

Pneumonia

ORG: M-5282 (RFC)

[Link to Codes](#)

MCG Health

Recovery Facility Care
30th Edition

- Clinical Indications for Admission to Recovery Facility
- Alternative Levels of Care
- Length of Stay
- Evaluation and Treatment
 - General Treatment Course
 - Extended Stay
 - Patient Education
- Discharge Planning
- Quality Measures
- Evidence Summary
 - Criteria
 - Rationale
 - Related CMS Coverage Guidance
- References
- Footnotes
- Definitions
- Codes

Clinical Indications for Admission to Recovery Facility

- Skilled nursing facility (SNF) or subacute facility care is/was needed for appropriate care of patient because of **ALL** of the following:
 - There are no acute hospital care needs and **1 or more** of the following(1):
 - Patient requires 3-day qualifying hospital stay or applicable waiver, and care is related to hospital condition.[A]
 - Patient does not require a prequalifying stay.
 - The patient has Intense and complex care needs that make recovery facility care safer and more practical than attempting care at a lower level and **ALL** of the following[B](4):
 - These care needs include the multiple components of care that are delivered by skilled professionals at a recovery facility.[C]
 - There is a plan to provide **ALL** of the following(6)(7):
 - Care plan management and evaluation to meet patient needs, achieve treatment goals, and ensure medical safety(2)
 - Observation and assessment of patient's changing condition to evaluate need for treatment modification or for additional procedures until condition stabilized
 - Education services to teach patient self-maintenance or to teach caregiver patient care(8)
 - Skilled care daily (or more frequent), including **1 or more** of the following[D](9)(10):
 - Nursing treatments needed for **1 or more** of the following(6):
 - Intravenous (IV) infusion, IV injection, or intramuscular (IM) injection(11)

- Oxygen administration, starting or managing changes(12)
- Patient care training and assistance for **1 or more** of the following(13):
 - Exercise program (eg, range of motion, pulmonary, cardiac)(14)
 - Safe performance of ADL (eg, dressing, communicating, eating)
 - Skilled restorative nursing program[E](2)
- Therapy services (PT, OT, or SLP) needed for **1 or more** of the following[F](2):
 - Rehabilitation therapy treatments needed for **1 or more** of the following:
 - Ongoing assessment of rehabilitation needs and potential (eg, range of motion, strength, balance)
 - Supervision of therapeutic exercises or activities to ensure patient safety and treatment effectiveness
 - Gait evaluation and training
 - Maintenance therapy treatments needed for **ALL** of the following[G]:
 - Maintain the current condition or prevent/slow further deterioration.
 - Supervision of therapeutic exercises or activities to ensure patient safety and treatment effectiveness

Alternative Levels of Care

- Patient may be candidate for other levels of care, including:
 - Home care. For admission criteria, see:
 - Pneumonia [HC](#)
 - Pneumonia Due to Pneumocystis [HC](#)

Length of Stay

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

Subacute or Skilled Nursing Rehabilitation Commercial Length of Stay					Subacute or Skilled Nursing Rehabilitation Medicare Length of Stay				
10%ile	20%ile	30%ile	40%ile	50%ile	10%ile	20%ile	30%ile	40%ile	50%ile
4	8	13	16	20	7	10	14	17	20

Evaluation and Treatment

General Treatment Course

Stage	Clinical Status	Interventions
1	• Clinical indications for admission met • Recovery facility comprehensive assessment and initial evaluation complete[H] QM(16)	• Transition of care planning initiated with evaluation for next level of care QM • Interdisciplinary care plan established and implemented QM

- | | |
|---|--|
| <ul style="list-style-type: none"> Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment  SR complete for evaluation of current level of functioning (eg,  Activities of Daily Living (ADL) Scoring Tool Calculator) QM Psychosocial Assessment  SR complete QM Social determinants of health screening complete. See Social Determinants of Health Screening Tool  SR for further information. QM Medication reconciliation complete. See Medication Reconciliation Tool  SR for more information. QM(17)(18) Hospital readmission risk factor evaluation QM [I](20) Rehabilitation or maintenance therapy program initiated with service frequency at patient's maximum participation level without compromising safety or exceeding ability or tolerance[J](2) Skilled needs identified | <ul style="list-style-type: none"> Chronic condition management as indicated(21) Education for self-care QM (22) Fall risk management QM (23) IV infusion (eg, fluids, antibiotics, parenteral nutrition)(24)(25) Laboratory testing or monitoring, if ordered(26) Medication management QM (27)(28) Nutrition management(29) Pressure injury risk management QM (30) Psychosocial issues identified and management initiated, as needed QM Respiratory care[K](28)(31) Physical therapy (PT) referral and evaluation Occupational therapy (OT) referral and evaluation |
| <p>2</p> <ul style="list-style-type: none"> Therapeutic response to interventions QM Rehabilitation or maintenance therapy program established and patient participating as able with evaluation of current level of functioning (eg,  Activities of Daily Living (ADL) Scoring Tool Calculator)[J] QM(2) Physical therapy (PT) progression Occupational therapy (OT) progression | <ul style="list-style-type: none"> Care plan continues. Ongoing assessment of clinical needs Transition of care planning continues with evaluation for next level of care. QM Education continues. QM |
| <p>3</p> <ul style="list-style-type: none"> Inserted or implanted device discontinued, or functioning normally and manageable at lower level of care(25) Medical equipment and supplies available at next level of care, and safe use demonstrated Medical status stable for patient's condition and manageable at lower level of care Medication regimen established and reconciliation completed QM Rehabilitation or maintenance therapy program completed for safe transfer to lower level of care, or patient no longer demonstrating significant functional gains (eg,  Activities of Daily Living (ADL) Scoring Tool Calculator)[J](2) Skilled services (as needed) and logistical requirements can be met at lower level of care. Transition plans and education understood | <ul style="list-style-type: none"> Transition of care planning completed QM Safe to go home and transition to community or transition to alternative level of care (eg, home care) QM |

Recovery Milestones are indicated in **bold**.

Extended Stay

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

- Extended recovery facility stay may be indicated when **ALL** of the following exist[L]:
 - Continued absence of acute hospital care needs
 - There are Intense and complex care needs making inpatient care a more efficient option.
 - Skilled care needed **at least daily for 1 or more** of the following:
 - ☐ Fall management; examples include(33)(34):
 - Functional status significantly impaired, impacting ability to perform ADL or IADL
 - Evaluation and treatment for underlying medical etiology of fall
 - Treatment of fall injury, and injury regimen not established
 - Assessment or care unmanageable at lower level of care
 - Expect brief to moderate stay extension.
 - ☐ Fever management; examples include(35):
 - Temperature status outside prescribed parameters
 - Laboratory values outside normal limits(36)
 - Hemodynamic measurements outside normal limits
 - Behavioral symptoms (eg, agitation, somnolence, or inappropriate behavior) that interfere with medical care
 - Assessment or care unmanageable at lower level of care
 - Expect brief to moderate stay extension.
 - ☐ Gastrointestinal complications management; examples include(37)(38):
 - Nutrition and oral hydration not tolerated or maintained
 - Stool output inadequate for medical condition or surgical procedure
 - Bowel function impeded by opioids
 - Laboratory values outside normal limits
 - Assessment or care unmanageable at lower level of care
 - Expect brief to moderate stay extension.
 - ☐ Infusion therapy; examples include(39):
 - New intravenous medication until safe tolerance established
 - Administration of agent that requires on-site monitoring by clinical personnel (eg, chemotherapy)(40)
 - Complications of infusion therapy (eg, extravasation of vesicant)
 - Infusion therapy unmanageable at lower level of care
 - Expect brief to moderate stay extension.
 - ☐ Malnutrition, dehydration, or electrolyte management; examples include:
 - Oral nutrition and hydration not tolerated or maintained
 - Enteral or parenteral nutrition complications(41)
 - Transition from enteral or parenteral nutrition to oral nutrition(42)
 - Hemodynamic measurements outside normal limits
 - Laboratory values outside normal limits(43)
 - Urinary output below prescribed parameters(43)
 - Assessment or care unmanageable at lower level of care
 - Expect brief to moderate stay extension.
 - ☐ Respiratory management; examples include(12)(44):
 - Breathing abnormalities and oxygen regimen not established
 - Laboratory values outside normal limits
 - Respiratory status assessment to evaluate patient's response to treatment (eg, suctioning or pulmonary hygiene that requires skilled intervention or monitoring)(16)

- Assessment or care unmanageable at lower level of care
- Expect brief to moderate stay extension.
- ☐ Significant comorbid disease exacerbation with need for skilled clinical intervention and monitoring(45)
 - Assessment or care unmanageable at lower level of care
 - Stay extension varies depending on condition.
- ☐ PT, OT, or SLP services; examples include(46):
 - Unanticipated functional problems impacting safe completion of therapy
 - Multiple comorbidities or frailty impairing functional improvement
 - Cognitive impairment requiring additional intervention and education(47)
 - Communication impairment requiring additional intervention and education
 - Assessment or care unmanageable at lower level of care
 - Expect brief to moderate stay extension.

Patient Education

- Patient and caregiver education. See:
 - Pneumonia Due to Pneumocystis: Patient Education for Clinicians [↗](#) SR
 - Pneumonia: Patient Education for Clinicians [↗](#) SR

Discharge Planning

- Transition of care planning may include(13):
 - ☐ Assessment and early establishment of anticipated discharge destination and plans for care, including(4):
 - Treatment plan development involving multiple providers
 - Premorbid functioning
 - Patient and caregiver preferences and abilities
 - Evaluation for skilled services at next level of care as appropriate for patient's continued needs
 - Psychosocial status. See Psychosocial Assessment [↗](#) SR for further information. **QM**(48)
 - Social determinants of health screening. See Social Determinants of Health Screening Tool [↗](#) SR for further information. **QM**(49)
 - Acceptance for care for patient at next level of care, as appropriate
 - Transition of care plan complete, which may include:
 - Patient and caregiver education complete. See Teach-Back Tool [↗](#) SR for further information.
 - ☐ Medication reconciliation completion includes **QM** (50)(51):
 - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
 - Assess each medication for correlation to disease state or medical condition.
 - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
 - Provide reconciled medication list to all treating providers.
 - Confirm that patient or caregiver can acquire medication.
 - Educate patient and caregiver.
 - Provide complete medication list to patient and caregiver.
 - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
 - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(8)(52)

- Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
- See Medication Reconciliation Tool [SR](#) for further information.
- ☐ Appointments planned or scheduled:
 - Primary care provider(53)(54)(55)
 - Infectious disease specialist(56)
 - Outpatient imaging, tests, or procedures(12)
 - Palliative or end-of-life care provider[M](12)
 - Pulmonologist(17)(21)
 - Rehabilitation therapy (eg, PT) at next level of care(14)
 - Respiratory therapy
 - Specialists for management of comorbidities as needed(57)
 - Other
- ☐ Referrals made for assistance or support, which may include:
 - Alcohol and other drug abuse or dependence treatment, as needed **QM** (56)(58)
 - Community services(59)(60)
 - Educational program (eg, chronic condition management, self-management)(8)(55)
 - End-stage disease planning
 - Financial, for follow-up care, medication, and transportation
 - Home healthcare(61)(62)
 - Social services (eg, social programs, advance directives)
 - Tobacco use treatment, as needed **QM** (63)(64)
 - Other
- ☐ Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), as indicated(65):
 - Medication equipment and supplies
 - Nutritional care equipment and supplies
 - Respiratory equipment and supplies
 - Other
- Transition plan communicated to all members of patient's care team **QM**

Quality Measures

- HEDIS® Measures include(66):
 - Medication reconciliation is completed.
 - Transition of care needs are assessed and addressed.
 - Psychosocial status (eg, depression screening) is assessed and addressed.
 - Fall risk is assessed and addressed.
 - Tobacco use is assessed and addressed.
 - Immunization status is assessed and addressed.
 - Readmission risk is assessed and addressed.
 - Alcohol and substance misuse is assessed and addressed.
 - Social needs screening and intervention is completed.
- Nursing Home Compare Quality Measures include(67):
 - ADL status is assessed for improvement.

- o Readmission risk is assessed and addressed.
 - o Antipsychotic medication use is assessed.
 - o Immunization status is assessed and addressed.
 - o Pressure injury risk is assessed and addressed.
 - o Medication reconciliation is completed.
 - o Discharge to the community is completed.
- Skilled Nursing Facility Quality Reporting Program measures include(68):
 - o Pressure injury risk is assessed and addressed.
 - o Medication reconciliation is completed.
 - o Readmission risk is assessed and addressed.
 - o Transfer of health information to patient and provider is completed.
 - o ADL status is assessed for improvement.
 - o Immunization status is assessed and addressed.
 - o Discharge to the community is completed.
 - o Healthcare-associated infection risk is reduced.
- Skilled Nursing Facility Value-Based Purchasing Program quality measures include(69):
 - o Readmission risk is assessed and addressed.
 - o Healthcare-associated infection risk is reduced.
- The Joint Commission Nursing Care Center National Patient Safety Goals include(70):
 - o Medication reconciliation is completed. Education is provided on medication administration including the importance of bringing up-to-date medication lists to all provider visits.
 - o Healthcare-associated infection risk is reduced.
 - o Fall risk is assessed and addressed.
 - o Pressure injury risk is assessed and addressed.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 4 published peer reviewed articles and 6 book sections.

Rationale

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

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

Related CMS Coverage Guidance

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

Code of Federal Regulations (CFR): 42 CFR 409.32(9); 42 CFR 409.33(6); 42 CFR 409.35(71); 42 CFR 409.44(10); 42 CFR 410.38(65)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance(2); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6 - Medical Review of Inpatient Hospital Claims for Part A(72)

Medicare Coverage Determinations: Medicare Coverage Database(73)

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

References

1. Prusynski RA, Brown C, Johnson JK, Edelstein J. Skilled nursing and home health policy: a primer for the hospital clinician. Archives of Physical Medicine and Rehabilitation 2024;DOI: 10.1016/j.apmr.2024.08.017. [Context Link 1] View abstract...
2. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Rev. 12283 [Internet] Centers for Medicare and Medicaid Services. 2023 Oct 05 Accessed at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/>. [accessed 2025 Sep 09] [Context Link 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12]
3. Hoffman GJ, Min LC, Liu H, Marciniak DJ, Mody L. Role of post-acute care in readmissions for preexisting healthcare-associated infections. Journal of the American Geriatrics Society 2020;68(2):370-378. DOI: 10.1111/jgs.16208. [Context Link 1] View abstract...
4. Program standards. In: CARF, International, editors. Medical Rehabilitation Standards Manual. 2025 ed. Tucson, AZ: Commission on Accreditation of Rehabilitation Facilities; 2025:189-272. [Context Link 1, 2]
5. Oseran AS, Lage DE, Jernigan MC, Metlay JP, Shah SJ. A "hospital-day-1" model to predict the risk of discharge to a skilled nursing facility. Journal of the American Medical Directors Association 2019;20(6):689-695.e5. DOI: 10.1016/j.jamda.2019.03.035. [Context Link 1] View abstract...
6. Centers for Medicare and Medicaid Services. "Examples of skilled nursing and rehabilitation services." 42 CFR Pt. 409.33 Washington, DC 2023 Oct [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/>. [Context Link 1, 2, 3]
7. Mauk KL. Post-acute care. In: Larsen PD, editor. Lubkin's Chronic Illness: Impact and Intervention. 11th ed. Jones & Bartlett Learning; 2022:477-520. [Context Link 1]
8. Health education and health promotion. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:56-70. [Context Link 1, 2, 3]
9. Centers for Medicare and Medicaid Services. "Criteria for skilled services and the need for skilled service." 42 CFR Pt. 409.32 Washington, DC 2023 Oct 02 [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/>. [Context Link 1, 2, 3]
10. Centers for Medicare and Medicaid Services. "Skilled services requirements." 42 CFR Pt. 409.44 Washington, DC 2023 Oct 02 [accessed 2025 Jul 23] Accessed at: <https://www.ecfr.gov/>. [Context Link 1, 2, 3]
11. Makam AN, Grabowski DC. Policy in clinical practice: choosing post-acute care in the new decade. Journal of Hospital Medicine 2021;16(3):171-174. DOI: 10.12788/jhm.3577. [Context Link 1] View abstract...
12. Management of patients with chest and lower respiratory tract disorders. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:526-601. [Context Link 1, 2, 3, 4, 5]
13. Medical-surgical nursing. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:33-55. [Context Link 1, 2]
14. Tan Dy RC, Nguyen N. Therapeutic exercise. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:145-154. [Context Link 1, 2]
15. Therapy Outcomes in Post-Acute Care Settings (TOPS) Study Chartbook. [Internet] American Occupational Therapy Association, Inc and American Physical Therapy Association. 2021 Apr Accessed at: <https://www.aota.org/>. [accessed 2025 Sep 05] [Context Link 1]

16. Centers for Medicare and Medicaid Services. "Long-term care facility resident assessment instrument 3.0 user's manual." version 1.20.1v4 2025 Sep [accessed 2025 Nov 10] Accessed at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>. [Context Link 1, 2, 3, 4]
17. Admitting, transfer, and discharge. In: Perry AG, Potter PA, Ostendorf WR, Laplante N, editors. *Clinical Nursing Skills and Techniques*. 11th ed. Elsevier; 2025:40-51. [Context Link 1, 2]
18. Vasilevskis EE, et al. Medication discrepancies among older hospitalized adults discharged from post-acute care facilities to home. *Journal of the American Medical Directors Association* 2024;25(7):105017. DOI: 10.1016/j.jamda.2024.105017. [Context Link 1] View abstract...
19. Werner RM, Coe NB, Qi M, Konetzka RT. Patient outcomes after hospital discharge to home with home health care vs to a skilled nursing facility. *JAMA Internal Medicine* 2019;179(5):617-623. DOI: 10.1001/jamainternmed.2018.7998. [Context Link 1] View abstract...
20. Chandra A, et al. Risk prediction model for 6-month mortality for patients discharged to skilled nursing facilities. *Journal of the American Medical Directors Association* 2022;23(8):1403-1408. DOI: 10.1016/j.jamda.2022.01.069. [Context Link 1] View abstract...
21. Simpson AJ, et al. BTS clinical statement on aspiration pneumonia. *Thorax* 2023;78(Suppl 1):s3-s21. DOI: 10.1136/thorax-2022-219699. [Context Link 1, 2] View abstract...
22. Morris BC. Patient and caregiver teaching. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. *Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems*. 12th ed. St. Louis, MO: Mosby; 2023:49-62. [Context Link 1]
23. Falls: assessment and prevention in older people and in people 50 and over at higher risk. NICE Guideline NG249 [Internet] National Institute for Health and Care Excellence. 2025 Apr Accessed at: <https://www.nice.org.uk/>. [accessed 2025 Aug 18] [Context Link 1]
24. Rafeq R, Igneri LA. Infectious pulmonary diseases. *Emergency Medicine Clinics of North America* 2022;40(3):503-518. DOI: 10.1016/j.emc.2022.05.005. [Context Link 1] View abstract...
25. Nickel B, et al. Infusion therapy standards of practice, 9th edition. *Journal of Infusion Nursing* 2024 Jan-Feb 01;47(1S Suppl 1):S1-S285. DOI: 10.1097/NAN.0000000000000532. [Context Link 1, 2] View abstract...
26. Fluid and electrolytes. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. 15th ed. Wolters Kluwer; 2022:224-272. [Context Link 1]
27. Dinh A, et al. Discontinuing β -lactam treatment after 3 days for patients with community-acquired pneumonia in non-critical care wards (PTC): a double-blind, randomised, placebo-controlled, non-inferiority trial. *Lancet* 2021;397(10280):1195-1203. DOI: 10.1016/S0140-6736(21)00313-5. [Context Link 1] View abstract...
28. Aliberti S, Dela Cruz CS, Amati F, Sotgiu G, Restrepo MI. Community-acquired pneumonia. *Lancet* 2021;398(10303):906-919. DOI: 10.1016/S0140-6736(21)00630-9. [Context Link 1, 2] View abstract...
29. Pulmonary disorders. In: Escott-Stump S, editor. *Nutrition and Diagnosis-Related Care*. 9th ed. Wolters Kluwer; 2022:380-442. [Context Link 1]
30. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline Online Living Guideline 4th Edition* [Internet] National Pressure Injury Advisory Panel. 2025 Feb Accessed at: <https://npiap.com/page/InternationalGuidelines>. [accessed 2025 Sep 16] [Context Link 1]
31. The client with alterations in respiratory function. In: Haugen N, Galura SJ, editors. *Ulrich & Canale's Nursing Care Planning Guides, 8th Edition Revised Reprint with 2021-2023 NANDA-I Updates*. 8th ed. Elsevier; 2022:116-216. [Context Link 1]
32. Turcotte LA, Perlman CM, Fries BE, Hirdes JP. Clinical predictors of protracted length of stay in Ontario complex continuing care hospitals. *BMC Health Services Research* 2019;19(1):218. DOI: 10.1186/s12913-019-4024-2. [Context Link 1] View abstract...
33. Bourke R, Rivasi G, Kenny RA. Falls, Dizziness and Funny Turns. In: O'Hanlon S, Smith M, editors. *Comprehensive Guide to Rehabilitation of the Older Patient*. 4th ed. Elsevier; 2021. [Context Link 1]
34. Oh-Park M, Gruber L. Geriatrics. In: Cifu DX, Lew HL, editors. *Braddom's Rehabilitation Care: A Clinical Handbook*. 2nd ed. Elsevier; 2025:289-296. [Context Link 1]
35. Stress and inflammatory responses. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. 15th ed. Wolters Kluwer; 2022:97-115. [Context Link 1]
36. Shock, sepsis, and multiple organ dysfunction syndrome. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. 15th ed. Wolters Kluwer; 2022:273-300. [Context Link 1]
37. Ventura KA. Assessment: gastrointestinal system. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. *Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems*. 12th ed. St. Louis, MO: Mosby; 2023:987-1008. [Context Link 1]

38. Assessment of digestive and gastrointestinal function. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. 15th ed. Wolters Kluwer; 2022:1206-1227. [Context Link 1]
39. Intravenous and vascular access therapy. In: Perry AG, Potter PA, Ostendorf WR, Laplante N, editors. *Clinical Nursing Skills and Techniques*. 11th ed. Elsevier; 2025:842-894. [Context Link 1]
40. Management of patients with oncologic disorders. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. 15th ed. Wolters Kluwer; 2022:301-366. [Context Link 1]
41. Complications of parenteral nutrition. In: Ayers P, Bobo ES, Hurt RT, Mays AA, Worthington PH, editors. *A.S.P.E.N. Parenteral Nutrition Handbook*. 3rd ed. Silver Spring, MD: American Society for Parenteral and Enteral Nutrition; 2020:173-198. [Context Link 1]
42. Parenteral nutrition administration and monitoring. In: Ayers P, Bobo ES, Hurt RT, Mays AA, Worthington PH, editors. *A.S.P.E.N. Parenteral Nutrition Handbook*. 3rd ed. Silver Spring, MD: American Society for Parenteral and Enteral Nutrition; 2020:141-172. [Context Link 1]
43. Rateau MR. Fluid, electrolyte, and acid-base imbalances. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. *Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems*. 12th ed. St. Louis, MO: Mosby; 2023:302-334. [Context Link 1, 2]
44. Vital signs. In: Perry AG, Potter PA, Ostendorf WR, Laplante N, editors. *Clinical Nursing Skills and Techniques*. 11th ed. Elsevier; 2025:70-109. [Context Link 1]
45. Ainger E, Ninan S. Exercise tolerance. In: O'Hanlon S, Smith M, editors. *Comprehensive Guide to Rehabilitation of the Older Patient*. 4th ed. Elsevier; 2021:171-176. [Context Link 1]
46. Shyu SG, Liang HW. The psychiatric history and physical examination. In: Cifu DX, Lew HL, editors. *Braddom's Rehabilitation Care: A Clinical Handbook*. 2nd ed. Elsevier; 2025:3-16. [Context Link 1]
47. Preston C. Psychological input. In: O'Hanlon S, Smith M, editors. *Comprehensive Guide to Rehabilitation of the Older Patient*. 4th ed. Elsevier; 2021:80-84. [Context Link 1]
48. Adult health and physical, nutritional, and cultural assessment. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*. 15th ed. Wolters Kluwer; 2022:71-96. [Context Link 1]
49. Imran A, Rawal MD, Botre N, Patil A. Improving and promoting social determinants of Health at a system level. *Joint Commission Journal on Quality and Patient Safety* 2022;48(8):376-384. DOI: 10.1016/j.jcjq.2022.06.004. [Context Link 1] View abstract...
50. The nursing process in drug therapy and patient safety. In: Tucker RG, editor. *Karch's Focus on Nursing Pharmacology*. 9th ed. Wolters Kluwer; 2023:47-57. [Context Link 1]
51. Adverse drug reactions and medication errors. In: Burchum JR, Rosenthal LD, editors. *Lehne's Pharmacology for Nursing Care*. 12th ed. Elsevier; 2025:64-75. [Context Link 1]
52. Safe medication preparation. In: Perry AG, Potter PA, Ostendorf WR, Laplante N, editors. *Clinical Nursing Skills and Techniques*. 11th ed. Elsevier; 2025:586-607. [Context Link 1]
53. Lee RA, Centor RM, Humphrey LL, Jokela JA, Andrews R, Qaseem A. Appropriate use of short-course antibiotics in common infections: best practice advice from the American College of Physicians. *Annals of Internal Medicine* 2021;174(6):822-827. DOI: 10.7326/M20-7355. (Reaffirmed 2025 Jun) [Context Link 1] View abstract...
54. Dyer SM, et al. Impact of relational continuity of primary care in aged care: a systematic review. *BMC Geriatrics* 2022;22(1):Online. DOI: 10.1186/s12877-022-03131-2. [Context Link 1] View abstract...
55. Anderson TS, Ayanian JZ, Herzig SJ, Souza J, Landon BE. Gaps in primary care follow-up after hospital discharge among Medicare beneficiaries. *Journal of the American Geriatrics Society* 2025;DOI: 10.1111/jgs.19496. [Context Link 1, 2] View abstract...
56. Jenkins-Lonidier L. Pulmonary infections, including ventilator-associated pneumonia. *Critical Care Nursing Clinics of North America* 2021;33(4):381-393. DOI: 10.1016/j.cnc.2021.08.002. [Context Link 1, 2] View abstract...
57. Sungurlu S, Balk RA. The role of biomarkers in the diagnosis and management of pneumonia. *Infectious Disease Clinics of North America* 2024;38(1):35-49. DOI: 10.1016/j.idc.2023.12.005. [Context Link 1] View abstract...
58. Dockrell DH, Ho A, Gordon SB. Community-acquired pneumonia. In: Broaddus VC, et al., editors. *Murray & Nadel's Textbook of Respiratory Medicine*. 7th ed. Elsevier Saunders; 2022:600-619.e47. [Context Link 1]
59. Angelelli J, et al. Effect of social determinants of health interventions on adults living with disabilities: a scoping review. *Archives of Physical Medicine and Rehabilitation* 2022;103(5):1023-1033.e11. DOI: 10.1016/j.apmr.2021.06.021. [Context Link 1] View abstract...
60. Ezell JM, Hamdi S, Borrero N. Approaches to addressing nonmedical services and care coordination needs for older adults. *Research on Aging* 2022 Mar-Apr;44(3-4):323-333. DOI: 10.1177/01640275211033929. [Context Link 1] View abstract...

61. Martinez-Kratz M. Guide to planning care. In: Makic MB, Martinez-Kratz MR, editors. *Ackley and Ladwig's Nursing Diagnosis Handbook*. 13th ed. Elsevier; 2023:125-1051. [Context Link 1]
62. Li J. Home health agencies with high quality of patient care star ratings reduced short-term hospitalization rates and increased days independently at home. *Medical Care* 2024;62(1):11-20. DOI: 10.1097/MLR.0000000000001930. [Context Link 1] View abstract...
63. Bassil NK, Ohanian MLK, Bou Saba TG. Nicotine use disorder in older adults. *Clinics in Geriatric Medicine* 2022;38(1):119-131. DOI: 10.1016/j.cger.2021.07.008. [Context Link 1] View abstract...
64. Harding MM. Substance use disorders in acute care. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. *Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems*. 12th ed. St. Louis, MO: Mosby; 2023:162-178. [Context Link 1]
65. Centers for Medicare and Medicaid Services. "Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS): scope and conditions." 42 CFR Pt. 410.38 Washington, DC 2024 Jan 01 [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/current/title-42/>. [Context Link 1, 2]
66. HEDIS® quality measures 2026. [Internet] NCQA. Accessed at: <https://www.ncqa.org/hedis/measures/>. Updated 2026 [accessed 2026 Apr 02] [Context Link 1]
67. Care and Compare. Find and Compare Nursing Homes, Hospitals, and Other Providers Near You [Internet] Medicare.gov. Accessed at: <https://www.medicare.gov/care-compare/>. [accessed 2025 Apr 02] [Context Link 1]
68. Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual. Effective October 1, 2024 [Internet] Centers for Medicare & Medicaid Services. v. 6.0; 2022 Accessed at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>. [accessed 2025 Sep 09] [Context Link 1]
69. Centers for Medicare and Medicaid Services (CMS). Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025. *Federal Register* [Internet] 2024 Aug Accessed at: <https://www.federalregister.gov/documents/search>. [accessed 2025 Apr 008] [Context Link 1]
70. National Patient Safety Goals. 2026 National Patient Safety Goals [Internet] Joint Commission on Accreditation of Healthcare Organizations. Accessed at: https://www.jointcommission.org/standards_information/npsgs.aspx. Updated 2025 Aug 11 [accessed 2025 Oct 27] [Context Link 1]
71. Centers for Medicare and Medicaid Services. "Criteria for 'practical matter'." 42 CFR Pt. 409.35 Washington, DC 2023 Oct [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/>. [Context Link 1]
72. Centers for Medicare and Medicaid Services. Medicare Program Integrity Manual. Chapter 6 - Medical Review of Inpatient Hospital Claims for Part A Payment Rev. 10365 [Internet] Centers for Medicare and Medicaid Services. 2020 Oct 02 Accessed at: <https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms>. [accessed 2025 Sep 09] [Context Link 1]
73. Medicare Coverage Database. [Internet] Centers for Medicare and Medicaid Services. Accessed at: <https://www.cms.gov/medicare-coverage-database/search.aspx>? Updated 2025 [accessed 2025 Oct 23] [Context Link 1]

Footnotes

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

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

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

[D] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) defines reasonable and necessary skilled care as a service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel" based on the documented assessment of

the patient's individual care needs. In some cases, a service that would originally be considered unskilled may be considered skilled if the patient's underlying conditions or complications require the involvement of licensed personnel to ensure that essential nonskilled care is achieving its purpose.(9)(10) [D in Context Link 1]

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

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

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

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

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

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

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

[L] **Evidence:** A retrospective analysis of 91,113 episodes of care in skilled nursing facilities found that risk factors for prolonged length of stay included functional and cognitive impairment; greater pressure ulcer risk; paralysis; antibiotic-resistant infection; HIV infection; and need for a feeding tube, dialysis, tracheostomy, ventilator or respirator, and psychological therapy.(32) [L in Context Link 1]

[M] Pneumocystis pneumonia carries a higher morbidity and mortality rate in patients who are immunocompromised (eg, acquired immune deficiency syndrome (AIDS), chemotherapy regimen).(12) [M in Context Link 1]

Definitions

Custodial care

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

References

1. Mauk KL. Post-acute care. In: Larsen PD, editor. Lubkin's Chronic Illness: Impact and Intervention. 11th ed. Jones & Bartlett Learning; 2022:477-520.

Intense and complex care needs

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

References

1. Shyu SG, Liang HW. The psychiatric history and physical examination. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:3-16.
2. Centers for Medicare and Medicaid Services. "Criteria for 'practical matter'." 42 CFR Pt. 409.35 Washington, DC 2023 Oct [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/>.

Occupational therapy (OT) progression

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

References

1. Bennett K. Setting rehabilitation goals. In: O'Hanlon S, Smith M, editors. Comprehensive Guide to Rehabilitation of the Older Patient. 4th ed. Elsevier; 2021:49-52.
2. Pryor J, O'Reilly K, Bonser M, Garret G, McKenchnie D. Rehabilitation for the individual and family. In: Chang E, Johnson A, editors. Living With Chronic Illness and Disability. 4th ed. Chatswood NSW 2067: Elsevier; 2022:161-182.
3. Carter WE III, Peretiatko S. Quality and outcome measures for medical rehabilitation. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:55-62.
4. Kee YYK. Measuring progress with rehabilitation. In: O'Hanlon S, Smith M, editors. Comprehensive Guide to Rehabilitation of the Older Patient. 4th ed. Elsevier; 2021:111-115.

Footnotes

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

Physical therapy (PT) progression

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

References

- Centers for Medicare and Medicaid Services. "Skilled services requirements." 42 CFR Pt. 409.44 Washington, DC 2023 Oct 02 [accessed 2025 Jul 23] Accessed at: <https://www.ecfr.gov/>.
- Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Rev. 12283 [Internet] Centers for Medicare and Medicaid Services. 2023 Oct 05 Accessed at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/>. [accessed 2025 Sep 09]
- Hussein N. Acute medical conditions. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:253-264.
- Carter WE III, Peretiak S. Quality and outcome measures for medical rehabilitation. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:55-62.
- Scalzitti DA. Examination of function. In: Fulk G, Chui K, editors. O'Sullivan & Schmitz's Physical Rehabilitation. 8th ed. USA: F.A. Davis Company; 2024:270-291.

Footnotes

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

Safe to go home

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

References

- Elements of Excellence in Transitions of Care (TOC). TOC Checklist [Internet] National Transitions of Care Coalition. 2006 Accessed at: <https://www.ntocc.org/>. [accessed 2025 Sep 16]

2. Medical-surgical nursing. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:33-55.
3. Admitting, transfer, and discharge. In: Perry AG, Potter PA, Ostendorf WR, Laplante N, editors. Clinical Nursing Skills and Techniques. 11th ed. Elsevier; 2025:40-51.

Skilled care

- Skilled care may be direct (eg, in-person assessment and administration of treatments) or indirect (eg, coordinating care between providers, supervising care aides); examples include(1)(2)(3)(4):
 - Performed or supervised by professional or technical personnel
 - Exceed scope of Custodial care
 - Service is considered skilled as indicated by either of the following:
 - Service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel" based on the documented assessment of the patient's individual care needs.
 - Service that would originally be considered unskilled may be considered skilled if the patient's underlying conditions or complications require the involvement of licensed personnel to ensure that essential nonskilled care is achieving its purpose.

References

1. Centers for Medicare and Medicaid Services. "Criteria for skilled services and the need for skilled service." 42 CFR Pt. 409.32 Washington, DC 2023 Oct 02 [accessed 2025 Jul 22] Accessed at: <https://www.ecfr.gov/>.
2. Harding MM. Professional nursing. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:1-18.
3. Medical-surgical nursing. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:33-55.
4. Centers for Medicare and Medicaid Services. Medicare Program Integrity Manual. Chapter 6 - Medical Review of Inpatient Hospital Claims for Part A Payment Rev. 10365 [Internet] Centers for Medicare and Medicaid Services. 2020 Oct 02 Accessed at: <https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms>. [accessed 2025 Sep 09]

Transition of care planning completed

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

References

1. Standards of Practice for Case Management. [Internet] Case Management Society of America. 2024 Oct Accessed at: <https://www.cmsa.org/>. [created 2022; accessed 2025 Sep 09]
2. Transitions of Care Standards. A New Way Forward [Internet] American Case Management Association. Accessed at: <https://www.acmaweb.org/>. [accessed 2025 Sep 05]

3. Myers CR. Health equity and population vulnerability. In: Stanhope M, Lancaster J, Hoffman JE, Levin PF, Turner L, editors. Public Health Nursing: Population-Centered Health Care in the Community. 11th ed. Elsevier; 2025:127a-145.

Footnotes

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

Codes

ICD-10 Diagnosis: A21.2, A22.1, A37.01, A37.11, A37.81, A37.91, A48.1, A70, A78, B20, B37.1, B44.0, B59, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.61, J15.69, J15.7, J15.8, J15.9, J16.0, J16.8, J17, J18.0, J18.1, J18.8, J18.9 [Hide]

MCG Health
Recovery Facility Care 30th Edition
Copyright © 2026 MCG Health, LLC
All Rights Reserved

Last Update: 1/25/2026 1:51:06 AM
Build Number: 30.0.2026012500524.025256