27697-2	PHYSICAL THERAPY TREATMENT PLAN, AUTHOR IDENTIFIER		II	1,1 NPI UPIN or other provider identifier
	Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information. <i>/ClinicalDocument/author/assignedAuthor/id</i>			
27667-5	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR PROFESSION		CD	0,1 PTX
	As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. <i>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</i>			
<b>27674-1</b> 27674-1	<b>PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT</b>	<b>ENC</b>	<b>TS</b>	<b>0,1</b>
	The information about the encounter leading to treatment is stored in an <encounter> element in the section describing this encounter. The date range includes the Hospitalization Start Date and the Hospitalization End Date.			
	The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument/section[code/@code="27674-1" and code/@codeSystem=\$LOINC]/encounter[code/@code="27674-1" and code/@codeSystem=\$LOINC]/low/@value</i>			
	The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument/section[code/@code="27674-1" and code/@codeSystem=\$LOINC]/encounter [code/@code="27674-1" and</i>			

LOINC code	19002-5 Physical Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card	Numeric Units
Component Answer	Description and Value				
	<code>code/@codeSystem=\$LOINC/high/@value</code>				
<b>27675-8</b> 27675-8	<b>PHYSICAL THERAPY TREATMENT PLAN, CONTINUATION STATUS</b>  The continuation status is recorded in the <act> element describing the treatment.  This act can be found using the following XPath expression: <code>/ClinicalDocument//section[code/@code="27675-8" and code/@codeSystem=\$LOINC]//act[code/@code="27675-8" and code/@codeSystem=\$LOINC]/statuscode</code>	ACT	CS	0,1	ActStatus
<b>LOINC-TBD</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b>  Contains information about the referring person, date of referral and reason for referral.			0,1	
Same as above	PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION  A narrative description of the reason for the referral.  <code>/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text</code>		ED	0,1	
<b>LOINC-TBD</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME</b>  The name of the individual who referred the patient for treatment.  <code>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name</code>	PART	PN	0,1	
<b>LOINC-TBD</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER</b>  Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.  This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.  <code>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/id</code>		II	0,1	NPI UPIN or other provider identifier
<b>LOINC-TBD</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT</b>		TS	1,1	

LOINC code	19002-5				
Component	Physical Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
Card	Numeric Units				
<p>The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a &lt;participant&gt; element.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/time</p>					
<b>27679-0</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)</b>	<b>PART</b>		<b>0,1</b>	
<p>The &lt;legalAuthenticator&gt; element in the CDA Header records information about the signing of the document by the legally responsible party for the content.</p> <p>This element can be found using the following XPath expression:</p> <p>/ClinicalDocument/legalAuthenticator</p>					
27679-0	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE		CS	1,1	ParticipationSignature
<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p> <p>/ClinicalDocument/legalAuthenticator/signatureCode/@code</p> <p>S A signature is on file from this participant.</p> <p>(any other) A signature is not on file.</p>					
27677-4	PHYSICAL THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED		TS	1,1	
<p>The &lt;time&gt; element of the &lt;legalAuthenticator&gt; element provides the time at which the document was signed.</p> <p>/ClinicalDocument/legalAuthenticator/time/@value</p>					
<b>27680-8</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, SIGNATURE OF PHYSICAL THERAPY PROFESSIONAL ON FILE (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>	
<p>The &lt;authenticator&gt; element in the CDA Header records information about the signing of the document by another (not legally responsible<sup>11</sup>) party for the content.</p> <p>This element can be found using the following XPath expression:</p> <p>/ClinicalDocument/authenticator</p>					
27680-8	The <signatureCode> element provides the value indicating the signature status of the document.		CS	1,1	ParticipationSignature

<sup>11</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	19002-5			
Component Answer	Physical Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
	Description and Value			
	/ClinicalDocument/authenticator/signatureCode/@code			
	S A signature is on file from this participant.			
	(any other) A signature is not on file.			
27678-1	PHYSICAL THERAPY TREATMENT PLAN, DATE REHABILITATION PROFESSIONAL SIGNED		TS	1,1
	The time at which the plan was signed by is stored in the <time> element of the <authenticator> element in the CDA Header.			
	/ClinicalDocument/authenticator/time/@value			
27681-6	PHYSICAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED	SBADM		0,n
27681-6	<p><b>Note: This item spans more than one page, below.</b></p> <p>Information about the administration of medication is recorded in an &lt;substanceAdministration&gt; element in the appropriate section.</p> <p>This information can be found using the following XPath expression:            /ClinicalDocument//section[code/@code="27681-6" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27681-6" and code/@codeSystem=\$LOINC]</p> <p><b>Repeat the components as needed</b> to report all medications administered as part of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINCs used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 <i>Additional Information Specification 0006: Medications Attachment</i>.</p> <p>To affirmatively document that no medication was administered, include the section, but do not include any &lt;substanceAdministration&gt; elements inside it. Within the section narrative, indicate that no medications were provided.</p> <p>To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the &lt;substanceAdministration&gt; element.</p> <p>Medications uses a single LOINC answer part code that contains multiple components of medication information.</p>			
	PHYSICAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION NAME + IDENTIFIER		MMAT	1,1

LOINC code	19002-5				
Component	Physical Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
	Information about the medication administered is stored in the <manufacturedMaterial> element of the <manufacturedProduct> element of the <consumable> element describing the medication administered. The <manufacturedMaterial> element records the name of the medication in the <name> element, and a code describing the medication in the <code> element.				
	NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.				
	<i>/ClinicalDocument//section[code/@code="27681-6" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27681-6" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/</i>				
	The code can be found here: <i>/ClinicalDocument//section[code/@code="27681-6" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27681-6" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code</i>		CD	0,1	NDC RxNorm SCD RxNorm SBD
	The name of the substance can be found here: <i>/ClinicalDocument//section[code/@code="27681-6" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27681-6" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name</i>		ED	1,1	
	PHYSICAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION DOSE		PQ	1,1	UCUM
	Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.				
	<i>/ClinicalDocument//section[code/@code="27681-6" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27681-6" and code/@codeSystem=\$LOINC]/doseQuantity</i>				
	<b>When the dose is specified in "eaches"</b> (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.				
	PHYSICAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION RATE		PQ	0,1	UCUM
	Information about the dose rate (e.g., for IV administered medications) is stored in the <rateQuantity> element.				
	<i>/ClinicalDocument//section[code/@code="27681-6" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27681-6" and code/@codeSystem=\$LOINC]/rateQuantity</i>				
	The @value attribute contains the rate measurement, and				

LOINC code	19002-5				
Component	Physical Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	the @units attribute contains the units of measure.				
	PHYSICAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION TIMING		GTS	1,1	UCUM
	The <effectiveTime> element of the <substanceAdministration> element records both the start and end of the administration period, and the frequency of administration.  /ClinicalDocument//section[code/@code="27681-6" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="2 7681-6" and code/@codeSystem=\$LOINC]/effectiveTime				
	One or more <effectiveTime> elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.				
	PHYSICAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION ROUTE		CD	1,1	RouteCode
	Information about the medication route is stored in the <routeCode> element of the <substanceAdministration> element.  /ClinicalDocument//section[code/@code="27681-6" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="2 7681-6" and code/@codeSystem=\$LOINC]/routeCode/@code				
<b>27682-4</b> 27682-4	<b>PHYSICAL THERAPY TREATMENT PLAN, PROGNOSIS FOR PHYSICAL THERAPY</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	Subset of SNOMED CT
	The prognosis for rehabilitation is stored in an <observation> element in the appropriate section.  The XPath Expression for this information is : /ClinicalDocument//section[code/@code="27682-4" and code/@codeSystem=\$LOINC]//observation[code/@code="27682-4" and code/@codeSystem=\$LOINC]				
	The <value> of the <observation> is a code describing the prognosis for rehabilitation.  /ClinicalDocument//section[code/@code="27682-4" and code/@codeSystem=\$LOINC]//observation[code/@code="27682-4" and code/@codeSystem=\$LOINC]/value/@code				
	170969009 Poor 67334001 Guarded 65872000 Fair 170968001 Good				
<b>27684-0</b> 27684-0	<b>PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>	<b>ACT</b>	<b>IVL_TS</b>	<b>0,1</b>	
	Identifies the from and through date range that certifies the Plan of Care.				

LOINC code	19002-5 Physical Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
	<p>This element can be identified using the following XPath expression.</p> <pre>/ClinicalDocument//section[code/@code="27684-0"]//act[code/@code="27684-0"]/effectiveTime</pre>			
<b>LOINC-TBD</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.			
<b>LOINC-TBD</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE</b>	<b>ACT</b>	<b>TS</b>	<b>0,1</b>
	The begin date of the actual start of care.			
	<p>This element can be identified using the following XPath expression.</p> <pre>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</pre>			
<b>27685-7</b> 27685-7	<b>PHYSICAL THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>
May need new LOINC due to title change.				
<b>LOINC-TBD</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>
	Contains information about the level of function of the patient, both prior and current.			
<b>LOINC-TBD</b>	<b>PRIOR LEVEL OF FUNCTION (NARRATIVE)</b>		<b>ED</b>	<b>1,1</b>
	Information about the patient's prior level of function in narrative form.			
	<pre>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</pre>			
<b>LOINC-TBD</b>	<b>CURRENT LEVEL OF FUNCTION (NARRATIVE)</b>		<b>ED</b>	<b>1,1</b>
	Information about the patient's current level of function in narrative form.			
	<pre>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</pre>			
<b>27686-5</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)</b>	<b>???</b>		<b>1,n</b>
	Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition. If required to send both the initial			

LOINC code	19002-5				
Component Answer	Physical Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	assessment and a re-evaluation, send two occurrences of this component. At least one of the assessment narratives must be provided if this component is used.				
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR		CD	1,1	HL97055
	Identifies if this is the initial assessment or a re-evaluation of the patient's condition.				
	true Initial Assessment false Re-evaluation				
	/ClinicalDocument//section[code/@code="27686-5" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code				
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE		ED	0,1	
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE		ED	0,1	
27687-3 27687-3	PHYSICAL THERAPY TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)	Section	ED	1,1	
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)	Section	ED	0,1	
	A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.				
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) INFORMATION (COMPOSITE)	Section	ED	0,1	
	Information supplied from the Individual Education Plan (IEP) about the patient's treatment or condition.				
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) – DEFINED SCHOOL YEAR (FROM/THROUGH)		IVL_TS	1,1	
	The From and Through dates of the school year for the patient.				
	/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime				



LOINC code	19002-5				
Component	Physical Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units
<b>27688-1</b>	<b>PHYSICAL THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)</b>	<b>Section</b>		<b>0,n</b>	
	If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.				
LOINC-TBD	PHYSICAL THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE		TS	1,1	
	/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime				
<b>27689-9</b> 27689-9	<b>PHYSICAL THERAPY TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
<b>27690-7</b> 27690-7	<b>PHYSICAL THERAPY TREATMENT PLAN, JUSTIFICATION (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	

### 3.6 Psychiatric Rehabilitation Service Value Table

Table 3.6 Psychiatric Rehabilitation Service Value Table

LOINC code	18594-2 Psychiatric Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
Component Answer	Description and Value				
18626-2 18626-2	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, NEW/REVISED</b>  If the treatment plan is revised, then it shall reference the previous treatment plan in the header.  <i>/ClinicalDocument/relatedDocument/@typeCode</i>  RPLC            Revised any other       New	REL	CS	1,1	ActRelationship Document
19007-4 19007-4	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>  The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary diagnosis section.  This entry can be located using the following XPath expression. <i>/ClinicalDocument//section[code/@code="19007-4" and code/@codeSystem=\$LOINC]//observation[code/@code="19007-4" and code/@codeSystem=\$LOINC]</i>	OBS		1,1	
	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS</b>  The diagnosis code is stored in the <code> element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.  This entry can be located using the following XPath expression, where "value" is the diagnosis code. <i>/ClinicalDocument//section[code/@code="19007-4" and code/@codeSystem=\$LOINC]//observation [code/@code="19007-4" and code/@codeSystem=\$LOINC]/value/@code</i>		CD	1,1	I9C I10C
	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>  The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation.  <i>/ClinicalDocument//section[code/@code="19007-4" and code/@codeSystem=\$LOINC]//observation [code/@code="19007-4" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</i>		TS	1,1	
LOINC-TBD	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT</b>	ACT	TS	1,1	

LOINC code	18594-2				
Component	Psychiatric Rehabilitation Service				Response
Answer	Description and Value	Entry Type	Data Type	Card	Code / Numeric Units

The rehabilitation plan is documentation of the act of providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.

Information about that act is found in the header of the clinical document through use of the <serviceEvent> element describing the act being documented.

This element can be identified using the following XPath expression.

`/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]`

The start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element.

`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/low/@value`

The estimated end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.

`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`

<b>18637-9</b> 18637-9	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>
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The visit frequency is stored in an <observation> element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.

`/ClinicalDocument//section[code/@code="18637-9" and code/@codeSystem=$LOINC]/observation [code/@code="18637-9" and code/@codeSystem=$LOINC]/value`

<b>18631-2</b> 18631-2	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
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The diagnosis information (code and date) is carried in an <observation> entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the <code> element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.

This entry can be located using the following XPath expression, where "value" is the diagnosis code and code is the coding system.

`/ClinicalDocument//section[code/@code="18631-2" and code/@codeSystem=$LOINC]/observation [code/@code="18631-2" and`

LOINC code	18594-2 Psychiatric Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
	<code>code/@codeSystem=\$LOINC/value/@code</code>			
<b>18632-0</b>	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>
	The author of the treatment plan is recorded in the header of the CDA Document.			
	It can be found using the following XPath expression. <code>/ClinicalDocument/author</code>			
18633-8	PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR NAME		PN	1,1
	The name of the author is stored at the following location. <code>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</code>			
18730-2	PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR IDENTIFIER		II	1,1 NPI UPIN or other provider identifier
	Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information. <code>/ClinicalDocument/author/assignedAuthor/id</code>			
18634-6	PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR PROFESSION		CD	0,1 PTX
	As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. <code>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</code>			
<b>18642-9</b> 18642-9	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT</b>	<b>ENC</b>	<b>TS</b>	<b>0,1</b>
	The information about the encounter leading to treatment is stored in an <encounter> element in the section describing this encounter. The date range includes the Hospitalization Start Date and the Hospitalization End Date.  The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <code>/ClinicalDocument//section[code/@code="18642-9" and code/@codeSystem=\$LOINC]/encounter[code/@code="18642-9" and code/@codeSystem=\$LOINC]/low/@value</code>			
	The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.			

LOINC code	18594-2				
Component Answer	Psychiatric Rehabilitation Service	Entry Type	Data Type	Response Code / Card	Numeric Units
	<p>/ClinicalDocument/section[code/@code="18642-9" and code/@codeSystem=\$LOINC]/encounter [code/@code="18642-9" and code/@codeSystem=\$LOINC]/high/@value</p>				
18645-2 18645-2	<p><b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, CONTINUATION STATUS</b></p> <p>The continuation status is recorded in the &lt;act&gt; element describing the treatment.</p> <p>This act can be found using the following XPath expression: /ClinicalDocument/section[code/@code="18645-2" and code/@codeSystem=\$LOINC]/act[code/@code="18645-2" and code/@codeSystem=\$LOINC]/statusCode</p>	ACT	CS	0,1	ActStatus
LOINC-TBD	<p><b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b></p> <p>Contains information about the referring person, date of referral and reason for referral.</p>			0,1	
Same as above	<p>PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION</p> <p>A narrative description of the reason for the referral.</p> <p>/ClinicalDocument/section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text</p>		ED	0,1	
LOINC-TBD	<p>PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME</p> <p>The name of the individual who referred the patient for treatment.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playing Entity/name</p>	PART	PN	0,1	
LOINC-TBD	<p>PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER</p> <p>Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.</p> <p>This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/id</p>		II	0,1	NPI UPIN or other provider identifier
LOINC-TBD	<p>PSYCHIATRIC REHABILITATION TREATMENT</p>		TS	1,1	

LOINC code	18594-2				
Component Answer	Psychiatric Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT</p> <p>The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a &lt;participant&gt; element.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/time</p>				
LOINC-TBD	<p>PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION – COMMUNICATION TO REFERRING PHYSICIAN INDICATOR</p> <p>An indicator defining if written communication has been sent back to the referring entity. <b>Y indicates that written communication has been sent and n indicates that it has not been sent.</b></p> <p>/ClinicalDocument//section[code/@code = "TBD"] //observation[code/@code = "TBD"]/value/@value</p>		BL	0,1	
18649-4	<p><b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)</b></p> <p>The &lt;legalAuthenticator&gt; element in the CDA Header records information about the signing of the document by the legally responsible party for the content.</p> <p>This element can be found using the following XPath expression: /ClinicalDocument/legalAuthenticator</p>	PART		0,1	
18649-4	<p>PSYCHIATRIC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE</p> <p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p> <p>/ClinicalDocument/legalAuthenticator/signatureCode/@code</p> <p>S A signature is on file from this participant. (any other) A signature is not on file.</p>		CS	1,1	ParticipationSignature
18647-8	<p>PSYCHIATRIC REHABILITATION DATE TREATMENT PLAN, AUTHOR SIGNED</p> <p>The &lt;time&gt; element of the &lt;legalAuthenticator&gt; element provides the time at which the document was signed.</p> <p>/ClinicalDocument/legalAuthenticator/time/@value</p>		TS	1,1	

LOINC code	18594-2 Psychiatric Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
18650-2	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE (COMPOSITE)</b>  The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible <sup>12</sup> ) party for the content.  This element can be found using the following XPath expression: <i>/ClinicalDocument/authenticator</i>	PART		1,1
18650-2	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE</b>  The <signatureCode> element provides the value indicating the signature status of the document  <i>/ClinicalDocument/authenticator/signatureCode/@code</i>  S            A signature is on file from this participant. (any other) A signature is not on file.		CS	1,1 ParticipationSignature
18648-6	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE REHAB PROFESSIONAL SIGNED</b>  The time at which the plan was signed by is stored in the <time> element of the <authenticator> element in the CDA Header.  <i>/ClinicalDocument/authenticator/time/@value</i>		TS	1,1
18651-0 18651-0	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED</b>  Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.  This information can be found using the following XPath expression: <i>/ClinicalDocument//section[code/@code="18651-0" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="18651-0" and code/@codeSystem=\$LOINC]</i>  <b>Repeat the components as needed</b> to report all medications administered as part of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINCs used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use	SBADM		0,n

Note: This item spans more than one page, below.

<sup>12</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	18594-2				
Component	Psychiatric Rehabilitation Service				Response
Answer	Description and Value	Entry Type	Data Type	Card	Code / Numeric Units

of various components of this structure, see  
CDAR2AIS0006R030 *Additional Information*  
*Specification 0006: Medications Attachment*.

To affirmatively document that no medication was administered, include the section, but do not include any <substanceAdministration> elements inside it. Within the section narrative, indicate that no medications were provided.

To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the <substanceAdministration> element.

Medications uses a single LOINC answer part code that contains multiple components of medication information.

PSYCHIATRIC REHABILITATION TREATMENT  
PLAN, MEDICATION NAME + IDENTIFIER

MMAT 1,1

Information about the medication administered is stored in the <manufacturedMaterial> element of the <manufacturedProduct> element of the <consumable> element describing the medication administered. The <manufacturedMaterial> element records the name of the medication in the <name> element, and a code describing the medication in the <code> element.

NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.

/ClinicalDocument//section[code/@code="18651-0" and  
code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="1  
8651-0" and  
code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/

The code can be found here:

/ClinicalDocument//section[code/@code="18651-0" and  
code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="1  
8651-0" and  
code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code

CD 0,1 NDC  
RxNorm SCD  
RxNorm SBD

The name of the substance can be found here:

/ClinicalDocument//section[code/@code="18651-0" and  
code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="1  
8651-0" and  
code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name

ED 1,1

PSYCHIATRIC REHABILITATION TREATMENT  
PLAN, MEDICATION DOSE

PQ 1,1 UCUM

Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.



LOINC code	18594-2				
Component Answer	Psychiatric Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
<p>/ClinicalDocument//section[code/@code="18651-0" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="18651-0" and code/@codeSystem=\$LOINC]/doseQuantity</p> <p><b>When the dose is specified in "eaches"</b> (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.</p>					
	PSYCHIATRIC REHABILITATION TREATMENT PLAN, MEDICATION RATE		PQ	0,1	UCUM
<p>Information about the dose rate (e.g., for IV administered medications) is stored in the &lt;rateQuantity&gt; element.</p> <p>/ClinicalDocument//section[code/@code="18651-0" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="18651-0" and code/@codeSystem=\$LOINC]/rateQuantity</p> <p>The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.</p>					
	PSYCHIATRIC REHABILITATION TREATMENT PLAN, MEDICATION TIMING		GTS	1,1	UCUM
<p>The &lt;effectiveTime&gt; element of the &lt;substanceAdministration&gt; element records both the start and end of the administration period, and the frequency of administration.</p> <p>/ClinicalDocument//section[code/@code="18651-0" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="18651-0" and code/@codeSystem=\$LOINC]/effectiveTime</p> <p>One or more &lt;effectiveTime&gt; elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.</p>					
	PSYCHIATRIC REHABILITATION TREATMENT PLAN, MEDICATION ROUTE		CD	1,1	RouteCode
<p>Information about the medication route is stored in the &lt;routeCode&gt; element of the &lt;substanceAdministration&gt; element.</p> <p>/ClinicalDocument//section[code/@code="18651-0" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="18651-0" and code/@codeSystem=\$LOINC]/routeCode/@code</p>					
18652-8 18652-8	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PROGNOSIS FOR REHABILITATION	OBS	CD	1,1	Subset of SNOMED CT
<p>The prognosis for rehabilitation is stored in an &lt;observation&gt; element in the appropriate section.</p> <p>The XPath Expression for this information is: /ClinicalDocument//section[code/@code="18652-8" and code/@codeSystem=\$LOINC]//observation[code/@code="18652-8 and</p>					

LOINC code	18594-2				
Component Answer	Psychiatric Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p><code>code/@codeSystem=\$LOINC]</code></p> <p>The &lt;value&gt; of the &lt;observation&gt; is a code describing the prognosis for rehabilitation.</p> <p><code>/ClinicalDocument//section[code/@code="18652-8" and code/@codeSystem=\$LOINC]/observation[code/@code="18652-8" and code/@codeSystem=\$LOINC]/value/@code</code></p> <p>170969009 Poor 67334001 Guarded 65872000 Fair 170968001 Good</p>				
<b>18654-4</b> 18654-4	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>	<b>ACT</b>	<b>IVL_TS</b>	<b>0,1</b>	
	<p>Identifies the from and through date range that certifies the Plan of Care.</p> <p>This element can be identified using the following XPath expression. <code>/ClinicalDocument//section[code/@code="18654-4"]//act[code/@code="18654-4"]/effectiveTime</code></p>				
<b>LOINC-TBD</b>	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.				
<b>LOINC-TBD</b>	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE</b>	<b>ACT</b>	<b>TS</b>	<b>0,1</b>	
	<p>The begin date of the actual start of care.</p> <p>This element can be identified using the following XPath expression. <code>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</code></p>				
<b>18655-1</b> 18655-1 May need new LOINC due to title change.	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
<b>LOINC-TBD</b>	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>			<b>1,1</b>	
	Contains information about the level of function of the patient, both prior and current.				
<b>LOINC-TBD</b>	<b>PRIOR LEVEL OF FUNCTION (NARRATIVE)</b>		<b>CD</b>	<b>1,1</b>	<b>GAF</b>
	Information about the patient's prior level of function in				

LOINC code	18594-2				
Component Answer	Psychiatric Rehabilitation Service	Entry Type	Data Type	Response Code /	Numeric Units
	Description and Value			Card	
	narrative form.				
	/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value				
LOINC-TBD	CURRENT LEVEL OF FUNCTION (NARRATIVE)		CD	1,1	GAF
	Information about the patient's current level of function in narrative form.				
	/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value				
18656-9	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)</b>	???		1,n	
	Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition. If required to send both the initial assessment and a re-evaluation, send two occurrences of this component. At least one of the assessment narratives must be provided if this component is used.				
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR		CD	1,1	
	Identifies if this is the initial assessment or a re-evaluation of the patient's condition.				
	true Initial Assessment false Re-evaluation				
	/ClinicalDocument//section[code/@code="18656-9" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code				
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE		ED	0,1	
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE		ED	0,1	
18657-7 18657-7	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)</b>	Section	ED	1,1	
LOINC-TBD	PSYCHIATRIC REHABILITATION TREATMENT	Section	ED	0,1	

LOINC code	18594-2				
Component Answer	Psychiatric Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<b>PLAN, TREATMENT ENCOUNTER (NARRATIVE)</b>				
	A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.				
LOINC-TBD	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PAST TREATMENT ATTEMPTS (NARRATIVE)</b>	Section	ED	0,1	
	A narrative description of the past treatment attempts.				
18658-5	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)</b>	Section		0,n	
	If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.				
LOINC-TBD	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE</b>		IVL_TS	1,1	
	/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime				
18659-3 18659-3	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)</b>	Section	ED	1,1	
18660-1 18660-1	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, JUSTIFICATION (NARRATIVE)</b>	Section	ED	0,1	
18661-9 18661-9	<b>PSYCHIATRIC REHABILITATION TREATMENT PLAN, PSYCHIATRIC SYMPTOMS (NARRATIVE)</b>	Section	ED	0,1	

### 3.7 Respiratory Therapy Rehabilitation Service Value Table

Table 3.7 Respiratory Therapy Rehabilitation Service Value Table

LOINC code	19003-3 Respiratory Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
Component Answer	Description and Value				
<b>27699-8</b> 27699-8	<b>RESPIRATORY THERAPY TREATMENT PLAN, NEW/REVISED</b>  If the treatment plan is revised, then it shall reference the previous treatment plan in the header.  <i>/ClinicalDocument/relatedDocument/@typeCode</i>  RPLC            Revised any other       New	<b>REL</b>	<b>CS</b>	<b>1,1</b>	ActRelationship Document
<b>27740-0</b> 27740-0	<b>RESPIRATORY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>  The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary diagnosis section.  This entry can be located using the following XPath expression. <i>/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=\$LOINC]//observation[code/@code="27740-0" and code/@codeSystem=\$LOINC]</i>	<b>OBS</b>		<b>1,1</b>	
	<b>RESPIRATORY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS</b>  The diagnosis code is stored in the <code> element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.  This entry can be located using the following XPath expression, where "value" is the diagnosis code. <i>/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=\$LOINC]//observation [code/@code="27740-0" and code/@codeSystem=\$LOINC]/value/@code</i>		<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
	<b>RESPIRATORY THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>  The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation.  <i>/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=\$LOINC]//observation [code/@code="27740-0" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</i>		<b>TS</b>	<b>1,1</b>	
<b>LOINC-TBD</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT</b>  The rehabilitation plan is documentation of the act of	<b>ACT</b>	<b>TS</b>	<b>1,1</b>	

LOINC code	19003-3				
Component	Respiratory Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units
	<p>providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.</p> <p>Information about that act is found in the header of the clinical document through use of the &lt;serviceEvent&gt; element describing the act being documented.</p> <p>This element can be identified using the following XPath expression.</p> <p><i>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]</i></p> <p>The start date is stored in the &lt;low&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.</p> <p><i>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/low/@value</i></p> <p>The estimated end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.</p> <p><i>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value</i></p>				
<b>27708-7</b> 27708-7	<b>RESPIRATORY THERAPY TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	<b>UCUM</b>
	<p>The visit frequency is stored in an &lt;observation&gt; element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.</p> <p><i>/ClinicalDocument//section[code/@code="27708-7" and code/@codeSystem=\$LOINC]//observation [code/@code="27708-7" and code/@codeSystem=\$LOINC]/value</i></p>				
<b>27703-8</b> 27703-8	<b>RESPIRATORY THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
	<p>The diagnosis information is carried in an &lt;observation&gt; entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.</p> <p><i>/ClinicalDocument//section[code/@code="27703-8" and code/@codeSystem=\$LOINC]//observation [code/@code="27703-8" and code/@codeSystem=\$LOINC]/value@code</i></p>				

LOINC code	19003-3 Respiratory Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
27704-6	<b>RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>  The author of the treatment plan is recorded in the header of the CDA Document.  It can be found using the following XPath expression. <i>/ClinicalDocument/author</i>	PART		1,1
27705-3	<b>RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR NAME</b>  The name of the author is stored at the following location. <i>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</i>		PN	1,1
27736-8	<b>RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR IDENTIFIER</b>  Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information. <i>/ClinicalDocument/author/assignedAuthor/id</i>		II	1,1 NPI UPIN or other provider identifier
27706-1	<b>RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR PROFESSION</b>  As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. <i>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</i>		CD	0,1 PTX
27713-7 27713-7	<b>RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT</b>  The information about the encounter leading to treatment is stored in an <encounter> element in the section describing this encounter. The date range includes the Hospitalization Start Date and the Hospitalization End Date.  The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument//section[@code="27713-7" and code/@codeSystem=\$LOINC]/encounter[code/@code="27713-7 and code/@codeSystem=\$LOINC]/low/@value</i>  The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument//section[code/@code="27713-7" and code/@codeSystem=\$LOINC]/encounter [code/@code="27713-7" and</i>	ENC	TS	0,1

LOINC code	19003-3				
Component Answer	Respiratory Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	code/@codeSystem=\$LOINC]/high/@value				
<b>27714-5</b> 27714-5	<b>RESPIRATORY THERAPY TREATMENT PLAN, CONTINUATION STATUS</b>	<b>ACT</b>	<b>CS</b>	<b>0,1</b>	ActStatus
	The continuation status is recorded in the <act> element describing the treatment.				
	This act can be found using the following XPath expression: /ClinicalDocument//section[code/@code="27714-5" and code/@codeSystem=\$LOINC]/act[code/@code="27714-5" and code/@codeSystem=\$LOINC]/statusCode				
<b>LOINC-TBD</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b>			<b>0,1</b>	
	Contains information about the referring person, date of referral and reason for referral.				
Same as above	RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION		ED	0,1	
	A narrative description of the reason for the referral. /ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text				
<b>LOINC-TBD</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME</b>	<b>PART</b>	<b>PN</b>	<b>0,1</b>	
	The name of the individual who referred the patient for treatment. /ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name				
<b>LOINC-TBD</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER</b>		<b>II</b>	<b>0,1</b>	NPI UPIN or other provider identifier
	Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute. /ClinicalDocument/participant[@typeCode="REF"]/participantRole/id				
<b>LOINC-TBD</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT</b>		<b>TS</b>	<b>1,1</b>	



LOINC code	19003-3				
Component	Respiratory Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	<p>The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a &lt;participant&gt; element.</p> <p><i>/ClinicalDocument/participant[@typeCode="REF"]/time</i></p>				
<b>27718-6</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)</b>	<b>PART</b>		<b>0,1</b>	
	<p>The &lt;legalAuthenticator&gt; element in the CDA Header records information about the signing of the document by the legally responsible party for the content.</p> <p>This element can be found using the following XPath expression:  <i>/ClinicalDocument/legalAuthenticator</i></p>				
27718-6	RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE		CS	1,1	ParticipationSignature
	<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p> <p><i>/ClinicalDocument/legalAuthenticator/signatureCode/@code</i></p> <p>S A signature is on file from this participant.            (any other) A signature is not on file.</p>				
27716-0	RESPIRATORY THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED		TS	1,1	
	<p>The &lt;time&gt; element of the &lt;legalAuthenticator&gt; element provides the time at which the document was signed.</p> <p><i>/ClinicalDocument/legalAuthenticator/time/@value</i></p>				
<b>27719-4</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE RESPIRATORY THERAPY PROFESSIONAL ON FILE (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>	
	<p>The &lt;authenticator&gt; element in the CDA Header records information about the signing of the document by another (not legally responsible<sup>13</sup>) party for the content.</p> <p>This element can be found using the following XPath expression:  <i>/ClinicalDocument/authenticator</i></p>				
27719-4	RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE RESPIRATORY		CS	1,1	ParticipationSignature

<sup>13</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	19003-3			
Component	Respiratory Therapy Rehabilitation Service	Entry	Data	Response
Answer	Description and Value	Type	Type	Code /
				Card
				Numeric Units

## THERAPY PROFESSIONAL ON FILE

The <signatureCode> element provides the value indicating the signature status of the document

/ClinicalDocument/authenticator/signatureCode/@code

S A signature is on file from this participant.  
(any other) A signature is not on file.

27717-8 RESPIRATORY THERAPY TREATMENT PLAN, DATE RESPIRATORY THERAPY PROFESSIONAL SIGNED TS 1,1

The time at which the plan was signed by is stored in the <time> element of the <authenticator> element in the CDA Header.

/ClinicalDocument/authenticator/time/@value

27720-2 RESPIRATORY THERAPY REHABILITATION SBADM 0,n  
27720-2 TREATMENT PLAN, MEDICATION ADMINISTERED

Note: This item spans more than one page, below.

Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.

This information can be found using the following XPath expression:

/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]

**Repeat the components as needed** to report all medications administered as part of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINCs used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 *Additional Information Specification 0006: Medications Attachment*.

To affirmatively document that no medication was administered, include the section, but do not include any <substanceAdministration> elements inside it. Within the section narrative, indicate that no medications were provided.

To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the <substanceAdministration> element.

Medications uses a single LOINC answer part code that contains multiple components of medication information.

LOINC code	19003-3				
Component	Respiratory Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	Numeric Units
	RESPIRATORY THERAPY REHABILITATION TREATMENT PLAN, MEDICATION NAME + IDENTIFIER		MMAT	1,1	
	Information about the medication administered is stored in the <manufacturedMaterial> element of the <manufacturedProduct> element of the <consumable> element describing the medication administered. The <manufacturedMaterial> element records the name of the medication in the <name> element, and a code describing the medication in the <code> element.				
	NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.				
	<i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/</i>				
	The code can be found here: <i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code</i>		CD	0,1	NDC RxNorm SCD RxNorm SBD
	The name of the substance can be found here: <i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name</i>		ED	1,1	
	RESPIRATORY THERAPY REHABILITATION REHABILITATION TREATMENT PLAN, MEDICATION DOSE		PQ	1,1	UCUM
	Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.				
	<i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/doseQuantity</i>				
	<b>When the dose is specified in "eaches"</b> (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.				
	RESPIRATORY THERAPY REHABILITATION REHABILITATION TREATMENT PLAN, MEDICATION RATE		PQ	0,1	UCUM

LOINC code	19003-3				
Component	Respiratory Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Card	Code / Numeric Units
	<p>Information about the dose rate (e.g., for IV administered medications) is stored in the &lt;rateQuantity&gt; element.</p> <p><i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/rateQuantity</i></p> <p>The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.</p>				
	<p>RESPIRATORY THERAPY REHABILITATION REHABILITATION TREATMENT PLAN, MEDICATION TIMING</p>		GTS	1,1	UCUM
	<p>The &lt;effectiveTime&gt; element of the &lt;substanceAdministration&gt; element records both the start and end of the administration period, and the frequency of administration.</p> <p><i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/effectiveTime</i></p> <p>One or more &lt;effectiveTime&gt; elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.</p>				
	<p>RESPIRATORY THERAPY REHABILITATION REHABILITATION TREATMENT PLAN, MEDICATION ROUTE</p>		CD	1,1	RouteCode
	<p>Information about the medication route is stored in the &lt;routeCode&gt; element of the &lt;substanceAdministration&gt; element.</p> <p><i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/routeCode/@code</i></p>				
27721-0 27721-0	<p><b>RESPIRATORY THERAPY TREATMENT PLAN, PROGNOSIS FOR RESPIRATORY THERAPY</b></p>	OBS	CD	1,1	Subset of SNOMED CT
	<p>The prognosis for rehabilitation is stored in an &lt;observation&gt; element in the appropriate section.</p> <p>The XPath Expression for this information is: <i>/ClinicalDocument//section[code/@code="27721-0" and code/@codeSystem=\$LOINC]//observation[code/@code="27721-0" and code/@codeSystem=\$LOINC]</i></p> <p>The &lt;value&gt; of the &lt;observation&gt; is a code describing the prognosis for rehabilitation.</p> <p><i>/ClinicalDocument//section[code/@code="27721-0" and code/@codeSystem=\$LOINC]//observation[code/@code="27721-0" and code/@codeSystem=\$LOINC]/value/@code</i></p>				
	<p>170969009    Poor 67334001    Guarded</p>				

LOINC code	19003-3				
Component Answer	Respiratory Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card	Numeric Units
	65872000 Fair 170968001 Good				
<b>27723-6</b> 27723-6	<b>RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>	<b>ACT</b>	<b>IVL_TS</b>	<b>0,1</b>	
	Identifies the from and through date range that certifies the Plan of Care.  This element can be identified using the following XPath expression. <code>/ClinicalDocument//section[code/@code="27723-6"]//act[code/@code="27723-6"]/effectiveTime</code>				
<b>LOINC-TBD</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.				
<b>LOINC-TBD</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE</b>	<b>ACT</b>	<b>TS</b>	<b>0,1</b>	
	The begin date of the actual start of care.  This element can be identified using the following XPath expression. <code>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</code>				
<b>27724-4</b> 27724-4 May need new LOINC due to title change	<b>RESPIRATORY THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
<b>LOINC-TBD</b>	<b>RESPIRATORY THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
	Contains information about the level of function of the patient, both prior and current.				
<b>LOINC-TBD</b>	<b>PRIOR LEVEL OF FUNCTION (NARRATIVE)</b>		<b>ED</b>	<b>1,1</b>	
	Information about the patient's prior level of function in narrative form.  <code>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</code>				
<b>LOINC-TBD</b>	<b>CURRENT LEVEL OF FUNCTION (NARRATIVE)</b>		<b>ED</b>	<b>1,1</b>	
	Information about the patient's current level of function in narrative form.  <code>/ClinicalDocument//section[code/@code="Same as question" and</code>				

LOINC code	19003-3				
Component Answer	Respiratory Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	code/@codeSystem=\$LOINC//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value				
27725-1 27725-1	<b>RESPIRATORY THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)</b>  Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition. If required to send both the initial assessment and a re-evaluation, send two occurrences of this component.	???		1,n	
LOINC-TBD	<b>RESPIRATORY THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR</b>  Identifies if this is the initial assessment or a re-evaluation of the patient's condition.  true Initial Assessment false Re-evaluation  /ClinicalDocument//section[code/@code="27725-1" and code/@codeSystem=\$LOINC//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code		CD	1,1	
LOINC-TBD	<b>RESPIRATORY THERAPY TREATMENT PLAN, ASSESSMENT – ASSESSMENT NARRATIVE</b>		ED	1,1	
27726-9 27726-9	<b>RESPIRATORY THERAPY TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)</b>	Section	ED	1,1	
LOINC-TBD	<b>RESPIRATORY THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)</b>  A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.	Section	ED	0,1	
27727-7	<b>RESPIRATORY THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)</b>  If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.	???		0,n	
LOINC-TBD	<b>RESPIRATORY THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE</b>  /ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime		TS	1,1	
27728-5 27728-5	<b>RESPIRATORY THERAPY TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)</b>	Section	ED	0,1	
27729-3 27729-3	<b>RESPIRATORY THERAPY TREATMENT PLAN, JUSTIFICATION (NARRATIVE)</b>	Section	ED	0,1	



### 3.8 Pulmonary Therapy Rehabilitation Service Value Table

Table 3.8 Pulmonary Therapy Rehabilitation Service Value Table

LOINC code	(LOINC-TBD) Pulmonary Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
Component Answer	Description and Value				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, NEW/REVISED</b>	REL	CS	1,1	ActRelationship Document
	<p>If the treatment plan is revised, then it shall reference the previous treatment plan in the header.</p> <p>/ClinicalDocument/relatedDocument/@typeCode</p> <p>RPLC          Revised any other      New</p>				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>	OBS		1,1	
	<p>The primary diagnosis information (code and date) is carried in an &lt;observation&gt; entry contained within the primary diagnosis section.</p> <p>This entry can be located using the following XPath expression.</p> <p>/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=\$LOINC]/observation[code/@code="27740-0" and code/@codeSystem=\$LOINC]</p>				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS</b>		CD	1,1	I9C I10C
	<p>The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.</p> <p>/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=\$LOINC]/observation [code/@code="27740-0" and code/@codeSystem=\$LOINC]/value/@code</p>				
	<b>PULMONARY THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>		TS	1,1	
	<p>The date of onset or exacerbation of the diagnosis is stored in the &lt;effectiveTime&gt; element of this observation.</p> <p>/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=\$LOINC]/observation [code/@code="27740-0" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</p>				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT</b>	ACT	TS	1,1	



LOINC code	(LOINC-TBD) Pulmonary Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card	Numeric Units
Component Answer	Description and Value				
	<p>The rehabilitation plan is documentation of the act of providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.</p> <p>Information about that act is found in the header of the clinical document through use of the &lt;serviceEvent&gt; element describing the act being documented.</p> <p>This element can be identified using the following XPath expression.  <code>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]</code></p> <p>The start date is stored in the &lt;low&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/low/@value</code></p> <p>The estimated end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value</code></p>				
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	<b>UCUM</b>
	<p>The visit frequency is stored in an &lt;observation&gt; element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.</p> <p><code>/ClinicalDocument//section[code/@code="27708-7" and code/@codeSystem=\$LOINC]//observation [code/@code="27708-7" and code/@codeSystem=\$LOINC]/value</code></p>				
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
	<p>The diagnosis information is carried in an &lt;observation&gt; entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.</p> <p><code>/ClinicalDocument//section[code/@code="27703-8" and code/@codeSystem=\$LOINC]//observation [code/@code="27703-8" and code/@codeSystem=\$LOINC]/value@code</code></p>				

LOINC code	(LOINC-TBD) Pulmonary Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>	PART		1,1
	<p>The author of the treatment plan is recorded in the header of the CDA Document.</p> <p>It can be found using the following XPath expression.  <i>/ClinicalDocument/author</i></p>			
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, AUTHOR NAME</b>		PN	1,1
	<p>The name of the author is stored at the following location.  <i>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</i></p>			
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, AUTHOR IDENTIFIER</b>		II	1,1 NPI UPIN or other provider identifier
	<p>Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.</p> <p>See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.  <i>/ClinicalDocument/author/assignedAuthor/id</i></p>			
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, AUTHOR PROFESSION</b>		CD	0,1 PTX
	<p>As described by the Health Care Provider Taxonomy. The Author profession can be found in the &lt;code&gt; element of the &lt;assignedAuthor&gt;.</p> <p><i>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</i></p>			
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT</b>	ENC	TS	0,1
	<p>The information about the encounter leading to treatment is stored in an &lt;encounter&gt; element in the section describing this encounter. The date range includes the Hospitalization Start Date and the Hospitalization End Date.</p> <p>The start date is stored in the &lt;low&gt; element of the &lt;effectiveTime&gt; element of the &lt;encounter&gt; element.  <i>/ClinicalDocument//section[@code="27713-7" and code/@codeSystem=\$LOINC]//encounter[code/@code="27713-7 and code/@codeSystem=\$LOINC]/low/@value</i></p> <p>The plan end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;encounter&gt; element.  <i>/ClinicalDocument//section[code/@code="27713-7" and</i></p>			

LOINC code	(LOINC-TBD) Pulmonary Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card	Numeric Units
Component Answer	Description and Value				
	code/@codeSystem=\$LOINC//encounter [code/@code="27713-7" and code/@codeSystem=\$LOINC]/high/@value				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, CONTINUATION STATUS</b>	ACT	CS	0,1	ActStatus
	The continuation status is recorded in the <act> element describing the treatment.				
	This act can be found using the following XPath expression: /ClinicalDocument//section[code/@code="27714-5" and code/@codeSystem=\$LOINC]/act[code/@code="27714-5" and code/@codeSystem=\$LOINC]/statuscode				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b>			0,1	
	Contains information about the referring person, date of referral and reason for referral.				
same as above	<b>PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION</b>		ED	0,1	
	A narrative description of the reason for the referral.  /ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME</b>	PART	PN	0,1	
	The name of the individual who referred the patient for treatment.  /ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER</b>		II	0,1	NPI UPIN or other provider identifier
	Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.  This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.  /ClinicalDocument/participant[@typeCode="REF"]/participantRole/id				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT</b>		TS	1,1	

LOINC code	(LOINC-TBD) Pulmonary Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card	Numeric Units
Component Answer	Description and Value				
	<p>The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a &lt;participant&gt; element.</p> <p><i>/ClinicalDocument/participant[@typeCode="REF"]/time</i></p>				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)</b>	<b>PART</b>		<b>0,1</b>	
	<p>The &lt;legalAuthenticator&gt; element in the CDA Header records information about the signing of the document by the legally responsible party for the content.</p> <p>This element can be found using the following XPath expression: <i>/ClinicalDocument/legalAuthenticator</i></p>				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE</b>		CS	1,1	ParticipationSignature
	<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p> <p><i>/ClinicalDocument/legalAuthenticator/signatureCode/@code</i></p> <p>S            A signature is on file from this participant. (any other) A signature is not on file.</p>				
LOINC-TBD	<b>PULMONARY THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED</b>		TS	1,1	
	<p>The &lt;time&gt; element of the &lt;legalAuthenticator&gt; element provides the time at which the document was signed.</p> <p><i>/ClinicalDocument/legalAuthenticator/time/@value</i></p>				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE RESPIRATORY THERAPY PROFESSIONAL ON FILE (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>	
	<p>The &lt;authenticator&gt; element in the CDA Header records information about the signing of the document by another (not legally responsible<sup>14</sup>) party for the content.</p> <p>This element can be found using the following XPath expression: <i>/ClinicalDocument/authenticator</i></p>				
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN,</b>		CS	1,1	ParticipationSignature

<sup>14</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	(LOINC-TBD) Pulmonary Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
	SIGNATURE OF RESPONSIBLE PULMONARY THERAPY PROFESSIONAL ON FILE			nature
	<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p> <p>/ClinicalDocument/authenticator/signatureCode/@code</p> <p>S A signature is on file from this participant. (any other) A signature is not on file.</p>			
LOINC-TBD	PULMONARY THERAPY TREATMENT PLAN, DATE PULMONARY THERAPY PROFESSIONAL SIGNED		TS	1,1
	<p>The time at which the plan was signed by is stored in the &lt;time&gt; element of the &lt;authenticator&gt; element in the CDA Header.</p> <p>/ClinicalDocument/authenticator/time/@value</p>			
LOINC-TBD	PULMONARY THERAPY REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED	SBADM		0,n
Note: This item spans more than one page, below.	<p>Information about the administration of medication is recorded in an &lt;substanceAdministration&gt; element in the appropriate section.</p> <p>This information can be found using the following XPath expression: /ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]</p> <p><b>Repeat the components as needed</b> to report all medications administered as part of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINCs used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 <i>Additional Information Specification 0006: Medications Attachment</i>.</p> <p>To affirmatively document that no medication was administered, include the section, but do not include any &lt;substanceAdministration&gt; elements inside it. Within the section narrative, indicate that no medications were provided.</p> <p>To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the &lt;substanceAdministration&gt; element.</p> <p>Medications uses a single LOINC answer part code that contains multiple components of medication information.</p>			

LOINC code	(LOINC-TBD)				
Component	Pulmonary Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Card	Code / Numeric Units
RESPIRATORY THERAPY REHABILITATION TREATMENT PLAN, MEDICATION NAME + IDENTIFIER	Information about the medication administered is stored in the <manufacturedMaterial> element of the <manufacturedProduct> element of the <consumable> element describing the medication administered. The <manufacturedMaterial> element records the name of the medication in the <name> element, and a code describing the medication in the <code> element.  NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.  <i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/</i>	MMAT		1,1	
The code can be found here: <i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code</i>		CD		0,1	NDC RxNorm SCD RxNorm SBD
The name of the substance can be found here: <i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name</i>		ED		1,1	
PULMONARY THERAPY REHABILITATION REHABILITATION TREATMENT PLAN, MEDICATION DOSE	Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.  <i>/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/doseQuantity</i>	PQ		1,1	UCUM
When the dose is specified in "eaches" (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.					
PULMONARY THERAPY REHABILITATION REHABILITATION TREATMENT PLAN, MEDICATION RATE		PQ		0,1	UCUM

LOINC code	(LOINC-TBD)	Entry Type	Data Type	Response Code /
Component Answer	Pulmonary Therapy Rehabilitation Service			Card Numeric Units
Description and Value				
Information about the dose rate (e.g., for IV administered medications) is stored in the <rateQuantity> element.				
/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/rateQuantity				
The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.				
PULMONARY THERAPY REHABILITATION REHABILITATION TREATMENT PLAN, MEDICATION TIMING		GTS	1,1	UCUM
The <effectiveTime> element of the <substanceAdministration> element records both the start and end of the administration period, and the frequency of administration.				
/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/effectiveTime				
One or more <effectiveTime> elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.				
PULMONARY THERAPY REHABILITATION REHABILITATION TREATMENT PLAN, MEDICATION ROUTE		CD	1,1	RouteCode
Information about the medication route is stored in the <routeCode> element of the <substanceAdministration> element.				
/ClinicalDocument//section[code/@code="27720-2" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27720-2" and code/@codeSystem=\$LOINC]/routeCode/@code				
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, PROGNOSIS FOR PULMONARY THERAPY</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>
				Subset of SNOMED CT
The prognosis for rehabilitation is stored in an <observation> element in the appropriate section.				
The XPath Expression for this information is: /ClinicalDocument//section[code/@code="27721-0" and code/@codeSystem=\$LOINC]//observation[code/@code="27721-0" and code/@codeSystem=\$LOINC]				
The <value> of the <observation> is a code describing the prognosis for rehabilitation.				
/ClinicalDocument//section[code/@code="27721-0" and code/@codeSystem=\$LOINC]//observation[code/@code="27721-0" and code/@codeSystem=\$LOINC]/value/@code				
170969009	Poor			
67334001	Guarded			

LOINC code	(LOINC-TBD) Pulmonary Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
	65872000 Fair			
	170968001 Good			
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>	<b>ACT</b>	<b>IVL_TS</b>	<b>0,1</b>
	Identifies the from and through date range that certifies the Plan of Care.			
	This element can be identified using the following XPath expression. <i>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</i>			
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.			
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE</b>	<b>ACT</b>	<b>TS</b>	<b>0,1</b>
	The begin date of the actual start of care.			
	This element can be identified using the following XPath expression. <i>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</i>			
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>
	Contains information about the level of function of the patient, both prior and current.			
<b>LOINC-TBD</b>	<b>PRIOR LEVEL OF FUNCTION (NARRATIVE)</b>		<b>ED</b>	<b>1,1</b>
	Information about the patient's prior level of function in narrative form.			
	<i>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</i>			
<b>LOINC-TBD</b>	<b>CURRENT LEVEL OF FUNCTION (NARRATIVE)</b>		<b>ED</b>	<b>1,1</b>
	Information about the patient's current level of function in narrative form.			
	<i>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</i>			



LOINC code	(LOINC-TBD) Pulmonary Therapy Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)</b>  Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition. If required to send both the initial assessment and a re-evaluation, send two occurrences of this component. At least one of the assessment narratives must be provided if this component is used.	???		1,n
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR</b>  Identifies if this is the initial assessment or a re-evaluation of the patient's condition.  true Initial Assessment false Re-evaluation  <i>/ClinicalDocument//section[code/@code="see above" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code</i>		CD	1,1 HL79055
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE</b>		ED	0,1
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE</b>		ED	0,1
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE</b>		ED	0,1
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE</b>		ED	0,1
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)</b>	Section	ED	1,1
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)</b>  A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.	Section	ED	0,1
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)</b>	???		0,n
LOINC-TBD	<b>PULMONARY THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE</b>  <i>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</i>		IVL_TS	1,1

<b>LOINC code</b>	<b>(LOINC-TBD) Pulmonary Therapy Rehabilitation Service</b>	<b>Entry Type</b>	<b>Data Type</b>	<b>Response Code / Numeric Units</b>
<b>Component Answer</b>	<b>Description and Value</b>			<b>Card</b>
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>
<b>LOINC-TBD</b>	<b>PULMONARY THERAPY TREATMENT PLAN, JUSTIFICATION (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>

### 3.9 Skilled Nursing Rehabilitation Service Value Table

Table 3.9 Skilled Nursing Rehabilitation Service Value Table

LOINC code	19004-1 Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Response Code / Card	Numeric Units
Component Answer	Description and Value				
<b>27470-4</b> 27470-4	<b>SKILLED NURSING TREATMENT PLAN, NEW/REVISED</b>  If the treatment plan is revised, then it shall reference the previous treatment plan in the header.  <i>/ClinicalDocument/relatedDocument/@typeCode</i>  RPLC            Revised any other       New	<b>REL</b>	<b>CS</b>	<b>1,1</b>	ActRelationship Document
<b>27587-5</b> 27587-5	<b>SKILLED NURSING TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>  The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary diagnosis section.  This entry can be located using the following XPath expression. <i>/ClinicalDocument/section[code/@code="27587-5" and code/@codeSystem=\$LOINC]/observation[code/@code="27587-5" and code/@codeSystem=\$LOINC]</i>  SKILLED NURSING TREATMENT PLAN, PRIMARY DIAGNOSIS  The diagnosis code is stored in the <code> element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.  This entry can be located using the following XPath expression, where "value" is the diagnosis code. <i>/ClinicalDocument/section[code/@code="27587-5" and code/@codeSystem=\$LOINC]/observation [code/@code="27587-5" and code/@codeSystem=\$LOINC]/value/@code</i>	<b>OBS</b>		<b>1,1</b>	
			<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
			<b>TS</b>	<b>1,1</b>	
<b>LOINC-TBD</b>	<b>SKILLED NURSING TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>  The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation.  <i>/ClinicalDocument/section[code/@code="27587-5" and code/@codeSystem=\$LOINC]/observation [code/@code="27587-5" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</i>	<b>ACT</b>	<b>TS</b>	<b>1,1</b>	
	<b>RANGE OF TREATMENT</b>				

LOINC code	19004-1				
Component Answer	Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>The rehabilitation plan is documentation of the act of providing treatment over the plan time period. As this treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.</p> <p>Information about that act is found in the header of the clinical document through use of the &lt;serviceEvent&gt; element describing the act being documented.</p> <p>This element can be identified using the following XPath expression.  <code>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]</code></p> <p>The start date is stored in the &lt;low&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]/effectiveTime/low/@value</code></p> <p>The estimated end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]/effectiveTime/high/@value</code></p>				
<b>27555-2</b>	<b>SKILLED NURSING TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	<b>UCUM</b>
27555-2	<p>The visit frequency is stored in an &lt;observation&gt; element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.</p> <p><code>/ClinicalDocument//section[code/@code="27555-2" and code/@codeSystem=\$LOINC]/observation [code/@code="27555-2" and code/@codeSystem=\$LOINC]/value</code></p>				
<b>27550-3</b>	<b>SKILLED NURSING TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
27550-3	<p>The diagnosis information is carried in an &lt;observation&gt; entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.</p> <p><code>/ClinicalDocument//section[code/@code="27550-3" and code/@codeSystem=\$LOINC]/observation [code/@code="27550-3" and code/@codeSystem=\$LOINC]/value/@code</code></p>				

LOINC code	19004-1 Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
27551-1	<b>SKILLED NURSING TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>  The author of the treatment plan is recorded in the header of the CDA Document.  It can be found using the following XPath expression. <i>/ClinicalDocument/author</i>	PART		1,1
27552-9	<b>SKILLED NURSING TREATMENT PLAN, AUTHOR NAME</b>  The name of the author is stored at the following location.  <i>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</i>		PN (ballot says IPN)	1,1
27583-4	<b>SKILLED NURSING TREATMENT PLAN, AUTHOR IDENTIFIER</b>  Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information. <i>/ClinicalDocument/author/assignedAuthor/id</i>		II	1,1 NPI UPIN or other provider identifier
27553-7	<b>SKILLED NURSING TREATMENT PLAN, AUTHOR PROFESSION</b>  As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>.  <i>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</i>		CD	0,1 PTX
27560-2 27560-2	<b>SKILLED NURSING TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT</b>  The information about the encounter leading to treatment is stored in an <encounter> element in the section describing this encounter. The date range includes the Hospitalization Start Date and the Hospitalization End Date.  The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument//section[code/@code="27560-2" and code/@codeSystem=\$LOINC]/encounter[code/@code="27560-2" and code/@codeSystem=\$LOINC]/low/@value</i>  The plan end date is stored in the <high> element of the	ENC	TS	0,1

LOINC code	19004-1 Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
	<p>&lt;effectiveTime&gt; element of the &lt;encounter&gt; element.</p> <p>/ClinicalDocument//section[code/@code="27560-2" and code/@codeSystem=\$LOINC]//encounter [code/@code="27560-2" and code/@codeSystem=\$LOINC]/high/@value</p>			
<b>27561-0</b> 27561-0	<b>SKILLED NURSING TREATMENT PLAN, CONTINUATION STATUS</b>	<b>ACT</b>	<b>CS</b>	<b>0,1</b> ActStatus
	<p>The continuation status is recorded in the &lt;act&gt; element describing the treatment.</p> <p>This act can be found using the following XPath expression:</p> <p>/ClinicalDocument//section[code/@code="27561-0" and code/@codeSystem=\$LOINC]//act[code/@code="27561-0" and code/@codeSystem=\$LOINC]/statusCode</p>			
<b>LOINC-TBD</b>	<b>SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b>			<b>0,1</b>
	Contains information about the referring person, date of referral and reason for referral.			
Same as above	<b>SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION – REASON FOR REFERRAL (NARRATIVE)</b>		<b>ED</b>	<b>0,1</b>
	<p>A narrative description of the reason for the referral.</p> <p>/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text</p>			
<b>LOINC-TBD</b>	<b>SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME</b>	<b>PART</b>	<b>PN</b>	<b>0,1</b>
	<p>The name of the individual who referred the patient for treatment.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name</p>			
<b>LOINC-TBD</b>	<b>SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER</b>		<b>II</b>	<b>0,1</b> NPI UPIN or other provider identifier
	<p>Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.</p> <p>This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.</p> <p>/ClinicalDocument/participant[@typeCode="REF"]/participantRole/id</p>			

LOINC code	19004-1 Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT  The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a <participant> element.  <i>/ClinicalDocument/participant[@typeCode="REF"]/time</i>		TS	1,1
27565-1	SKILLED NURSING TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)  The <legalAuthenticator> element in the CDA Header records information about the signing of the document by the legally responsible party for the content.  This element can be found using the following XPath expression: <i>/ClinicalDocument/legalAuthenticator</i>	PART		0,1
27565-1	SKILLED NURSING TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE  The <signatureCode> element provides the value indicating the signature status of the document  <i>/ClinicalDocument/legalAuthenticator/signatureCode/@code</i>  S            A signature is on file from this participant. (any other) A signature is not on file.		CS	1,1    ParticipationSignature
27563-6	SKILLED NURSING DATE TREATMENT PLAN, AUTHOR SIGNED  The <time> element of the <legalAuthenticator> element provides the time at which the document was signed.  <i>/ClinicalDocument/legalAuthenticator/time/@value</i>		TS	1,1
27566-9	SKILLED NURSING TREATMENT PLAN, SIGNATURE OF RESPONSIBLE NURSING PROFESSIONAL ON FILE (COMPOSITE)  The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible <sup>15</sup> ) party for the content.  This element can be found using the following XPath expression: <i>/ClinicalDocument/authenticator</i>	PART		1,1

<sup>15</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	19004-1 Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
27566-9	SKILLED NURSING TREATMENT PLAN, SIGNATURE OF RESPONSIBLE NURSING PROFESSIONAL ON FILE		CS	1,1 ParticipationSignature
	<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document</p> <p>/ClinicalDocument/authenticator/signatureCode/@code</p> <p>S A signature is on file from this participant.</p> <p>(any other) A signature is not on file.</p>			
27564-4	SKILLED NURSING TREATMENT PLAN, DATE NURSING PROFESSIONAL SIGNED		TS	1,1
	<p>The time at which the plan was signed by is stored in the &lt;time&gt; element of the &lt;authenticator&gt; element in the CDA Header.</p> <p>/ClinicalDocument/authenticator/time/@value</p>			
<b>27567-7</b>	<b>SKILLED NURSING TREATMENT PLAN, MEDICATION ADMINISTERED</b>	<b>SBADM</b>		<b>0,n</b>
27567-7	<p><b>Note: This item spans more than one page, below.</b></p> <p>Information about the administration of medication is recorded in an &lt;substanceAdministration&gt; element in the appropriate section.</p> <p>This information can be found using the following XPath expression:            /ClinicalDocument//section[code/@code="27567-7" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27567-7" and code/@codeSystem=\$LOINC]</p> <p><b>Repeat the components as needed</b> to report all medications administered as part of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINCs used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 <i>Additional Information Specification 0006: Medications Attachment</i>.</p> <p>To affirmatively document that no medication was administered, include the section, but do not include any &lt;substanceAdministration&gt; elements inside it. Within the section narrative, indicate that no medications were provided.</p> <p>To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the &lt;substanceAdministration&gt; element.</p> <p>Medications uses a single LOINC answer part code that contains multiple components of medication information.</p>			



LOINC code	19004-1				
Component Answer	Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	SKILLED NURSING TREATMENT PLAN, MEDICATION NAME + IDENTIFIER		MMAT	1,1	
	Information about the medication administered is stored in the <manufacturedMaterial> element of the <manufacturedProduct> element of the <consumable> element describing the medication administered. The <manufacturedMaterial> element records the name of the medication in the <name> element, and a code describing the medication in the <code> element.				
	NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.				
	<i>/ClinicalDocument//section[code/@code="27567-7" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27567-7" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/</i>				
	The code can be found here: <i>/ClinicalDocument//section[code/@code="27567-7" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27567-7" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code</i>		CD	0,1	NDC RxNorm SCD RxNorm SBD
	The name of the substance can be found here: <i>/ClinicalDocument//section[code/@code="27567-7" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27567-7" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name</i>		ED	1,1	
	SKILLED NURSING TREATMENT PLAN, MEDICATION DOSE		PQ	1,1	UCUM
	Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.				
	<i>/ClinicalDocument//section[code/@code="27567-7" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="27567-7" and code/@codeSystem=\$LOINC]/doseQuantity</i>				
	<b>When the dose is specified in "eaches"</b> (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.				
	SKILLED NURSING TREATMENT PLAN, MEDICATION RATE		PQ	0,1	UCUM
	Information about the dose rate (e.g., for IV administered medications) is stored in the <rateQuantity> element.				

LOINC code	19004-1				
Component Answer	Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p><i>/ClinicalDocument//section[code/@code="27567-7" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27567-7" and code/@codeSystem=\$LOINC]/rateQuantity</i></p> <p>The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.</p> <p>SKILLED NURSING TREATMENT PLAN, MEDICATION TIMING</p> <p>The &lt;effectiveTime&gt; element of the &lt;substanceAdministration&gt; element records both the start and end of the administration period, and the frequency of administration.</p> <p><i>/ClinicalDocument//section[code/@code="27567-7" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27567-7" and code/@codeSystem=\$LOINC]/effectiveTime</i></p> <p>One or more &lt;effectiveTime&gt; elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.</p> <p>SKILLED NURSING TREATMENT PLAN, MEDICATION ROUTE</p> <p>Information about the medication route is stored in the &lt;routeCode&gt; element of the &lt;substanceAdministration&gt; element.</p> <p><i>/ClinicalDocument//section[code/@code="27567-7" and code/@codeSystem=\$LOINC]//substanceAdministration[code/@code="27567-7" and code/@codeSystem=\$LOINC]/routeCode/@code</i></p>				
<b>27568-5</b>	<b>SKILLED NURSING TREATMENT PLAN, PROGNOSIS FOR REHABILITATION</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	Subset of SNOMED CT
27568-5	<p>The prognosis for rehabilitation is stored in an &lt;observation&gt; element in the appropriate section.</p> <p>The XPath Expression for this information is:  <i>/ClinicalDocument//section[code/@code="27568-5" and code/@codeSystem=\$LOINC]//observation[code/@code="27568-5" and code/@codeSystem=\$LOINC]</i></p> <p>The &lt;value&gt; of the &lt;observation&gt; is a code describing the prognosis for rehabilitation.</p> <p><i>/ClinicalDocument//section[code/@code="27568-5" and code/@codeSystem=\$LOINC]//observation[code/@code="27568-5" and code/@codeSystem=\$LOINC]/value/@code</i></p> <p>170969009    Poor  67334001    Guarded  65872000    Fair  170968001    Good</p>				
<b>27570-1</b>	<b>SKILLED NURSING TREATMENT PLAN, DATE</b>	<b>ACT</b>	<b>IVL_TS</b>	<b>0,1</b>	

LOINC code	19004-1 Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
27570-1	<b>RANGE CERTIFYING THE PLAN OF CARE</b>  Identifies the from and through date range that certifies the Plan of Care.  This element can be identified using the following XPath expression. <code>/ClinicalDocument//section[code/@code="27570-1"]//act[code/@code="27570-1"]/effectiveTime</code>			
LOINC-TBD	<b>SKILLED NURSING TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>  A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.	Section	ED	0,1
LOINC-TBD	<b>SKILLED NURSING TREATMENT PLAN, ACTUAL START OF CARE DATE</b>  The begin date of the actual start of care.  This element can be identified using the following XPath expression. <code>/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</code>	ACT	TS	0,1
27571-9 27571-9	<b>SKILLED NURSING TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)</b>	Section	ED	1,1
LOINC-TBD	<b>SKILLED NURSING TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>  Contains information about the level of function of the patient, both prior and current.	Section	ED	1,1
LOINC-TBD	<b>PRIOR LEVEL OF FUNCTION (NARRATIVE)</b>  Information about the patient's prior level of function in narrative form.  <code>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</code>		ED	1,1
LOINC-TBD	<b>CURRENT LEVEL OF FUNCTION (NARRATIVE)</b>  Information about the patient's current level of function in narrative form.  <code>/ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value</code>		ED	1,1
27572-7	<b>SKILLED NURSING TREATMENT PLAN, INITIAL ASSESSMENT (NARRATIVE)</b>  Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a	Section		1,n

LOINC code	19004-1 Skilled Nursing Rehabilitation Service	Entry Type	Data Type	Response Code / Card Numeric Units
Component Answer	Description and Value			
	patient's condition. If required to send both the initial assessment and a re-evaluation, send two occurrences of this component. At least one of the assessment narratives must be provided if this component is used.			
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR		CD	1,1
	Identifies if this is the initial assessment or a re-evaluation of the patient's condition.			
	true Initial Assessment false Re-evaluation			
	<a href="#">/ClinicalDocument//section[code/@code="27572-7" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code</a>			
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE		ED	0,1
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE		ED	0,1
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE		ED	0,1
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE		ED	0,1
27573-5 27573-5	SKILLED NURSING TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)	Section	ED	1,1
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)	Section	ED	0,1
	A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.			
27574-3	SKILLED NURSING TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)	Section		0,n
LOINC-TBD	SKILLED NURSING TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE		TS	1,1
	<a href="#">/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime</a>			
27575-0 27575-0	SKILLED NURSING TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)	Section	ED	0,1

LOINC code	19004-1				
Component	Skilled Nursing Rehabilitation Service		Entry	Data	Response
Answer	Description and Value	Type	Type	Card	Code /
					Numeric Units
27576-8	SKILLED NURSING TREATMENT PLAN,	Section	ED	0,1	
27576-8	JUSTIFICATION (NARRATIVE)				

### 3.10 Speech Therapy Rehabilitation Service Value Table

Table 3.10 Speech Therapy Rehabilitation Service Value Table

LOINC code	29206-0				
Component Answer	Speech Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
<b>29162-5</b> 29162-5	<b>SPEECH THERAPY TREATMENT PLAN, NEW/REVISED</b>	<b>REL</b>	<b>CS</b>	<b>1,1</b>	ActRelationship Document
	<p>If the treatment plan is revised, then it shall reference the previous treatment plan in the header.</p> <p>/ClinicalDocument/relatedDocument/@typeCode</p> <p>RPLC          Revised any other      New</p>				
<b>29166-6</b> 29166-6	<b>SPEECH THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)</b>	<b>OBS</b>		<b>1,1</b>	
	<p>The primary diagnosis information (code and date) is carried in an &lt;observation&gt; entry contained within the primary diagnosis section.</p> <p>This entry can be located using the following XPath expression.</p> <p>/ClinicalDocument//section[code/@code="29166-6" and code/@codeSystem=\$LOINC]/observation[code/@code="29166-6" and code/@codeSystem=\$LOINC]</p>				
	<b>SPEECH THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS</b>		<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
	<p>The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.</p> <p>/ClinicalDocument//section[code/@code="29166-6" and code/@codeSystem=\$LOINC]/observation [code/@code="29166-6" and code/@codeSystem=\$LOINC]/value/@code</p>				
	<b>SPEECH THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS</b>		<b>TS</b>	<b>1,1</b>	
	<p>The date of onset or exacerbation of the diagnosis is stored in the &lt;effectiveTime&gt; element of this observation.</p> <p>/ClinicalDocument//section[code/@code="29166-6" and code/@codeSystem=\$LOINC]/observation [code/@code="29166-6" and code/@codeSystem=\$LOINC]/effectiveTime/low/@value</p>				
<b>LOINC-TBD</b>	<b>SPEECH THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT</b>	<b>ACT</b>	<b>TS</b>	<b>1,1</b>	
	<p>The rehabilitation plan is documentation of the act of providing treatment over the plan time period. As this</p>				

LOINC code	29206-0				
Component Answer	Speech Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>treatment is a component of the act of providing the complete treatment occurring over a longer time period, it is also documentation of that act. The date range of treatment includes a Start Date and an Estimated Date of Completion.</p> <p>Information about that act is found in the header of the clinical document through use of the &lt;serviceEvent&gt; element describing the act being documented.</p> <p>This element can be identified using the following XPath expression.  <code>/ClinicalDocument/documentationOf/serviceEvent[code/@code="LOINC-TBD"]</code></p> <p>The start date is stored in the &lt;low&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent [@code="LOINC-TBD"]/effectiveTime/low/@value</code></p> <p>The estimated end date is stored in the &lt;high&gt; element of the &lt;effectiveTime&gt; element of the &lt;serviceEvent&gt; element.  <code>/ClinicalDocument/documentationOf/serviceEvent [@code="LOINC-TBD"]/effectiveTime/high/@value</code></p>				
<b>29169-0</b> 29169-0	<b>SPEECH THERAPY TREATMENT PLAN, VISIT FREQUENCY</b>	<b>OBS</b>	<b>PQ</b>	<b>1,1</b>	
	<p>The visit frequency is stored in an &lt;observation&gt; element. The integer recorded in @value gives number of visits in a unit of time. The @unit attribute is a coded value specifying the frequency units. Note that frequencies are expressed as 1/a unit of time.</p> <p><code>/ClinicalDocument//section[@code="29169-0" and code/@codeSystem=\$LOINC]/observation [@code="29169-0" and code/@codeSystem=\$LOINC]/value</code></p>				
<b>29167-4</b> 29167-4	<b>SPEECH THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	<b>I9C I10C</b>
	<p>The diagnosis information is carried in an &lt;observation&gt; entry contained within the diagnosis addressed by plan section of the document. The diagnosis code is stored in the &lt;code&gt; element of this observation. Diagnoses are coded with ICD-9-CM codes. At some point, ICD-10-CM will be mandated for future use. When mandated for use, ICD-10 will be the diagnosis coding system used in all attachment standards.</p> <p>This entry can be located using the following XPath expression, where "value" is the diagnosis code.  <code>/ClinicalDocument//section[code/@code="29167-4" and code/@codeSystem=\$LOINC]/observation [code/@code="29167-4" and code/@codeSystem=\$LOINC]/value/@code</code></p>				
<b>29168-2</b>	<b>SPEECH THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>	
	<p>The author of the treatment plan is recorded in the header of</p>				

LOINC code	29206-0				
Component Answer	Speech Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	the CDA Document.				
	It can be found using the following XPath expression. <i>/ClinicalDocument/author</i>				
29189-8	SPEECH THERAPY TREATMENT PLAN, AUTHOR NAME		PN	1,1	
	The name of the author is stored at the following location. <i>/ClinicalDocument/author/assignedAuthor/assignedPerson/name</i>				
29188-0	SPEECH THERAPY TREATMENT PLAN, AUTHOR IDENTIFIER		II	1,1	NPI UPIN or other provider identifier
	Unique identifier for the professional who established the treatment plan. This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute. See 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information. <i>/ClinicalDocument/author/assignedAuthor/id</i>				
29190-6	SPEECH THERAPY TREATMENT PLAN, AUTHOR PROFESSION		CD	0,1	PTX
	As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. <i>/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code</i>				
29203-7 29203-7	SPEECH THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT	ENC	TS	0,1	
	The information about the encounter leading to treatment is stored in an <encounter> element in the section describing this encounter. The date range includes the Hospitalization Start Date and the Hospitalization End Date.  The start date is stored in the <low> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument//section[@code="29203-7" and code/@codeSystem=\$LOINC]/encounter[@code="29203-7" and code/@codeSystem=\$LOINC]/low/@value</i>  The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element. <i>/ClinicalDocument//section[@code="29203-7" and code/@codeSystem=\$LOINC]/encounter [ @code="29203-7" and code/@codeSystem=\$LOINC]/high/@value</i>				
29171-6 29171-6	SPEECH THERAPY TREATMENT PLAN, CONTINUATION STATUS	ACT	CS	0,1	ActStatus



LOINC code	29206-0				
Component	Speech Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Card	Code / Numeric Units
	The continuation status is recorded in the <act> element describing the treatment.				
	This act can be found using the following XPath expression: /ClinicalDocument/section[@code="29171-6" and code/@codeSystem=\$LOINC]/act[@code="29171-6" and code/@codeSystem=\$LOINC]/statusCode				
LOINC-TBD	<b>SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)</b>			0,1	
	Contains information about the referring person, date of referral and reason for referral.				
Same as above	SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION		ED	0,1	
	A narrative description of the reason for the referral.  /ClinicalDocument/section[@code="LOINC-TBD" and @codeSystem=\$LOINC]/text				
LOINC-TBD	<b>SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME</b>	PART	PN	0,1	
	The name of the individual who referred the patient for treatment.  /ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name				
LOINC-TBD	<b>SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON IDENTIFIER</b>		II	0,1	NPI UPIN or other provider identifier
	Unique identifier for the professional who referred the patient for treatment. If the referring person is someone other than a Physician, the identifier is not required. See section 3.8 on Instance Identifier Data Type in the <i>HL7 Additional Information Specification Implementation Guide</i> for more information.  This identifier will record the OID of the assigning authority for the identifier in the @root attribute, and the identifier in the @extension attribute.  /ClinicalDocument/participant[@typeCode="REF"]/participantRole/id				
LOINC-TBD	<b>SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION - DATE PATIENT REFERRED FOR TREATMENT</b>		TS	1,1	
	The time at which the patient was referred for treatment is the same as the time at which a provider participated in the referring process. This information is recorded in the CDA Header in a <participant> element.  /ClinicalDocument/participant[@typeCode="REF"]/time				

LOINC code	29206-0				
Component Answer	Speech Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
<b>29174-0</b>	<b>SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE (COMPOSITE)</b>	<b>PART</b>		<b>0,1</b>	
	<p>The &lt;legalAuthenticator&gt; element in the CDA Header records information about the signing of the document by the legally responsible party for the content.</p> <p>This element can be found using the following XPath expression:  <a href="#">/ClinicalDocument/legalAuthenticator</a></p>				
29174-0	SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE		CS	1,1	ParticipationSignature
	<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document.</p> <p><a href="#">/ClinicalDocument/legalAuthenticator/signatureCode/@code</a></p> <p>S A signature is on file from this participant.            (any other) A signature is not on file.</p>				
29173-2	SPEECH THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED		TS	1,1	
	<p>The &lt;time&gt; element of the &lt;legalAuthenticator&gt; element provides the time at which the document was signed.</p> <p><a href="#">/ClinicalDocument/legalAuthenticator/time/@value</a></p>				
<b>29176-5</b>	<b>SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE SPEECH THERAPY PROFESSIONAL ON FILE (COMPOSITE)</b>	<b>PART</b>		<b>1,1</b>	
	<p>The &lt;authenticator&gt; element in the CDA Header records information about the signing of the document by another (not legally responsible<sup>16</sup>) party for the content.</p> <p>This element can be found using the following XPath expression:  <a href="#">/ClinicalDocument/authenticator</a></p>				
29176-5	SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE SPEECH THERAPY PROFESSIONAL ON FILE		CS	1,1	ParticipationSignature
	<p>The &lt;signatureCode&gt; element provides the value indicating the signature status of the document.</p> <p><a href="#">/ClinicalDocument/authenticator/signatureCode/@code</a></p> <p>S A signature is on file from this</p>				

<sup>16</sup> A rehab professional will likely author the document, but may not be able to "legally" authenticate the document. However, they can still review and sign the document.

LOINC code	29206-0			
Component	Speech Therapy Rehabilitation Service	Entry	Data	Response
Answer	Description and Value	Type	Type	Code / Card Numeric Units
	<p>participant.</p> <p>(any other) A signature is not on file.</p>			
29175-7	<p>SPEECH THERAPY TREATMENT PLAN, DATE SPEECH THERAPY PROFESSIONAL SIGNED</p> <p>The time at which the plan was signed by is stored in the &lt;time&gt; element of the &lt;authenticator&gt; element in the CDA Header.</p> <p>/ClinicalDocument/authenticator/time/@value</p>		TS	1,1
29177-3	<p><b>SPEECH THERAPY TREATMENT PLAN, MEDICATION ADMINISTERED</b></p>	SBADM		0,n
29177-3	<p><b>Note: This item spans more than one page, below.</b></p> <p>Information about the administration of medication is recorded in an &lt;substanceAdministration&gt; element in the appropriate section.</p> <p>This information can be found using the following XPath expression: /ClinicalDocument//section[code/@code="29177-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="29177-3" and code/@codeSystem=\$LOINC]</p> <p><b>Repeat the components as needed</b> to report all medications administered as past of the rehabilitation treatment plan within the dates of service of the associated claim or for the period defined by the modifier codes. The structure and LOINC's used to provide Medications Administered data for Rehabilitation Services is inclusive in this AIS. For additional narrative details about the use of various components of this structure, see CDAR2AIS0006R030 <i>Additional Information Specification 0006: Medications Attachment</i>.</p> <p>To affirmatively document that no medication was administered, include the section, but do not include any &lt;substanceAdministration&gt; elements inside it. Within the section narrative, indicate that no medications were provided.</p> <p>To affirmatively document that a specific medication was not administered, set the @negationInd attribute to "true" on the &lt;substanceAdministration&gt; element.</p> <p>Medications uses a single LOINC answer part code that contains multiple components of medication information.</p>			
	<p>SPEECH THERAPY TREATMENT, MEDICATION NAME + IDENTIFIER</p> <p>Information about the medication administered is stored in the &lt;manufacturedMaterial&gt; element of the &lt;manufacturedProduct&gt; element of the &lt;consumable&gt; element describing the medication administered. The &lt;manufacturedMaterial&gt; element records the name of the medication in the &lt;name&gt; element, and a code describing</p>		MMAT	1,1

LOINC code	29206-0				
Component	Speech Therapy Rehabilitation Service	Entry	Data	Response	
Answer	Description and Value	Type	Type	Code /	
				Card	Numeric Units
the medication in the <code> element.					
NDC, RxNorm SBD or RxNorm SCD can be used for the code number. If the number is not available, just the name of the medication can be used.					
/ClinicalDocument//section[code/@code="29177-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="29177-3" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/					
The code can be found here:			CD	0,1	NDC RxNorm SCD RxNorm SBD
/ClinicalDocument//section[code/@code="29177-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="29177-3" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/code/@code					
The name of the substance can be found here:			ED	1,1	
/ClinicalDocument//section[code/@code="29177-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="29177-3" and code/@codeSystem=\$LOINC]/manufacturedProduct/manufacturedMaterial/name					
SPEECH THERAPY TREATMENT PLAN, MEDICATION DOSE			PQ	1,1	UCUM
Information about the dose amount is stored in the <doseQuantity> element of the <substanceAdministration> element. The @value attribute contains the dose measurement, and the @units attribute contains the units of measure.					
/ClinicalDocument//section[code/@code="29177-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="29177-3" and code/@codeSystem=\$LOINC]/doseQuantity					
<b>When the dose is specified in "eaches"</b> (e.g., tablets, pills, bottle, drops, or portions thereof, e.g., ½ tablet), where there is no standard unit of measure, the @unit attribute should not be present.					
SPEECH THERAPY TREATMENT PLAN, MEDICATION RATE			PQ	0,1	UCUM
Information about the dose rate (e.g., for IV administered medications) is stored in the <rateQuantity> element.					
/ClinicalDocument//section[code/@code="29177-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="29177-3" and code/@codeSystem=\$LOINC]/rateQuantity					
The @value attribute contains the rate measurement, and the @units attribute contains the units of measure.					
SPEECH THERAPY TREATMENT PLAN, MEDICATION TIMING			GTS	1,1	UCUM
The <effectiveTime> element of the					

LOINC code	29206-0				
Component Answer	Speech Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	<p>&lt;substanceAdministration&gt; element records both the start and end of the administration period, and the frequency of administration.</p> <p>/ClinicalDocument//section[code/@code="29177-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="29177-3" and code/@codeSystem=\$LOINC]/effectiveTime</p> <p>One or more &lt;effectiveTime&gt; elements may be present to describe the timing regimen. The first of these will describe the overall duration, and the second and subsequent will describe the frequency of administration.</p> <p>SPEECH THERAPY TREATMENT PLAN, MEDICATION ROUTE</p> <p>Information about the medication route is stored in the &lt;routeCode&gt; element of the &lt;substanceAdministration&gt; element.</p> <p>/ClinicalDocument//section[code/@code="29177-3" and code/@codeSystem=\$LOINC]/substanceAdministration[code/@code="29177-3" and code/@codeSystem=\$LOINC]/routeCode/@code</p>				
<b>29178-1</b> 29178-1	<b>SPEECH THERAPY TREATMENT PLAN, PROGNOSIS FOR THERAPY</b>	<b>OBS</b>	<b>CD</b>	<b>1,1</b>	Subset of SNOMED CT
	<p>The prognosis for rehabilitation is stored in an &lt;observation&gt; element in the appropriate section.</p> <p>The XPath Expression for this information is: /ClinicalDocument//section[@code="29178-1" and code/@codeSystem=\$LOINC]/observation[code/@code="29178-1" and code/@codeSystem=\$LOINC]</p> <p>The &lt;value&gt; of the &lt;observation&gt; is a code describing the prognosis for rehabilitation.</p> <p>/ClinicalDocument//section[@code="29178-1" and code/@codeSystem=\$LOINC]/observation[code/@code="29178-1" and code/@codeSystem=\$LOINC]/value/@code</p> <p>170969009 Poor 67334001 Guarded 65872000 Fair 170968001 Good</p>				
<b>29180-7</b> 29180-7	<b>SPEECH THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE</b>	<b>ACT</b>	<b>IVL_TS</b>	<b>0,1</b>	
	<p>Identifies the from and through date range that certifies the Plan of Care.</p> <p>This element can be identified using the following XPath expression. /ClinicalDocument//section[code/@code="29180-7"]//act[code/@code="29180-7"]/effectiveTime</p>				
<b>LOINC-TBD</b>	<b>SPEECH THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	

LOINC code	29206-0				
Component Answer	Speech Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	Description and Value				
	A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.				
LOINC-TBD	<b>SPEECH THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE</b>	ACT	TS	0,1	
	The begin date of the actual start of care.				
	This element can be identified using the following XPath expression. /ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime				
29181-5 29181-5 May need new LOINC due to title change	<b>SPEECH THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)</b>	Section	ED	1,1	
LOINC-TBD	<b>SPEECH THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)</b>	Section	ED	1,1	
	Contains information about the level of function of the patient, both prior and current.				
LOINC-TBD	PRIOR LEVEL OF FUNCTION (NARRATIVE)		ED	1,1	
	Information about the patient's prior level of function in narrative form.  /ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value				
LOINC-TBD	CURRENT LEVEL OF FUNCTION (NARRATIVE)		ED	1,1	
	Information about the patient's current level of function in narrative form.  /ClinicalDocument//section[code/@code="Same as question" and code/@codeSystem=\$LOINC]//observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value				
29182-3	<b>SPEECH THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)</b>	Section		1,n	
	Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition. If required to send both the initial assessment and a re-evaluation, send two occurrences of this component. At least one of the assessment narratives must be provided if this component is used.				
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR		CD	1,1	HL79055
	Identifies if this is the initial assessment or a re-evaluation of				

LOINC code	29206-0				
Component Answer	Speech Therapy Rehabilitation Service	Entry Type	Data Type	Card	Response Code / Numeric Units
	the patient's condition.				
	true Initial Assessment false Re-evaluation				
	/ClinicalDocument//section[code/@code="29182-3" and code/@codeSystem=\$LOINC]/observation[code/@code="TBD" and code/@codeSystem=\$LOINC]/value/@code				
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN AN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE		ED	0,1	
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE		ED	0,1	
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE		ED	0,1	
<b>29183-1</b> 29183-1	<b>SPEECH THERAPY TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>1,1</b>	
<b>LOINC-TBD</b>	<b>SPEECH THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>0,1</b>	
	A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.				
<b>LOINC-TBD</b>	<b>SPEECH THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) INFORMATION (COMPOSITE)</b>	<b>OBS</b>		<b>0,1</b>	
	Information supplied from the Individual Education Plan (IEP) about the patient's treatment or condition.				
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) – DEFINED SCHOOL YEAR (FROM/THROUGH)		TS	1,1	
	The From and Through dates of the school year for the patient.				
	/ClinicalDocument//section[code/@code="LOINC-TBD"]/act[code/@code="LOINC-TBD"]/effectiveTime				
<b>29184-9</b>	<b>SPEECH THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (NARRATIVE)</b>	<b>Section</b>	<b>ED</b>	<b>0,n</b>	
LOINC-TBD	SPEECH THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE		IVL_TS	1,1	
	/ClinicalDocument//section[code/@code="LOINC-				

LOINC code	29206-0				
Component	Speech Therapy Rehabilitation Service				Response
Answer	Description and Value	Entry Type	Data Type	Card	Code / Numeric Units
	TBD"/> <td></td> <td></td> <td></td> <td></td>				
29185-6 29185-6	SPEECH THERAPY TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)	Section	ED	0,1	
29186-4 29186-4	SPEECH THERAPY TREATMENT PLAN, JUSTIFICATION (NARRATIVE)	Section	ED	0,1	



## 4 Coding Examples

### 4.1 Scenario

The following message encodes a Psychiatric Rehabilitation plan for patient Peter M. Jones with medical record number STHHL12378.

The claim associated with this CDA document is identified by the value 123456789A in data element TRN02-Attachment Control Number of Loop 2000A-Payer/Provider Control Number.

**Figure 4.1 Psychiatric Rehabilitation Plan Data**

PRINCIPAL DIAGNOSIS (IDENTIFIER)	296.4
(TEXT)	BIPOLAR AFFECTIVE D/O
OTHER DIAGNOSIS CODES	None
START OF CARE/ADMISSION DATE	06122006
STATEMENT FROM	07172003 through 07312003
PHYSICIAN	JOHN E. SMITH, MD
NEW JERSEY IDENTIFIER	1298379
PROVIDER TAXONOMY CODE	Psychiatrist (203BP0800Y)
REFERRAL DATE	06122006
REHAB PROFESSIONAL	JONAH J. JONES, MS
NEW JERSEY IDENTIFIER	3582901
PROVIDER TAXONOMY CODE	Psychologist (103T00000N)
PRIOR HOSPITALIZATION DATES	03262006 through 03292006
DATE OF ONSET/ EXACERBATION OF PRIN DX	03262006
TOTAL VISITS FROM START OF CARE	1
TREATMENT DIAGNOSIS (IDENTIFIER)	296.4
(TEXT)	BIPOLAR AFFECTIVE D/O
<b>PLAN OF TREATMENT</b>	
DATE ESTABLISHED	06122006
DATE SIGNED	06222006
FOR PERIOD	06222006 through 09222006
FREQUENCY/DURATION	3 VISITS PER WEEK FOR 90 DAYS
ESTIMATED COMPLETION DATE	09302006
DATE PLAN LAST CERTIFIED	(not applicable)
PROGNOSIS	2
<b>MEDICAL HISTORY/PRIOR FUNCTIONAL LEVEL</b>	
PATIENT HAS HAD MULTIPLE PSYCHIATRIC HOSPITALIZATIONS OVER MANY YEARS, MOST RECENTLY 2 INPATIENT ADMISSIONS TO GENERAL HOSPITAL FOR SUICIDAL IDEATION AND SEVERE ANXIETY. PATIENT HAS BEEN UN OR UNDEREMPLOYED SINCE SUICIDE DEATH OF HIS TWIN BROTHER.	
<b>INITIAL ASSESSMENT</b>	
PATIENT IS EXTREMELY ANXIOUS, AGITATED AND NEEDY, CANNOT HOLD EMPLOYMENT, HAS DIFFICULTY ATTENDING PROGRAM REGULARLY, AND CANNOT SIT IN GROUPS FOR 10 MINUTES AT A TIME. RETURNS TO HOSPITAL INPATIENT WARDS WHENEVER ANXIETY BECOMES OVERWHELMING, WHICH IS OFTEN.	
<b>FUNCTIONAL GOALS</b>	
GOAL 1: PATIENT IS WORKING TO COME UP WITH ALTERNATIVES TO INPATIENT HOSPITALIZATION WHEN HE FEELS ABANDONED OR ANXIOUS	
GOAL 2: PATIENT IS EXPECTED TO RETURN TO THE LEVEL OF EMPLOYMENT THAT IS COMMENSORATE WITH HIS COGNITIVE ABILITIES.	
<b>PLAN OF TREATMENT</b>	
915/90853 GROUP THERAPY: SYMPTOM MANAGEMENT 3X WEEK WITH PSYCHOLOGIST	

LAB WORK 1X MONTH: TO MONITOR LITHIUM FOR THERAPEUTIC LEVEL.

**MEDICATION ADMIN.:**

LITHIUM LEVEL 600 MG PO QAM, 900 MG PO QHS

THIOTHIXENE 5 MG PO TID

BENZTROPINE 1 MG PO TID

INDOMETHACIN 50 MG PO TID

**PROGRESS REPORT**

915/90853 GROUP THERAPY: SYMPTOM MANAGEMENT ON 7/17,22,24,27,29,31 WITH PSYCHOLOGIST: PATIENT MADE ATTEMPTS TO COME AND PARTICIPATE IN SYMPTOM MANAGEMENT GROUP. PATIENT WAS URGED TO USE ANXIETY CONTROL TECHNIQUES HE HAD BEEN TAUGHT TO TOLERATE INCREASING LONGER STAGES IN GROUP. PATIENT RESPONDED BY BEING ABLE TO STAY AND PARTICIPATE IN GROUP 50% LONGER. LAB WORK DONE ON {DATE} 07/17/00 {TEST} LITHIUM LEVEL {RESULT} 90 {JUSTIFY} ROUTINE MONITORING OF THERAPEUTIC RESPONSE.

**CONTINUED TREATMENT**

PATIENT HAS ACTIVE ANXIETY SYMPTOMS AND SUICIDAL IDEATION AND REQUIRES THIS LEVEL OF CARE TO HELP PREVENT RELAPSE AND INPATIENT TREATMENT.

**JUSTIFICATION FOR ADMISSION**

PATIENT HAD SEVERAL RECENT PSYCHIATRIC HOSPITALIZATIONS FOR ANXIETY AND SUICIDAL IDEATION, AND REQUIRED THE SUPPORT AND STRUCTURE OF DAY HOSPITAL PROGRAM TO PREVENT RELAPSE AND REHOSPITALIZATION.

**SYMPTOMS/PRESENT BEHAVIOR**

PATIENT WAS AGITATED, ANXIOUS AND NEEDY, EXPRESSING FEARS OF ABANDONMENT AND PASSIVE SUICIDAL IDEATION. PATIENT REQUIRED FREQUENT REINFORCEMENT IN ORDER TO CONTINUE TO FUNCTION OUTSIDE OF AN INPATIENT PSYCHIATRIC WARD.

#### **4.1.1 Coded Rehabilitation Plan, Human-Decision Variant**

The HDV XML example file of a CDA document that will be included within the 275 response can be found in the **rehabhdv.xml** file **in the ballot package**. The file includes comments that explain the various sections of the CDA structure and contents.

Figure 1 shows a portion of the human-decision variant as rendered by a popular browser.

**Figure 1. Portion of Rendered Human-Decision Variant**

<b>Psychiatric Treatment Plan</b>	
<b>Patient:</b> Peter Jones	MRN: 184569
	Sex: Male
<b>Consultant:</b> John Smith , MD	<b>Created On:</b> August 12, 2003
<b>PRIMARY DIAGNOSIS</b>	
bipolar affective disorder as of 26 March 2006	
<b>Treatment Dates</b>	
June 12, 2006 - September 30, 2006	
<b>Plan Dates</b>	
June 22, 2006 - September 22, 2006	
<b>Frequency of Visits</b>	
3 times per week	
<b>DIAGNOSIS ADDRESSED BY PLAN</b>	
bipolar affective disorder	
<b>Prior Hospitalizations</b>	
March 26, 2006 - March 29, 2006	
<b>PMH + Prior Function</b>	
PATIENT HAS HAD MULTIPLE PSYCHIATRIC HOSPITALIZATIONS OVER MANY YEARS, MOST RECENTLY 2 INPATIENT ADMISSIONS TO GENERAL HOSPITAL FOR SUICIDAL IDEATION AND SEVERE ANXIETY. PATIENT HAS BEEN UN OR UNDEREMPLOYED SINCE SUICIDE DEATH OF HIS TWIN BROTHER.	

#### **4.1.2 Coded Rehabilitation Plan, Computer-Decision Variant**

A CDV example file of a CDA document that will be included within the 275 response can be found in the **rehabcdv.xml** file in the ballot package. The file includes comments that explain the various sections of the CDA structure and contents.

The computer-decision variant as rendered in the same fashion as shown above in Figure 1 for the human-decision variant.

## 5 Response Code Sets

This section describes response codes that may be used in the computer-decision variant when the value table indicates a coded data type (CD) or to represent units when the attachment component is of the physical quantity (PQ) data type. The entry in the value table that refers to these code sets is used in the subsection titles.

ISO object identifiers (OIDs) uniquely identify the organization responsible for issuing a code or entity identifier. The OID can be used to find more information regarding a coded data value or an identifier for a person, organization, or other entity. For more information, see the section on ISO Object Identifiers in the *HL7 Additional Information Specification Implementation Guide*.

The values for some code sets appear directly in this document. In other cases, the section cites another document as the source.

### 5.1 Placeholder OIDs Used in Examples

Some of the OIDs used in the narrative and examples of this specification are placeholder or demonstration ones. They will need to be changed upon site-specific implementation. The “HL7 Example” OID root is used for this purpose. The placeholder OIDs in this specification are:

Site-specific OIDs – these must change during implementation of the specification:

- 2.16.840.1.113883.19.2744.1.1 - representing the assigner of the CDA document instance ID
- 2.16.840.1.113883.19.2744.1.2 - representing the assigner of the patient identifier (may be appended with .1, .2, .3, etc. if an example shows multiple patient identifiers assigned by different assigners)
- 2.16.840.1.113883.19.2744.1.3 - representing the assigner of the doctor/provider identifier (may be appended with .1, .2, .3, etc. if an example shows multiple provider identifiers assigned by different assigners)
- 2.16.840.1.113883.19.2744.1.4 - representing the assigner of the visit/encounter
- 2.16.840.1.113883.19.2744.1.5 - representing the assigner of the attachment control number

## 5.2 HL7 RouteOfAdministration

HL7 codes for route of administration, called RouteCode.

The OID for this table is 2.16.840.1.113883.5.112

**Table 5.2 – RouteOfAdministration**

Description	Code	Description	Code
Chew, oral	CHEW	Injection, insulin pump	IPUMPINJ
Diffusion, extracorporeal	EXTCORPDIF	Injection, interameningeal	INTERMENINJ
Diffusion, hemodialysis	HEMODIFF	Injection, interstitial	INTERSTITINJ
Diffusion, transdermal	TRNSDERMD	Injection, intra-abdominal	IABDINJ
Dissolve, oral	DISSOLVE	Injection, intraarterial	IAINJ
Dissolve, sublingual	SL	Injection, intraarterial, push	IAINJP
Douche, vaginal	DOUCHE	Injection, intraarterial, slow push	IAINJSP
Electro-osmosis	ELECTOSMOS	Injection, intraarticular	IARTINJ
Enema, rectal	ENEMA	Injection, intrabursal	IBURSINJ
Enema, rectal retention	RETENEMA	Injection, intracardiac	ICARDINJ
Flush, intravenous catheter	IVFLUSH	Injection, intracardiac, push	ICARINJP
Gargle	GARGLE	Injection, intracardiac, rapid push	ICARDINJRP
Immersion (soak)	SOAK	Injection, intracardiac, slow push	ICARDINJSP
Implantation, intradermal	IDIMPLNT	Injection, intracartilaginous	ICARTINJ
Implantation, intravitreal	IVITIMPLNT	Injection, intracaudal	ICAUDINJ
Implantation, subcutaneous	SQIMPLNT	Injection, intracavernous	ICAVINJ
Infusion, epidural	EPI	Injection, intracavitary	ICAVITINJ
Infusion, intraarterial catheter	IA	Injection, intracerebral	ICEREBINJ
Infusion, intracardiac	IC	Injection, intracervical (uterus)	IUINJC
Infusion, intracoronary	ICOR	Injection, intracisternal	ICISTERNINJ
Infusion, intraosseous, continuous	IOSSC	Injection, intracoronary	ICORONINJ
Infusion, intrathecal	IT	Injection, intracoronary, push	ICORONINJP
Infusion, intravascular	IVASCINFUS	Injection, intracorporeal	ICORPAINJ
Infusion, intravenous	IV	Injection, intradermal	IDINJ
Infusion, intravenous catheter	IVC	Injection, intradiscal	IDISCINJ
Infusion, intravenous catheter, continuous	IVCC	Injection, intraductal	IDUCTINJ
Infusion, intravenous catheter, intermittent	IVCI	Injection, intradural	IDURINJ
Infusion, intravenous catheter, pca pump	PCA	Injection, intraepidermal	IEPIDINJ
Infusion, subcutaneous	SQINFUS	Injection, intraepithelial	IEPITHINJ
Inhalation, intermittent positive pressure breathing (ippb)	IPPB	Injection, intralesional	ILESINJ
Inhalation, nasal	NASINHL	Injection, intraluminal	ILUMINJ
Inhalation, nasal cannula	NASINHLC	Injection, intralymphatic	ILYMPJINJ
Inhalation, nasal cannula	NP	Injection, intramedullary	IMEDULINJ
Inhalation, nebulization	NEB	Injection, intramuscular	IM
Inhalation, nebulization, nasal	NASNEB	Injection, intramuscular, deep	IMD
Inhalation, nebulization, oral	ORNEB	Injection, intramuscular, z track	IMZ
Inhalation, oral intermittent flow	ORIFINHL	Injection, intraocular	IOINJ
Inhalation, oral rebreather mask	REBREATH	Injection, intraosseous	IOSSINJ
Inhalation, respiratory	ORINHL	Injection, intraovarian	IOVARINJ
Inhalation, tracheostomy	TRACH	Injection, intrapericardial	IPCARDINJ
Inhalation, ventilator	VENT	Injection, intraperitoneal	IPERINJ
Inhalation, ventimask	VENTMASK	Injection, intrapleural	IPLRINJ
Injection, amniotic fluid	AMNINJ	Injection, intraprostatic	IPROSTINJ
Injection, biliary tract	BILINJ	Injection, intrapulmonary	IPINJ
Injection, cervical	CERVINJ	Injection, intraspinal	ISINJ
Injection, endosinusial	ENDOSININJ	Injection, intrasternal	ISTERINJ
Injection, epidural	EPIDURINJ	Injection, intrasynovial	ISYNINJ
Injection, epidural, push	EPIINJ	Injection, intratendinous	ITENDINJ
Injection, epidural, slow push	EPINJSP	Injection, intratesticular	ITESTINJ
Injection, extra-amniotic	EXTRAMNINJ	Injection, intrathecal	ITINJ
Injection, extracorporeal	EXTCORPINJ	Injection, intrathoracic	ITHORINJ
Injection, for cholangiography	CHOLINJ	Injection, intratubular	ITUBINJ
Injection, gastric button	GBINJ	Injection, intratumor	ITUMINJ
Injection, gingival	GINGINJ	Injection, intratympanic	ITYMPINJ
Injection, hemodialysis port	HEMOPORT	Injection, intraureteral, retrograde	IURETINJ
		Injection, intrauterine	IUINJ

Description	Code
Injection, intravascular	IVASCINJ
Injection, intravenous	IVINJ
Injection, intravenous, bolus	IVINJBOL
Injection, intravenous, push	IVPUSH
Injection, intravenous, rapid push	IVRPUSH
Injection, intravenous, slow push	IVSPUSH
Injection, intraventricular (heart)	IVENTINJ
Injection, intravesicle	IVESINJ
Injection, intravitreal	IVITINJ
Injection, paranasal sinuses	PNSINJ
Injection, parenteral	PARENTINJ
Injection, periarticular	PAINJ
Injection, peridural	PDURINJ
Injection, perineural	PNINJ
Injection, periodontal	PDONTINJ
Injection, peritoneal dialysis port	PDPINJ
Injection, retrobulbar	RBINJ
Injection, soft tissue	SOFTISINJ
Injection, subarachnoid	SUBARACHINJ
Injection, subconjunctival	SCINJ
Injection, subcutaneous	SQ
Injection, sublesional	SLESINJ
Injection, submucosal	SUBMUCINJ
Injection, transplacental	TRPLACINJ
Injection, transtracheal	TRTRACHINJ
Injection, ureteral	URETINJ
Injection, urethral	URETHINJ
Injection, urinary bladder	BLADINJ
Insertion, cervical (uterine)	CERVINS
Insertion, intraocular, surgical	IOSURGINS
Insertion, intrauterine	IU
Insertion, lacrimal puncta	LPINS
Insertion, rectal	PR
Insertion, subcutaneous, surgical	SQSURGINS
Insertion, urethral	URETHINS
Insertion, vaginal	VAGINSI
Instillation, cecostomy	CECINSTL
Instillation, chest tube	CTINSTL
Instillation, continuous ambulatory peritoneal dialysis port	CAPDINSTL
Instillation, endotracheal tube	ETINSTL
Instillation, enteral	ENTINSTL
Instillation, enteral feeding tube	EFT
Instillation, gastro-jejunostomy tube	GJT
Instillation, gastrostomy tube	GT
Instillation, intrabronchial	IBRONCHINSTIL
Instillation, intraduodenal	IDUODINSTIL
Instillation, intraesophageal	IESOPHINSTIL
Instillation, intragastric	IGASTINSTIL
Instillation, intraileal	IILEALINJ
Instillation, intraocular	IOINSTL
Instillation, intrasinal	ISININSTIL
Instillation, intratracheal	ITRACHINSTIL
Instillation, intrauterine	IUINSTL
Instillation, jejunostomy tube	JTINSTL
Instillation, laryngeal	LARYNGINSTIL
Instillation, nasal	NASALINSTIL
Instillation, nasogastric	NASOGASINSTIL
Instillation, nasogastric tube	NGT
Instillation, nasotracheal tube	NTT
Instillation, orogastric tube	OGT
Instillation, orojejunum tube	OJJ
Instillation, otic	OT
Instillation, paranasal sinuses	PNSINSTL
Instillation, peritoneal dialysis port	PDPINSTL
Instillation, rectal	RECINSTL

Description	Code
Instillation, rectal tube	RECTINSTL
Instillation, sinus, unspecified	SININSTIL
Instillation, soft tissue	SOFTISINSTIL
Instillation, tracheostomy	TRACHINSTL
Instillation, transtympanic	TRTYMPINSTIL
instillation, urethral	URETHINSTL
Instillation, urinary catheter	BLADINSTL
Insufflation	INSUF
Irrigation, genitourinary	GUIRR
Irrigation, intragastric	IGASTIRR
Irrigation, intralesional	ILESIRR
Irrigation, intraocular	IOIRR
Irrigation, rectal	RECIRR
Irrigation, urinary bladder	BLADIRR
Irrigation, urinary bladder, continuous	BLADIRRC
Irrigation, urinary bladder, tidal	BLADIRRT
Lavage, intragastric	IGASTLAV
Mucosal absorption, intraduodenal	IDUODMAB
Mucosal absorption, intratracheal	ITRACHMAB
Mucosal absorption, submucosal	SMUCMAB
Nebulization, endotracheal tube	ETNEB
Occlusive dressing technique	OCDESTA
Rinse, dental	DENRINSE
Rinse, oral	ORRINSE
Shampoo	SHAMPOO
Subconjunctival	SUBCONJTA
Suck, oromucosal	SUCK
Suppository, urethral	URETHSUP
Swallow, oral	PO
Swish and spit out, oromucosal	SWISHSPIT
Swish and swallow, oromucosal	SWISHSWAL
Topical	TOPICAL
Topical absorption, transtympanic	TTYMPTABSORP
Topical application, buccal	BUCC
Topical application, cervical	CERV
Topical application, dental	DEN
Topical application, gingival	GIN
Topical application, hair	HAIR
Topical application, intracorneal	ICORNTA
Topical application, intracoronal (dental)	ICORONTA
Topical application, intraesophageal	IESOPHTA
Topical application, intraileal	IILEALTA
Topical application, intralesional	ILTOP
Topical application, intraluminal	ILUMTA
Topical application, intraocular	IOTOP
Topical application, iontophoresis	IONTO
Topical application, laryngeal	LARYNGTA
Topical application, mucous membrane	MUC
Topical application, nail	NAIL
Topical application, nasal	NASAL
Topical application, ophthalmic	OPHTALTA
Topical application, oral	ORALTA
Topical application, oromucosal	ORMUC
Topical application, oropharyngeal	OROPHARTA
Topical application, perianal	PERIANAL
Topical application, perineal	PERINEAL
Topical application, periodontal	PDONTTA
Topical application, rectal	RECTAL
Topical application, scalp	SCALP
Topical application, skin	SKIN
Topical application, soaked dressing	DRESS
Topical application, swab	SWAB
Topical application, transmucosal	TMUCTA
Topical application, vaginal	VAGINS
Transdermal	TRNSDERM
Translingual	TRNSLING

### 5.3 ActRelationshipDocument

HL7-defined vocabulary domain table used to enumerate the relationships between two clinical documents for document management, based on ActRelationshipType

The OID for this table is 2.16.840.1.113883.11.11610.

**Table 5.3 ActRelationshipDocument**

Code	Rehabilitation Plan Status
RPLC	Revised
any other	New

### 5.4 ActStatus

HL7-defined vocabulary domain table used to indicate whether the plan will be continued or discontinued.

The OID for this table is 2.16.840.1.113883.5.14.

**Table 5.4 ActStatus**

Code	Continuing or Discontinued
active	The treatment is ongoing
aborted	The treatment has been discontinued.

### 5.5 Rehabilitation Plan Prognosis

HL7-defined vocabulary using a Subset of SNOMED CT® codes to indicate rehabilitation prognosis. Only the SNOMED CT® values listed in table 5.5 below can be used for rehabilitation prognosis.

SNOMED Clinical Terms (SNOMED CT®) is the Systematized Nomenclature of Medicine, a system of standardized medical terminology developed by the College of American Pathologists (CAP).

The OID for this table is 2.16.840.1.113883.6.96.

**Table 5.5 Rehabilitation Plan Prognosis**

Code	Rehabilitation Prognosis
170969009	Poor
67334001	Guarded
65872000	Fair
170968001	Good

### 5.6 Rehabilitation Service Remission Status

HL7-defined vocabulary using a Subset of SNOMED CT® codes to indicate rehabilitation remission status. Only the SNOMED CT® values listed in table 5.6 below can be used for rehabilitation service remission status.

SNOMED Clinical Terms (SNOMED CT®) is the Systematized Nomenclature of Medicine, a system of standardized medical terminology developed by the College of American Pathologists (CAP).

The OID for this table is 2.16.840.1.113883.6.96.

**Table 5.6 Rehabilitation Service Remission Status**

Code	Rehabilitation Services Remission Status
416984007	Early Remission
417618009	Partial Remission
416312007	Full Remission

### 5.7 I9C: ICD-9-CM

International Classification of Diseases, Clinical Modification. The OID for this table is 2.16.840.1.113883.6.103

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes I, II (diagnoses) describes the classification of morbidity and mortality information for statistical purposes and for the indexing of healthcare records by diseases and procedures.

### 5.8 I10C: ICD-10-CM

International Classification of Diseases, Clinical Modification. The OID for this table is ICD-10-CM - 2.16.840.1.113883.6.90.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), describes the classification of morbidity and mortality information for statistical purposes and for the indexing of healthcare records by diseases.

### 5.9 GAF: Global Assessment of Functioning

The Global Assessment of Functioning code set is developed and maintained by the American Psychiatric Association (APA). It is used in the context of the rehabilitation attachments with Psychiatric Rehabilitation and Alcohol-Substance Abuse Rehabilitation.

Global Assessment of Functioning (GAF) Scale: Psychological functioning on a scale of 0-100. Documented in the current version of "Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (Text Revision)" and prior versions, available from the American Psychiatric Association (APA) at [www.psych.org](http://www.psych.org)

The OID for this data component is 2.16.840.1.113883.4.77

### 5.10 UCUM: Unified Code for Units of Measure

The Unified Code for Units of Measure is a code system intended to include all units of measures being contemporarily used in international science, engineering, and business. The purpose is to facilitate unambiguous electronic communication of quantities together with their units. The focus is on electronic communication, as opposed to communication between humans. A typical application of The Unified Code for Units of Measure are electronic data interchange (EDI) protocols, but there is nothing that prevents it from being used in other types of machine communication.

Due to its length the table is included in the *HL7 Additional Information Specification Implementation Guide* rather than in this Additional Information Specification.

Any use of UCUM is fixed by HL7 data types; therefore, an OID is not needed.

### 5.11 NDC: National Drug Code

The National Drug Code (NDC), administered by the FDA, provides a unique code for each distinct drug, dose form, manufacturer, and package. (Available from the National Drug Code Director, FDA, Rockville, MD, and other sources.)

The OID for this table is 2.16.840.1.113883.6.69.



## **5.12 RxNorm SCD & RxNorm SBD**

RxNorm provides standard names for clinical drugs (active ingredient + strength + dose form) and for dose forms as administered to a patient. It provides links from clinical drugs, both branded and generic, to their active ingredients, drug components (active ingredient + strength), and related brand names. NDCs (National Drug Codes) for specific drug products (where there are often many NDC codes for a single product) are linked to that product in RxNorm. RxNorm links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary.

RxNorm is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information.

The OID for this table is 2.16.840.1.113883.6.88.

## **5.13 NPI: National Provider Identifier**

On January 23, 2004, the Secretary of HHS published a final rule (Federal Register volume 69, page 3434) which establishes the standard for a unique health identifier for health care providers for use in the health care system, and announces the adoption of the National Provider Identifier (NPI) as that standard. It also establishes the implementation specifications for obtaining and using the standard unique health identifier for health care providers.

For more information contact the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), 7500 Security Blvd., Baltimore, MD 21244

The DHHS Administrative Simplification web site is <http://aspe.hhs.gov/admsimp>.

The OID for this table is 2.16.840.1.113883.4.6

## **5.14 UPIN: Unique Physician Identification Number**

A unique physician identification number, or UPIN, is used by Medicare to identify doctors across the United States. UPINs are six-place alpha numeric identifiers assigned to all physicians.

The United States Congress authorized the creation of UPIN IDs through Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985. The Centers for Medicare and Medicaid Services (CMS) is responsible for creation of the UPIN IDs for each doctor accepting Medicare insurance.

UPINs will be discontinued in the second quarter of 2007 and will be replaced by National Provider Identifier, or NPI numbers.

The OID for this data component is 2.16.840.1.113883.4.8.

## **5.15 State Provider License Number**

The unique license number assigned to a physician or health care provider may be used as a provider identification number. HL7 has assigned an OID for each US state and territory that assigns the license number to the provider for that state or territory.

These OIDs may be obtained from the HL7 OID database at <http://www.hl7.org/oid/index.cfm>

## 5.16 Other Provider Identifiers

Other provider identifiers, such as those assigned by health care organizations may be used. See section 3.8 on Instance Identifier Data Type in the *HL7 Additional Information Specification Implementation Guide* for more information.

## 5.17 PTX: Health Care Provider Taxonomy

The National Uniform Claim Committee (NUCC) maintains the Health Care Provider Taxonomy. The code set is available through Washington Publishing. See: <http://www.wpc-edi.com/codes/>

The OID for this table is 2.16.840.1.113883.6.101.

## 5.18 ParticipationSignature

HL7-defined vocabulary domain table used to indicate whether or not a signature is on file for the participant for this document.

The OID for this table is 2.16.840.1.113883.5.89

**Table 5.17 ParticipationSignature**

Code	Paticipation Signature Status
S	A signature is on file from this participant
any other	A signature is not on file.

--End of document--