CDAR2AIS0003R030

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® Tables

*Draft ~~November 2006~~**March 2007***

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1 Introduction

This publication provides the **defined data items and their corresponding** LOINC®[1] code values specific to a rehabilitation services attachment for the following applications.

- Those codes that ~~define~~ **identify** the attachment or attachment components used in transactions such as those defined by the ASC ~~X12N~~ 277 *Health Care Claim Request for Additional Information* and the ASC X12~~N~~ 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.[2,3]
- ~~All of the~~**Those** codes ~~may be~~ 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*[4]

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:

In this specification, there are many new or revised data elements (questions and/or answers on an attachment) that require assignment of a new LOINC code by Regenstrief. In this document, these are indicated by the text "LOINC-TBD" (or similar). Upon completion of the ballot process, during the final publishing steps, we will update these placeholders with the real codes.

[1] LOINC® is a registered trademark of Regenstrief Institute and the LOINC Committee. The LOINC database and LOINC Users" Guide are copyright 1998-~~2004~~ **2006** Regenstrief Institute and the LOINC Committee and the LOINC database codes and names are available at no cost from http://www.LOINC.org. ~~Regenstrief Institute, 1050 Wishard Blvd., Indianapolis, IN 46202~~ Email: LOINC@regenstrief.org

[2] Information on this and other X12~~N~~/HIPAA-related implementation guides is available from the Washington Publishing Company, ~~747 177th Lane NE, Bellevue, WA 98008. Phone: 425 562 2245 or~~ http://www.wpc-edi.com/

[3] Within this Health Level Seven document, references to the transaction defined by these X12~~N~~ implementation guides will be abbreviated by calling them 275 and 277.

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

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 ~~documentation~~ **additional information** to support other health care transactions**, such as the ASC X12 837 claims and the ASC X12 Health Care Services Review**.

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~~N~~ Transactions, and HL7 CDA Documents, see section 1.5 in the *HL7 Additional Information Specification Implementation Guide.*

1.3 Revision History

Date	*Purpose*
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 9-253-2005** HIPAA NPRM)~~Release 2.1 Publication~~
November 2006	Draft using CDA R2
March 2007	**Second Informatitive 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.

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

~~The **human-decision variant** is used solely for information that will be rendered for a person to look at, in order to make a decision. 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** has the same content as the human-decision variant, but additional coded and structured information is included so that a computer could provide decision support based on the document. Attachments in the computer-decision variant can be rendered for human decisions using the same style sheet that HL7 provides for rendering documents formatted according to the human-decision variant.~~

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 captures 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** ~~the~~ 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

LOINC code	*Attachment Name*
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~~N~~ 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 ~~seven~~ **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).** ~~.~~ 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
18823-5	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION ATTACHMENT**
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**
~~27515-6~~	~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS~~
27477-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
18672-6	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SYMPTIONS 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)**
~~27482-9~~	~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, VISIT FREQUENCY~~
~~27487-8~~	~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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~~27492-8~~	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ~~DATE PATIENT REFERRED FOR TREATMENT~~**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 ~~OF LAST PLAN OF TREATMENT~~**RANGE CERTIFYING THE PLAN OF CARE** ~~CERTIFICATION~~
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~~27502-4~~	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY~~+ LEVEL OF FUNCTION~~
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
27503-2	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ~~INITIAL~~ 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**

LOINC Code	Description
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 REFERRAL +~~ REASON FOR RELAPSE IF KNOWN
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 ~~REHABILITATION~~ TREATMENT
~~18671-8~~	~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, NEXT PLAN OF TREATMENT TEXT~~
~~18672-6~~	~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ALCOHOL/SUBSTANCE ABUSE SYMPTOMS WITH PHYSIOLOGICAL DEPENDENCE INDICATOR~~
~~18673-4~~	~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REHABILITATION PROBLEM REMISSION STATUS~~
~~18674-2~~	~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LONGEST PERIOD OF SOBRIETY FOR ABUSED SUBSTANCE~~

Note to Ballot Reviewers:
Many of the tables shown in this document have known formatting issues that will be corrected in the final editing process. Fixing these now (March 2007) would confuse the tracked changes feature.

For example, when changes resulted in an entire table row being deleted, or moved to another position in the table, you may seen a lot of vertical space representing the previous length of the row. Or, columns in the table may be misaligned due to improper insertion of new rows. Such things occur when there are multiple human editors sharing the documents within multiple versions of software products.

~~2.4.2~~

2.4.2 Cardiac Rehabilitation Attachment

Table 2.4.2 Data Components for Cardiac Rehabilitation Attachment

LOINC Code	Description
18824-3	**CARDIAC REHABILITATION ATTACHMENT**
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**
~~27457-1~~	~~CARDIAC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS~~
27518-0	CARDIAC REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27519-8	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN **(COMPOSITE)**
~~27531-3~~	~~CARDIAC REHABILITATION TREATMENT PLAN, VISIT FREQUENCY~~
~~27533-9~~	~~CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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 ~~27540-4~~	CARDIAC REHABILITATION TREATMENT PLAN, ~~DATE PATIENT REFERRED FOR TREATMENT~~**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 ~~OF LAST PLAN OF~~**RANGE CERTIFYING THE PLAN OF CARE** ~~TREATMENT CERTIFICATION~~
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT**
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE**
~~27549-5~~LOINC-TBD	CARDIAC REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY~~+ LEVEL OF FUNCTION~~
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
27445-6	CARDIAC REHABILITATION TREATMENT PLAN, ~~INITIAL~~ 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
18825-0	**MEDICAL SOCIAL SERVICES REHABILITATION ATTACHMENT**
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**
~~27791-3~~	~~MEDICAL SOCIAL SERVICES TREATMENT PLAN, PRIMARY DIAGNOSIS~~
27754-1	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27755-8	MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR OF TREATMENT PLAN **(COMPOSITE)**
~~27759-0~~	~~MEDICAL SOCIAL SERVICES TREATMENT PLAN, VISIT FREQUENCY~~
~~27761-6~~	~~MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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~~27766-5~~	MEDICAL SOCIAL SERVICES TREATMENT PLAN, ~~DATE PATIENT REFERRED FOR TREATMENT~~**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 ~~OF LAST PLAN OF TREATMENT CERTIFICATION~~**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~~27775-6~~	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PAST MEDICAL HISTORY~~+ LEVEL OF FUNCTION~~
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
27776-4	MEDICAL SOCIAL SERVICES TREATMENT PLAN, ~~INITIAL~~ 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
18826-8	**OCCUPATIONAL THERAPY REHABILITATION ATTACHMENT**
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**
~~27635-2~~	~~OCCUPATIONAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS~~
27601-4	OCCUPATIONAL THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27602-2	OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN **(COMPOSITE)**
~~27606-3~~	~~OCCUPATIONAL THERAPY TREATMENT PLAN, VISIT FREQUENCY~~
~~27608-9~~	~~OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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~~27613-9~~	OCCUPATIONAL THERAPY TREATMENT PLAN, ~~DATE PATIENT REFERRED FOR TREATMENT~~**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 ~~OF LAST PLAN OF TREATMENT CERTIFICATION~~**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 ~~27622-0~~	OCCUPATIONAL THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY ~~+ LEVEL OF FUNCTION~~
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
27623-8	OCCUPATIONAL THERAPY TREATMENT PLAN, ~~INITIAL~~ \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
19002-5	**PHYSICAL THERAPY REHABILITATION ATTACHMENT**
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**
~~27698-0~~	~~PHYSICAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS~~
27664-2	PHYSICAL THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27665-9	PHYSICAL THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN **(COMPOSITE)**
~~27669-1~~	~~PHYSICAL THERAPY TREATMENT PLAN, VISIT FREQUENCY~~
~~27671-7~~	~~PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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~~27676-6~~	PHYSICAL THERAPY TREATMENT PLAN, ~~DATE PATIENT REFERRED FOR TREATMENT~~**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 ~~OF LAST PLAN OF TREATMENT CERTIFICATION~~**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~~27685-7~~	PHYSICAL THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY ~~+ LEVEL OF FUNCTION~~
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
27686-5	PHYSICAL THERAPY TREATMENT PLAN, ~~INITIAL~~ 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
18594-2	**PSYCHIATRIC REHABILITATION ATTACHMENT**
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**
~~19007-4~~	~~PSYCHIATRIC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS~~
18631-2	PSYCHIATRIC REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
18632-0	PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN **(COMPOSITE)**
~~18637-9~~	~~PSYCHIATRIC REHABILITATION TREATMENT PLAN, VISIT FREQUENCY~~
~~18639-5~~	~~PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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~~18646-0~~	PSYCHIATRIC REHABILITATION TREATMENT PLAN, ~~DATE PATIENT REFERRED FOR TREATMENT~~**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 ~~OF LAST PLAN OF TREATMENT CERTIFICATION~~**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~~18655-1~~	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY ~~+ LEVEL OF FUNCTION~~
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
18656-9	PSYCHIATRIC REHABILITATION TREATMENT PLAN, ~~INITIAL~~ 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

~~*2.4.7Respiratory Therapy Rehabilitation Attachment*~~

Table 2.4.7 Data Components for Respiratory Therapy Rehabilitation Attachment

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

LOINC Code	Description
19003-3	**RESPIRATORY THERAPY REHABILITATION ATTACHMENT**
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**
~~27740-0~~	~~RESPIRATORY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS~~
27703-8	RESPIRATORY THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27704-6	RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN **(COMPOSITE)**
~~27708-7~~	~~RESPIRATORY THERAPY TREATMENT PLAN, VISIT FREQUENCY~~
~~27710-3~~	~~RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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~~27715-2~~	RESPIRATORY THERAPY TREATMENT PLAN, ~~DATE PATIENT REFERRED FOR TREATMENT~~**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 ~~OF LAST PLAN OF TREATMENT CERTIFICATION~~**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~~27724-4~~	RESPIRATORY THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY ~~+ LEVEL OF FUNCTION~~
LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
27725-1	RESPIRATORY THERAPY TREATMENT PLAN, ~~INITIAL~~ 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
19003-3	**RESPIRATORY THERAPY REHABILITATION ATTACHMENT**
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**

~~2.4.8~~2.4.9 *Skilled Nursing Rehabilitation Attachment*

Table 2.4.9 Data Components for Skilled Nursing Rehabilitation Attachment

LOINC Code	Description
19004-1	**SKILLED NURSING REHABILITATION ATTACHMENT**
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**
~~27587-5~~	~~SKILLED NURSING TREATMENT PLAN, PRIMARY DIAGNOSIS~~
27550-3	SKILLED NURSING TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
27551-1	SKILLED NURSING TREATMENT PLAN, AUTHOR OF TREATMENT PLAN **(COMPOSITE)**
~~27555-2~~	~~SKILLED NURSING TREATMENT PLAN, VISIT FREQUENCY~~
~~27557-8~~	~~SKILLED NURSING TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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, ~~DATE PATIENT REFERRED FOR~~
~~27562-8~~	~~TREATMENT~~**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 ~~OF LAST PLAN OF TREATMENT CERTIFICATION~~**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 ~~+ LEVEL OF~~
~~27571-9~~	~~FUNCTION~~
LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
27572-7	SKILLED NURSING TREATMENT PLAN, ~~INITIAL~~ 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

~~2.4.9~~2.4.10 Speech Therapy Rehabilitation Attachment

Table 2.4.10 Data Components for Speech Therapy Rehabilitation Attachment

LOINC Code	Description
29206-0	**SPEECH THERAPY REHABILITATION ATTACHMENT**
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**
~~29166-6~~	~~SPEECH THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS~~
29167-4	SPEECH THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN
29168-2	SPEECH THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN **(COMPOSITE)**
~~29169-0~~	~~SPEECH THERAPY TREATMENT PLAN, VISIT FREQUENCY~~
~~29170-8~~	~~SPEECH THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~
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, ~~DATE PATIENT REFERRED FOR TREATMENT~~**REFERRAL INFORMATION (COMPOSITE)**
~~29172-4~~	
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 ~~OF LAST PLAN OF TREATMENT CERTIFICATION~~**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 ~~+ LEVEL OF~~ FUNCTION
~~29181-5~~	
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)**
29182-3	SPEECH THERAPY TREATMENT PLAN, ~~INITIAL~~ 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~~

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)

~~The minimum attachment data set equates to the required components; those identified in the value table, below, with cardinality (Card) of~~

~~{1,1} (component is required and has one and only one occurrence) or~~

~~{1,n} (component is required and has one or more occurrences).~~

~~Those data components with a cardinality of~~

~~{0,1} (if available has one and only one occurrence) or~~

~~{0,n} (if available may have one or more occurrences)~~

~~shall be sent if available.~~

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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27474-6 27474-6	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` **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.** ~~RPLC Revised~~ ~~any other New~~	**REL**	**CS**	**1,1**	ActRelationship Document
27515-6 **27515-6**	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** 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. `/ClinicalDocument//section[code/@code="27515-6" and code/@codeSystem=$LOINC]//observation[code/@code="275151-6" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~27515-6~~	ALCOHOL-SUBSTANCE ABUSE REHABILITATION 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27515-6" and code/@codeSystem=$LOINC]//observation [code/@code="27515-6" and code/@codeSystem=$LOINC]/value/@code`		CD	1,1	I9C I10C
~~27515-6~~	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="27515-6" and code/@codeSystem=$LOINC]//observation [code/@code="27515-6" and code/@codeSystem=$LOINC]/ effectiveTime/low/@value`		TS	1,1	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. 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/low/@value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`
		ACT	**TS**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~27487-8~~ 27487-8	~~ALCOHOL SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN~~ ~~The rehabilitation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.~~ ~~/ClinicalDocument/documentationOf/serviceEvent [code/@code="27487-8"]/effectiveTime/low/@value~~ ~~/ClinicalDocument/documentationOf/serviceEvent [code/@code="27487-8"]/effectiveTime/high/@value~~	~~ACT~~	~~TS~~	~~1,1~~	
27482-9 27482-9	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, VISIT FREQUENCY** 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="27482-9" and code/@codeSystem=$LOINC]//observation [code/@code="27482-9" and code/@codeSystem=$LOINC]/value`	**OBS**	**PQ**	**1,1**	**UCUM**

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27477-9 27477-9	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN** 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27477-9" and code/@codeSystem=$LOINC]//observation[code/@code="27477-9" and code/@codeSystem=$LOINC]/value/@code`	**OBS**	**CD**	**1,1**	I9C I10C
18672-6 18672-6	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ALCOHOL/SUBSTANCE ABUSE SYMPTOMS WITH PHYSIOLOGICAL DEPENDENCE INDICATOR** 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. `/ClinicalDocument//section[code/@code="18672-6" and code/@codeSystem=$LOINC]//observation[code/@code="18672-6" and code/@codeSystem=$LOINC]/value/@value`	**OBS**	**BL**	**1,1**	
18673-4 18673-4	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REHABILITATION PROBLEM REMISSION STATUS** 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. `/ClinicalDocument//section[code/@code="18672-6" and code/@codeSystem=$LOINC]//observation[code/@code="18672-6" and code/@codeSystem=$LOINC]/value/@code` 416984007 Early Remission 417618009 Partial Remission 416312007 Full Remission	**OBS**	**CD**	**1,1**	Subset of SNOMED CT

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
18674-2	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LONGEST PERIOD OF SOBRIETY FOR ABUSED SUBSTANCE (COMPOSITE)** This information is stored in an <observation> pertaining to the diagnosis addressed by the plan. The XPath Expression to access this information is: `/ClinicalDocument//section[code/@code="18674-2" and code/@codeSystem=$LOINC]//observation[code/@code="18674-2" and code/@codeSystem=$LOINC]`	**OBS**		**0,n**	
18676-7	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LONGEST PERIOD OF SOBRIETY The <value> element of the <observation> indicates the longest period of sobriety. The @value attribute indicates the length of the period. `/ClinicalDocument//section[code/@code="18674-2" and code/@codeSystem=$LOINC]//observation[code/@code="18676-7" and code/@codeSystem=$LOINC]/value/@value` Include units for the period of sobriety in the @unit attribute: d days mo months wk weeks		PQ	1,1	UCUM
18675-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ABUSED SUBSTANCE Information about the substance is stored in a <participant> element attached to the sobriety observation. The XPath expression for the name of the substance is[5]: `/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`		EN	1,1	
27478-7	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	

[5] 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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27479-5	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor/assignedPerson/name`		PN	1,1	
27514-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR IDENTIFIER Unique identifier for the professional who established the treatment plan. See section 3.8 on Instance Identifier Data Type in the *HL7 Additional Information Specification Implementation Guide* 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/author/assignedAuthor/id`		II	1,1	NPI UPIN or other provider identifier
27480-3	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AUTHOR PROFESSION As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor/code/@code`		CD	0,1	PTX

27490-2
27490-2
	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	`/ClinicalDocument//section[code/@code="27490-2" and code/@codeSystem=$LOINC]//encounter[code/@code="27490-2" and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="27490-2" and code/@codeSystem=$LOINC]//encounter[code/@code="27490-2" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27491-0 27491-0	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, CONTINUATION STATUS** 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="27491-0" and code/@codeSystem=$LOINC]//act[code/@code="27491-0" and code/@codeSystem=$LOINC]/statuscode` active The treatment is ongoing. aborted The treatment has been discontinued.	**ACT**	**CS**	**0,1**	ActStatus
~~**27492-8**~~**LOINC-TBD** ~~27492-8~~	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT, ~~DATE PATIENT REFERRED FOR TREATMENT~~REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.** ~~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`~~	~~**PART ???**~~**Section**	~~**TS**~~	**0,1**	
Same as Above	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** ~~**Add xpath expression here...**~~`/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name`		**PN**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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.** ~~Add xpath expression here…~~/ClinicalDocument/participant[@typeCode="REF"]/participantRole/id		**II**	**0,1**	**NPI UPIN or other provider identifier**
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION 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.** /ClinicalDocument/participant[@typeCode="REF"]/time		**TS**	**1,1**	
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION – COMMUNICATION TO REFERRING PHYSICIAN INDICATOR** **An indicator defining if written communication has been sent back to the referring entity.** **~~Y~~true~~-~~ indicates that written communication has been sent ~~and~~** **~~n~~ false indicates that it has not been sent.** /ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]//observation[code/@code="LOINC-TBD" and @codeSystem=$LOINC]/value/@value ~~Add xpath expression here…~~		**BL**	**0,1**	
27495-1	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION 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: /ClinicalDocument/legalAuthenticator	**PART**		**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27495-1	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE 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.		CS	1,1	ParticipationSignature
27493-6	ALCOHOL-SUBSTANCE ABUSE REHABILITATION DATE TREATMENT PLAN, AUTHOR SIGNED The <time> element of the <legalAuthenticator> element provides the time at which the document was signed. `/ClinicalDocument/legalAuthenticator/time/ @value`		TS	1,1	
27496-9	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE (COMPOSITE)** The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[6]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
27496-9	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB 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.		CS	1,1	ParticipationSignature
27494-4	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE REHAB PROFESSIONAL SIGNED 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`		TS	1,1	
27498-5 27498-5	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED**	**SBADM**		**0,n**	

[6] 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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

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

This information can be found using the following XPath

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27499-3
27499-3
	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGNOSIS FOR REHABILITATION
	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="27499-3" and code/@codeSystem=$LOINC]//observation[code/@code="27499-3" and code/@codeSystem=$LOINC]`
	
	The <value> of the <observation> is a code describing the prognosis for rehabilitation.
	
	`/ClinicalDocument//section[code/@code="27499-3" and code/@codeSystem=$LOINC]//observation[code/@code="27499-3"and code/@codeSystem=$LOINC]/value/@code`
	
	170969009 Poor
	67334001 Guarded
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	Subset of SNOMED CT

27501-6 27501-6	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE~~OF LAST PLAN OF TREATMENT CERTIFICATION~~** **Identifies the from and through date range that certifies the Plan of Care.** **This element can be identified using the following XPath expression.** `~~Add xpath expression here…~~/ClinicalDocument//section[code/@code='27501-6']//act[code/@code='27501-6']/effectiveTime`	**~~OBS~~ACT**	**IVL_TS**	**0,1**	
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` **~~Add xpath expression here…~~**	**~~???~~ACT**	**TS**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27502-4 27502-4 **May need new LOINC due to change of title.**	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY~~ + LEVEL OF FUNCTION~~ (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**~~???~~OBS**		**1,1**	
LOINC-TBD	**~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN,~~ PRIOR LEVEL OF FUNCTION** **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`**~~Add xpath expression here…~~**		**C~~D~~O**[7]	**1,1**	**GAF**
LOINC-TBD	**~~ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN,~~ CURRENT LEVEL OF FUNCTION** **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`**~~Add xpath expression here…~~**		**C~~D~~O**[7]	**1,1**	**GAF**
27503-2 **~~27503-2~~**	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)** **Information about the assessment of the patient. This can be the initial assessment and/or the re-evaluation of a patient's condition.**	**~~Section??~~ ?Section**	**~~ED~~**	**1,~~1~~n**	
27503-2	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, ASSESSMENT – ASSESSMENT NARRATIVE** `/ClinicalDocument//section[code/@code="27503-2" and`		**ED**	**1,1**	

[7] **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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	code/@codeSystem=$LOINC]/text				
LOINC-TBD	**INITIAL** ASSESSMENT INDICATOR **Identifies if this is the initial assessment or a re-evaluation of the patient's condition.** **~~I~~true – Initial Assessment** **~~R~~false – Re-evaluation** /ClinicalDocument//section[code/@code="27503-2" and code/@codeSystem=$LOINC]//observation[code/@code="TBD"and code/@codeSystem=$LOINC]/value/@code**~~Add xpath expression here…~~**	**OBS**	**~~CD~~BL**	**1,1**	**~~HL97055~~**
27504-0 27504-0	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)** **A narrative of the entire plan of treatment.**	**Section**	**ED**	**1,1**	
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)** **A narrative of the current treatment provided to support the services billed for the specified time period on the claim. Does not include the progress note.**	**Section**	**ED**	**0,1**	
27505-7 ~~27505-7~~	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS (COMPOSITE) ~~(NARRATIVE)~~** **If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.**	**~~Section~~ ~~OBS~~ ~~???~~Section**	**~~ED~~**	**0,~~1~~n**	
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS NARRATIVE**		**ED**	**1,1**	
LOINC-TBD	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PROGRESS NOTE + ATTAINMENT OF GOALS DATE RANGE** /ClinicalDocument//section[code/@code="27505-7" and code/@codeSystem=$LOINC]//observation[code/@code="TBD"and code/@codeSystem=$LOINC]/value/@value **~~Add xpath expression here…~~**		**TS**	**1,1**	
27506-5 27506-5	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)**	**Section**	**ED**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
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 REFERRAL~~+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)** **A narrative description of the past treatment attempts.**	**Section**	**ED**	**0,1**	
18664-3	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, FOLLOWUP APPROACH (COMPOSITE)** 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.	**ENC**		**0,1**	
18665-0	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, AGENCY THAT WILL FOLLOW UP Information about the agency that will follow up is recorded in the <representedOrganization> element of the <assignedEntity> element, and can be found in the <performer> element associated with the intended <encounter>. `/ClinicalDocument//section[code/@code="18664-3" and code/@codeSystem=$LOINC]//encounter[code/@code="18664-3" and code/@codeSystem=$LOINC]/performer/assignedEntity/representedOrganization/name` Provider may respond with agency or person. If both are sent, the person should be affiliated with the agency.		PRF	0,1	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
18666-8	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, PERSON THAT WILL FOLLOW UP Information about the person that will follow up is recorded in the <assignedPerson> element of the <assignedEntity> element, and can be found in the <performer> element associated with the intended <encounter>. `/ClinicalDocument//section[code/@code="18664-3" and code/@codeSystem=$LOINC]//encounter[code/@code="18664-3" and code/@codeSystem=$LOINC]/performer/assignedEntity/assignedPerson/name` Provider may respond with agency or person. If both are sent, the person should be affiliated with the agency.		PN	0,1	
18667-6	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, METHODOLOGY FOR FOLLOW UP The methodology for follow-up is stored in the <text> element of the <encounter>. `/ClinicalDocument//section[code/@code="18664-3" and code/@codeSystem=$LOINC]//encounter[code/@code="18664-3" and code/@codeSystem=$LOINC]/text`	~~Section~~	ED	1,1	
18668-4	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, FREQUENCY OF ASSESSMENTS FOR FOLLOW UP The frequency of assessments is stored as an <observation> element attached to the <encounter>. `/ClinicalDocument//section[@code="18664-3" and code/@codeSystem=$LOINC]//encounter[@code="18664-3" and code/@codeSystem=$LOINC]//observation[@code="18668-4"]/value`	OBS	GTS	1,1	
18669-2 18669-2	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, LEVEL OF PATIENT PARTICIPATION** This information is stored as an <observation>. `/ClinicalDocument//section[code/@code="18669-2" and code/@codeSystem=$LOINC]//observation[code/@code="18669-2" and code/@codeSystem=$LOINC]/value`	**OBS**	**TX**	**1,1**	
18671-8 18671-8	**ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, NEXT PLAN OF TREATMENT TEXT (NARRATIVE)**	**OBS**	**TX**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27513-1
27513-1
	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF NEXT PLANNED TREATMENT
	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`
		ENC	**TS**	**0,1**	

3.2 Cardiac Rehabilitation Service Value Table

~~3.2Cardiac Rehabilitation Service Value Table~~

Table 3.2 Cardiac Rehabilitation Service Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27483-7 27483-7	**CARDIAC REHABILITATION TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` RPLC Revised any other New	**REL**	**CS**	**1,1**	ActRelationshipDocument
27457-1 27457-1	**CARDIAC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** 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. `/ClinicalDocument//section[code/@code="27457-1" and code/@codeSystem=$LOINC]//observation[code/@code="27457-1" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	
~~27457-1~~	CARDIAC REHABILITATION 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27457-1" and code/@codeSystem=$LOINC]//observation[code/@code="27457-1" and code/@codeSystem=$LOINC]/value/@code`		CD	1,1	I9C I10C

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	CARDIAC REHABILITATION TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="27457-1" and code/@codeSystem=$LOINC]//observation[code/@code="27457-1" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		TS	1,1	

LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. 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/low/@value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`
		ACT	**TS**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~27533-9~~ 27533-9	~~**CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN**~~ ~~The rehabilitation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27533-9"]/effectiveTime/low/@value`~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27533-9]/effectiveTime/high/@value`~~	~~**ACT**~~	~~**TS**~~	~~**1,1**~~	
27531-3 27531-3	**CARDIAC REHABILITATION TREATMENT PLAN, VISIT FREQUENCY** 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`	**OBS**	**PQ**	**1,1**	**UCUM**

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27518-0 27518-0	**CARDIAC REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN** 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 attachments 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`	**OBS**	**CD**	**1,1**	**I9C** **I10C**
27519-8	**CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	
27520-6	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor/ assignedPerson/name`		PN	1,1	
27456-3	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information. `/ClinicalDocument/author/assignedAuthor/id`		II	1,1	NPI UPIN or other provider identifier
27521-4	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR PROFESSION As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor/ assignedAuthor/code/@code`		CD	0,1	PTX

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27536-2
27536-2
	CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	`/ClinicalDocument//section[code/@code="27536-2" and code/@codeSystem=$LOINC]//encounter[code/@code="27536-2" and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="27536-2" and code/@codeSystem=$LOINC]//encounter[code/@code="27536-2" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

27539-6 27539-6	**CARDIAC REHABILITATION TREATMENT PLAN, CONTINUATION STATUS** 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="27539-6 and code/@codeSystem=$LOINC]//act[code/@code="27539-6" and code/@codeSystem=$LOINC]/statuscode`	**ACT**	**CS**	**0,1**	ActStatus
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.**	**Section**		**0,1**	
Same as above	**CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** /ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name~~Add xpath expression here…~~		**PN**	**0,1**	
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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~~Add xpath expression here…~~		**II**	**0,1**	**NPI UPIN or other provider identifier**
LOINC-TBD	**CARDIAC REHABILITATION 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.** /ClinicalDocument/participant[@typeCode="REF"]/time		**TS**	**1,1**	
~~27540-4~~ ~~27540-4~~	~~**CARDIAC REHABILITATION TREATMENT PLAN, 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.~~ ~~/ClinicalDocument/participant[typeCode="REF"]/time~~	~~**PART**~~	~~**TS**~~	~~**0,1**~~	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27543-8	**CARDIAC REHABILITATION 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: `/ClinicalDocument/legalAuthenticator`	**PART**		**0,1**	
27543-8	CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE 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.		CS	1,1	ParticipationSignature
27541-2	CARDIAC REHABILITATION DATE TREATMENT PLAN, AUTHOR SIGNED The <time> element of the <legalAuthenticator> element provides the time at which the document was signed. `/ClinicalDocument/legalAuthenticator/time/ @value`		TS	1,1	
27544-6	**CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE CARDIAC REHABILITATION PROFESSIONAL ON FILE (COMPOSITE)** The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[8]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
27544-6	CARDIAC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB 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.		CS	1,1	ParticipationSignature
~~27678-2~~**27542-0**	CARDIAC REHABILITATION TREATMENT PLAN, DATE CARDIAC REHABILITATION PROFESSIONAL SIGNED		TS	1,1	

[8] 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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	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`				

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27545-3	**MEDICATION ADMINISTERED**	Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27546-1
27546-1
	CARDIAC REHABILITATION TREATMENT PLAN, PROGNOSIS FOR CARDIAC REHABILITATION
	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="27546-1" and code/@codeSystem=$LOINC]//observation[code/@code="27546-1" and code/@codeSystem=$LOINC]`
	The <value> of the <observation> is a code describing the prognosis for rehabilitation.
	`/ClinicalDocument//section[code/@code="27546-1" and code/@codeSystem=$LOINC]//observation[code/@code="27546-1" and code/@codeSystem=$LOINC]/value/@code`
	170969009 Poor
	67334001 Guarded
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	Subset of SNOMED CT

27548-7 27548-7	**CARDIAC REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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='27548-7']//act[code/@code='27548-7']/effectiveTime` ~~**Add xpath expression here…**~~ ~~**DATE OF LAST PLAN OF TREATMENT CERTIFICATION**~~	**OBS**	**TS**	**0,1**	
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**CARDIAC REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	**???**	**TS**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27549-5 27549-5 **May need new LOINC due to title change.**	**CARDIAC REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY~~+LEVEL OF FUNCTION (~~(NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**Section**	**ED**	**1,1**	
LOINC-TBD	PRIOR LEVEL OF FUNCTION (NARRATIVE) 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`		ED	1,1	
LOINC-TBD	**~~CARDIAC REHABILITATION TREATMENT PLAN,~~ CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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`~~**Add xpath expression here…**~~		**ED**	**1,1**	
27445-6 ~~27445-6~~	**CARDIAC REHABILITATION TREATMENT PLAN, ~~INITIAL~~ ASSESSMENT INFORMATION (COMPOSITE~~NARRATIVE~~)** **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.**	**~~Section~~Section**	**~~ED~~**	**1,~~1~~n**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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="27445-6" and code/@codeSystem=$LOINC]//observation[code/@code="TBD"and code/@codeSystem=$LOINC]/value/@code`~~**ASSESSMENT INDICATOR**~~ ~~**Identifies if this is the initial assessment or a re-evaluation of the patient's condition.**~~ ~~**I – Initial Assessment**~~ ~~**R – Re-evaluation**~~ ~~**Add xpath expression here…**~~		**CD**	**1,1**	**HL97055**
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**	
27446-4 27446-4	**CARDIAC REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)** **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**	
27447-2 ~~27447-2~~	**CARDIAC REHABILITATION TREATMENT, PROGRESS NOTE+ATTAINMENT OF GOALS (**~~**NARRATIVE**~~**COMPOSITE)** **If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.**	~~**Section??**~~ **?Section**	**ED**	**0,**~~**1**~~**n**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**CARDIAC REHABILITATION TREATMENT, PROGRESS NOTE + ATTAINMENT OF GOALS DATE RANGE** /ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime ~~**Add xpath expression here…**~~		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

~~3.3Medical Social Services Rehabilitation Value Table~~

Table 3.3 Medical Social Services Rehabilitation Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27750-9 27750-9	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` RPLC Revised any other New	**REL**	**CS**	**1,1**	ActRelationship Document
27791-3 **27791-3**	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary ~~h~~diagnosis section. 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]`	**OBS**		**1,1**	
~~27791-3~~	MEDICAL SOCIAL SERVICES 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 attachments standards.** 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`		CD	1,1	I9C I10C

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="27791-3" and code/@codeSystem=$LOINC]//observation[code/@code="27791-3" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		TS	1,1	

LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. 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/low/@value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`
		ACT	**TS**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~27761-6~~ 27761-6	~~**MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN**~~ ~~The rehabiltation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27761-6"]/effectiveTime/low/@value`~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27761-6"]/effectiveTime/high/@value`~~	~~**ACT**~~	~~**TS**~~	~~**1,1**~~	
27759-0 27759-0	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, VISIT FREQUENCY** 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`	**OBS**	**PQ**	**1,1**	**UCUM**

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27754-1 27754-1	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN** 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 attachments 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=$LOINC]//observation[code/@code="27754-1" and code/@codeSystem=$LOINC]/value/@code`	**OBS**	**CD**	**1,1**	**I9C** **I10C**
27755-8	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	
27756-6	MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor/ assignedPerson/name`		~~II~~**PN**	1,1	
27787-1	MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information. `/ClinicalDocument/author/assignedAuthor/id`		II	1,1	NPI UPIN or other provider identifier
27757-4	MEDICAL SOCIAL SERVICES TREATMENT PLAN, AUTHOR PROFESSION The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor/ assignedAuthor/code/@code` As described by the Health Care Provider Taxonomy.		CD	0,1	PTX

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27764-0
27764-0
	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	`/ClinicalDocument//section[code/@code="27764-0" and code/@codeSystem=$LOINC]//encounter[code/@code="27764-0" and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="27764-0" and code/@codeSystem=$LOINC]//encounter[code/@code="27760-4" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

27765-7 27765-7	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, CONTINUATION STATUS** 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="27765-7" and code/@codeSystem=$LOINC]//act[code/@code="27765-7" and code/@codeSystem=$LOINC]/statuscode`	**ACT**	**CS**	**0,1**	ActStatus
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.**	**Section**		**0,1**	
Same as above	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION – REASON FOR REFERRAL (NARRATIVE)** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION – REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** `/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name`~~**Add xpath expression here…**~~	**PART**	**PN**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, REFERRAL INFORMATION – REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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~~Add xpath expression here…~~`		**II**	**0,1**	**NPI UPIN or other provider identifier**
LOINC-TBD	**MEDICAL SOCIAL SERVICES 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.** `/ClinicalDocument/participant[@typeCode="REF"]/time`		**TS**	**1,1**	
~~27766-5~~ ~~27766-5~~	~~**MEDICAL SOCIAL SERVICES TREATMENT PLAN, 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~~ ~~`/ClinicalDocument/participant[@typeCode="REF"]/time`~~	~~**PART**~~	~~**TS**~~	~~**0,1**~~	
27769-9	**MEDICAL SOCIAL SERVICES 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: `/ClinicalDocument/legalAuthenticator`	**PART**		**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27769-9	MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE 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.		CS	1,1	ParticipationSignature
27767-3	MEDICAL SOCIAL SERVICES DATE TREATMENT PLAN, AUTHOR SIGNED The <time> element of the <legalAuthenticator> element provides the time at which the document was signed. `/ClinicalDocument/legalAuthenticator/time/ @value`		**TS**	**1,1**	
27770-7	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE MEDICAL SOCIAL SERVICES PROFESSIONAL ON FILE (COMPOSITE)** The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[9]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
27770-7	MEDICAL SOCIAL SERVICES TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB 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.		CS	1,1	ParticipationSignature
27768-1	MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE MEDICAL SOCIAL SERVICES PROFESSIONAL SIGNED 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`		TS	1,1	
27771-5 27771-5	**MEDICAL SOCIAL SERVICES REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED**	**SBADM**		**0,n**	

[9] 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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

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

This information can be found using the following XPath

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27772-3
27772-3
	MEDICAL SOCIAL SERVICES TREATMENT PLAN, PROGNOSIS FOR MEDICAL SOCIAL SERVICES
	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="27772-3" and codeSystem=$LOINC]//observation[code/@code="27772-3" and code/@codeSystem=$LOINC]`
	
	The <value> of the <observation> is a code describing the prognosis for rehabilitation.
	
	`/ClinicalDocument//section[code/@code="27772-3" and codeSystem=$LOINC]//observation[code/@code="27772-3" and code/@codeSystem=$LOINC]/value/@code`
	
	170969009 Poor
	67334001 Guarded
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	Subset of SNOMED CT

27774-9 27774-9	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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` ~~**Add xpath expression here…**~~ ~~**DATE OF LAST PLAN OF TREATMENT CERTIFICATION**~~	~~**OBS**~~**ACT**	**IVL_TS**	**0,1**	
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **A statement or narrative that the Physician has certified the services being performed as part of this treatment plan.**	**Section**	**ED**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	~~**???**~~**ACT**	**TS**	**0,1**	
27775-6 27775-6 **May need new LOINC due to title change.**	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, PAST MEDICAL HISTORY**~~**+LEVEL OF FUNCTION**~~ **(NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**Section**	**ED**	**1,1**	
LOINC-TBD	**PRIOR LEVEL OF FUNCTION (NARRATIVE)** **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` ~~**MEDICAL SOCIAL SERVICES TREATMENT PLAN, PRIOR LEVEL OF FUNCTION (NARRATIVE)**~~ ~~**Information about the patient's prior level of function in narrative form.**~~ ~~**Add xpath expression here…**~~		**ED**	**1,1**	
LOINC-TBD	**CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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` ~~**MEDICAL SOCIAL SERVICES TREATMENT PLAN, CURRENT LEVEL OF FUNCTION (NARRATIVE)**~~ ~~**Information about the patient's current level of function in narrative form.**~~ ~~**Add xpath expression here…**~~		**ED**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27776-4 ~~27776-4~~	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, ~~INITIAL~~ ASSESSMENT INFORMATION (COMPOSITE~~NARRATIVE~~)** **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.**	~~Section~~Section	~~ED~~	1,~~1~~n	
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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`~~**ASSESSMENT INDICATOR**~~ ~~**Identifies if this is the initial assessment or a re-evaluation of the patient's condition.**~~ ~~**I – Initial Assessment**~~ ~~**R – Re-evaluation**~~ ~~**Add xpath expression here…**~~		**CD**	**1,1**	**HL79055**
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**	
27777-2 27777-2	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)** **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 code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27778-0 ~~27778-0~~	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (~~NARRATIVE~~COMPOSITE)** **If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.**	**~~Section~~??~~?~~Section**	**ED**	**0,~~1~~n**	
LOINC-TBD	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE** `/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` **~~Add xpath expression here…~~**		**IVL_TS**	**1,1**	
27779-8 27779-8	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)**	**Section**	**ED**	**0,1**	
27780-6 27780-6	**MEDICAL SOCIAL SERVICES TREATMENT PLAN, JUSTIFICATION (NARRATIVE)**	**Section**	**ED**	**0,1**	

3.4 Occupational Therapy Rehabilitation Service Value Table

~~3.4Occupational Therapy Rehabilitation Service Value Table~~

Table 3.4 Occupational Therapy Rehabilitation Service Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27597-4 27597-4	**OCCUPATIONAL THERAPY TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` RPLC Revised any other New	**REL**	**CS**	**1,1**	ActRelationship Document
27635-2 27635-2	**OCCUPATIONAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** 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. `/ClinicalDocument//section[code/@code="27635-2" and code/@codeSystem=$LOINC]//observation[code/@code="27635-2" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	
~~27635-2~~	OCCUPATIONAL THERAPY 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 attachments standards.** 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`		CD	1,1	I9C I10C

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	OCCUPATIONAL THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="27635-2" and code/@codeSystem=$LOINC]//observation[code/@code="27635-2" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		TS	1,1	

LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. Information about that act is found in the header of the clinical document through use of the <serviceEvent> element describing the act being documented. The date range of treatment includes a Start Date and an Estimated Date of Completion.
	
	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. 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/low/ @value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/ @value`
		ACT	**TS**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~27608-9~~ 27608-9	~~**OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN**~~ ~~The rehabilitation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27608-9"]/effectiveTime/low/@value`~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27608-9"]/effectiveTime/high/@value`~~	~~**ACT**~~	~~**TS**~~	~~**1,1**~~	
27606-3 27606-3	**OCCUPATIONAL THERAPY TREATMENT PLAN, VISIT FREQUENCY** 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="27606-3" and code/@codeSystem=$LOINC]//observation [code/@code="27606-3" and code/@codeSystem=$LOINC]/value`	**OBS**	**PQ**	**1,1**	**UCUM**

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27601-4 **27601-4**	**OCCUPATIONAL THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN (COMPOSITE)** 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27601-4" and code/@codeSystem=$LOINC]//observation[code/@code="27601-4" and code/@codeSystem=$LOINC]/value/@code`	**OBS**	**CD**	**1,1**	**I9C** **I10C**
27602-2	**OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	
27603-0	OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor/assignedPerson/name`		PN	1,1	
27634-5	OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information. `/ClinicalDocument/author/assignedAuthor/id`		II	1,1	NPI UPIN or other provider identifier
27604-8	OCCUPATIONAL THERAPY TREATMENT PLAN, AUTHOR PROFESSION As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code`		CD	0,1	PTX

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27611-3
27611-3
	OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	`/ClinicalDocument//section[code/@code="27611-3" and code/@codeSystem=$LOINC]//encounter[code/@code="27611-3" and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="27611-3" and code/@codeSystem=$LOINC]//encounter[code/@code="27611-3" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

Note to Ballot Reviewers:
There is a formatting problem with this table that will be corrected in the final editing process. Fixing it now (March 2007) would confuse the tracked changes feature.

The following table fragment will be appended into the above table, and this will allow the previous page headings for the table to carry forward throughout the remainder of this table.

27612-1 27612-1	**OCCUPATIONAL THERAPY TREATMENT PLAN, CONTINUATION STATUS** 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="27612-1" and code/@codeSystem=$LOINC]//act[code/@code="27612-1" and code/@codeSystem=$LOINC]/statuscode`	**ACT**	**CS**	**0,1**	ActStatus
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.**			**0,1**	

LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** `/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name`~~**Add xpath expression here…**~~	**PART**	**PN**	**0,1**	
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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`~~Add xpath expression here…~~		**II**	**0,1**	**NPI** **UPIN** **or other provider identifier**
LOINC-TBD	**OCCUPATIONAL THERAPY 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.** `/ClinicalDocument/participant[@typeCode="REF"]/time`		**TS**	**1,1**	
~~**27613-9**~~ ~~27613-9~~	~~**OCCUPATIONAL THERAPY TREATMENT PLAN, 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.~~ ~~`/ClinicalDocument/participant[@typecode="REF"]/time`~~	~~**PART**~~	~~**TS**~~	~~**0,1**~~	

27616-2	**OCCUPATIONAL THERAPY 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: `/ClinicalDocument/legalAuthenticator`	**PART**		**0,1**	
27616-2	OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE 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		CS	1,1	ParticipationSignature
27614-7	OCCUPATIONAL THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED The <time> element of the <legalAuthenticator> element provides the time at which the document was signed. `/ClinicalDocument/legalAuthenticator/time/ @value`		TS	1,1	
27617-0	**OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE OCCUPATIONAL THERAPY PROFESSIONAL ON FILE (COMPOSITE)** The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[10]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
27617-0	OCCUPATIONAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE OCCUPATIONAL 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.		CS	1,1	ParticipationSignature
27615-4	OCCUPATIONAL THERAPY TREATMENT PLAN, DATE OCCUPATIONAL THERAPY PROFESSIONAL SIGNED The time at which the plan was signed by is stored in the <time> element of the <authenticator> element in the CDA Header.		TS	1,1	

[10] 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.

```
/ClinicalDocument/authenticator/time/@v
alue
```

	ADMINISTERED		
	Information about the administration of medication is recorded in an <substanceAdministration> element in the		

Note to Ballot Reviewers:
There is a formatting problem with this table that will be corrected in the final editing process. Fixing it now (March 2007) would confuse the tracked changes feature.

The following table fragment will be appended into the above table, and this will allow the previous page headings for the table to carry forward throughout the remainder of this table.

27619-6
27619-6
	OCCUPATIONAL THERAPY TREATMENT PLAN, PROGNOSIS FOR PHYSICAL THERAPY
	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="27499-3" and code/@codeSystem=$LOINC]//observation[code/@code="27499-3" and code/@codeSystem=$LOINC]`
	
	The <value> of the <observation> is a code describing the prognosis for rehabilitation.
	
	`/ClinicalDocument//section[code/@code="27619-6" and code/@codeSystem=$LOINC]//observation[code/@code="27619-6" and code/@codeSystem=$LOINC]/value/@code`
	
	170969009 Poor
	67334001 Guarded
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	Subset of SNOMED CT

27621-2 27621-2	**OCCUPATIONAL THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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='27621-2']//act[code/@code='27621-2']/effectiveTime` ~~**Add xpath expression here…**~~ ~~**DATE OF LAST PLAN OF TREATMENT CERTIFICATION**~~	~~**OBS**~~**ACT**	**IVL_TS**	**0,1**	
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**OCCUPATIONAL THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	~~**???**~~**ACT**	**TS**	**0,1**
27622-0 27622-0 **May need new LOINC due to title change.**	**OCCUPATIONAL THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY**~~**+LEVEL OF FUNCTION**~~ **(NARRATIVE)**	**Section**	**ED**	**1,1**
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**Section**		**1,1**
LOINC-TBD	**PRIOR LEVEL OF FUNCTION (NARRATIVE)** **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` ~~**OCCUPATIONAL THERAPY TREATMENT PLAN, PRIOR LEVEL OF FUNCTION (NARRATIVE)**~~ ~~**Information about the patient's prior level of function in narrative form.**~~ ~~**Add xpath expression here…**~~		**ED**	**1,1**
LOINC-TBD	**CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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` ~~**OCCUPATIONAL THERAPY TREATMENT PLAN, CURRENT LEVEL OF FUNCTION (NARRATIVE)**~~ ~~**Information about the patient's current level of function in narrative form.**~~ ~~**Add xpath expression here…**~~		**ED**	**1,1**

27623-8 ~~27623-8~~	**OCCUPATIONAL THERAPY TREATMENT PLAN, ~~INITIAL~~ ASSESSMENT INFORMATION (~~NARRATIVE~~COMPOSITE)** **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.**	**~~Section~~? ??**	**~~ED~~**	**1,~~1~~n**	
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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="27623-8" and code/@codeSystem=$LOINC]//observation[code/@code="TBD"and code/@codeSystem=$LOINC]/value/@code~~ASSESSMENT INDICATOR~~` **~~Identifies if this is the initial assessment or a re-evaluation of the patient's condition.~~** **~~I – Initial Assessment~~** **~~R – Re-evaluation~~** **~~Add xpath expression here…~~**		**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	**OCCUPATIONAL THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)** **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	**OCCUPATIONAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) INFORMATION (COMPOSITE)** **Information supplied from the Individual Education Plan (IEP) about the patient's treatment or condition.**	**~~OBS???~~Section**	**ED**	**0,1**
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) – DEFINED SCHOOL YEAR (FROM/THROUGH)** **The From and Through dates of the school year for the patient.** `/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` **~~Add xpath expression here…~~**		**IVL_TS**	**1,1**
27625-3 ~~27625-3~~	**OCCUPATIONAL THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (~~NARRATIVE~~COMPOSITE)** **If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.**	**~~Section?~~ ~~??~~Section**	**ED**	**0,~~1~~n**
LOINC-TBD	**OCCUPATIONAL THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE** `/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` **~~Add xpath expression here…~~**		**IVL_TS**	**1,1**
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

~~3.5Physical Therapy Rehabilitation Value Table~~

Table 3.5 Physical Therapy Rehabilitation Service Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27660-0 27660-0	**PHYSICAL THERAPY TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` RPLC Revised any other New	**REL**	**CS**	**1,1**	ActRelationship Document
27698-0 **27698-0**	**PHYSICAL THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary ~~h~~diagnosis section. This entry can be located using the following XPath expression. `/ClinicalDocument//section[code/@code="27698-0" and code/@codeSystem=$LOINC]//observation[code/@code="27698-0" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	
~~27698-0~~	PHYSICAL THERAPY 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27698-0" and code/codeSystem=$LOINC]//observation[code/@code="27698-0" and code/@codeSystem=$LOINC]/value/@code`		CD	1,1	I9C I10C

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	PHYSICAL THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="27698-0" and code/@codeSystem=$LOINC]//observation[code/@code="27698-0" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		TS	1,1	

LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. 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/low/@value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`
		ACT	**TS**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~27671-7~~ ~~27671-7~~	~~**PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN**~~ ~~The rehabilitation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27671-7"]/effectiveTime/low/@value`~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27671-7"]/effectiveTime/high/@value`~~	~~ACT~~	~~TS~~	~~1,1~~	
27669-1 27669-1	**PHYSICAL THERAPY TREATMENT PLAN, VISIT FREQUENCY** 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="27669-1" and code/@codeSystem=$LOINC]//observation [code/@code="27669-1" and code/@codeSystem=$LOINC]/value`	**OBS**	**PQ**	**1,1**	**UCUM**
27664-2 27664-2	**PHYSICAL THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN** 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27477-9" and code/@codeSystem=$LOINC]//observation [code/@code="27477-9" and code/@codeSystem=$LOINC]/value/@code`	**OBS**	**CD**	**1,1**	**I9C** **I10C**

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27665-9	**PHYSICAL THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	
27666-7	PHYSICAL THERAPY TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor / assignedPerson/name`		PN	1,1	
27697-2	PHYSICAL THERAPY TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information. `/ClinicalDocument/author/assignedAuthor /id`		II	1,1	NPI UPIN or other provider identifier
27667-5	CARDIAC REHABILITATION TREATMENT PLAN, AUTHOR PROFESSION As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor / assignedAuthor/code/@code`		CD	0,1	PTX

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27674-1
27674-1
	PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	`/ClinicalDocument//section[code/@code="27674-1" and code/@codeSystem=$LOINC]//encounter[code/@code="27674-1" and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="27674-1" and code/@codeSystem=$LOINC]//encounter[code/@code="27674-1" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

27675-8 27675-8	**PHYSICAL THERAPY TREATMENT PLAN, CONTINUATION STATUS** 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="27675-8" and code/@codeSystem=$LOINC]//act[code/@code="27675-8" and code/@codeSystem=$LOINC]/statuscode`	**ACT**	**CS**	**0,1**	ActStatus
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **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.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** `/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name`~~**Add xpath expression here…**~~	**PART**	**PN**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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~~Add xpath expression here…~~`		**II**	**0,1**	**NPI UPIN or other provider identifier**
LOINC-TBD	**PHYSICAL THERAPY 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.** `/ClinicalDocument/participant[@typeCode="REF"]/time`		**TS**	**1,1**	
~~**27676-6**~~ ~~27676-6~~	~~**PHYSICAL THERAPY TREATMENT PLAN, 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.~~ ~~`/ClinicalDocument/participant[@typeCode="REF"]/time`~~	~~**PART**~~	~~**TS**~~	~~**0,1**~~	
27679-0	**PHYSICAL THERAPY 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: `/ClinicalDocument/legalAuthenticator`	**PART**		**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27679-0	ALCOHOL-SUBSTANCE ABUSE REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE 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.		CS	1,1	ParticipationSignature
27677-4	PHYSICAL THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED The <time> element of the <legalAuthenticator> element provides the time at which the document was signed. `/ClinicalDocument/legalAuthenticator/time/ @value`		TS	1,1	
27680-8	**PHYSICAL THERAPY TREATMENT PLAN, SIGNATURE OF PHYSICAL THERAPY PROFESSIONAL ON FILE (COMPOSITE)** The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[11]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
27680-8	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.		CS	1,1	ParticipationSignature
27678-1	PHYSICAL THERAPY TREATMENT PLAN, DATE REHABILITATION PROFESSIONAL SIGNED 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`		TS	1,1	
27681-6 27681-6	**PHYSICAL THERAPY REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED** 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	**SBADM**		**0,n**	

[11] 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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

```
Expression: //ClinicalDocument//section[code/@code="
27681-6" and code/@codeSystem=$LOINC]//
substanceAdministration[code/@code="276
81-6" and code/@codeSystem=$LOINC]
```

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27682-4
27682-4
	PHYSICAL THERAPY TREATMENT PLAN, PROGNOSIS FOR PHYSICAL THERAPY
	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
		OBS	**CD**	**1,1**	Subset of SNOMED CT

27684-0 27684-0	**PHYSICAL THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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='27684-0']//act[code/@code='27684-0']/effectiveTime` ~~**Add xpath expression here…**~~ ~~**DATE OF LAST PLAN OF TREATMENT CERTIFICATION**~~	~~**OBS**~~**ACT**	**IVL_TS**	**0,1**	
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**PHYSICAL THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	~~**???**~~**ACT**	**TS**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27685-7 27685-7 **May need new LOINC due to title change.**	**PHYSICAL THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY~~+LEVEL OF FUNCTION~~ (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**Section**	**ED**	**1,1**	
LOINC-TBD	**PRIOR LEVEL OF FUNCTION (NARRATIVE)** **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` **~~PHYSICAL THERAPY TREATMENT PLAN, PRIOR LEVEL OF FUNCTION (NARRATIVE)~~** **~~Information about the patient's prior level of function in narrative form.~~** **~~Add xpath expression here…~~**		**ED**	**1,1**	
LOINC-TBD	**CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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` **~~PHYSICAL THERAPY TREATMENT PLAN, CURRENT LEVEL OF FUNCTION (NARRATIVE)~~** **~~Information about the patient's current level of function in narrative form.~~** **~~Add xpath expression here…~~**		**ED**	**1,1**	
27686-5 ~~27686-5~~	**PHYSICAL THERAPY TREATMENT PLAN, ~~INITIAL ASSESSMENT~~ ASSESSMENT INFORMATION (~~NARRATIVE~~COMPOSITE)** **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.**	**~~Section~~?? ?**	**~~ED~~**	**1,~~1~~n**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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`~~**ASSESSMENT INDICATOR**~~ ~~**Identifies if this is the initial assessment or a re-evaluation of the patient's condition.**~~ ~~**I – Initial Assessment**~~ ~~**R – Re-evaluation**~~ ~~**Add xpath expression here…**~~		**CD**	**1,1**	**HL97055**
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)** **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	**PHYSICAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) INFORMATION (COMPOSITE)** **Information supplied from the Individual Education Plan (IEP) about the patient's treatment or condition.**	~~**OBS???**~~**Section**	**ED**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) – DEFINED SCHOOL YEAR (FROM/THROUGH)** **The From and Through dates of the school year for the patient.** `/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` ~~**Add xpath expression here…**~~		**IVL_TS**	**1,1**	
27688-1 ~~27688-1~~	**PHYSICAL THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (~~NARRATIVE~~COMPOSITE)** **If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.**	~~**Section??**~~ **?Section**	~~**ED**~~	**0,~~1~~n**	
LOINC-TBD	**PHYSICAL THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE** `/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` ~~**Add xpath expression here…**~~		**TS**	**1,1**	
27689-9 27689-9	**PHYSICAL THERAPY TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)**	**Section**	**ED**	**0,1**	
27690-7 27690-7	**PHYSICAL THERAPY TREATMENT PLAN, JUSTIFICATION (NARRATIVE)**	**Section**	**ED**	**0,1**	

3.6 Psychiatric Rehabilitation Service Value Table

~~3.6Psychiatric Rehabilitation Service Value Table~~

Table 3.6 Psychiatric Rehabilitation Service Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
18626-2 18626-2	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` RPLC Revised any other New	**REL**	**CS**	**1,1**	ActRelationship Document

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
19007-4 19007-4	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary ~~h~~diagnosis section. This entry can be located using the following XPath expression. `/ClinicalDocument//section[code/@code="19007-4" and code/@codeSystem=$LOINC]//observation[code/@code="19007-4" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	
	PSYCHIATRIC REHABILITATION 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="19007-4" and code/@codeSystem=$LOINC]//observation[code/@code="19007-4" and code/@codeSystem=$LOINC]/value/@code`		CD	1,1	I9C I10C
	PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="19007-4" and code/@codeSystem=$LOINC]//observation[code/@code="19007-4" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		TS	1,1	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. 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/low/@value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`
		ACT	**TS**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~18639-5~~ 18639-5	~~**PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN (COMPOSITE)**~~ ~~The rehabilitation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="18639-5"]/effectiveTime/low/@value`~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="18639-5"]/effectiveTime/high/@value`~~	~~**ACT**~~	~~**TS**~~	~~**1,1**~~	
18637-9 18637-9	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, VISIT FREQUENCY** 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`	**OBS**	**PQ**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
18631-2 18631-2	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN** 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 attachments 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=$LOINC]//observation[code/@code="18631-2" and code/@codeSystem=$LOINC]/value/@code`	**OBS**	**CD**	**1,1**	**I9C** **I10C**
18632-0	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	
18633-8	PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor/ assignedPerson/name`		PN	1,1	
18730-2	PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information. `/ClinicalDocument/author/assignedAuthor/id`		II	1,1	NPI UPIN or other provider identifier
18634-6	PSYCHIATRIC REHABILITATION TREATMENT PLAN, AUTHOR PROFESSION As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor/ assignedAuthor/code/@code`		CD	0,1	PTX

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

18642-9
18642-9
	PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	`/ClinicalDocument//section[code/@code="18642-9" and code/@codeSystem=$LOINC]//encounter[code/@code="18642-9" and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="18642-9" and code/@codeSystem=$LOINC]//encounter[code/@code="18642-9" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

18645-2 18645-2	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, CONTINUATION STATUS** 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="18645-2" and code/@codeSystem=$LOINC]//act[code/@code="18645-2" and code/@codeSystem=$LOINC]/statuscode`	**ACT**	**CS**	**0,1**	ActStatus
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.**			**0,1**	
Same as above	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** /ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name~~Add xpath expression here…~~	**PART**	**PN**	**0,1**	
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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~~Add xpath expression here…~~		**II**	**0,1**	**NPI UPIN or other provider identifier**
LOINC-TBD	**PSYCHIATRIC REHABILITATION 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.** /ClinicalDocument/participant[@typeCode="REF"]/time		**TS**	**1,1**	
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, REFERRAL INFORMATION – COMMUNICATION TO REFERRING PHYSICIAN INDICATOR** **An indicator defining if written communication has been sent back to the referring entity. Y indicates that written communication has been sent and n indicates that it has not been sent.** /ClinicalDocument//section[code/@code = 'TBD'] //observation[code/@code = 'TBD']/value/@value ~~Add xpath expression here…~~		**BL**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~18646-0~~ ~~18646-0~~	~~**PSYCHIATRIC REHABILITATION TREATMENT PLAN, 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.~~ ~~`/ClinicalDocument/participant[@typeCode="REF"]/time`~~	~~**PART**~~	~~**TS**~~	~~**0,1**~~	
18649-4	**PSYCHIATRIC REHABILITATION 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: `/ClinicalDocument/legalAuthenticator`	**PART**		**0,1**	
18649-4	PSYCHIATRIC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE 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.		CS	1,1	ParticipationSignature
18647-8	PSYCHIATRIC REHABILITATION DATE TREATMENT PLAN, AUTHOR SIGNED The <time> element of the <legalAuthenticator> element provides the time at which the document was signed. `/ClinicalDocument/legalAuthenticator/time/ @value`		TS	1,1	
18650-2	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, SIGNATURE OF RESPONSIBLE REHAB PROFESSIONAL ON FILE (COMPOSITE)** The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[12]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
18650-2	PSYCHIATRIC REHABILITATION TREATMENT		CS	1,1	ParticipationSig

[12] 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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	PLAN, SIGNATURE OF RESPONSIBLE REHAB 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.				nature
18648-6	PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE REHAB PROFESSIONAL SIGNED 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`		TS	1,1	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
18610-6	**MEDICATION ADMINISTERED** Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.			0,n	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

18652-8
18652-8
	PSYCHIATRIC REHABILITATION TREATMENT PLAN, PROGNOSIS FOR REHABILITATION
	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="18652-8" and code/@codeSystem=$LOINC]//observation[code/@code="18652-8 and code/@codeSystem=$LOINC]`
	
	The <value> of the <observation> is a code describing the prognosis for rehabilitation.
	
	`/ClinicalDocument//section[code/@code="18652-8" and code/@codeSystem=$LOINC]//observation[code/@code="18652-8" and code/@codeSystem=$LOINC]/value/@code`
	
	170969009 Poor
	67334001 Guarded
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	Subset of SNOMED CT

18654-4 18654-4	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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='18654-4']//act[code/@code='18654-4']/effectiveTime` ~~**Add xpath expression here…**~~ ~~**DATE OF LAST PLAN OF TREATMENT CERTIFICATION**~~	~~**OBS**~~**ACT**	**IVL_TS**	**0,1**	
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	~~**???**~~**ACT**	**TS**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
18655-1 18655-1 **May need new LOINC due to title change.**	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, PAST MEDICAL HISTORY~~+LEVEL OF FUNCTION~~ (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**			**1,1**	
LOINC-TBD	**PRIOR LEVEL OF FUNCTION (NARRATIVE)** **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` **~~PSYCHIATRIC REHABILITATION TREATMENT PLAN, PRIOR LEVEL OF FUNCTION~~** **~~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.~~** **~~Add xpath expression here…~~**		**CD**	**1,1**	**GAF**
LOINC-TBD	**CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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` **~~PSYCHIATRIC REHABILITATION TREATMENT PLAN, CURRENT LEVEL OF FUNCTION~~** **~~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.~~** **~~Add xpath expression here…~~**		**CD**	**1,1**	**GAF**
18656-9 ~~18656-9~~	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, ~~INITIAL~~ ASSESSMENT INFORMATION (COMPOSITE~~NARRATIVE~~)** **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.**	**~~Section~~??**	**~~ED~~**	**1,~~1~~n**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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` ~~**ASSESSMENT INDICATOR**~~ ~~**Identifies if this is the initial assessment or a re-evaluation of the patient's condition.**~~ ~~**I – Initial Assessment**~~ ~~**R – Re-evaluation**~~ ~~**Add xpath expression here…**~~		**CD**	**1,1**	
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	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)** **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	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, PAST TREATMENT ATTEMPTS (NARRATIVE)** **A narrative description of the past treatment attempts.**	**Section**	**ED**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
18658-5 ~~18658-5~~	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (~~NARRATIVE~~COMPOSITE)** **If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.**	**Section**	**~~ED~~**	**0,~~1~~n**	
LOINC-TBD	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE** `/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` **~~Add xpath expression here…~~**		**IVL_TS**	**1,1**	
18659-3 18659-3	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)**	**Section**	**ED**	**1,1**	
18660-1 18660-1	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, JUSTIFICATION (NARRATIVE)**	**Section**	**ED**	**0,1**	
18661-9 18661-9	**PSYCHIATRIC REHABILITATION TREATMENT PLAN, PSYCHIATRIC SYMPTOMS (NARRATIVE)**	**Section**	**ED**	**0,1**	

3.7 Respiratory Therapy Rehabilitation Service Value Table

~~3.7Respiratory Therapy Rehabilitation Service Value Table~~

Table 3.7 Respiratory Therapy Rehabilitation Service Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27699-8 27699-8	**RESPIRATORY THERAPY TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` RPLC Revised any other New	**REL**	**CS**	**1,1**	ActRelationship Document
27740-0 ~~27740-0~~	**RESPIRATORY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** 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. `/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=$LOINC]//observation[code/@code="27740-0" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	
~~27740-0~~	RESPIRATORY THERAPY 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=$LOINC]//observation[code/@code="27740-0" and code/@codeSystem=$LOINC]/value/@code`		CD	1,1	I9C I10C

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	RESPIRATORY THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=$LOINC]//observation[code/@code="27740-0" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		TS	1,1	

Note to Ballot Reviewers:
There is a formatting problem with this table that will be corrected in the final editing process. Fixing it now (March 2007) would confuse the tracked changes feature.

The following table fragment will be appended into the above table, and this will allow the previous page headings for the table to carry forward throughout the remainder of this table.

LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. 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/low/@value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD"]/effectiveTime/high/@value`
		ACT	**TS**	**1,1**

~~27710-3~~ 27710-3	~~**RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN**~~ ~~The rehabilitation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27710-3"]/effectiveTime/low/@value`~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27710-3"]/effectiveTime/high/@value`~~	~~**ACT**~~	~~**TS**~~	~~**1,1**~~

27708-7 27708-7	**RESPIRATORY THERAPY TREATMENT PLAN, VISIT FREQUENCY** 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="27708-7" and code/@codeSystem=$LOINC]//observation[code/@code="27708-7" and code/@codeSystem=$LOINC]/value`	**OBS**	**PQ**	**1,1**	**UCUM**
27703-8 27703-8	**RESPIRATORY THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN** 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27703-8" and code/@codeSystem=$LOINC]//observation[code/@code="27703-8" and code/@codeSystem=$LOINC]/value@code`	**OBS**	**CD**	**1,1**	**I9C** **I10C**
27704-6	**RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	
27705-3	RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor/ assignedPerson/name`		PN	1,1	
27736-8	RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information. `/ClinicalDocument/author/assignedAuthor/id`		II	1,1	NPI UPIN or other provider identifier

27706-1	RESPIRATORY THERAPY TREATMENT PLAN, AUTHOR PROFESSION As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor / assignedAuthor/code/@code`		CD	0,1	PTX

27713-7
27713-7
	RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	
	`/ClinicalDocument//section[@code="27713-7" and code/@codeSystem=$LOINC]//encounter[code/@code="27713-7 and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="27713-7" and code/@codeSystem=$LOINC]//encounter [code/@code="27713-7" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

27714-5 27714-5	**RESPIRATORY THERAPY TREATMENT PLAN, CONTINUATION STATUS** 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`	**ACT**	**CS**	**0,1**	ActStatus
LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.**			**0,1**	
Same as above	**RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	

LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** `/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name`~~**Add xpath expression here…**~~	**PART**	**PN**	**0,1**	
LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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`~~`Add xpath expression here…`~~		**II**	**0,1**	**NPI UPIN or other provider identifier**
LOINC-TBD	**RESPIRATORY THERAPY 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.** `/ClinicalDocument/participant[@typeCode="REF"]/time`		**TS**	**1,1**	
~~27715-2~~ ~~27715-2~~	~~**RESPIRATORY THERAPY TREATMENT PLAN, 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.~~ ~~`/ClinicalDocument/participant[@typeCode="REF"]/time`~~	~~**PART**~~	~~**TS**~~	~~**0,1**~~	
27718-6	**RESPIRATORY THERAPY 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: `/ClinicalDocument/legalAuthenticator`	**PART**		**0,1**	

27718-6	RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE 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.		CS	1,1	ParticipationSignature
27716-0	RESPIRATORY THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED The <time> element of the <legalAuthenticator> element provides the time at which the document was signed. `/ClinicalDocument/legalAuthenticator/time/ @value`		TS	1,1	
27719-4	**RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE RESPIRATORY THERAPY PROFESSIONAL ON FILE (COMPOSITE)** The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[13]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
27719-4	RESPIRATORY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE RESPIRATORY 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.		CS	1,1	ParticipationSignature
27717-8	RESPIRATORY THERAPY TREATMENT PLAN, DATE RESPIRATORY THERAPY PROFESSIONAL SIGNED 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`		TS	1,1	
27720-2 27720-2	**RESPIRATORY THERAPY REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED** Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.	**SBADM**		**0,n**	

[13] 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.

expression:

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

27721-0
27721-0
	RESPIRATORY THERAPY TREATMENT PLAN, PROGNOSIS FOR RESPIRATORY THERAPY
	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
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	Subset of SNOMED CT

27723-6 27723-6	**RESPIRATORY THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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='27723-6']//act[code/@code='27723-6']/effectiveTime` ~~**Add xpath expression here…**~~ ~~**DATE OF LAST PLAN OF TREATMENT CERTIFICATION**~~	~~**OBS**~~**ACT**	~~**TS**~~**IVL_TS**	**0,1**	
LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**RESPIRATORY THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	~~**???**~~**ACT**	**TS**	**0,1**	

27724-4 27724-4 **May need new LOINC due to title change**	**RESPIRATORY THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY~~+LEVEL OF FUNCTION~~ (NARRATIVE)**	**Section**	**ED**	**1,1**
LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**Section**	**ED**	**1,1**
LOINC-TBD	**PRIOR LEVEL OF FUNCTION (NARRATIVE)** **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 **~~RESPIRATORY THERAPY TREATMENT PLAN, PRIOR LEVEL OF FUNCTION (NARRATIVE)~~** **~~Information about the patient's prior level of function in narrative form.~~** **~~Add xpath expression here…~~**		**ED**	**1,1**
LOINC-TBD	**CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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 **~~RESPIRATORY THERAPY ABUSE REHABILITATION TREATMENT PLAN, CURRENT LEVEL OF FUNCTION (NARRATIVE)~~** **~~Information about the patient's current level of function in narrative form.~~** **~~Add xpath expression here…~~**		**ED**	**1,1**
27725-1 27725-1	**RESPIRATORY THERAPY TREATMENT PLAN, ~~INITIAL~~ ASSESSMENT INFORMATION (COMPOSITE~~NARRATIVE~~)** **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.**	**~~Section~~? ??**	**~~ED~~**	**1,~~1~~n**

LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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`~~**ASSESSMENT INDICATOR**~~ ~~**Identifies if this is the initial assessment or a re-evaluation of the patient's condition.**~~ ~~**I – Initial Assessment**~~ ~~**R – Re-evaluation**~~ ~~**Add xpath expression here…**~~		**CD**	**1,1**
LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, ASSESSMENT – ASSESSMENT NARRATIVE**		**ED**	**1,1**
27726-9 27726-9	**RESPIRATORY THERAPY TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)**	**Section**	**ED**	**1,1**
LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)** **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 ~~27727-7~~	**RESPIRATORY THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (**~~**NARRATIVE**~~**COMPOSITE)** **If this is the initial Plan of Treatment, the Progress Note and Attainment of Goals Narrative is not required; otherwise, it is required.**	~~**Section**~~**??**	~~**ED**~~	**0,**~~**1**~~**n**
LOINC-TBD	**RESPIRATORY THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE** `/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` ~~**Add xpath expression here…**~~		**TS**	**1,1**
27728-5 27728-5	**RESPIRATORY THERAPY TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)**	**Section**	**ED**	**0,1**
27729-3 27729-3	**RESPIRATORY THERAPY TREATMENT PLAN, JUSTIFICATION (NARRATIVE)**	**Section**	**ED**	**0,1**

3.8 Pulmonary Therapy Rehabilitation Service Value Table

Table 3.8 Pulmonary Therapy Rehabilitation Service Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, NEW/REVISED** **If the treatment plan is revised, then it shall reference the previous treatment plan in the header.** `/ClinicalDocument/relatedDocument/@typeCode` **RPLC Revised** **any other New**	**REL**	**CS**	**1,1**	**ActRelationshipDocument**
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** **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.** `/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=$LOINC]//observation[code/@code="27740-0" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	
LOINC-TBD	**PULMONARY THERAPY 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 attachments standards.** **This entry can be located using the following XPath expression, where "value" is the diagnosis code.** `/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=$LOINC]//observation[code/@code="27740-0" and code/@codeSystem=$LOINC]/value/@code`		**CD**	**1,1**	**I9C** **I10C**

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	PULMONARY THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS **The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation.** `/ClinicalDocument//section[code/@code="27740-0" and code/@codeSystem=$LOINC]//observation[code/@code="27740-0" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		**TS**	**1,1**	

Note to Ballot Reviewers:
There is a formatting problem with this table that will be corrected in the final editing process. Fixing it now (March 2007) would confuse the tracked changes feature.

The following table fragment will be appended into the above table, and this will allow the previous page headings for the table to carry forward throughout the remainder of this table.

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. 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/low/@value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="`**LOINC-TBD**`"]/effectiveTime/high/@value`
		ACT	**TS**	**1,1**	

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, VISIT FREQUENCY** **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="27708-7" and code/@codeSystem=$LOINC]//observation[code/@code="27708-7" and code/@codeSystem=$LOINC]/value`	**OBS**	**PQ**	**1,1**	**UCUM**

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN** **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 attachments standards.** **This entry can be located using the following XPath expression, where "value" is the diagnosis code.** `/ClinicalDocument//section[code/@code="27703-8" and code/@codeSystem=$LOINC]//observation[code/@code="27703-8" and code/@codeSystem=$LOINC]/value@code`	**OBS**	**CD**	**1,1**	**I9C** **I10C**
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** **The author of the treatment plan is recorded in the header of the CDA Document.** **It can be found using the following XPath expression.** `/ClinicalDocument/author`	**PART**		**1,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, AUTHOR NAME** **The name of the author is stored at the following location.** `/ClinicalDocument/author/assignedAuthor/ assignedPerson/name`		**PN**	**1,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information.** `/ClinicalDocument/author/assignedAuthor/id`		**II**	**1,1**	**NPI** **UPIN** **or other provider identifier**
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, AUTHOR PROFESSION** **As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>.** `/ClinicalDocument/author/assignedAuthor/ assignedAuthor/code/@code`		**CD**	**0,1**	**PTX**

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT**
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	
	`/ClinicalDocument//section[@code="27713-7" and code/@codeSystem=$LOINC]//encounter[code/@code="27713-7 and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="27713-7" and code/@codeSystem=$LOINC]//encounter[code/@code="27713-7" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, CONTINUATION STATUS** **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`	**ACT**	**CS**	**0,1**	**ActStatus**
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.**			**0,1**	
same as above	**PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** `/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name`~~**Add xpath expression here…**~~	**PART**	**PN**	**0,1**	

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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~~Add xpath expression here…~~`		**II**	**0,1**	**NPI UPIN or other provider identifier**
LOINC-TBD	**PULMONARY THERAPY 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.** `/ClinicalDocument/participant[@typeCode="REF"]/time`		**TS**	**1,1**	
LOINC-TBD	**PULMONARY THERAPY 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:** `/ClinicalDocument/legalAuthenticator`	**PART**		**0,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE** **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.**		**CS**	**1,1**	**ParticipationSignature**
LOINC-TBD	**PULMONARY THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED** **The <time> element of the <legalAuthenticator> element provides the time at which the document was signed.** `/ClinicalDocument/legalAuthenticator/time/ @value`		**TS**	**1,1**	

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE RESPIRATORY THERAPY PROFESSIONAL ON FILE (COMPOSITE)** **The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[14]) party for the content.** **This element can be found using the following XPath expression:** `/ClinicalDocument/authenticator`	**PART**		**1,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE PULMONARY 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.**		**CS**	**1,1**	**ParticipationSignature**
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, DATE PULMONARY THERAPY PROFESSIONAL SIGNED** **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`		**TS**	**1,1**	
LOINC-TBD	**PULMONARY THERAPY REHABILITATION TREATMENT PLAN, MEDICATION ADMINISTERED** **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 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**	**SBADM**		**0,n**	

[14] 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.

To affirmatively document that no medication was administered, include the section, but do not include

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, PROGNOSIS FOR PULMONARY THERAPY**
	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
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	**Subset of SNOMED CT**

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` ~~**Add xpath expression here…**~~	~~**OBS**~~**ACT**	**IVL_TS**	**0,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**PULMONARY THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	~~**???**~~**ACT**	**TS**	**0,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY (NARRATIVE)**	**Section**	**ED**	**1,1**	

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**Section**	**ED**	**1,1**
LOINC-TBD	**PRIOR LEVEL OF FUNCTION (NARRATIVE)** **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 ~~**PULMONARY THERAPY TREATMENT PLAN, PRIOR LEVEL OF FUNCTION (NARRATIVE)**~~ ~~**Information about the patient's prior level of function in narrative form.**~~ ~~**Add xpath expression here…**~~		**ED**	**1,1**
LOINC-TBD	**CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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 ~~**PULMONARY THERAPY TREATMENT PLAN, CURRENT LEVEL OF FUNCTION (NARRATIVE)**~~ ~~**Information about the patient's current level of function in narrative form.**~~ ~~**Add xpath expression here…**~~		**ED**	**1,1**
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT INFORMATION (COMPOSITE)** **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	**PULMONARY THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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="see above" and code/@codeSystem=$LOINC]//observation[code/@code="TBD"and code/@codeSystem=$LOINC]/value/@code` ~~**ASSESSMENT INDICATOR**~~ ~~**Identifies if this is the initial assessment or a re-evaluation of the patient's condition.**~~ ~~**I – Initial Assessment**~~ ~~**R – Re-evaluation**~~ ~~**Add xpath expression here…**~~		**CD**	**1,1**	**HL79055**
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT – FUNCTIONAL STATUS NARRATIVE**		**ED**	**0,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT – ACTIVITIES PERMITTED NARRATIVE**		**ED**	**0,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT – MENTAL STATUS NARRATIVE**		**ED**	**0,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, ASSESSMENT – ADDITIONAL ASSESSMENT NARRATIVE**		**ED**	**0,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)** **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	**PULMONARY THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (COMPOSITE)**	**???**		**0,n**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE** `/ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime` ~~**Add xpath expression here…**~~		**IVL_TS**	**1,1**	
LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)**	**Section**	**ED**	**0,1**	

LOINC-TBD	**PULMONARY THERAPY TREATMENT PLAN, JUSTIFICATION (NARRATIVE)**	**Section**	**ED**	**0,1**

3.9 Skilled Nursing Rehabilitation Service Value Table

~~3.8Skilled Nursing Rehabilitation Service Value Table~~

Table 3.9 Skilled Nursing Rehabilitation Service Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27470-4 27470-4	**SKILLED NURSING TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` RPLC Revised any other New	**REL**	**CS**	**1,1**	ActRelationship Document
27587-5 27587-5	**SKILLED NURSING TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** The primary diagnosis information (code and date) is carried in an <observation> entry contained within the primary hdiagnosis section. This entry can be located using the following XPath expression. `/ClinicalDocument//section[code/@code="27587-5" and code/@codeSystem=$LOINC]//observation[code/@code="27587-5" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	
~~27587-5~~	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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="27587-5" and code/@codeSystem=$LOINC]//observation[code/@code="27587-5" and code/@codeSystem=$LOINC]/value/@code`		CD	1,1	I9C I10C

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	SKILLED NURSING TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="27587-5" and code/@codeSystem=$LOINC]//observation[code/@code="27587-5" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		TS	1,1	

LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. 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/low/@value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [code/@code="LOINC-TBD "]/effectiveTime/high/@value`
		ACT	**TS**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~27557-8~~ 27557-8	~~**SKILLED NURSING TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN**~~ ~~The rehabilitation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> eleme~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27557-8"]/effectiveTime/low/@value`~~ ~~`/ClinicalDocument/documentationOf/serviceEvent [code/@code="27557-8"]/effectiveTime/high/@value`~~	~~**ACT**~~	~~**TS**~~	~~**1,1**~~	
27555-2 27555-2	**SKILLED NURSING TREATMENT PLAN, VISIT FREQUENCY** 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="27555-2" and code/@codeSystem=$LOINC]//observation[code/@code="27555-2" and code/@codeSystem=$LOINC]/value`	**OBS**	**PQ**	**1,1**	**UCUM**

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27550-3	**SKILLED NURSING TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN**	**OBS**	**CD**	**1,1**	**I9C** **I10C**
27550-3	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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code= "27550-3" and code/@codeSystem=$LOINC]//observation [code/@code="27550-3" and code/@codeSystem=$LOINC]/value/@code`				
27551-1	**SKILLED NURSING TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	
27552-9	SKILLED NURSING TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor/ assignedPerson/name`		~~II~~**IPN**	1,1	
27583-4	SKILLED NURSING TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information. `/ClinicalDocument/author/assignedAuthor/id`		~~CD~~**II**	1,1	NPI UPIN or other provider identifier
27553-7	SKILLED NURSING TREATMENT PLAN, AUTHOR PROFESSION As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor/ assignedAuthor/code/@code`		CD	0,1	PTX

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27560-2
27560-2
	SKILLED NURSING TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	`/ClinicalDocument//section[code/@code="27560-2" and code/@codeSystem=$LOINC]//encounter[code/@code="27560-2" and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[code/@code="27560-2" and code/@codeSystem=$LOINC]//encounter[code/@code="27560-2" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

27561-0 27561-0	**SKILLED NURSING TREATMENT PLAN, CONTINUATION STATUS** 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="27561-0" and code/@codeSystem=$LOINC]//act[code/@code="27561-0" and code/@codeSystem=$LOINC]/statuscode`	**ACT**	**CS**	**0,1**	ActStatus
LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.**			**0,1**	
Same as above	**SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION – REASON FOR REFERRAL (NARRATIVE)** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** /ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name~~Add xpath expression here…~~	**PART**	**PN**	**0,1**	
LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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~~Add xpath expression here…~~		**II**	**0,1**	**NPI UPIN or other provider identifier**
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.** /ClinicalDocument/participant[@typeCode="REF"]/time		**TS**	**1,1**	
~~27562-8~~ ~~27562-8~~	~~**SKILLED NURSING TREATMENT PLAN, 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.~~ ~~/ClinicalDocument/participant[@typeCode="REF"]/time~~	~~**PART**~~	~~**TS**~~	~~**0,1**~~	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
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: `/ClinicalDocument/legalAuthenticator`	**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 `/ClinicalDocument/legalAuthenticator/signatureCode/@code`. 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. `/ClinicalDocument/legalAuthenticator/time/ @value`		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[15]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
27566-9	SKILLED NURSING TREATMENT PLAN, SIGNATURE OF RESPONSIBLE NURSING 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.		CS	1,1	ParticipationSignature
27564-4	SKILLED NURSING TREATMENT PLAN, DATE NURSING PROFESSIONAL SIGNED The time at which the plan was signed by is stored in the		TS	1,1	

[15] 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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	<time> element of the <authenticator> element in the CDA Header. `/ClinicalDocument/authenticator/time/@value`				

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

27568-5
27568-5
	SKILLED NURSING TREATMENT PLAN, PROGNOSIS FOR REHABILITATION
	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= "27568-5" and code/@codeSystem=$LOINC]//observation[ code/@code="27568-5" and code/@codeSystem=$LOINC]`
	
	The <value> of the <observation> is a code describing the prognosis for rehabilitation.
	
	`/ClinicalDocument//section[code/@code= "27568-5" and code/@codeSystem=$LOINC]//observation[ code/@code="27568-5" and code/@codeSystem=$LOINC]/value/@code`
	
	170969009 Poor
	67334001 Guarded
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	Subset of SNOMED CT

27570-1 27570-1	[0]**SKILLED NURSING TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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='27570-1']// act[code/@code='27570-1']/ effectiveTime` ~~**Add xpath expression here…**~~ ~~**DATE OF LAST PLAN OF TREATMENT CERTIFICATION**~~	~~**OBS**~~**ACT**	**IVL_TS**	**0,1**	
LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**SKILLED NURSING TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	~~**???**~~**ACT**	**TS**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
27571-9 27571-9	**SKILLED NURSING TREATMENT PLAN, PAST MEDICAL HISTORY ~~+ LEVEL OF FUNCTION~~ (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**Section**	**ED**	**1,1**	
LOINC-TBD	**PRIOR LEVEL OF FUNCTION (NARRATIVE)** **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` **~~SKILLED NURSING TREATMENT PLAN, PRIOR LEVEL OF FUNCTION (NARRATIVE)~~** **~~Information about the patient's prior level of function in narrative form.~~** **~~Add xpath expression here…~~**		**ED**	**1,1**	
LOINC-TBD	**CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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` **~~SKILLED NURSING TREATMENT PLAN, CURRENT LEVEL OF FUNCTION (NARRATIVE)~~** **~~Information about the patient's current level of function in narrative form.~~** **~~Add xpath expression here…~~**		**ED**	**1,1**	
27572-7 **~~27572-7~~**	**SKILLED NURSING TREATMENT PLAN, INITIAL ASSESSMENT (NARRATIVE)** **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.**	**~~Section~~Section**	**~~ED~~**	**1,~~1~~n**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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= "27572-7" and code/@codeSystem=$LOINC]//observation[ code/@code="TBD"and code/@codeSystem=$LOINC]/value/@code`~~**ASSESSMENT INDICATOR**~~ ~~**Identifies if this is the initial assessment or a re-evaluation of the patient's condition.**~~ ~~**I – Initial Assessment**~~ ~~**R – Re-evaluation**~~ ~~**Add xpath expression here…**~~		**CD**	**1,1**	
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)** **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**	
27574-3 ~~27574-3~~	**SKILLED NURSING TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (**~~**NARRATIVE**~~**COMPOSITE)**	~~**Section**~~**Section**	~~**ED**~~	**0,**~~**1**~~**n**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**SKILLED NURSING TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE** /ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime ~~**Add xpath expression here…**~~		**TS**	**1,1**	
27575-0 27575-0	**SKILLED NURSING TREATMENT PLAN, REASON TO CONTINUE (NARRATIVE)**	**Section**	**ED**	**0,1**	
27576-8 27576-8	**SKILLED NURSING TREATMENT PLAN, JUSTIFICATION (NARRATIVE)**	**Section**	**ED**	**0,1**	

3.10 Speech Therapy Rehabilitation Service Value Table

~~3.9Speech Therapy Rehabilitation Service Value Table~~

Table 3.10 Speech Therapy Rehabilitation Service Value Table

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
29162-5 29162-5	**SPEECH THERAPY TREATMENT PLAN, NEW/REVISED** If the treatment plan is revised, then it shall reference the previous treatment plan in the header. `/ClinicalDocument/relatedDocument/@typeCode` RPLC Revised any other New	**REL**	**CS**	**1,1**	ActRelationship Document
29166-6 29166-6	**SPEECH THERAPY TREATMENT PLAN, PRIMARY DIAGNOSIS (COMPOSITE)** 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. `/ClinicalDocument//section[code/@code="29166-6" and code/@codeSystem=$LOINC]//observation[code/@code="29166-6" and code/@codeSystem=$LOINC]`	**OBS**		**1,1**	
~~29166-6~~	SPEECH THERAPY 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="29166-6" and code/@codeSystem=$LOINC]//observation[code/@code="29166-6" and code/@codeSystem=$LOINC]/value/@code`		CD	1,1	I9C I10C

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
	SPEECH THERAPY TREATMENT PLAN, DATE ONSET OR EXACERBATION OF PRIMARY DIAGNOSIS The date of onset or exacerbation of the diagnosis is stored in the <effectiveTime> element of this observation. `/ClinicalDocument//section[code/@code="29166-6" and code/@codeSystem=$LOINC]//observation[code/@code="29166-6" and code/@codeSystem=$LOINC]/effectiveTime/low/@value`		TS	1,1	

LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, DATE RANGE OF TREATMENT**
	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. The estimated end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.
	
	`/ClinicalDocument/documentationOf/serviceEvent [@code="LOINC-TBD"]/effectiveTime/low/ @value`
	
	`/ClinicalDocument/documentationOf/serviceEvent [@code="LOINC-TBD"]/effectiveTime/high/ @value`
		ACT	**TS**	**1,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
~~29170-8~~ ~~29170-8~~	~~**SPEECH THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) DESCRIBED BY PLAN**~~ ~~The rehabilitation plan is documentation of the act of providing treatment. The date range includes the Treatment Plan Start Date and the Treatment Plan End Date.~~ ~~Information about the act being documented 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.~~ ~~The plan start date is stored in the <low> element of the <effectiveTime> element of the <serviceEvent> element. The plan end date is stored in the <high> element of the <effectiveTime> element of the <serviceEvent> element.~~ ~~/ClinicalDocument/documentationOf/serviceEvent [@code="29170-8"]/effectiveTime/low/@value~~ ~~/ClinicalDocument/documentationOf/serviceEvent [@code="29170-8"]/effectiveTime/high/@value~~	~~**ACT**~~	~~**TS**~~	~~**1,1**~~	
29169-0 29169-0	**SPEECH THERAPY TREATMENT PLAN, VISIT FREQUENCY** 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="29169-0" and code/@codeSystem=$LOINC]//observation [@code="29169-0" and code/@codeSystem=$LOINC]/value`	**OBS**	**PQ**	**1,1**	
29167-4 29167-4	**SPEECH THERAPY TREATMENT PLAN, DIAGNOSIS ADDRESSED BY PLAN** 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 attachments standards.** This entry can be located using the following XPath expression, where "value" is the diagnosis code. `/ClinicalDocument//section[code/@code="29167-4" and code/@codeSystem=$LOINC]//observation [code/@code="29167-4" and code/@codeSystem=$LOINC]/value/@code`	**OBS**	**CD**	**1,1**	**I9C** **I10C**

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
29168-2	**SPEECH THERAPY TREATMENT PLAN, AUTHOR OF TREATMENT PLAN (COMPOSITE)** The author of the treatment plan is recorded in the header of the CDA Document. It can be found using the following XPath expression. `/ClinicalDocument/author`	**PART**		**1,1**	
29189-8	SPEECH THERAPY TREATMENT PLAN, AUTHOR NAME The name of the author is stored at the following location. `/ClinicalDocument/author/assignedAuthor/assignedPerson/name`		PN	1,1	
29188-0	SPEECH THERAPY TREATMENT PLAN, AUTHOR 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 *HL7 Additional Information Specification Implementation Guide* for more information. `/ClinicalDocument/author/assignedAuthor/id`		II	1,1	NPI UPIN or other provider identifier
29190-6	SPEECH THERAPY TREATMENT PLAN, AUTHOR PROFESSION As described by the Health Care Provider Taxonomy. The Author profession can be found in the <code> element of the <assignedAuthor>. `/ClinicalDocument/author/assignedAuthor/assignedAuthor/code/@code`		CD	0,1	PTX

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

29203-7
29203-7
	SPEECH THERAPY TREATMENT PLAN, DATE RANGE (FROM/THROUGH) OF HOSPITALIZATION LEADING TO TREATMENT
	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. The plan end date is stored in the <high> element of the <effectiveTime> element of the <encounter> element.
	
	The XPath expression to locate this entry is:
	`/ClinicalDocument//section[@code="29203-7" and code/@codeSystem=$LOINC]//encounter[@code="29203-7" and code/@codeSystem=$LOINC]/low/@value`
	
	`/ClinicalDocument//section[@code="29203-7" and code/@codeSystem=$LOINC]//encounter[@code="29203-7" and code/@codeSystem=$LOINC]/high/@value`
		ENC	**TS**	**0,1**	

29171-6 29171-6	**SPEECH THERAPY TREATMENT PLAN, CONTINUATION STATUS** 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`	**ACT**	**CS**	**0,1**	ActStatus
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION (COMPOSITE)** **Contains information about the referring person, date of referral and reason for referral.**			**0,1**	
Same as above	**SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION** **A narrative description of the reason for the referral.** `/ClinicalDocument//section[@code="LOINC-TBD" and @codeSystem=$LOINC]/text`		**ED**	**0,1**	
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON NAME** **The name of the individual who referred the patient for treatment.** `/ClinicalDocument/participant[@typeCode="REF"]/participantRole/playingEntity/name`~~**Add xpath expression here…**~~	**PART**	**PN**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, REFERRAL INFORMATION - REFERRING PERSON 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 *HL7 Additional Information Specification Implementation Guide* 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~~Add xpath expression here…~~`		**II**	**0,1**	**NPI UPIN or other provider identifier**
LOINC-TBD	**SPEECH THERAPY 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.** `/ClinicalDocument/participant[@typeCode="REF"]/time`		**TS**	**1,1**	
~~**29172-4**~~ ~~29172-4~~	~~**SPEECH THERAPY TREATMENT PLAN, 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~~ ~~`/ClinicalDocument/participant[@typeCode="REF"]/time`~~	~~**PART**~~	~~**TS**~~	~~**0,1**~~	
29174-0	**SPEECH THERAPY 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: `/ClinicalDocument/legalAuthenticator`	**PART**		**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
29174-0	SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE 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.		CS	1,1	ParticipationSignature
29173-2	SPEECH THERAPY DATE TREATMENT PLAN, AUTHOR SIGNED The <time> element of the <legalAuthenticator> element provides the time at which the document was signed. `/ClinicalDocument/legalAuthenticator/time/ @value`		TS	1,1	
29176-5	**SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE SPEECH THERAPY PROFESSIONAL ON FILE (COMPOSITE)** The <authenticator> element in the CDA Header records information about the signing of the document by another (not legally responsible[16]) party for the content. This element can be found using the following XPath expression: `/ClinicalDocument/authenticator`	**PART**		**1,1**	
29176-5	SPEECH THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE SPEECH 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.		CS	1,1	ParticipationSignature
29175-7	SPEECH THERAPY TREATMENT PLAN, DATE SPEECH THERAPY PROFESSIONAL SIGNED 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`		TS	1,1	
29177-3 29177-3	**SPEECH THERAPY TREATMENT PLAN, MEDICATION ADMINISTERED** Information about the administration of medication is recorded in an <substanceAdministration> element in the appropriate section.	**SBADM**		**0,n**	

[16] 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 Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

```
/ClinicalDocument//section[code/@code="2
9177-3" and code/@codeSystem=$LOINC]//
substanceAdministration[code/@code="2917
```

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units

29178-1
29178-1
	SPEECH THERAPY TREATMENT PLAN, PROGNOSIS FOR THERAPY
	The prognosis for rehabilitation is stored in an <observation> element in the appropriate section.
	
	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]`
	
	The <value> of the <observation> is a code describing the prognosis for rehabilitation.
	
	`/ClinicalDocument//section[@code="29178-1" and code/@codeSystem=$LOINC]//observation[code/@code="29178-1" and code/@codeSystem=$LOINC]/value/@code`
	
	170969009 Poor
	67334001 Guarded
	65872000 Fair
	170968001 Good
		OBS	**CD**	**1,1**	Subset of SNOMED CT

29180-7 29180-7	**SPEECH THERAPY TREATMENT PLAN, DATE RANGE CERTIFYING THE PLAN OF CARE** **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='29180-7']//act[code/@code='29180-7']/ effectiveTime` ~~**Add xpath expression here…**~~ ~~**DATE OF LAST PLAN OF TREATMENT CERTIFICATION**~~	~~**OBS**~~**ACT**	**IVL_TS**	**0,1**	
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, PHYSICIAN CERTIFICATION STATEMENT** **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	**SPEECH THERAPY TREATMENT PLAN, ACTUAL START OF CARE DATE** **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` ~~**Add xpath expression here…**~~	~~**???**~~**ACT**	**TS**	**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
29181-5 29181-5 **May need new LOINC due to title change**	**SPEECH THERAPY TREATMENT PLAN, PAST MEDICAL HISTORY~~+LEVEL OF FUNCTION~~ (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, LEVEL OF FUNCTION (COMPOSITE)** **Contains information about the level of function of the patient, both prior and current.**	**Section**	**ED**	**1,1**	
LOINC-TBD	**PRIOR LEVEL OF FUNCTION (NARRATIVE)** **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 **~~SPEECH THERAPY TREATMENT PLAN, PRIOR LEVEL OF FUNCTION (NARRATIVE)~~** **~~Information about the patient's prior level of function in narrative form.~~** **~~Add xpath expression here…~~**		**ED**	**1,1**	
LOINC-TBD	**CURRENT LEVEL OF FUNCTION (NARRATIVE)** **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 **~~SPEECH THERAPY TREATMENT PLAN, CURRENT LEVEL OF FUNCTION (NARRATIVE)~~** **~~Information about the patient's current level of function in narrative form.~~** **~~Add xpath expression here…~~**		**ED**	**1,1**	
29182-3 **~~29182-3~~**	**SPEECH THERAPY TREATMENT PLAN, ~~INITIAL~~ ASSESSMENT INFORMATION (COMPOSITE~~NARRATIVE~~)** **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.**	**~~Section~~Section**	**~~ED~~**	**1,~~1~~n**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, INITIAL ASSESSMENT INDICATOR** **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="29182-3" and code/@codeSystem=$LOINC]//observation[code/@code="TBD"and code/@codeSystem=$LOINC]/value/@code`~~**ASSESSMENT INDICATOR**~~ ~~**Identifies if this is the initial assessment or a re-evaluation of the patient's condition.**~~ ~~**I – Initial Assessment**~~ ~~**R – Re-evaluation**~~ ~~**Add xpath expression here…**~~		**CD**	**1,1**	**HL79055**
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**	
29183-1 29183-1	**SPEECH THERAPY TREATMENT PLAN, PLAN OF TREATMENT (NARRATIVE)**	**Section**	**ED**	**1,1**	
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, TREATMENT ENCOUNTER (NARRATIVE)** **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	**SPEECH THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) INFORMATION (COMPOSITE)** **Information supplied from the Individual Education Plan (IEP) about the patient's treatment or condition.**	**OBS**		**0,1**	

LOINC code Component Answer	Description and Value	Entry Type	Data Type	Card	Response Code / Numeric Units
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, INDIVIDUAL EDUCATION PLAN (IEP) – DEFINED SCHOOL YEAR (FROM/THROUGH)** **The From and Through dates of the school year for the patient.** /ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime ~~**Add xpath expression here…**~~		**TS**	**1,1**	
29184-9 ~~29184-9~~	**SPEECH THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS (NARRATIVE)**	~~**Section?**~~ **??Section**	**ED**~~**ED**~~	**0,**~~**1**~~**n**	
LOINC-TBD	**SPEECH THERAPY TREATMENT PLAN, PROGRESS NOTE+ATTAINMENT OF GOALS DATE RANGE** /ClinicalDocument//section[code/@code="LOINC-TBD"]//act[code/@code="LOINC-TBD"]/effectiveTime ~~**Add xpath expression here…**~~		**IVL_TS**	**1,1**	
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		~~06122003~~**06122006**
STATEMENT FROM		07172003 through 07312003
PHYSICIAN		JOHN E. SMITH, MD
NEW JERSEY IDENTIFIER		1298379
PROVIDER TAXONOMY CODE		Psychiatrist (203BP0800Y)
REFERRAL DATE		~~06122003~~**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

PLAN OF TREATMENT

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

MEDICAL HISTORY/PRIOR FUNCTIONAL LEVEL
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.

INITIAL ASSESSMENT
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.

FUNCTIONAL GOALS
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.

PLAN OF TREATMENT
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.

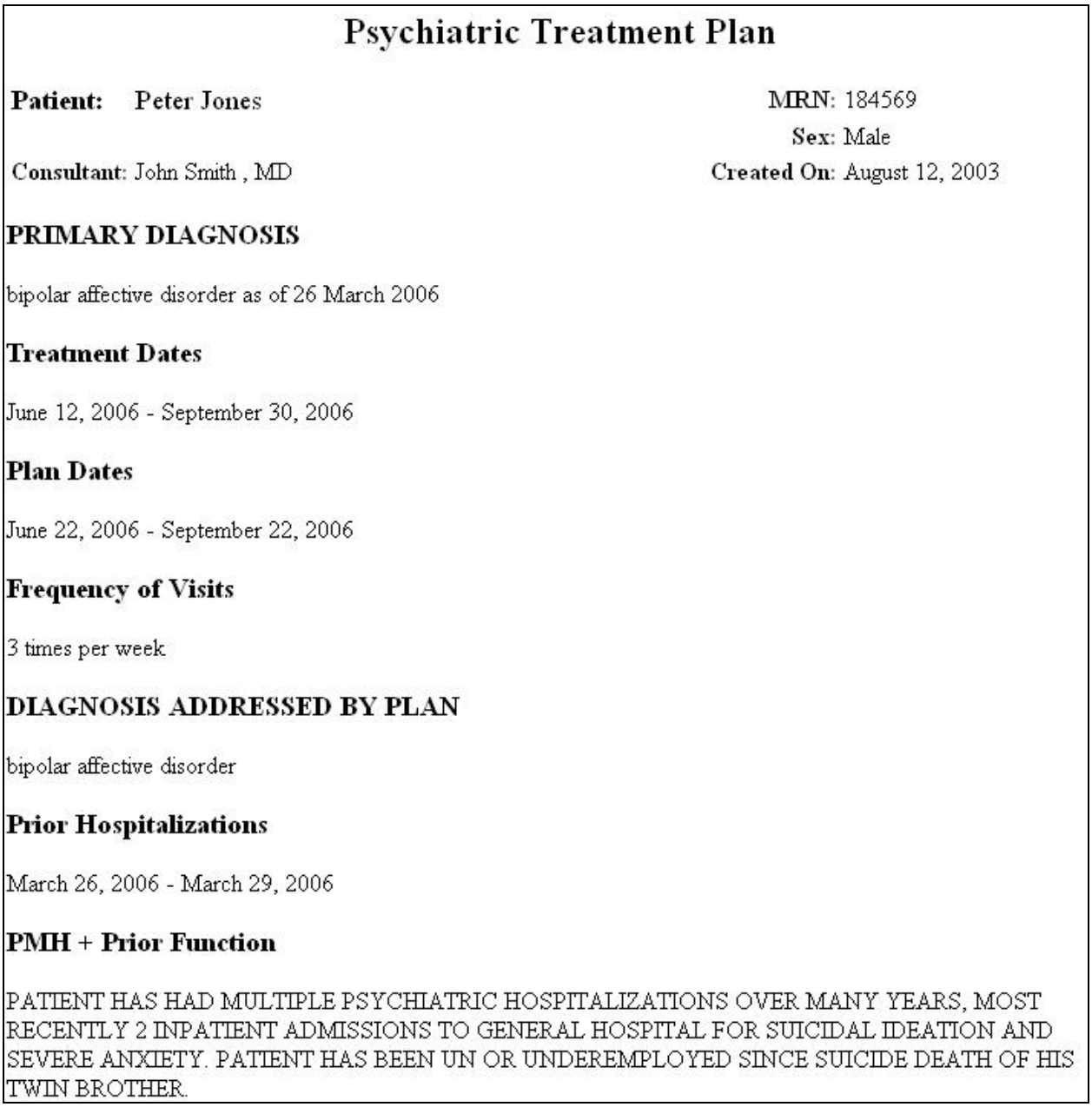
SYMPTOMS/PRESENT BEHAVIOR
PATIENT WAS AGITATED, ANXIOUS AND NEEDY, EXPRESSING FEARS OF ABANDONMENT AND PASSIVE SUICIDAL IDEATION. PATIENT REQUIRED FREQUENT REINFORCEMENT IN ORDER TO CONTINUE TO FUNCTION OUTSIDE OF AN INPATIENT PSYCHIATRIC WARD.

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

Figure 1. Portion of Rendered Human-Decision Variant



Psychiatric Treatment Plan

Patient: Peter Jones

MRN: 184569

Sex: Male

Consultant: John Smith , MD

Created On: August 12, 2003

PRIMARY DIAGNOSIS

bipolar affective disorder as of 26 March 2006

Treatment Dates

June 12, 2006 - September 30, 2006

Plan Dates

June 22, 2006 - September 22, 2006

Frequency of Visits

3 times per week

DIAGNOSIS ADDRESSED BY PLAN

bipolar affective disorder

Prior Hospitalizations

March 26, 2006 - March 29, 2006

PMH + Prior Function

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**~~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

ription	Code
Chew, oral	CHEW
Diffusion, extracorporeal	EXTCORPDIF
Diffusion, hemodialysis	HEMODIFF
Diffusion, transdermal	TRNSDERMD
Dissolve, oral	DISSOLVE
Dissolve, sublingual	SL
Douche, vaginal	DOUCHE
Electro-osmosis	ELECTOSMOS
Enema, rectal	ENEMA
Enema, rectal retention	RETENEMA
Flush, intravenous catheter	IVFLUSH

ription	Code
Gargle	GARGLE
Immersion (soak)	SOAK
Implantation, intradermal	IDIMPLNT
Implantation, intravitreal	IVITIMPLNT
Implantation, subcutaneous	SQIMPLNT
Infusion, epidural	EPI
Infusion, intraarterial catheter	IA
Infusion, intracardiac	IC
Infusion, intracoronary	ICOR
Infusion, intraosseous, continuous	IOSSC
Infusion, intrathecal	IT

ription	Code
Infusion, intravascular	IVASCINFUS
Infusion, intravenous	IV
Infusion, intravenous catheter	IVC
Infusion, intravenous catheter, continuous	IVCC
Infusion, intravenous catheter, intermittent	IVCI
Infusion, intravenous catheter, pca pump	PCA
Infusion, subcutaneous	SQINFUS
Inhalation, intermittent positive pressure breathing (ippb)	IPPB
Inhalation, nasal	NASINHL
Inhalation, nasal cannula	NASINHLC
Inhalation, nasal cannula	NP
Inhalation, nebulization	NEB
Inhalation, nebulization, nasal	NASNEB
Inhalation, nebulization, oral	ORNEB
Inhalation, oral intermittent flow	ORIFINHL
Inhalation, oral rebreather mask	REBREATH
Inhalation, respiratory	ORINHL
Inhalation, tracheostomy	TRACH
Inhalation, ventilator	VENT
Inhalation, ventimask	VENTMASK
Injection, amniotic fluid	AMNINJ
Injection, biliary tract	BILINJ
Injection, cervical	CERVINJ
Injection, endosinusial	ENDOSININJ
Injection, epidural	EPIDURINJ
Injection, epidural, push	EPIINJ
Injection, epidural, slow push	EPINJSP
Injection, extra-amniotic	EXTRAMNINJ
Injection, extracorporeal	EXTCORPINJ
Injection, for cholangiography	CHOLINJ
Injection, gastric button	GBINJ
Injection, gingival	GINGINJ
Injection, hemodialysis port	HEMOPORT
Injection, insulin pump	IPUMPINJ
Injection, interameningeal	INTERMENINJ
Injection, interstitial	INTERSTITINJ
Injection, intra-abdominal	IABDINJ
Injection, intraarterial	IAINJ
Injection, intraarterial, push	IAINJP
Injection, intraarterial, slow push	IAINJSP
Injection, intraarticular	IARTINJ
Injection, intrabursal	IBURSINJ
Injection, intracardiac	ICARDINJ
Injection, intracardiac, push	ICARINJP
Injection, intracardiac, rapid push	ICARDINJRP
Injection, intracardiac, slow push	ICARDINJSP
Injection, intracartilaginous	ICARTINJ
Injection, intracaudal	ICAUDINJ
Injection, intracavernous	ICAVINJ
Injection, intracavitary	ICAVITINJ
Injection, intracerebral	ICEREBINJ
Injection, intracervical (uterus)	IUINJC
Injection, intracisternal	ICISTERNINJ
Injection, intracoronary	ICORONINJ
Injection, intracoronary, push	ICORONINJP
Injection, intracorpus cavernosum	ICORPCAVINJ
Injection, intradermal	IDINJ
Injection, intradiscal	IDISCINJ
Injection, intraductal	IDUCTINJ
Injection, intradural	IDURINJ
Injection, intraepidermal	IEPIDINJ
Injection, intraepithelial	IEPITHINJ
Injection, intralesional	ILESINJ

ription	Code
Injection, intraluminal	ILUMINJ
Injection, intralymphatic	ILYMPJINJ
Injection, intramedullary	IMEDULINJ
Injection, intramuscular	IM
Injection, intramuscular, deep	IMD
Injection, intramuscular, z track	IMZ
Injection, intraocular	IOINJ
Injection, intraosseous	IOSSINJ
Injection, intraovarian	IOVARINJ
Injection, intrapericardial	IPCARDINJ
Injection, intraperitoneal	IPERINJ
Injection, intrapleural	IPLRINJ
Injection, intraprostatic	IPROSTINJ
Injection, intrapulmonary	IPINJ
Injection, intraspinal	ISINJ
Injection, intrasternal	ISTERINJ
Injection, intrasynovial	ISYNINJ
Injection, intratendinous	ITENDINJ
Injection, intratesticular	ITESTINJ
Injection, intrathecal	ITINJ
Injection, intrathoracic	ITHORINJ
Injection, intratubular	ITUBINJ
Injection, intratumor	ITUMINJ
Injection, intratympanic	ITYMPINJ
Injection, intraureteral, retrograde	IURETINJ
Injection, intrauterine	IUINJ
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

ription	Code
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	JJTINSTL
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
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	IDOUDMAB
Mucosal absorption, intratracheal	ITRACHMAB
Mucosal absorption, submucosal	SMUCMAB

ription	Code
Nebulization, endotracheal tube	ETNEB
Occlusive dressing technique	OCDRESTA
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	BUC
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	OPTHALTA
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

~~**Assessment Indicator**~~

~~**HL7-defined vocabulary to indicate the type of assessment (initial or re-evaluation)**~~

~~**The OID for this table is 2.16.840.1.113883.12.9055.**~~

~~**Table 5.7 Assessment Indicator**~~

~~Code~~	~~Rehabilitation Services Remission Status~~
~~I~~	~~Initial Assessment~~
~~R~~	~~Re-evaluation~~

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 Alchohol~~-~~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

The OID for this data component is 2.16.840.1.113883.4.77

~~5.9~~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 OI~~S~~D is not needed.

~~The OID for this table is 2.16.840.1.113883.6.8.~~

~~5.10~~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.

~~5.11~~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.

~~5.12~~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/admnsimp .

The OID for this table is 2.16.840.1.113883.4.6

~~5.13~~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.

~~5.1~~45.15 State Provider License Number

The unique license number assigned to a physician or health care provider may be used as an 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

~~5.15~~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.

~~5.16~~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.

~~5.17~~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--