Inpatient Rehabilitation PPS Presents New Challenges, Opportunities

by Patricia Trela, RHIA

As of January 1, 2002, inpatient rehabilitation facilities will implement the Medicare Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS). What is covered under this system, what data collection tool is used, and why are many facilities enthusiastic about the new system? This article answers these and other questions.

Published in the August 7, 2001, *Federal Register*, the long-anticipated final rule for the IRF PPS features an 85-item, rehabilitation-specific Functional Independence Measure (FIM). This replaces the data collection instrument included in the proposed rule published in 2000—the 350-item MDS PAC instrument. The IRF PPS is implemented for cost reporting periods beginning on or after January 1, 2002.

The system is designed to control increasing costs to the Medicare program with payment based on the characteristics of each patient admitted. Payment is based on discharge as the unit of measure, as it is for the Diagnostic Related Groups (DRGs) payment system. The IRF PPS is similar to the DRG payment system in that there is a single payment for each admission, and comorbid conditions can result in additional payment.

All costs of covered inpatient rehabilitation services are included. Each case is assigned to a case mix group (CMG) as determined from admission data captured on the patient assessment instrument (PAI). IRFs must collect patient assessment data using the IRF-PAI for Medicare Part A fee-for-service patients for patients admitted or discharged on or after January 1, 2002, although payment under the new system will not begin until the start of the IRF's cost reporting period in 2002.

Because of the delay in the effective date of the IRF PPS, IRFs will go directly to Year 2 of the phase-in to the PPS. Payment will consist of one-third of the current payment and two-thirds of the payment under PPS. Hospitals have the option of being paid 100 percent under PPS, effective for cost reporting periods beginning on or after January 1, 2002. If a facility decides to exercise this option, the IRF must send a written notification that is received by the Medicare fiscal intermediary at least 30 days in advance of the beginning of the first cost reporting period.

What Are the Criteria?

The IRF PPS applies to inpatient rehabilitation services furnished to Medicare Part A fee-for-service patients by Medicare participating rehabilitation hospitals or distinct part rehabilitation units in acute care hospitals. Veterans Administration hospitals, hospitals that are reimbursed under state cost control systems, and hospitals reimbursed by demonstration projects are not subject to the IRF PPS.

For example, to be classified as an IRF, a facility must have an inpatient population in which at least 75 percent of the patients require intensive rehabilitation services for one or more of the 10 conditions specified in the regulations—stroke, amputation, brain injury, spinal cord injury, major multiple trauma, hip fracture, polyarthritis, neuro disorders, burns, or congenital disorders.

The law requires classification of patient discharges from rehabilitation facilities by functional-related groups. The IRF PPS uses the patient's impairment, age, and functional status to determine the Rehabilitation Impairment Category (RIC). Comorbid conditions are used to determine the amount of the payment. Discharges are assigned to CMGs that are predictive of the estimated amount of resources required to treat patients within each CMG. The IRF PAI is used to collect the information necessary to classify patients into a CMG.

An Information-collecting Tool

The PAI consists of nine different types of patient information, including identification information, admission information, payer information, medical information, medical needs, function modifiers, the FIM instrument, discharge information, and quality indicators.

Accurate coding and reporting of these items is essential for correct Medicare payment. The PAI must be completed for each Medicare patient on admission and again at discharge. Information collected and reported on the PAI on admission is used to classify patients into a CMG.

How Are Patients Classified?

The first step in assignment of a CMG is determination of the RIC. One of the items on the PAI is the Rehabilitation Impairment Group (RIG). Eighty-five RIG codes are used to group an inpatient admission into a RIC. There are 21 RICs.

The RIG code consists of a two-digit ID number, a decimal point, and one to four digits representing the subgroups. This code represents the primary reason for admission to the IRF.

When multiple impairments are due to trauma, an impairment code that represents major multiple trauma should be selected. When two impairments meet the definition of the primary impairment, the RIG for either impairment can be reported. An impairment from a recently treated acute condition would generally be selected over an impairment resulting from a long-standing chronic condition. Documentation throughout the medical record should support the assigned impairment group code.

CMS provides grouper software free of charge. When the PAI is entered into the grouper, the software assigns the RIC based on the RIG assigned by the IRF.

The Functional Independence Measure

Rehabilitation facilities welcome the inclusion of the FIM as the instrument to measure a patient's functional status. The story of the FIM's creation goes back as far as the 1980s, when members of the rehabilitation community identified the need for a standardized instrument to measure the severity of a patient's impairments.

Today, about 75 percent of IRFs in the nation already use the FIM. Facilities also have the option of subscribing to the Uniform Data System for Medical Rehabilitation, which has one of the largest rehabilitation databases in the country, to process the data collected.

The FIM consists of 18 items measured on a seven-level scale that classifies patients according to their ability to perform certain activities. A score of "7" on an item indicates complete independence, and a score of "1" indicates complete dependence. An additional level reported with "0" was added to the PAI. An item is scored a "0" if the item is not assessed.

The instrument is intended to show what a patient actually does and not what the patient should be able to do. Any trained clinician can use the FIM to measure disability. However, facilities may find it beneficial to have specific disciplines score certain items.

Prior to implementation of the IRF PPS, many facilities that completed patient assessment instruments often had all items completed by clinicians who did not have formal training in assignment of ICD-9-CM codes.

Although these instruments were used to measure the severity of the case mix and the functional improvements made by the patients, the accuracy of the diagnosis codes was not an issue, as these assessment instruments had no effect on the payment received from the third-party payer.

Comparing the Codes

The IRF PPS requires assignment of ICD-9-CM codes by Day 4 of the inpatient admission, and the codes must be accurate for correct payment under the IRF PPS. Completion of the form requires ICD-9-CM codes for the etiology of the impairment, comorbidities, complications, and the reason for interruption or death. Guidelines for assignment of codes and the conditions reported on the PAI are not the same as conditions and guidelines used to report codes on the UB-92. The codes on the IRF-PAI and the UB-92 are not expected to match. (See "Comparing the Codes".)

A code for the principal diagnosis is not reported on the IRF PAI. A code is reported for the etiology of the problem that led to the condition that required the inpatient rehabilitation admission. The date of onset is the date that the condition reported as the etiology occurred. Instructions in the IRF-PAI training manual provide information on the date to report when the date is not known.

Coding Comorbid Conditions

Comorbid conditions are defined as conditions that coexist at admission. Other conditions that are documented during the rehabilitation stay should also be reported as comorbid conditions. Conditions that occur on the day of discharge or the day before discharge should not be coded and reported as a comorbid condition, as CMS has indicated that these conditions do not have a significant impact on the resources consumed during the entire rehabilitation stay. Codes for these conditions should be reported on the UB-92.

The presence of certain comorbid conditions can have a major effect on the cost of providing inpatient rehabilitation care. A list of comorbid conditions that affect the payment rate for the CMG can be found in Appendix C of the IRF-PPS final rule published in the *Federal Register* on August 7, 2001, and in the IRF-PAI training manual.

Certain comorbid conditions that are inherent to a RIC are excluded from the list of comorbidities for that RIC. The excluded RICs for each ICD-9-CM code are listed in the far right column on the list of comorbidities.

There are approximately 980 comorbid conditions that can affect the payment rate. The comorbidities are separated into three tiers based on the cost of resources used to treat the comorbid conditions. Costs associated with comorbid conditions listed in tier 1 are considered high, tier 2 are considered medium, and tier 3 are considered low.

The PAI includes space to report 10 comorbid conditions. Codes should be assigned for all comorbid conditions and reported as space allows. There are no specific sequencing rules for comorbid condition codes. However, for accurate CMG payment, codes for conditions that impact the CMG payment should be reported on the PAI. When more than one impactive comorbid condition is reported, payment is made based on the comorbid condition that assigns the case to the tier with the highest payment.

Coding Complications

Codes for complications that occur after admission should be reported both as a comorbid condition and a complication. This will provide CMS with the information necessary to make adjustments to the comorbid conditions assigned to the CMG payment tiers.

For patients who are transferred or expire during the stay, an additional item on the PAI allows facilities to report the ICD-9-CM code that represents the reason for transfer or death.

Code Confusion?

A frequent source of confusion is the fact that ICD-9-CM codes reported on the UB-92 and the IRF-PAI are not the same. Codes on the IRF PAI are used for research and for grouping a patient into a CMG and determining the payment tier.

Codes reported on the UB-92 are assigned based on coding guidelines. CMS has indicated that the principal diagnosis for an admission to an IRF should be reported with a code from the V57.xx series of codes. These codes recognize admissions for various types of rehabilitation services. Additional codes are assigned to represent the conditions that are treated, comorbidities, and complications.

If the etiology is reported, it is often reported with a code for a late effect as the etiology has already been treated or is no longer present. When assigning ICD-9-CM codes for the UB-92, the fiscal intermediary should be consulted, as each fiscal intermediary has specific guidelines for the codes they want reported and how the codes are sequenced. See “Comparing the Forms”.

Completion and Transmission of Data

Electronic transmission of the IRF-PAI is required. All items on the IRF-PAI must be completed before the data is transmitted to the Centers for Medicare and Medicaid Services (CMS), except for medical needs and quality indicators, as completion of this information is voluntary. The PAI must be encoded according to specific time guidelines, although a facility may change the data at any time prior to transmission if the data was incorrectly entered.

Data needs to be gathered, encoded, and electronically transmitted within strict time frames. The initial functional assessment includes information collected during the first three calendar days of admission. Admission assessments that are the basis for CMG assignment must be completed according to a specific timetable. See "Admission Assessment Timetable".

The IRF-PAI must be kept in paper or electronic format for five years. There will be Medicare compliance audits of the CMG assignments with review of the supporting medical documentation.

Case Mix Groups

Of the 100 case mix groups, 95 represent typical cases and 5 are for special cases. The 95 CMGs for typical cases are based on the clinical characteristics of the patient on admission. The CMG is assigned based on the RIC, initial functional status (motor and cognitive FIM scores), and age. Each of these CMGs has four payment rates. Comorbid conditions determine the payment rate. There is one rate for cases without a comorbid condition and three rates for cases with comorbid conditions to account for the cost of the resources required to treat the patient.

In addition, there are four CMGs for patients who expire that are based on whether the impairment treated was for an orthopedic or non-orthopedic condition and the length of stay. There is only one payment rate for each of these four CMGs.

One CMG is for short stays of three calendar days or fewer. There is only one payment rate for this CMG.

The first two digits of the CMG represents the number assigned to the RIC. The last two digits are assigned sequentially.

The CMG is reported on the UB-92 with a letter prefix. The first digit will indicate the payment tier that the CMG is to be paid (A for no comorbidities, B for Tier 1 comorbidities, C for Tier 2 comorbidities, and D for Tier 3 comorbidities). The next two digits represent the RIC, and the last two digits are for the sequential numbering within each RIC.

Payment Rates and Adjustments

Federal payment rates were established using a budget-neutral conversion factor. Relative payment weights that account for the difference in resource use across the CMGs are applied to the budget neutral conversion factor, and then facility and case-level adjustments are applied. Facility adjustments include the wage index, the percentage of low-income patients, and location in a rural area. Case-level adjustments include:

- **Interrupted stays**: the patient is discharged from the IRF and returns to the same facility within three consecutive calendar days. One CMG will be paid for the entire stay. The length of stay will include the days prior to the interruption and the days when the patient returned to the facility. One CMG will be paid for the stay based on the initial assessment.
  If the patient is transferred and returns from the acute hospital on the same day, the acute hospital will not receive a DRG payment and the costs of the acute care will be absorbed into the CMG payment. If the patient returns after midnight of the third calendar day, it is considered a new admission and a new PAI will need to be completed
- **Transfer cases**: the patient is transferred to an inpatient acute care hospital, another rehabilitation facility, a long-term care hospital, or a nursing home that is paid under the Medicare or Medicaid program. If the length of stay at the IRF is less than the average length of stay for the CMG, the case is paid on a per diem basis with the addition of a half day for the initial day of the stay. The per diem amount is calculated by dividing the CMG payment by the average length of stay. Payment is calculated by adding .5 to the length of stay and multiplying the result by the CMG per diem amount
- **Short stays**: admissions for three calendar days or less. There is one CMG for these cases
- **Death or end of benefits**: If the patient expires or runs out of Part A Medicare benefits during the inpatient admission, it is considered a discharge from the Medicare program and the discharge assessment must be completed based on the date of death or end of Medicare coverage

- **Cost outliers**: when the cost of a case exceeds an adjusted threshold amount, the case is considered a high cost outlier. The outlier payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold

What's on the To-Do List?

There will be challenges to face as administrators and chief financial officers look to HIM professionals to provide codes for the PAI. These include:

- **designing** a procedure for assignment of codes by the fourth calendar day of the admission
- **establishing** coding guidelines for assignment of the codes on the PAI
- **training** coders
- **meeting** the established timetables for collecting, recording, and transmitting data
- **coordinating** with the billing department as the CMG assignment must be reported on the UB-92
- **assessing** information systems for the ability to electronically transfer information to and from the PAI

The IRF PPS will also provide new opportunities for HIM professionals, as many facilities are considering the need for a CMG coordinator to be responsible for coordinating and reviewing the accuracy of the coding, completion and transmission of the PAI data on a timely basis to the Medicare program.

References

"Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities' Final Rule." 42 CFR Parts 412 and 413. *Federal Register* 66, no. 152 (August 7, 2001): 41316-41430.
"Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities; Proposed Rule." 42 CFR Parts 412 and 413. *Federal Register* 65, no. 214 (November 3, 2000): 66304-66442.
Medicare Inpatient Rehabilitation Facility Prospective Payment System for Medicare Fiscal Intermediaries, September 28, 2001.
IRF-PAI Training Manual, Interim Version, Revised 10/03/01.
Program Memorandum Intermediaries, Transmittal
A-01-110, September 14, 2001.

Comparing the Forms

ICD-9-CM Comparison: Patient admitted to acute care hospital for treatment of prostate cancer. During surgery sustained a subdural hemorrhage. Codes are as follows:

Hospital	PAI	Rehab UB-92
185 997.02 432.1	432.1	V57.89 438.21

Comparing the Codes

The codes on the IRF PAI and the UB-92 are not expected to match, as they are used for different purposes:

UB-92	IRF-PAI

Principal Diagnosis Secondary Diagnosis • Comorbid Conditions • Complications • Other conditions affecting the length of stay or outcome	Etiology Comorbid Conditions • Different weights for comorbid conditions

Admission Assessment Timetable		
Admission assessments that are the basis for CMG assignment must be completed according to a specific timetable.		
	Admission	Discharge
Observation Period	Days 1-3	Date of discharge or end of Medicare Part A fee-for-service coverage
Assessment Reference Date	Day 3	Date of discharge or discontinuation of covered services
Completion Date	Day 4	Day 5 following discharge or discontinuation of covered services
Encoded Date	Day 10	Day 7 following completion date [Count completion date as day 1]
Transmission Date	with discharge assessment	Day 7 following the encoded date
If data is transmitted late, payment will be reduced by 25 percent.		

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