

*Impact on Compliance,
Reasonable and
Necessary Criteria, Length
of Stay, and
Reimbursement*



Importance of Accurate Coding

- RAC Demonstration Project
- Difference in CMI of 1.15 versus 1.20
 - 400 Discharges a Year

\$280,000.00



Importance of Accurate Coding

- Compliance
 - Presumptive
 - Conditional
- Reimbursement
 - Impact on CMG Relative Weight
- Length of Stay Management



- The impact of accurate coding:
 - Determination of an IRF's 60/40 compliance percentage
 - Ensures optimal patient access for IRFs



Presumptive Compliance

- A study of the rehab impairment group codes, etiologic diagnoses, and comorbidities from IRF-PAIs that have been submitted to the CMS database
- Addresses a match of impairment group codes and ICD-9-CM codes between the transmitted IRF-PAIs and those in Appendix A of Transmittal 938



Conditional Compliance

- Determined through medical record review
- Involves search in the documentation for support of the codes on the IRF-PAI
- Who is responsible for providing supporting documentation?



- Proper Use of Co-morbid Qualifiers

- Example: If 332.0 – Parkinson’s is in the co-morbidity field and is the code that is presumptively categorizing the patient as in the 60% group, does the chart indicate:
 - *“The co-morbidity has caused a significant decline in function in the patient such that, even in the absence of the admitting condition, the patient would require the intensive rehabilitation treatment provided in IRFs”*
 - *“The patient could not be cared for in another setting”*



Proper Use of Comorbid Qualifiers (cont.):

- **Step 1**: In order for the comorbid to qualify the patient for 60% classification, the comorbid must impact:
 - Length of Stay
 - Plan of Care
 - Utilization of resources
- **Step 2**: Supporting Documentation



- Proper Use of Co-morbid Qualifiers (cont.):
 - **Physician:** must highlight how the Co-morbid condition in the H&P that he/she intends to qualify the patient for 60% status will have an impact on the Length of Stay, Plan of Care, and the utilization of resources.
 - This should carry into the daily progress notes as well
 - **Therapy team:** must also document the same not only in their Initial Assessment but also in their daily progress notes
 - For example: Documentation must support a significant decline in function and/or a significant gait dysfunction and ADL dysfunction attributed the exacerbation of the Parkinson's



Coding for Compliance: Expectations

- **Should know 60/40 percentage at all times**
- To ensure conditional compliance, “team” documentation must defend use of various codes for 60% categorization
 - Focus of monthly chart audits
- Managers are expected to review data and any reports available to them weekly to ensure accuracy



- Accurate and complete capture of a patient's clinical presentation in an IRF is critical to support medical necessity and payment on that claim
- The purpose of coding on the IRF PAI is to capture medical information on the patients' current conditions and burden of care
- The medical record must support codes reported on the PAI; code all documented conditions that meet reporting guidelines, even if they don't affect payment
- IRF medical coding is listed in the IRF PAI #21 - #24, and in # 47 (#23 is date of onset)



INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT

Identification Information*	Payer Information*												
1. Facility Information A. Facility Name _____ _____ B. Facility Medicare Provider Number _____ 2. Patient Medicare Number _____ 3. Patient Medicaid Number _____ 4. Patient First Name _____ 5A. Patient Last Name _____ 5B. Patient Identification Number _____ 6. Birth Date _____ <div style="text-align: center;">MM / DD / YYYY</div> 7. Social Security Number _____ 8. Gender (1 - Male; 2 - Female) _____ 9. Race/Ethnicity (Check all that apply) <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 20px;">American Indian or Alaska Native</td> <td>A. _____</td> </tr> <tr> <td style="padding-left: 40px;">Asian</td> <td>B. _____</td> </tr> <tr> <td style="padding-left: 20px;">Black or African American</td> <td>C. _____</td> </tr> <tr> <td style="padding-left: 40px;">Hispanic or Latino</td> <td>D. _____</td> </tr> <tr> <td style="padding-left: 20px;">Native Hawaiian or Other Pacific Islander</td> <td>E. _____</td> </tr> <tr> <td style="padding-left: 40px;">White</td> <td>F. _____</td> </tr> </table> 10. Marital Status (1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced) _____ 11. Zip Code of Patient's Pre-Hospital Residence _____	American Indian or Alaska Native	A. _____	Asian	B. _____	Black or African American	C. _____	Hispanic or Latino	D. _____	Native Hawaiian or Other Pacific Islander	E. _____	White	F. _____	20. Payment Source A. Primary Source _____ B. Secondary Source _____ (01 - Blue Cross; 02 - Medicare non-MCO; 03 - Medicaid non-MCO; 04 - Commercial Insurance; 05 - MCO HMO; 06 - Workers' Compensation; 07 - Crippled Children's Services; 08 - Developmental Disabilities Services; 09 - State Vocational Rehabilitation; 10 - Private Pay; 11 - Employee Courtesy; 12 - Unreimbursed; 13 - CHAMPUS; 14 - Other; 15 - None; 16 - No-Fault Auto Insurance; 51 - Medicare MCO; 52 - Medicaid MCO)
American Indian or Alaska Native	A. _____												
Asian	B. _____												
Black or African American	C. _____												
Hispanic or Latino	D. _____												
Native Hawaiian or Other Pacific Islander	E. _____												
White	F. _____												
Admission Information*	Medical Information*												
12. Admission Date _____ <div style="text-align: center;">MM / DD / YYYY</div> 13. Assessment Reference Date _____	21. Impairment Group _____ <div style="text-align: right; margin-right: 20px;">Admission Discharge</div> Condition requiring admission to rehabilitation; code according to Appendix A, attached. 22. Etiologic Diagnosis _____ (Use an ICD-9-CM code to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation) 23. Date of Onset of Impairment _____ <div style="text-align: center;">MM / DD / YYYY</div> 24. Comorbid Conditions; Use ICD-9-CM codes to enter up to ten medical conditions <table style="width: 100%; border: none;"> <tr> <td>A. _____</td> <td>B. _____</td> </tr> <tr> <td>C. _____</td> <td>D. _____</td> </tr> <tr> <td>E. _____</td> <td>F. _____</td> </tr> <tr> <td>G. _____</td> <td>H. _____</td> </tr> <tr> <td>I. _____</td> <td>J. _____</td> </tr> </table>	A. _____	B. _____	C. _____	D. _____	E. _____	F. _____	G. _____	H. _____	I. _____	J. _____		
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G. _____	H. _____												
I. _____	J. _____												

Coding for Reimbursement & LOS Management

- Impairment Group Code (IGC)
- Etiologic Diagnosis
- Tier Level Comorbid Conditions



Impairment Group Code (IGC)

- The code that best describes the primary reason for admission to the rehabilitation program
 - “the condition requiring admission to the rehabilitation”
- Case Mix Group (CMG) is assigned from IGC – accuracy is critical to ensuring proper payment
- Physician is primary “driver” of IGC assignment



Coding the IGC

- Impairment Group Code (IGC)
 - The IGC is not to be taken off of the Pre-Admission Screen and placed on the IRF-PAI without Physician Consultation
 - The physician determines the impairment group or the rehab diagnosis
 - An admission impairment group may be different than a discharge impairment group
 - **Only** the admission impairment group code drives reimbursement



Example 1: Proper IGC assignment for patient s/p lumbar laminectomy

- **Non-Traumatic Spinal Cord Dysfunction** – assign when myelopathy is present (lower extremity weakness, bowel/bladder dysfunction, plegia's) due directly to the spinal cord
- **Neurological Conditions** – Assign when deficits are outside the spinal cord (foot drop, radiculopathy)
- **Orthopedic Disorders** – Assign when primary focus is mobility and ADL training, with no neurological deficits present, and when pain is not the primary focus
- **Pain Syndrome** – Assign when Back Pain is primary focus and no neurological deficits are present

IMPACT ON PAYMENT AND **Relative Weight**

Example (base rate of \$13,000.00) - no tier, motor 20

- Non-Traumatic Spinal Cord IGC: A0506 **\$24,207.30**
(1.8621)
- Neurologic Condition IGC: A0604 **\$19,197.10**
(1.4767)
- Orthopedic Disorder IGC: A0904 **\$17,825.60**
(1.3712)
- Pain Syndrome IGC: A1603 **\$16,295.50** **(1.2535)**

IMPACT ON LOS

Example

(No Tier, Motor 20)

- Non-Traumatic Spinal Cord: A0506 **23 days**
- Neurologic Condition: A0604 **18 days**
- Orthopedic Disorder: A0904 **17days**
- Pain Syndrome: A1603 **16 days**

The medical record must reflect appropriateness of IGC selected



Coding the IGC

IMPACT ON PAYMENT, RELATIVE WEIGHT, & LOS Example 2 (base rate of \$13,000.00) **(No Tier, Motor 25.05)**

- Hip Fracture IGC: A0704
 \$17,605.90 (1.3543)
 17 days

- Total Hip Replacement: A0805
 \$13,000 (1.000)
 13 days

**The medical record must reflect appropriateness of
IGC selected**

Frequently Seen Mistakes:

- Use of 8.9-Other Orthopedic instead of 8.4-Major Multiple Fractures or 14.9-Other Major Multiple Trauma
- Use of 16-Debility instead of 9- Cardiac or 10.1/10.9 – Pulmonary
- Use of 05.9 – Other Amputation instead of 13- Other Disabling Impairments



Case Study: How would you code the IGC?

- HPI: Mr. Smith is admitted to the hospital for an emergency CABG surgery. Post-operatively, he suffers various complications, along with a severe exacerbation of his Parkinson's disease, for which he has never received treatment in an IRF. The exacerbation manifests itself through increased rigidity, increased difficulty initiating movement and difficulty swallowing, and a more pronounced shuffling and festinating gait.
- Social History: He had been living at home with his wife at a modified independent level of function for ambulation and ADLs.
- Functional Status: Mobility and ADL function have certainly been adversely affected so that he now requires moderate assistance for most FIM motor tasks.



Coding the Etiologic

- The reason that led to the impairment and need for IRF level of services
 - Relationship with IGC is “key” in supporting medical necessity and appropriate reimbursement
- Documenting the appropriate IGC and Etiologic Diagnosis begins during preadmission screening
 - Educating CRC’s is important in the documentation “road map” that justifies decision to admit patient to IRF level of care.



- Etiologic Diagnosis
 - Coders can refer to the acute care chart for clarification but can't directly code from
 - Reminder: No V-codes allowed for etiologic diagnosis
 - What was the diagnosis or condition that lead to the impairment?
 - The acute condition that caused the impairment is what is generally coded



“A comorbidity is a specific patient condition that affects a patient in addition to the principal diagnosis or impairment.”

- Comorbid Conditions may or may not affect payment, and are reported in **PAI Field #24**
- Medicare has assigned certain conditions additional payment to be added to the base payment when these conditions are active, current, and being treated in IRF
- These conditions reported are also evaluated or monitored for future refinements by Medicare

Coding the Comorbid Conditions

- When to put on the IRF-PAI (in section 24):
 - Clinical assessment
 - Additional diagnostic workup
 - Therapeutic treatment
 - An extended LOS
 - Nursing care and/or monitoring
- When **not** be placed on the IRF-PAI if:
 - They have resolved in the acute stay before the IRF admission
 - They correspond with an earlier incident or episode of care and are not truly “active” any longer
- Comorbidities that are “active” (or require one or more of the above bullet points) but do not affect payment should be placed on the PAI
 - CMS monitors Section #24 of the IRF-PAI and periodically adjusts the comorbidity list and tiered comorbidities



Four Levels (as seen on Appendix C) with example:

- Tier 1 (B): high cost co-morbidities
 - V45.11- Hemodialysis
 - V44.0 – Tracheostomy status
- Tier 2 (C): medium cost co-morbidities
 - 787.20 – Dysphagia
 - 008.45 - C-diff
- Tier 3 (D): low cost co-morbidities
 - 278.01 – Morbid obesity
 - 250.01 – Type 1 DM w/o complication, not uncontrolled
 - 428.20 – Systolic Heart Failure
 - 584.9 – Acute Renal Failure
- No tier (A): No qualifying co-morbidity



- Key team members should be educated on the list of tiered co-morbidities
 - Physician
 - Program Director/ Manager
 - Nurse Manager
 - Therapist
 - Coder
 - Preadmission Screener
- It is the team's responsibility to ensure documentation on the presence of co-morbid conditions that affect the burden of care, thus assuring accurate capture in IRF-PAI coding



- PDs must confer with physicians and staff to identify most commonly occurring tiered co-morbid conditions
- Ensure these codes are captured by coder and reported on PAI
- Ensure supportive documentation from the team that justifies additional payment assignment

Coding the Comorbid Conditions and Complications

- **How to prioritize which 10 co-morbid conditions to use:**
 - Sequence codes in PAI Field #24 to include listing any tiered conditions within the top 10 codes
 - this includes the addition of tiered complications that may have begun after the rehab stay started.
- **A tier is captured only in PAI Field #24, not in the #47**
 - Complications that occur during the stay should be coded in Sections 24 and 47 unless they occur the day prior or day of discharge



Coding the Co-morbid Conditions Rehab Care[®] delivering the post-acute continuum[™]

IMPACT ON **PAYMENT**, **RELATIVE WEIGHT**, and **LOS**

Example: 16 Debility IGC assigned with motor FIM score* 25.85

- Standard Payment, no tier

CMG: A2004

Payment: \$17,919.20

Relative Weight: 1.3784

LOS: 17

- Dysphagia diagnosed on 3rd day of admission and treated by ST. Listed in PAI #24 and #47

CHANGE: CMG: C2004

Payment: \$22,158.50

Relative Weight: 1.7045

LOS: 20



Coding: Expectations

- **Communication** – between physician, manager, and multidisciplinary team (Data, reports etc)
- **Concurrent Coding** – allows for physician query to identify, clarify, and specify accuracy of codes being reported
 - Mandated by CMS IRF-PAI Training Manual
- Knowledge of current IRF PPS guidelines and regulations
- Coding updates / education

- CMS IRF help desk: help@irfpai.com
- CMS List of Comorbidities (within data files, zip):
http://www.cms.hhs.gov/InpatientRehabFacPPS/04_IRFPAl.asp#TopOfPage
- IRF PPS Final Rule 2008
<http://edocket.access.gpo.gov/2008/pdf/e8-17797.pdf>
- IRF Training Manual 2004
<http://www.cms.hhs.gov/InpatientRehabFacPPS/downloads/irfpai-manual040104.pdf>
- ICD-9 CM Current Coding Manual/Encoder

