IRRS

interRAI Contact Assessment
CIHI Coding Reference Guide

2025

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Introduction

The *CIHI Coding Reference Guide for the interRAI Contact Assessment* was developed by the Canadian Institute for Health Information (CIHI). This guide highlights items from the interRAI Contact Assessment (interRAI CA ©) (version 10) that may require more clarification, thereby assisting coders to complete the more challenging items of the assessment.

Purpose

The purpose of this document is to assist assessors in completing the interRAI CA by highlighting some of the potentially challenging coding areas. It is intended to function as a companion guide for assessors completing the interRAI CA, to be used in conjunction with clinical judgment, expertise and relevant best practice guidelines.

Additional resources

The *interRAI CA User's Manual* remains the comprehensive resource to guide the understanding and documentation of assessment findings. In addition, resources are available to assessors to assist with accurate coding of the assessment.

eQuery: eQuery is a web-based application that stakeholders can use when they have a question about assessment-related topics. Search a repository of previously submitted questions and answers, or submit new questions if you're unable to find answers to specific coding questions.

Job aids: Several job aids specific to the interRAI CA provide further information to assessors. These job aids can be accessed through eQuery.

CIHI tips by assessment section

Section A Demographic Information

Item	CIHI tip
A12 — Location of Assessment	If a face-to-face assessment is completed in an outpatient program that is located within a hospital (e.g., a stroke clinic), code 4 (Other). If the assessment is being completed on a person who has been admitted to the hospital, code 2 (Hospital excluding emergency department). If a person is in the hospital (inpatient) and staff are conducting the interRAI CA from a community/home care office, code 2 (Hospital excluding emergency department). Code based on the location of the person, not the assessor.

Section B Intake and Initial History

Item	CIHI tip
B2ab — Referral Details: Indwelling catheter	If the catheter removal has been ordered or the catheter has been removed in the last 3 days, it may be captured. Code the appropriate time frame.
B2ae — Referral Details: Other	Dialysis can be captured in Section B2 — Referral Details as B2ae, which captures treatments that have been ordered. This category may include, but is not restricted to, respiratory therapy, ostomy management, nephrostomy tube management, feeding tube (nasogastric, gastric or jejunostomy) management and dialysis. Kidney failure may be captured in Section D5 — Disease Diagnoses using the appropriate ICD-10-CA codes if the presence of diseases or infections is relevant to the person's current activity of daily living (ADL) status, cognitive status, mood or behaviour status, medical treatments, monitoring or risk of death.
B4 — Expected Residential/Living Status During Service Provision	Code 2 (Board and care) if the person is living in a shared living arrangement such as a private home that provides some support. Code 3 (Assisted living or semi-independent living) when the person is in a larger type of shared living arrangement, such as a retirement home. Note that for analysis, codes 2 and 3 will be combined.

Section C Preliminary Screener

Item	CIHI tip
C2 — ADL Self-Performance	For each item in Section C2 — ADL Self-Performance, code for the most dependent episode of assistance in the last 24 hours. If the person did not complete the ADL in the last 24 hours, code the amount of assistance required when the activity was most recently completed.
C2a — ADL Self-Performance: Bathing	If the person has a full-body bed bath or sponge bath, the assessor should consider whether the bath achieved a similar degree of cleanliness to that achieved with a shower or tub bath. If the full-body bed bath or sponge bath did meet that criterion, it can be included in C2a.
C2e — ADL Self-Performance: Locomotion	This item assesses how the person moves between locations indoors only. Do not consider how they move about outdoors.
C3 — Dyspnea (Shortness of breath)	If the symptom was absent over the last 24 hours but would have been present had the person undertaken activity, code according to the activity level that would normally have caused the person to experience shortness of breath.
C7 — Home Care or Community Support Services May Be Required for This Person	Although the Self-Reliance Index may indicate that the person is self-reliant, this item allows the assessor to use clinical judgment to determine whether the assessment process should continue beyond Section C. Review all the information obtained about the person during the completion of sections A, B and C in order to make a clinical judgment about the need to continue with further assessment.

Section D Clinical Evaluation

Item	CIHI tip
D2 — Ability to Understand Others (Comprehension)	This does not test whether a comprehension issue is related to understanding a particular language. If the person does not normally wear a hearing aid (although they may have one) and they are not able to understand because of hearing problems, code D2 according to what they understand. Assess the person without the hearing aid if they do not normally wear it.
D5 — Disease Diagnoses	Do not include conditions that have been resolved or that no longer affect the person's functioning or care needs. An example of a disease being present but not requiring active treatment is cataracts. They are present and being monitored during an annual eye exam, but no treatment is prescribed (i.e., no eye medication/drops). There may be more than one primary diagnosis for current referral coded.
D7 — Problem Frequency	For a code of 1 (Present but not exhibited in last 3 days), there is no defined time frame for this option. It would be up to the assessor to use their clinical judgment to determine whether the symptom is of ongoing clinical concern and/or significant to the person being assessed.
D7c — Peripheral edema	If edema is not present because the person wears support stockings, code 0 (Not present). If there is edema once the stockings are removed or not worn, code accordingly.
D8a — Pain Symptoms: Frequency with which person complains or shows evidence of pain	If the person does not experience any pain because they are on a medication regimen that renders them pain-free, code 0 (No pain). For a code of 1 (Present but not exhibited in last 3 days), there is no defined time frame for this option. It would be up to the assessor to use their clinical judgment to determine whether the symptom is of ongoing clinical concern and/or significant to the person being assessed.
D9 — Smokes Tobacco Daily	Do not code e-cigarettes, vaping, Nicorette gum or nicotine patches in Section D9, as this item refers specifically to inhaled tobacco products.
D11 — Presence of Pressure Ulcer/Injury	If the person has more than one ulcer, determine which ulcer is in the highest (worst) stage and code based on that ulcer.
D14b — Treatments: IV therapy	Dialysis is not considered IV therapy and should not be coded in this section. Dialysis can be captured in Section B2 — Referral Details as B2ae, which captures treatments that have been ordered.
D14c — Oxygen therapy	Nebulizer treatments that use oxygen as the delivery method are not considered oxygen therapy.
D15 — Time Since Last Hospital Stay	Code 5 (Now in hospital) refers only to those who are formally admitted to hospital; do not include those who are being seen in the emergency department unless the person is considered admitted to hospital.
D16 — Emergency Department Visit	Do not include visits that resulted in a hospital admission or visits for pre-scheduled treatments or procedures that may take place in the emergency department.

Section E Summary

Item	CIHI tip
E2 — Expected Length of Service	The intent is to document the length of time the person is expected to require home care services. This time may also include waiting for specific services to begin that may take longer to arrange (i.e., occupational therapy). Use clinical judgment when determining how long the person may require home care services.
E3 — Assessment Urgency	The urgency of the need for a comprehensive in-home assessment should be determined using the results of the Assessment Urgency Algorithm and other key information obtained during completion of the assessment, as well as professional judgment.
E4 — Urgency of Needed Services	The urgency of needed services should be determined using the results of the Service Urgency Algorithm and other key information obtained during completion of the assessment, as well as professional judgment. Note: It is important that the decision be based on the person's need, not on the urgency level or on the services that the home care agency is able to offer.

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