Here Comes Rehab PPS!

Save to myBoK

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Just when you thought it was safe to come up for air.

After Medicare's introduction of the Outpatient Prospective Payment System (PPS, which brought us APCs), the Home Health PPS (with its HHRGs), and Skilled Nursing Facility PPS (with RUGS), another new reimbursement system is upon us.

Effective January 1, 2002, inpatient rehabilitation units (formerly exempt from the diagnosis-related groups [DRG] system) and specialty rehabilitation hospitals will be reimbursed by Medicare under the new inpatient rehabilitation PPS. For a summary of the final regulations, refer to the "Extra," insert (48A-D) in the January 2002 issue of the *Journal of AHIMA*.

HIM professionals can do several things to be in the best position for the new system. Here are a few suggestions:

Pay Attention to Rehabilitation Medical Records

Documentation practices have not been as thoroughly scrutinized in rehabilitation units and facilities as in other inpatient care facilities, because reimbursement has not traditionally been based on coding, which depends on quality and timely documentation. Care documentation by physicians, nurses, and the therapy staff should be analyzed to ensure that information is recorded in a timely and accurate fashion.

This may be a good time to take inventory of the forms used in the rehab area and ensure that there is no duplication or blanks in charting. As charts are audited in the future against proper coding, it is important that the documentation for each episode of care matches the appropriate service dates and there is clear delineation within the different phases of rehab care.

Educate Staff, Clinicians About Coding, Data Collection

There is often confusion about coding guidelines to be used for the new inpatient rehab PPS. Two types of coding are required.

One type, with its own definitions and rules, is used when completing the Patient Assessment Instrument (PAI) form within 72 hours of admission and again at discharge. The form uses an "etiologic diagnosis," presenting the reason for the acute care admission prior to the rehabilitation phase of treatment, in other words, acute CVA.

Also still required is the "routine" UB-92 coding that facilities have always completed upon discharge. UB-92 coding follows the American Hospital Association's *Coding Clinic* guidelines (V code as principal diagnosis) on proper classification for epidemiologic purposes and is followed by the appropriate secondary diagnoses (complications and comorbidities and procedures performed).

It is important to realize that some fiscal intermediaries may not be aware of proper coding guidelines and may not understand the difference between UB-92 coding and coding for the PAI and case mix group (CMG). It may be necessary to educate them about the reason for proper and consistent coding.

Collecting the Right Data

Defining what is collected, whether by rehab staff, HIM staff, or business office staff, will become increasingly important. In addition to new data elements such as the Rehab Impairment Code (RIC) and the CMG, which is used to generate the actual reimbursement for Medicare rehab patients, many other data elements must be collected on the PAI.

Is your data abstracting system set up to collect these elements, and can it analyze expected versus actual reimbursement? Can your coding system calculate the correct CMG for submission to your financial or billing system? Facilities may still wish

to calculate and store the DRG based on the UB-92 discharge coding, as many have been doing over the years for data analysis. Other commercial payers may also still reimburse facilities based on a DRG, even though Medicare payments depend on the CMG.

PPS FAQs

Following are some frequently asked questions that may assist you as you tackle the challenges and opportunities provided by the new inpatient rehab PPS.

Where are the final regulations published? Check the *Federal Register* 42, CFR Parts 412 and 413. A good Web site for information about the final regulations can be found at www.snfinfo.com/ppsrc/#Inpatient.

What types of facilities will be reimbursed based on this new PPS? Acute care hospitals with an attached inpatient rehabilitation unit (currently exempt from the DRG PPS for acute care), as well as freestanding inpatient rehabilitation facilities/hospitals, will be included.

How is this different from the DRG system? There are multiple differences. Patients are grouped into CMGs instead of DRGs. CMGs are based on RIC, age, related prior hospitalization (etiologic diagnosis based on a patient's acute condition), comorbidities, and other factors. A PAI must be completed upon admission and discharge on all rehab patients (similar to the OASIS form in home health and the MDS form for long-term care facilities).

Are there similarities to the DRG system? Yes, there are many similarities, including:

- facilities will use a grouper technology and logic to assign the proper CMG
- there are outlier payment rates for patients who fall outside the typical length of stay
- transfer payment rates are provided for patients transferred to another rehab facility and who stay in the transferred facility for less than the average length of stay

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