Best Practice Guidance for HIM Professionals in Long-Term and Post-Acute Care Settings

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The need for health information management (HIM) professionals in long-term and post-acute care (LT-PAC) settings has grown exponentially in the past decade. With the implementation of setting-specific reimbursement models and quality initiatives, the skill sets that HIM professionals bring to the table are invaluable to any healthcare organization. They are a source of expertise in data analysis, documentation, privacy and security, quality, compliance, coding, and information systems.

Organizations and HIM professionals from the various LT-PAC settings have reached out to industry experts for resources to assist in developing best practices for maintaining regulatory compliance. Workgroups of AHIMA volunteers from these settings have pooled their knowledge and expertise to develop these best practices, which are detailed in several AHIMA toolkits. This Practice Brief will introduce the Inpatient Rehabilitation Facility (IRF) Toolkit for Health Information Management Professionals and the Skilled Nursing Facility/Nursing Facility (SNF/NF) Toolkit for Health Information Management Professionals. These toolkits, both currently in production with expected delivery in 2018, will provide valuable resources for HIM professionals working in an IRF or SNF/NF, including designated units in an acute care general hospital.

IRF Toolkit for HIM Professionals

An IRF is for patients needing intensive rehabilitation services that require a skilled level of nursing care. These are usually patients who have had an injury or medical condition resulting in disabilities. There are specific criteria to demonstrate the IRF admission is reasonable and necessary, and key areas that the HIM professional should focus on for documentation improvement and auditing.

At the time of admission, the patient must:

- Require active and ongoing therapeutic intervention of multiple disciplines
- Require intensive rehabilitation therapy (15 hours in seven days)
- Reasonably be expected to actively participate in, and benefit from, the IRF program
- Have a condition and/or status that requires the level of physician supervision available in the IRF
- Require an intensive and coordinated interdisciplinary approach to providing rehabilitation

The criteria in the preceding list are demonstrated in routine documentation in the health record but must also be demonstrated in the required documentation outlined in the Medicare Benefit Policy Manual, Chapter 1, Section 110.1. The documentation requirements include:

- Preadmission screening
- Post-admission physician evaluation (PAPE)
- Individualized overall plan of care
- Admission orders
- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

The above criteria have specific requirements and timeframes for completion. For example, the pre-admission screening must be completed within the 48 hours prior to the patient’s admission to the IRF. The PAPE must be completed by the rehabilitation physician within the first 24 hours of admission. The PAPE must also include the history and physical exam that is required by Medicare and other payers for any type of inpatient admission. Another important documentation requirement is that the rehabilitation physician must have three documented face-to-face visits with the patient each week.

Along with documentation requirements specific to the IRF, for reimbursement to occur using the IRF Prospective Payment System (PPS), additional criteria must be met. Medicare requires that 60 percent of the patients receiving care during the facility's 12-month compliance review period fall into one of the following 16 qualifying conditions/impairment group codes (IGCs):

- 1.1 – Stroke – left body involvement (right brain)
- 1.2 – Stroke – right body involvement (left brain)
- 1.3 – Stroke – bilateral involvement
- 1.4 – Stroke – No paresis
- 3.1 – Neurologic Conditions – Multiple sclerosis
- 3.2 – Neurologic Conditions – Parkinsonism
- 5.3 – Amputation – Unilateral lower limb above the knee (AK)
- 5.5 – Amputation – Bilateral lower limb above the knee (AK/AK)
- 5.6 – Amputation – Bilateral lower limb above/below the knee (AK/BK)
- 5.7 – Amputation – Bilateral lower limb below the knee (BK/BK)
- 8.51 – Status post unilateral hip replacement – Age must be 85+ or BMI 50+ to be presumptively compliant
- 8.52 – Status post bilateral hip replacement
- 8.61 – Status post unilateral knee replacement – Age must be 85+ or BMI 50+ to be presumptively compliant
- 8.62 – Status post bilateral knee replacement
- 8.71 – Status post knee and hip replacements (same side) – Age must be 85+ or BMI 50+ to be presumptively compliant
- 8.72 – Status post knee and hip replacements (different sides)

The IGC along with diagnoses and patient-specific information is reported to the Centers for Medicare and Medicaid Services (CMS) for reimbursement using an assessment tool called the IRF-PAI. The IRF must also submit the appropriate UB-04 claim form on all patients. Ensuring that each of these documents provide the same clinical picture for the patient is an important piece of the IRF PPS. This assessment tool is also utilized for the Quality Reporting Program (QRP), which affects facility reimbursement.

The coding professional that works in the IRF setting must understand the documentation requirements noted above, but also the nuances that surround coding for two separate documents: the IRF-PAI and the UB-04. While the UB-04 requires a principal diagnosis as defined by UHDDS, the IRF-PAI requires an etiologic diagnosis. The etiologic diagnosis is described in the IRF-PAI Training Manual as the "problem that led to the impairment for which the patient is receiving rehabilitation." The coding professional is also tasked with understanding how the etiologic diagnosis, along with the comorbid conditions and complications, affect the IGC.

SNF/NF Toolkit for HIM Professionals

Nursing homes are facilities that are certified as such by CMS. Services provided in a nursing home determine if it is a SNF and/or a NF. SNFs are for patients that require the higher level of skilled care from nursing or rehabilitation services. Skilled care includes services like wound care, physical therapy, injections, and intravenous (IV) therapy. A patient can be admitted to a SNF for either a short period of time or for long-term care. Part A Medicare coverage for a SNF encounter has specific requirements and a limited coverage period. To be eligible for SNF benefits, the following conditions must be met by the patient:

- The patient must have Part A coverage and have available days in the benefit period
- They must have a qualifying hospital stay, which is three days (three midnights) as an inpatient
- The patient's doctor must make the decision that the patient requires daily skilled care
- The SNF must be certified by Medicare
- The skilled services are for a medical condition that was treated during the qualifying hospital stay or a condition that started during the SNF encounter

Once the patient has exhausted the available days for Part A Medicare coverage, reimbursement for the patient care in the nursing home will shift to a different payment source. Most often this source is Medicaid. At this point, the patient is no longer considered a SNF patient. They transition to becoming a NF patient or resident.

The documentation requirements for a nursing home resident are extensive and ongoing due to the longevity of the stay. Ongoing qualitative and quantitative audits are one of the key duties the HIM professional is responsible for, whether done internally or by a contractor. Reimbursement is also very different for SNF/NF and, like other LT-PAC settings, is reliant on the patient assessment instrument. In the SNF/NF, this assessment tool is called the Minimum Data Set (MDS). The MDS also has sections required for the Nursing Home Quality Measures.

Coding for the SNF/NF resident is an ongoing process, again due to the extended length of the stay of the resident. A process to review resident records in order to capture any new diagnoses is essential to complete accurate coding for both the MDS and the UB-04. Concurrent coding is the best practice for keeping the diagnosis/problem list current and can be accomplished by different processes. If concurrent coding is not feasible, review of the record to update the diagnosis/problem list should occur at a minimum frequency as follows:

- Prior to admission
- When a resident is admitted, readmitted, or returns from a hospital stay
- Quarterly to coincide with the MDS schedule or when a significant change assessment is required
- Upon discharge

The Inpatient Rehabilitation Facility (IRF) Toolkit for Health Information Management Professionals, with publication expected by mid-2018, and the Skilled Nursing Facility/Nursing Facility (SNF/NF) Toolkit for Health Information Management Professionals, with publication expected by the end of 2018, provide several appendices with examples of job descriptions, query examples, and audit tools. Both toolkits will be available online in the AHIMA store at www.ahimastore.org, as well as in AHIMA's HIM Body of Knowledge at http://bok.ahima.org.

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