IRF PPS Coding Challenges

by Patricia Trela, RHIA

Inpatient rehabilitation facility (IRF) coding can be a challenge due to the Medicare Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), which was implemented in 2002 to cover patients paid under Medicare Part A. IRF PPS requires completion of the IRF-Patient Assessment Instrument (PAI), a data collection form completed on admission and discharge. The conditions reported on the UB-04 and IRF-PAI differ, as do the guidelines for code assignment.

Because codes on the UB-04 and IRF-PAI do not need to match-and usually do not-and because Medicare fiscal intermediaries have had different interpretations of the ICD-9-CM Official Guidelines for Coding and Reporting in regard to principal diagnosis reporting on the UB-04, there has been coder confusion and misunderstanding on how to assign these codes. This article outlines the coding guidelines for the IRF PPS.

The Patient Assessment Instrument

The Functional Independence Measure (FIM) was developed by a task force appointed by the American Academy of Physical Medicine and Rehabilitation and the American Congress of Rehabilitation Medicine in the mid-1980s as a tool to measure the burden of care required by rehabilitation patients. It was easy to use (only 18 items with a seven-part scale) and could be completed by any clinician with consistent results.

The Uniform Data System for Medical Rehabilitation was established to provide a method of data collection that could be used for research and to improve care for rehabilitation patients. Additional fields were added to the FIM instrument to capture demographic data and diagnostic information. The Centers for Medicare and Medicaid Services (CMS) adopted the instrument for payment with little change. However, the adoption of the Uniform Data System for Medical Rehabilitation for the IRF PPS has presented several challenges for coders.

CMS provides reimbursement for inpatient rehabilitation facilities through case-mix groups. The classification system groups inpatient rehabilitation patients who are expected to use similar resources. Information collected on the IRF-PAI during the first three days of admission include the impairment, FIM score, and age of the patient, which are used to classify the patient into a case-mix group.

Each case-mix group has four payment tiers. A comorbidity that affects the cost of the rehabilitation admission is assigned to one of the payment tiers based on the cost of the resources to treat the comorbidity. Payment is based on the highest payment tier reported.

Multiple comorbidities assigned to payment tiers do not improve reimbursement. A comorbidity assigned to a payment tier should be sequenced within the first 10 comorbidities so it is reported on the IRF-PAI. A list of comorbidities assigned to a payment tier can be found on the CMS Web site.

Codes Reported on the IRF-PAI

Codes reported on the IRF-PAI include:

Impairment group. This code represents the condition that requires rehabilitation. There are 85 impairment group codes (IGCs).

Etiology. This is the condition responsible for the impairment reported with the IGC. A code for the acute condition responsible for the IGC should be reported. A code for history of the condition or a late effect of the condition is only reported when a prior inpatient rehabilitation program has been completed in an IRF for the same impairment.

Comorbidities. ICD-9-CM codes are assigned for additional conditions present on admission that are not reported by the IGC or the etiology.

Complications. ICD-9-CM codes are assigned for conditions that develop or are first discovered after admission to the facility. Complications must be reported as comorbidities to be considered in the assignment of the payment tier. Codes are not assigned for conditions that develop or are first identified the day prior to or the day of discharge.

Codes for procedures should not be reported on the IRF-PAI.

Code Assignment for the UB-04

The ICD-9-CM Official Guidelines for Coding and Reporting are used to assign codes reported on the UB-04. An IRF is considered a post-acute care facility, and conditions that are treated prior to admission to the IRF are reported with codes that include status post, history of, and late effects.

The first code reported for the principal diagnosis should be from the V57.xx series of codes, admission for rehabilitation procedures, which shows the reason for admission was for care involving rehabilitation procedures. The next code reported should be the reason the patient is receiving rehabilitation. This often represents the patient's impairment (e.g., hemiparesis, quadriparesis, aftercare following joint replacement). Additional codes are reported for comorbidities and complications.

A code for an acute condition is only reported if it is still present (e.g., multiple sclerosis) or is being treated (e.g., pneumonia still being treated with antibiotics). Codes are assigned for conditions first identified the day prior to or the day of discharge and for procedures performed during admission to the facility. However, codes are not assigned for conditions that are no longer present or that have been treated prior to admission.

The ICD-9-CM codes reported on the UB-04 do not affect Medicare reimbursement. A Health Insurance Prospective Payment System (HIPPS) code is assigned based on information reported on the IRF-PAI. The HIPPS code is reported on the UB-04 and determines the reimbursement for the case.

The 75 Percent Rule

To maintain its exemption from the DRG PPS, 75 percent of an IRF's inpatient population must require intensive rehabilitation therapy for one or more of 13 conditions. In 2004, CMS revised this criterion from 10 to 13 conditions and temporarily decreased the percentage that must meet the percent rule and compliance monitoring guidelines. A CMS transmittal available on its Web site indicates which IGC and ICD-9-CM codes affect meeting the 75 percent rule. Currently if these ICD-9-CM codes are reported as a comorbid condition, they will also count as presumptively meeting the rule until July 1, 2008.

The 75 percent rule poses another challenge for coders because codes assigned to a payment tier and codes listed as meeting the 75 percent rule are not all the same. Coders should have access to both sets of codes.

Challenges for the IRF Coder

Coders face a number of challenges coding in an inpatient rehabilitation facility. There is limited education and understanding for IRF-PAI coding. Instructions in the IRF-PAI training manual do not address ICD-9-CM code assignments and the use of the ICD-9-CM coding classification system. IRF-PAI guideline changes also are not included in the training manual on a timely basis.

Educational opportunities for coding requirements for the IRF PPS are limited and may be focused on just IGC assignment and not ICD-9-CM assignment. Current educational opportunities or consultations by a qualified instructor or consultant may be limited, as it is important to understand the coding classification system to provide these services.

The different coding guidelines for different forms can also prove confusing. Conditions reported on the IRF-PAI are not the same as conditions reported on the UB-04.

For example, conditions first discovered or identified on the day prior to or the day of discharge are reported on the UB-04 but not on the IRF-PAI. Conditions reported as acute by a short-term acute care hospital are reported as status post, late effects,

et cetera. This is confusing for coders that code for both an acute care hospital and a rehabilitation unit. The code reported on the UB-04 as the principal diagnosis, V57.89, admission for rehabilitation, is not reported on the IRF-PAI because it does not provide diagnostic information.

Documentation can also be an issue. Physician documentation does not always reflect documentation necessary for code assignment or provide information on the impairment or the etiology.

At the same time communication can prove problematic. Communication is necessary so the code for the etiology is consistent with the IGC. Take for example, a patient who is admitted following a CVA and a hip fracture. Either impairment could be reported by the IGC. If the hip fracture is reported as the impairment, the etiology should be reported with a code for hip fracture. Clinicians and coding professionals need to effectively communicate so sufficient documentation is available to support accurate code assignment.

What can the coder do? Coders should be proactive and actively monitor the CMS Web site for changes to the IRF PPS that could affect code assignment. Coders can also visit the AHIMA Coding Physical Medicine Rehabilitation Community of Practice for assistance with code assignment.

Coders should also keep an up-to-date toolbox that contains at a minimum:

- The current IRF training manual
- Current list of comorbid conditions
- Current list of conditions included in the 75 percent rule
- Final CMS regulations for the current year

Resource

Centers for Medicare and Medicaid Services. “Inpatient Rehabilitation Facility PPS.” Available online at http://www.cms.hhs.gov/InpatientRehabFacPPS.

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