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# Inpatient Rehabilitation Facility

# TOOLKIT

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## FOREWORD

As healthcare has evolved, patient care has narrowed in focus to provide increasingly specialized services. Inpatient rehabilitation facilities (IRFs) are one such service. This is a setting dedicated to improving the outcomes for all types of patients with physical difficulties, from simple joint replacements to congenital disabilities to those who have experienced a severe trauma. With the rapid growth in the past decade for this specialized care, the need for knowledgeable health information management (HIM) professionals has also grown. This toolkit provides useful resources and tools for HIM professionals working in an IRF or inpatient rehabilitation-designated unit in an acute care general hospital. The information in this toolkit will help the HIM professional who is just entering the workforce in this unique post-acute care setting, as well as the seasoned HIM professional and/or prospective payment system (PPS) coordinator in the IRF.

As more advances are made in technology and the desire for patient care to be provided outside of the acute care setting increases, the demand for HIM professionals in IRF and other post-acute care settings will continue to grow. This toolkit includes information related to the general duties of the HIM professional in the IRF and resources regarding coding and reimbursement differences between the IRF and other settings. It also includes the multiple uses of the IRF Patient Assessment Instrument (IRF-PAI), auditing and compliance in the IRF, and other setting-specific information.


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## BACKGROUND

Although physical therapists have been around for many years, the concept of physical medicine is more recent. In 1946, the American Medical Association (AMA) recognized the term "physiatrist" for physicians specializing in physical medicine and rehabilitation, and the American Board of Physical Medicine and Rehabilitation was incorporated and recognized the following year by both the AMA and the American Board of Medical Specialties.[1] With demands on the system such as the polio epidemic and the return of injured soldiers from war, the need for trained professionals, as well as hospitals, grew exponentially. These needs were not overlooked by the United States government. The Hospital Survey and Construction Act of 1946, also known as the Hill-Burton Act, provided federal funds to build hospitals across the country in exchange for those facilities providing free or reduced charges for care to the indigent. An amendment in 1954 expanded the Hill-Burton Act to include construction of rehabilitation facilities,[2] and President Eisenhower expanded Social Security benefits in 1956 to include disability insurance.[3] Both of these events led to improved care for those suffering from physical disabilities.

In 1983, cost-based payments for most hospital inpatient services were transitioned to a prospective payment system (PPS), which used Diagnosis Related Groups (DRGs) to identify a hospital's case mix and determine reimbursement. IRFs and rehabilitation units in hospitals were excluded from this system, but these facilities, and the number of patients receiving care in these facilities, continued to grow. Because of the resource-intensive services these patients needed, the cost of their care was escalating. To control these costs, Congress enacted section 4421 of the Balanced Budget Act of 1997, creating Section 1886(j) of the Social Security Act which authorized the creation of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). The final rule establishing the IRF PPS was published in the *Federal Register* on August 7, 2001.[4]

The Centers for Medicare and Medicaid Services (CMS) define an IRF as:

> Free standing rehabilitation hospitals and rehabilitation units in acute care hospitals. They provide an intensive rehabilitation program and patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day. [5]

Inpatient physical rehabilitation is hospital-level rehabilitation care provided in an acute setting, aimed at improving or restoring function, mobility, and independence to patients with disabilities resulting from injury or a medical condition. Inpatient rehabilitation is unique in that it requires a multifaceted care approach including medical, physical, occupational, speech, cognitive, behavioral, and social. It is an appropriate setting for patients with complex nursing, medical management, and physical rehabilitative needs. [6]

## HIM AND INPATIENT REHABILITATION—EVOLVING TOGETHER

HIM professionals have long been sought after as the subject matter experts in the field of health records, both in acute care facilities and post-acute facilities such as inpatient physical rehabilitation. HIM professionals are able to translate data into useful and meaningful information for multiple departments in a physical rehabilitation setting. They work closely with case managers, quality improvement staff, all therapists, providers, and administration in order to provide a range of translated data that ensures accuracy, integrity, and compliance of the legal health record, including the IRF Patient Assessment Instrument (IRF-PAI). No longer does the HIM professional simply gather the health record to assemble, analyze, and log deficiencies. The role of the HIM professional has evolved into a source of expertise in documentation, privacy and security, quality, compliance, coding, and information systems.

HIM professionals ensure the health record contains complete and accurate information to support the delivery of quality healthcare. They also play a major role in both the privacy and security of the health records and ensure accurate code assignment on both the IRF-PAI and the UB-04. With the increasing demand for data, the HIM professional is sought after for their knowledge and ability to abstract the necessary information for quality reporting, audits, performance improvement, and much more. In the IRF, the HIM professional is involved before the patient arrives in the unit and continues to monitor and track required documentation throughout the patient stay.

Traditional roles for HIM, such as a director or manager, coding professional, technician, and release of information specialist, are found in the IRF HIM department, but there can also be a unique position known as the PPS coordinator. Although specific responsibilities vary based on the needs of the IRF setting, the following criteria are the cornerstone of the PPS coordinator's role:

- Accurate IRF-PAI coding
- Documentation specificity of all disciplines to support medical necessity
- Staff education
- Ensuring compliance with CMS and other payer guidelines

Functions within the HIM department for an IRF may include:

- Coding of both IRF-PAI and claims
- Documentation improvement
- Data analysis to support decision making
- Coordination of the IRF-PAI completion and submission
- Qualitative and quantitative audits for medical necessity and deficiencies
- Release of information
- Appeals and denials management/coordination

## IRF REQUIREMENTS

Specific requirements for reimbursement under the IRF PPS are outlined in 42 CFR § 412.604 of the *Federal Register*.[7] The *Medicare Benefit Policy Manual* provides additional, more specific information as it relates to the regulations.[8] An IRF is for patients who have completed treatment in the acute care hospital and now require intensive therapy. For IRF care to be considered reasonable and necessary, the facility must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the facility:

- Requires the active and ongoing therapeutic intervention of multiple disciplines, one of which must be physical or occupational therapy. Multiple therapy disciplines (e.g., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics) must be actively involved in treating the patient throughout the IRF stay.
- Requires intensive rehabilitation therapy. Minimum therapy intensity can be demonstrated by at least three hours per day at least five days a week. Intensity may also be demonstrated by the provision of 15 hours in a seven-consecutive-day period starting from the date of admission, in certain well-documented cases. Documentation must clearly indicate the clinician's name, professional credentials, and the amount (in minutes) of each therapy service provided for each date.
- Must reasonably be expected to actively participate in and benefit from the IRF program. The patient's condition and functional status must be such that they can reasonably be expected to make measurable improvement participating in the intensive therapy program available at the IRF. The standard of care for IRF patients is individualized therapy (not group therapy).
- The patient's condition and/or status must require the level of physician supervision available in the IRF. The rehabilitation physician must conduct face-to-face visits with the patient at least three days per week throughout the patient's stay to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
- Requires an intensive and coordinated interdisciplinary approach to providing rehabilitation. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals. Each individual member of the team must work within their scope of practice and is expected to coordinate efforts to benefit the patient's progress and individual needs. Team conferences must be held at least once a week and the decisions made during these meetings, such as discharge planning, adjustments in goals or treatment program, must be recorded in the patient's health record. Documentation must also support that all required qualified team members are present at each interdisciplinary conference.

The means by which the above criteria are to be met are also outlined in the *Medicare Benefit Policy Manual* and include the following required documentation: [9]

### PRE-ADMISSION SCREENING

A comprehensive preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care. It must be conducted by qualified licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission.

The pre-admission screening documentation must indicate the patient's prior level of function (meaning prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, evaluation of the patient's risk for clinical complications, and the expected length of time necessary to achieve that level of improvement.

## POST-ADMISSION PHYSICIAN EVALUATION (PAPE)

The purpose of the PAPE is to document the patient's status after admission to the IRF, note any discrepancies when comparing to the patient's status documented in the pre-admission screening documentation, and then begin developing the patient's expected course of treatment that will be completed with input from all the interdisciplinary team members into the overall plan of care.

## INDIVIDUALIZED OVERALL PLAN OF CARE

The overall plan of care must be "individualized" to the unique care needs of the patient based on information found in the pre-admission screening, the post-admission physician evaluation, and what is collected in therapy assessments. The information must be integrated by a rehabilitation physician to support a documented overall plan of care that is completed and signed within four days of admission.

## ADMISSION PHYSICIAN ORDER

The physician must generate orders to admit the patient into the IRF. The orders must be retained in the patient's health record at the IRF and meet the signature requirements in *Medicare Program Integrity Manual*.[10]

## INTERDISCIPLINARY TEAM CONFERENCE

Although individual members of the interdisciplinary team work within their scope of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as the patient and the patient's caregivers.

At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines:

- A rehabilitation physician
- A registered nurse
- A social worker or a case manager
- A licensed or certified therapist from each discipline involved in treating the patient

## THE 60 PERCENT RULE AND PRESUMPTIVE COMPLIANCE

In addition to the required documentation to prove a patient needs IRF services, the IRF PPS also mandates that 60 percent of the patients receiving care during the facility's 12-month compliance review period fall into one of the 16 qualifying conditions listed below. Compliance with the 60 percent rule can be accomplished in two ways: presumptive compliance or health record review. The presumptive method is calculated by using CMS software that analyzes the IRF-PAI data submitted for the review period. The Medicare Audit Contractor (MAC) may also select random health records to calculate the compliance percentage. The Impairment Group Codes (IGCs) that meet presumptive compliance and the list of etiologic diagnoses for each that would cause the record to fail are listed in the data files on the CMS IRF PPS site. [11]

The 16 CMS qualifying conditions are:

- 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)

## IRF CODING AND REIMBURSEMENT

It is the rehabilitation physician's responsibility to clearly identify the primary reason for admission into the unit for patients they are treating. Accordingly it is extremely important that the IRF coding professional works very closely with all admitting providers, because inpatient rehabilitation coding is unique in that it involves coding two forms: the IRF-PAI and the UB-04. Although these forms are different, they must have the same clinical picture using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code set.

The IRF-PAI is an assessment tool that serves many purposes. The first three pages of this tool provide basic demographic, diagnostic, and functional information. The rest of the IRF-PAI is utilized for the IRF Quality Reporting Program (QRP), which is discussed later in this toolkit. The functional information is completed on both admission and discharge using the Functional Independence Measure (FIM™) which scores the patient's level of disability and aids in identifying the amount of resources necessary to care for the patient. The FIM score, along with the IGC, discussed below, determine the patient's case mix group (CMG).

ICD-10-CM Official Guidelines for Coding and Reporting are utilized to assign principal and secondary diagnosis codes reported on the UB-04 utilizing guidance for inpatient and rehabilitation.[12] It's important to note that the guidelines state that uncertain diagnoses (those documented as rule out, suspected, probable, etc.) at the time of discharge are NOT coded for the IRF encounter. ICD-10-CM codes are also reported on the IRF-PAI, but with some nuances. 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." [13]

### DRG VS. CMG

The DRG is the reimbursement method used in acute inpatient facilities. The method of DRG grouping is a method of case mix adjustments which are used to implement prospective payment to reimburse hospitals for Medicare and other PPS insurers for patients in the USA. Each DRG is associated with a per-case payment amount. The DRGs are comprised from the principal diagnosis, whether the patient is medical or surgical, CCs and MCCs (major comorbidities and complications), and age and discharge status.

CMG is the reimbursement method used in the IRF. CMG grouping is a methodology which characterizes patients based on the type, scope, and extent of inpatient services needed to diagnose and treat their medical condition. CMGs are comprised of age, motor score, and cognitive scores. CMGs are then grouped by comorbidities that increase the cost of care according to CMS.

CMGs are similar to DRGs as both are affected by CCs and MCCs or tiered comorbidities. Both DRGs and CMGs affect the length of stay (LOS) along with reimbursement.

## SELECTION OF ETIOLOGIC AND PRINCIPAL DIAGNOSES

| EXAMPLE 1 | |
|---|---|
| Reason for Admission: Cerebral Infarction 2/2 occlusion of left cerebral artery—right hemiplegia and oropharyngeal dysphagia | |
| UB-04 Principal Diagnosis | IRF-PAI Etiologic Diagnosis |
| • I69.351—Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side | • I63.50—Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery |
| ***Rationale:*** *This patient was admitted to the IRF for therapy related to the hemiplegia. The hemiplegia due to the cerebral infarction is the principal diagnosis that would be reported on the UB-04. For the IRF-PAI etiologic diagnosis, the cerebral infarction is "the problem that led to the impairment" that caused the patient to need services in the IRF.* | |

| EXAMPLE 2 | |
|---|---|
| **Reason for Admission:** A patient with difficulty walking is admitted to inpatient rehabilitation after discharge from the acute care facility status post bilateral total knee arthroplasty for treatment of osteoarthritis in both knees. The patient is admitted to the IRF for rehabilitative services, including physical therapy and surgical aftercare. | |
| UB-04 Principal Diagnosis | IRF-PAI Etiologic Diagnosis |
| • Z47.1 Aftercare following joint replacement surgery | • M17.0 - Bilateral primary osteoarthritis of knee |
| ***Rationale:*** *This patient was admitted to the IRF for therapy related to the joint replacement. In this case, there is an aftercare code that can be utilized as the principal diagnosis on the UB-04. The joint replacement was done because the patient had bilateral osteoarthritis, which is the etiologic diagnosis reported on the IRF-PAI.* | |

| EXAMPLE 3 | |
|---|---|
| **Reason for Admission:** A patient was admitted to the IRF following surgical treatment of a comminuted traumatic fracture of the shaft of the left femur. The patient was admitted to the IRF for rehabilitative services, including physical and occupational therapy. | |
| UB-04 Principal Diagnosis | IRF-PAI Etiologic Diagnosis |
| • S72.352D – Displaced comminuted fracture of shaft of left femur, subsequent encounter | • S72.352A – Displaced comminuted fracture of shaft of left femur, initial encounter |
| ***Rationale:*** *This patient was admitted to the IRF for therapy related to the femur fracture. In this case, the principal diagnosis on the UB-04 is the subsequent encounter for the fracture. On the IRF-PAI, the etiologic diagnosis would be the initial encounter for the fracture because the acute inpatient hospital stay was the initial encounter for the fracture, and the fracture led to the need for IRF services.* | |

## IMPAIRMENT GROUP CODE AND ETIOLOGICAL DIAGNOSIS CODE SELECTIONS

As stated above, the etiologic diagnosis indicates the condition that caused the need for IRF services, but it should also reflect the condition that is represented by the IGC. The IGC is defined by CMS in the IRF-PAI Training Manual as "the primary reason that the patient is being admitted to the rehabilitation program and relates directly to the goals of the rehabilitation program."[14] Each group incorporates patients that have similar resource consumption, much like the major diagnostic categories (MDCs) in the DRGs. There are 17 impairment groups identified by a two-digit code. Most are further broken down into subcategories that appear following a decimal placed after the two-digit impairment group. The list of IGCs is:

01—Stroke
02—Brain Dysfunction
03—Neurologic Conditions
04—Spinal Cord Dysfunction
05—Amputation of Limb
06—Arthritis
07—Pain Syndromes
08—Orthopedic Disorders
09—Cardiac
10—Pulmonary Disorders
11—Burns
12—Congenital Deformities
13—Other Disabling Impairments
14—Major Multiple Trauma
15—Developmental Disability
16—Debility
17—Medically Complex Conditions

The IRF-PAI Training Manual, Section 6, provides a crosswalk of IGCs and potential etiologic diagnoses.[15] However, this list is not all inclusive. It also provides information about which Rehabilitation Impairment Category (RIC) the IGCs are assigned to. CMS defines the RIC as "the highest level of classification for the payment (Case Mix Group) categories. The RIC is not recorded on the IRF-PAI but is assigned by the software based on the admission impairment group code."[16]

When the completed IRF-PAI is processed, it is grouped by the CMG grouping software. The CMG must be included on the UB-04.

Going back to our previous examples of the etiologic diagnosis versus the principal diagnosis, the examples have been expanded to include the IGC and the RIC each case would be assigned.

| EXAMPLE 1 | |
|---|---|
| Reason for Admission: Cerebral Infarction 2/2 occlusion of left cerebral artery - right hemiplegia and oropharyngeal dysphagia | |
| UB-04 Principal Diagnosis | IRF-PAI Etiologic Diagnosis |
| • I69.351—Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side | • I63.50—Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery |
| • Impairment Group: STROKE (01)<br>  • IGC: 01.2 Right Body (Left Brain)<br>  • RIC: Stroke (01)<br>*NOTE: Sequela of cerebrovascular disease is used only when an acute inpatient program has been completed for the same stroke prior to the current admission to the IRF, per IRF-PAI instructions.* | |

| EXAMPLE 2 | |
|---|---|
| Reason for Admission: A patient with difficulty walking is admitted to inpatient rehabilitation after discharge from the acute care facility status post bilateral total knee arthroplasty for treatment of osteoarthritis in both knees. The patient is admitted to the IRF for rehabilitative services, including physical therapy and surgical aftercare. | |
| UB-04 Principal Diagnosis | IRF-PAI Etiologic Diagnosis |
| • Z47.1 Aftercare following joint replacement surgery | • M17.0 - Bilateral primary osteoarthritis of knee |
| • Impairment Group: ORTHOPEDIC DISORDERS (08)<br>  • IGC: 08.62 Bilateral Knee Replacements<br>  • RIC: Replacement Lower Extremity Joint (08)<br>*NOTE: If replacement is secondary to arthritis, use the appropriate Orthopedic Impairment Group code in item 21 but with an arthritis ICD-10-CM code(s) for Etiologic Diagnosis in Item 22* | |

| EXAMPLE 3 | |
|---|---|
| Reason for Admission: A patient was admitted to the IRF following surgical treatment of a comminuted traumatic fracture of the shaft of the left femur. The patient was admitted to the IRF for rehabilitative services, including physical and occupational therapy. | |
| UB-04 Principal Diagnosis | IRF-PAI Etiologic Diagnosis |
| • S72.352D—Displaced comminuted fracture of shaft of left femur, subsequent encounter | • S72.352A—Displaced comminuted fracture of shaft of left femur, initial encounter |
| • Impairment Group: ORTHOPEDIC DISORDERS (08)<br>  • IGC: 08.2 Femur (Shaft) Fracture<br>  • RIC: Fracture of Lower Extremity (07)<br>*In this example, you can see how a patient can be in a certain impairment group but also fall into a different RIC than other cases that may fall into the same impairment group. Examples 2 and 3 both fall into IG 08, but they have different RICs.* | |

## CODING COMORBID CONDITIONS AND COMPLICATIONS

In addition to identifying both the etiologic diagnosis and the principal diagnosis, all secondary diagnoses are coded as per the ICD-10-CM Guidelines for Coding and Reporting; however, there is a caveat. 17 Comorbid conditions are entered in item 24 of the IRF-PAI and are any conditions the patient has on admission to the IRF that impact the patient's stay. Complications are those conditions that arise during the IRF stay and were not present on admission. These codes are listed in item 47 of the IRF-PAI and can also be listed in item 24 (Comorbid Conditions). If a condition arises, whether it is a comorbidity or a complication, it cannot be coded on the IRF-PAI if it occurred the day before discharge or the day of discharge but should be coded on the UB-04 according to ICD-10-CM guidelines.

CMS has included in the data files a list of comorbidities that are tiered based on the resource cost to treat the diagnosis.[18] This list used to be labeled as Appendix C of the IRF-PAI Training Manual. It is now located in the IRF PPS Final Rule Data Files.[19] A diagnosis on this list can be a tier 1, 2, or 3 and can result in an increase in reimbursement for a CMG. Tier 1 diagnosis codes provide the highest level of adjustment and include diagnoses that indicate, for example, the patient has a tracheostomy or is on dialysis. Tier 2 diagnoses do not increase reimbursement as much as a tier 1, but include diagnoses for more resource-intensive conditions such as *Clostridium difficile* enterocolitis and some of the dysphagia codes. There are very few tier 1 and 2 diagnoses, but there are a significant number of tier 3 diagnoses. These are the lowest of the tiered comorbidities, but they still provide an increase in reimbursement over a non-tiered CMG.

Also included in this same data file is a column titled RIC Exclusion that lists any RIC that a tiered comorbidity is excluded from. In the table below, the example of the tier 1 diagnosis, dependence on renal dialysis, shows that it is not excluded from any RIC. Therefore, this code will always allow for the highest reimbursement for its CMG. The tier 2 diagnosis of aphagia can be coded for a patient who has a stroke (RIC 01), but it will not affect reimbursement for that case because of the exclusion. If a patient with aphagia is placed in a different RIC, such as traumatic brain injury (RIC 02), then the case would be reimbursed at a tier 2 CMG because of the aphagia diagnosis. Finally, the tier 3 diagnosis for the infected knee prosthesis, initial encounter, would not be reimbursed at the higher CMG for a patient placed in RIC 08, Replacement Lower Extremity, but would if the RIC was one of the Major Multiple Trauma (RIC 17 or 18).

| Code | Code Description | Tier | RIC Exclusion |
|---|---|---|---|
| Z99.2 | Dependence on renal dialysis | 1 | — |
| R13.0 | Aphagia | 2 | 01 |
| T84.54XA | Infection and inflammatory reaction due to internal left knee prosthesis, initial encounter | 3 | 08 |

When sequencing comorbidities, the best practice is to place the highest tiered diagnoses closer to the top of the list.

The third and final item on the IRF-PAI that requires an ICD-10-CM code is item 46. Should the patient have an interruption in their IRF stay or expire in the IRF, the diagnosis that caused the interruption or patient death should be listed in item 46. An interrupted stay is when the patient is discharged from the IRF and returns within three calendar days. If the patient has an interrupted stay, all information needs to be updated, but the documentation requirements for medical necessity do not have to be completed again, (e.g., the pre-admission screening, the post-admission physical exam, etc). If the patient is out of the IRF for four or more consecutive calendar days, the patient is to be discharged, and all required documentation should be re-done.

## CLINICAL DOCUMENTATION IMPROVEMENT

Clinical documentation improvement (CDI) in the IRF has grown with increasing effectiveness. The continuous efforts between CDI, PPS coordinator, coding professional, and the providers to create high-quality documentation are the cornerstone to compliance. Through high-quality documentation, the coding professional can capture the accurate IGC.

### CRITERIA FOR HIGH-QUALITY CLINICAL DOCUMENTATION

The characteristics of high-quality clinical documentation discussed in Pamela Hess's book *Clinical Documentation Improvement: Principles and Practice* are:[20]

- Legible
- Reliable
- Precise
- Complete
- Consistent
- Clear
- Timely

42 CFR 482.24(c)(1) reflects this "gold standard" for clinical documentation.[21]

CDI in the IRF setting can be an interdisciplinary team comprised of nurses, HIM professionals, case managers, PPS coordinators, and a physician champion. The team reviews the physician documentation as well as nursing and therapy documentation to determine if the patient is progressing in therapy with the required intensity. CDI may review the physician's documentation for clinical indicators without a definitive diagnosis, as well as to ensure the physician is meeting the documentation requirements mandated by CMS. The physician is required to conduct three face-to-face visits per week to assess the patient's progress both medically and functionally according to CMS. The physician must document in the progress notes the patient's functional level and any barriers to the discharge plan. Any barriers the patient is experiencing during the rehabilitation stay will be discussed during the interdisciplinary team meeting along with any medical issues.

CDI performs concurrent record review and attends interdisciplinary team meetings to ensure any complications or changes to the patients care and status are documented in the medical record. For example, during the interdisciplinary team meeting each discipline has an opportunity to discuss the patient's function and barriers. The physician leading the interdisciplinary team meeting will have input and give direction to the team to ensure the patient meets therapy intensity while managing the care of the patient. Often there is a discussion regarding a new finding or a concern from nursing and/or therapy. CDI has an opportunity to perform a verbal query for clarification regarding a diagnosis of malnutrition discussed by the dietician ensuring the physician provides specificity in the documentation. The dietician discusses with the team that the patient is not eating well and has severe protein malnutrition. The physician agrees with the dietician and states the patient is "malnourished" which is also documented in the record. CDI can record the interaction and perform a record review to ensure the physician documented what was discussed in the interdisciplinary team meeting.

## SAMPLE CDI PROCESS FOR IRF

The CDI specialist may begin record review upon admission to ensure the history and physical (H&P) includes specificity needed to capture the correct IGC. For example:

> H&P Reason for Admission: 86-year-old male admitted to rehab for functional decline due to left femoral neck fracture. Open reduction and internal fixation completed at the acute care facility. Patient will receive intensive physical and occupational therapy to increase functional mobility due to increased risk of falls.

The CDI specialist would query the physician for specificity regarding the femoral fracture to ensure the correct IGC.

CDI specialists also review records concurrently for any opportunities to capture tiered comorbidities, as well as any secondary condition listed, to ensure it is being treated during the patient's stay. Capturing tiered comorbidities during the patient's stay rather than after discharge is imperative. The tiered comorbidity may increase the number of days the patient can remain in the IRF setting to reach their mobility goals.

Successful CDI programs in the IRF setting are accomplished through collaboration with multiple health professionals and constant communication regarding the patient's status. The physician champion will provide education to the physicians regarding areas identified through CDI communication, identified trends, and any lacking documentation issues affecting patient care and compliance.

## QUERIES

A query on IRF health record services may be necessary to obtain additional clarifying documentation to improve the specificity and completeness of the documentation to ensure accurate coding and documentation. Queries may be issued concurrently (while the patient is still "in house") or retrospectively (after the patient has been discharged from the facility or unit). To promote consistencies in documentation, it is best practice to use query templates. Below is a sample template that would become part of the health record, for clarification on an etiological diagnosis:

*Dear Provider,*

*TBI w/ + LOC was documented as the reason for admission on the H&P. If the duration of the loss of consciousness is known, can you please provide that information below?*

- *30 minutes or less*
- *31 to 59 minutes*
- *1 hour to 5 hours 59 minutes*
- *6 to 24 hours*
- *>24 hours with return to pre-existing conscious level*
- *>24 hours without return to pre-existing conscious level*
- *Other, please specify_____*
- *Unable to determine*

Only the clinically appropriate options for the individual patient are provided to the physician to choose from. "Other" and "clinically unable to determine" are always provided as options to the physician in the event they are unable to determine the appropriate diagnosis or another diagnosis applies that is not listed within the query. By obtaining clarification regarding the duration of loss of consciousness for the patient, the case is then considered compliant.[22]

Below are additional common query samples that could be used in an IRF when further clarification is necessary:

*Dear Provider,*

*Based on H&P and Progress Note documentation, "Patient was the driver during a MVC on 12/15 and suffered a T6 unstable burst fracture with spinal cord injury."*

*Please further clarify the spinal cord injury for your patient:*

- *Complete lesion*
- *Incomplete lesion NOS*
- *Anterior cord syndrome*
- *Brown-Sequard syndrome*
- *Posterior Cord Syndrome*
- *Other, please specify* _____
- *Unable to determine*

*Dear Provider,*

*Based on H&P documentation, "Hx significant for thoracic spinal stenosis w/ myelopathy, s/p T4-T7 laminectomy."*

*Please clarify if the following diagnoses are still present and are being treated for your patient:*

- *Thoracic spinal stenosis still present and being treated*
  - ☐ *Yes* _____
  - ☐ *No* _____
  - ☐ *Other* _____
  - ☐ *Clinically Undetermined* _____
- *Myelopathy still present and being treated*
  - ☐ *Yes* _____
  - ☐ *No* _____
  - ☐ *Other* _____
  - ☐ *Clinically Undetermined* _____

## COMPLIANCE

According to the Supplementary Appendices for the Medicare Fee-for-Service (FFS) 2015 Improper Payments Report, the improper payment rate for Inpatient Rehabilitation Hospitals was 55.7 percent, which accounted for a projected $1.1 billion in Medicare FFS improper payments. [23] Inpatient rehabilitation units accounted for a projected $605 million in Medicare FFS improper payments, with an improper payment rate of 34.4 percent.

In 2017, CMS started to analyze Medicare claims for calendar years 2014 and 2015, finding a significant increase in billing and payment for IRF services. CMS then retained Supplemental Medical Review Contractors (SMRC) to conduct the health record review of selected Medicare Part A and Part B claims.

Many of the claim denials or adjustments from the SMRC reviews were due to incomplete or missing technical data which included the following reasons and references to the *Medicare Benefit Policy Manual*:[24]

| |
|---|
| The documentation submitted for review did not support a valid preadmission screening as the preadmission screening was completed after admission and physician review occurred after admission (Pub. 100-02, Chapter 1, 110.1.1). |
| The documentation submitted for review did not support a valid post-admission physician evaluation as the beneficiary's prior functional condition was not reviewed (Pub. 100-02, Chapter 1, 110.1.2). |
| The documentation submitted for review did not support a valid individualized overall plan of care as the overall plan of care did not include the physiatrist's signature, an estimated length of stay, medical prognosis, anticipated interventions or discharge destination (Pub. 100-02, Chapter 1, 110.1.3). |
| The documentation submitted for review did not include the required IRF admission orders. When the beneficiary is admitted to the IRF, a physician must generate admission orders for the beneficiary's care. These admission orders must be maintained in the beneficiary's health record. The admission order is invalid if the physician did not sign the order (Pub. 100-02, Chapter 1, 110.1.4). |
| The documentation submitted for review did not support the beneficiary required active and ongoing intensive therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational therapy (Pub. 100-02, Chapter 1, 110.2.1). |
| The documentation submitted for review did not support the beneficiary required an intensive rehabilitation therapy program (Pub. 100-02, Chapter 1, 110.2.2). |
| The documentation submitted for review did not support valid team conference(s) as the team conference (2) did not include a discussion of barriers impeding progress toward goals and possible resolutions. The team conference did not include the names and professional designations for the physiatrist, physical therapy, occupational therapy, case management or nursing representatives (Pub. 100-02, Chapter 1, 110.2.5). |

CMS has noted that the most common IRF service errors involve claims that include one or more of the following deficiencies:

- Documentation that does not support medical necessity
- Missing, incomplete, or illegible signatures
- Coding errors

Therefore, to prevent improper payments to the Medicare program, IRF facilities need to make sure that the following documentation components are compliant and retained in the IRF health record.

## MEDICAL NECESSITY

Based on each patient's individual care needs, a determination is made as to whether the IRF stay is reasonable and necessary. According to the Medicare Benefit Policy Manual, Section 110.2, documentation in the patient's IRF health record must demonstrate a reasonable expectation that the following are met at the time of admission:[25]

*"The patient must:*

- *Require active and ongoing intervention of multiple therapy disciplines (Physical Therapy [PT], Occupational Therapy [OT], Speech-Language Pathology [SLP], or prosthetics/orthotics), at least one of which must be PT or OT;*
- *Require an intensive rehabilitation therapy program, generally consisting of:*
  - *Three hours of therapy per day at least five days per week; or*
  - *In certain well-documented cases, at least 15 hours of intensive rehabilitation therapy within a seven-consecutive day period, beginning with the date of admission;*
- *Reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program (the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement, expected to be made within a prescribed period of time and as a result of the intensive rehabilitation therapy program, that will be of practical value to improve the patient's functional capacity or adaptation to impairments);*
- *Require physician supervision by a rehabilitation physician, with face-to-face visits at least three days per week to assess the patient both medically and functionally and to modify the course of treatment as needed; and*
- *Require an intensive and coordinated interdisciplinary team approach to the delivery of rehabilitative care."*

Keep in mind that commercial payers may have different medical necessity requirements than Medicare, so be sure to check specific payer documentation requirements.

## DOCUMENTATION

The IRF patient's health record must contain the following documentation:[26]

1. **Preadmission screening**
2. **PAPE**
3. **Individualized overall plan of care**
4. **Required admission orders**

1. **Preadmission screening** is a comprehensive assessment of the patient's condition/disease process requiring rehabilitation therapy and medical treatment. The following items are required for this document:
   - Conducted by a licensed or certified clinician(s) (appropriately trained to assess the patient medically and functionally)
   - Completed within the 48 hours immediately preceding the IRF admission
     - If greater than 48 hours prior to admission, a reassessment must be done
   - Reviewed, signed, and dated by the rehabilitation physician prior to admission to the IRF

The documentation in the preadmission screening must validate that the patient requires and will benefit significantly from the IRF admission and is able to actively participate in the intense therapy required. The following must be included in the documentation:

- Specific details leading clinical staff to determine IRF admission is reasonable and necessary
- Patient's prior level of function
- Patient's expected degree of improvement
- Patient's expected LOS to reach expected degree of improvement
- Evaluation of patient's risk for complications
- Therapeutic disciplines needed
- Expected frequency and duration of treatment in the IRF
- Expected discharge disposition
- Anticipated post-discharge treatments
- Any and all other care needs of the patient relevant to the IRF stay

2. The **PAPE** is used to document the patient's status on admission to the IRF with the following requirements:
   - Must be performed by a rehabilitation physician
     - Completed within 24 hours after admission to the IRF
     - Identify changes that occurred between time of preadmission screening and time of PAPE
     - Support medical necessity
     - Dated, timed, and authenticated
   - Include an H&P that includes prior and current medical and functional conditions
     - Can be completed by a physician extender
     - If completed by a physician extender, rehabilitation physician must still see the patient complete required information

The discharge process must start immediately if the PAPE does not support IRF services.

3. **Individualized overall plan of care** is compiled by the rehabilitation physician from the preadmission screening, PAPE, and assessments of all disciplines treating the patient, and must:
   - Be completed within the first four days of the IRF admission
   - Support medical necessity
   - Detail patient's prognosis and interventions based on impairments, functional status, and other conditions or contributing factors, including:
     - Expected intensity (number of hours per day)
     - Expected frequency (number of days per week
     - Expected duration (LOS in the IRF)
   - Detail functional outcomes
   - Expected discharge disposition

4. **Admission orders** must be generated by a physician or by physician extenders working in collaboration with the physician at the time of admission and retained in the patient's IRF health record.

5. **IRF-PA**I is an assessment tool used to gather data to determine the reimbursement for each Medicare Part A FFS patient admitted to an IRF and must be retained in the patient's IRF health record (in either electronic or paper format).

# AUDITING AND MONITORING

## EXTERNAL AUDITING (GOVERNMENTAL REVIEWS)

It is not a matter of "if" but "when" a governmental or nongovernmental audit will occur. The decision to admit a patient to an IRF is an important component to determine whether the admission is reasonable and necessary. In an IRF, for example. it is all about managing the LOS and assigning the most accurate CMG to reflect the longest LOS possible, based on the patient's conditions. Monitoring the discharge disposition is also key, especially if the patient is discharged to a SNF because it affects the amount of reimbursement the IRF will receive. Therefore, it is crucial for IRFs to conduct internal reviews in order to decrease denials from external auditors. The requirements outlined in the Compliance section of this toolkit are necessary to avoid denials and should also include:[27]

- Multiple therapy disciplines
- Intensive level of rehabilitation services
- Ability to actively participate in the intensive rehabilitation programs
- Physician supervision (face-to-face visits at least three times a week)
- Interdisciplinary team approach to the delivery of IRF care

A vital step in preparing for possible external audits is to implement an ongoing internal monitoring review of the IRF health records.

## ONGOING INTERNAL REVIEW

A common mantra in the compliance world is: "Find your risks/opportunities for improvement before someone else does." It is imperative that IRFs have a comprehensive, ongoing compliance program. Best-practice facilities will avoid denials from government and non-government payers. In fact, the Office of the Inspector General (OIG) Supplemental Compliance Program Guidance for Hospitals asks, "Has the Hospital developed a risk assessment tool, which is re-evaluated on a regular basis, to assess and identify weaknesses and risks in operations?" [28]

When developing compliance tools to use during internal reviews, it is important to keep in mind that IRFs have unique compliance risks which will need to be included in the monitoring. Appendix C includes various sample compliance audit tools to consider utilizing when implementing an internal monitoring program.

The reasons for implementing an internal monitoring program include:

1. To ensure you are providing the best possible care to patients, in accordance with professional and governmental standards
2. To mitigate risks that are most damaging to the finances/reputation of the organization, especially those discovered by external enforcement agencies
3. To select the risk options and be aware of any expenditures not directly related to patient care

Internal risks are those that exist within the organization due to weaknesses in policies, procedures, systems, and personnel. Most organizations learn about internal risk through external audits/denials and by observing daily interaction and compliance with policies and procedures. Remember that internal risks are unique to every organization and that risks need to be identified and recounted when prioritizing and considering overall risk to the organization.

Mount Sinai Rehabilitation Center in New York City has developed the following steps to monitor compliance within their IRF: [29]

- IRF PPS staff review all cases upon admission for timely completion of the pre-admission screen, the PAPE, and the individualized plan of care.
- Select a number of cases to review for timeliness of the team conference note, which continues throughout the patient stay.
- Review of admissions is categorized by physician for ease of communication.
- IRF PPS coordinators communicate with physicians on an ongoing basis.
- IRF PPS coordinators record reasons for noncompliance after communicating directly with physicians.
- Monitoring results are shared on a monthly and quarterly basis with physicians during leadership meetings.

As a facility develops or improves an internal monitoring program, it would be beneficial to refer to the Compliance section of this toolkit to ensure all elements are included in the audit tool.

## QUALITY MEASURES AND REPORTING INITIATIVES

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized CMS to incentivize hospital quality reporting. Initially, hospitals were penalized 0.4 percentage points in the annual market basket update if the required quality measures were not reported, but this reduction later grew to 2.0 percentage points. Beginning Fiscal Year (FY) 2015, the American Recovery and Reinvestment Act (ARRA) of 2009 and the Affordable Care Act (ACA) of 2010 mandated that "reduction would be one-quarter of such applicable annual payment rate update if all Hospital Inpatient Quality Reporting Program requirements" were not met.[30] Additionally, a public comparison site was created to make the results of certain measures available to consumers. The intent was to help consumers make informed decisions about where to go for care and to encourage facilities to provide quality care to their patients.

The quality reporting program continued to expand to other settings and was required for all IRFs beginning FY 2012. To capture the quality measures, the IRF-PAI was expanded to allow for electronic submission of the data required for pressure ulcers, but a separate reporting process was needed for catheter associated urinary tract infections (CAUTI). All data submission for CAUTIs had to be reported to the Centers for Disease Control and Prevention through the National Healthcare Safety Network (NHSN) website.

Over time, the number of quality measures grew. Some were, again, additions to the IRF-PAI form and others submitted to NHSN. Still other data was gathered via claims. Then another piece of legislation required data for quality purposes but with the intent of enabling interoperability and improving access to longitudinal patient information. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which required standardized patient assessment data to be submitted by long-term care hospitals, SNFs, home health agencies, and IRFs. Many of the goals and initiatives were in line with the CMS triple aim to improve care, reduce costs, and improve population health.[31]

There are currently 19 quality measures to be reported by IRFs. For more information on the quality reporting program and the IMPACT Act, the CMS IRF QRP website provides a wealth of information, including training and standards manuals. [32]

## PEPPER REPORTS

The Program for Evaluating Payment Patterns Electronic Report or "PEPPER" is a free educational tool generated by CMS that began distribution to IRFs in 2011. The reports include data for three previous years, for example, the fourth quarter 2016 report included data for discharges between October 1, 2013 and September 30, 2016, or for federal fiscal years 2014, 2015, and 2016.

PEPPER Reports is an important resources for IRFs. The information on the report is useful to identify and address target areas that may put facilities at risk for overpayment. Target areas include:

- Miscellaneous CMGs
- CMGs at risk for unnecessary admissions
- Coding errors
- Outlier payments
- Short-term acute care hospital admissions following discharge

The reports are based on paid claims and billing rates in high-risk areas. They are designed to help hospitals, hospices, inpatient psychiatric and rehabilitation facilities, and partial hospitalization programs tailor their compliance monitoring to risk areas with greater potential for overpayments and underpayments.

PEPPER Reports compare a provider's Medicare billing practices with other similar providers in the state, MAC jurisdiction, and nation. They provide a red flag when billing in a risk area is at or above the 80$^{th}$ percentile, which means the provider bills a higher percentage for that risk area than most providers nationally. That doesn't necessarily mean an error was made, but it's up to the provider to determine whether there is a compliance issue versus some reasonable explanation.

IRF PEPPERs are released annually on or about April 16, each year. Access to a PEPPER report depends on the type of IRF:

- **Free-standing IRFs:** Available electronically to the IRF's CEO, president, administrator, or compliance officer via the PEPPER Resources Portal. You will need to enter your six-digit CMS Certification Number (also referred to as Provider Number or PTAN). The third digit of this number will be a "3."
- **IRF Distinct Part Units of short-term acute care and critical access hospitals:** Available electronically via QualityNet Portal.

More information can be found in the "PEPPER: Inpatient Rehabilitation Facility Program for Evaluating Payment Patterns Electronic Report."

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# APPENDIX A: GLOSSARY AND ABBREVIATIONS

## GLOSSARY OF TERMS

**Case Mix Group (CMG):** A patient classification system that groups together inpatient medical rehabilitation patients who are expected to have similar resource utilization needs and outcomes.[1]

**Comorbidity:** A patient comorbidity is defined as a secondary condition a patient may have in addition to the primary diagnosis for which the patient was admitted to the IRF.[2]

**Complication:** A specific patient condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category, and which began after the rehabilitation stay started.[3]

**Etiologic Diagnosis:** The etiologic problem that led to the impairment for which the patient is receiving rehabilitation.[4]

**FIM™ Instrument:** The functional assessment instrument included in the Uniform Data Set for Medical Rehabilitation.[5]

**Impairment:** Any loss or abnormality of psychological, physiological, or anatomical structure or function.[6]

**Impairment Group Code (IGC):** Describes the primary reason that the patient is being admitted to the rehabilitation program and relates directly to the goals of the rehabilitation program.[7]

**Individualized Plan of Care:** The individualized overall plan of care is synthesized by the rehabilitation physician from the preadmission screening, post-admission physician evaluation, and information garnered from the assessments of all disciplines involved in treating the patient.[8]

**Inpatient Physical Rehabilitation:** Inpatient physical rehabilitation is hospital-level rehabilitation care provided in an acute setting, aimed at improving or restoring function, mobility, and independence to patients with disabilities resulting from injury or a medical condition.[9]

**Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI):** A document that contains clinical, demographic, and other information on a patient in an inpatient rehabilitation facility.[10]

**Interrupted Stay:** A patient that is discharged from the IRF and returns to the same IRF within three consecutive calendar days. Since Medicare treats this situation as one combined IRF stay, the IRF would not need to repeat all the required documentation when the patient returns to the IRF after the interruption.[11]

**Length of Stay (LOS):** The number of days a patient spends in the rehabilitation program. The day of discharge is not counted in the length of stay calculation.[12]

**Physician Admission Orders:** An individual becomes an inpatient of a hospital, including a critical access hospital, when formally admitted as such pursuant to an order for inpatient admission by a physician or other qualified practitioner described in the final regulations. The order is required for payment of hospital inpatient services under Medicare Part A.[13]

**Post Admission Physician Evaluation:** The purpose of the post-admission physician evaluation is to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the patient's expected course of treatment that will be completed with input from all the interdisciplinary team members in the overall plan of care.[14]

**Preadmission Screening:** A preadmission screening is a detailed and comprehensive evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by a licensed or certified clinician(s) (appropriately trained to assess the patient medically and functionally) within the 48 hours immediately preceding the IRF admission. This screening is the initial determination of whether the patient meets the requirements for IRF admission.[15]

**Presumptive Compliance (60 Percent Rule):** During the cost reporting period, the IRF must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified in section 140.1.1C of Chapter 3 of the *Medicare Claims Processing Manual*.[16]

## GLOSSARY OF ABBREVIATIONS

| | |
|---|---|
| **ABMS** | American Board of Medical Specialties |
| **ABPMR** | American Board of Physical Medicine and Rehabilitation |
| **ACA** | Affordable Care Act |
| **AMA** | American Medical Association |
| **ARRA** | American Recovery and Reinvestment Act |
| **CAUTI** | Catheter Associated Urinary Tract Infection |
| **CDC** | Centers for Disease Control and Prevention |
| **CDI** | Clinical Documentation Improvement |
| **CMG** | Case Mix Group |
| **CMS** | Centers for Medicare and Medicaid Services |
| **DRG** | Diagnostic Related Group |
| **FFS** | Fee-for-service |
| **FIM** | Functional Independence Measure |
| **FY** | Fiscal Year |
| **H&P** | History and Physical |
| **HHA** | Home Health Agency |
| **HIM** | Health Information Management |
| **ICD-10-CM** | International Classification of Diseases, 10th Revision, Clinical Modification |
| **IGC** | Impairment Group Code |
| **IMPACT** | Improving Medicare Post-Acute Care Transformation |
| **IRF** | Inpatient Rehabilitation Facility |
| **IRF PAI** | Inpatient Rehabilitation Facility Patient Assessment Instrument |
| **IRF PPS** | Inpatient Rehabilitation Facility Prospective Payment System |
| **LOS** | Length of Stay |
| **LTCH** | Long-Term Care Hospital |
| **MAC** | Medicare Administrative Contractor |
| **MDC** | Major Diagnostic Category |
| **MMA** | Medicare Prescription Drug Improvement and Modernization Act |
| **NHSC** | National Healthcare Safety Network |
| **ONC** | Office of the National Coordinator of Health Information Technology |
| **OIG** | Office of Inspector General |
| **OT** | Occupational Therapy |
| **PAPE** | Post-Admission Physician Evaluation |
| **PEPPER** | Program for Evaluating Payment Patterns Electronic Report |
| **PPS** | Prospective Payment System |
| **PT** | Physical Therapy |
| **QRP** | Quality Reporting Program |
| **RIC** | Rehabilitation Impairment Category |
| **SLP** | Speech-Language Pathology |
| **SME** | Subject Matter Expert |
| **SMRC** | Supplemental Medical Review Contractors |
| **SNF** | Skilled Nursing Facility |
| **STACH** | Short-term acute care hospital |

## NOTES


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# APPENDIX B: SAMPLE IRF JOB DESCRIPTIONS

## SAMPLE POSITION DESCRIPTION

**Position Title:** Director of Health Information Management

**Purpose:**

Responsible for coordination and performance of all operations in the Health Information Management Department, including planning, developing, and maintaining the Health Information Management department activities in accordance with state and federal guidelines, accreditation standards, and hospital policies and procedures.

**Responsibilities:**

- Directs and develops health information management policies and procedures to promote compliance in regulatory standards for the Joint Commission and CARF.
- Oversees coding, abstracting, analyzing, and authentication of records.
- Ensures timely transmissions of IRF-PAI occur.
- Performs coding compliance reviews.
- Provides education to physicians and staff regarding coding, documentation, and IRF regulatory changes.
- Communicates effectively with clinical staff, physicians, and office staff regarding documentation.
- Monitors physician query effectiveness and compliance.
- Works closely with quality improvement staff for data abstraction for quality measures and compliance with IMPACT Act.
- Provides education on HIPAA privacy and compliance to staff and physicians.
- Protects confidentiality of patient information and all confidential information appropriately.
- Ensures all requests for information are handled appropriately and timely, including those for patients, claims, and external audits.
- Manages and/or participates in all claims appeals as related to the coding and medical necessity denials.

**Qualifications:**

- Certification as an RHIA or RHIT
- Experience in administrative and staff management
- Experience in project management
- Knowledge of information systems and healthcare applications in addition to database applications and report writing software
- Knowledge of federal, state, the Joint Commission, and CARF requirements
- Knowledge of IRF PPS and Medicare regulations
- Knowledge of ICD-10-CM, ICD-10-PCS, and CPT coding
- Knowledge of HIPAA privacy and security laws

## SAMPLE POSITION DESCRIPTION

**Position Title:** IRF Coder and CDI Specialist

**Department:** HIM

**Purpose:**

This position will provide active concurrent and retrospective review of documentation and assign ICD-10-CM codes as appropriate to the IRF-PAI as well as for the UB-04. As documentation is reviewed, this position will also provide feedback and educate clinical care providers to improve the documentation of all conditions, treatments, and care plans within the health record to accurately reflect the condition of the patient and promote patient care.

**Responsibilities:**

- Analyze health record to identify etiologic diagnosis and all co-morbidities and complications.
- Abides by the Standards of Ethical Coding as set forth by the American Health Information Management Association and adheres to official coding guidelines.
- Ensures all required documentation to meet IRF medical necessity is complete and timely.
- Queries the medical staff and other clinical caregivers as necessary.
- Identifies potential quality, severity of illness, risk of mortality, hospital/physician profiling, and reimbursement issues or missing documentation.
- Communicates documentation issues clearly and succinctly to clinical care providers and reports issues/trends to appropriate manager.
- Provides ongoing education to physicians and other clinical care providers related to documentation, changes in coding, compliance issues, profiling concerns, and reimbursement changes.
- Monitor changes in law, regulations, rules, and code assignment that impact documentation and reimbursement.

**Qualifications:**

- RHIA, RHIT, and/or CCS
- CDIP not required but a plus
- Preferred experience in an IRF
- Preferred two years minimum experience in inpatient coding

## SAMPLE POSITION DESCRIPTION

**Position Title:** PPS Coordinator

**Department:** HIM

**Purpose:**

This position ensures compliance with all state and federal requirements related to and oversees the accuracy and timely completion/transmission of the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI). Coordinates staff education and training related to scoring and documenting observations of Functional Independence Measures (FIM).

**Responsibilities:**

- Collaborates with physician and other staff to determine the anticipated case mix group (CMG).
- Collects pertinent demographic, clinical, and FIM data and enters it on the IRF-PAI.
- Communicates with coding professionals to determine etiologic diagnosis, co-morbid conditions, and any complications.
- Participates in all case conferences and reviews documentation concurrently throughout the stay to ensure accurate documentation of team conference discussion.
- Tracks and reports regularly on compliance with the 60 percent rule.
- Ensures completion of FIM re-credentialing for facility and all appropriate staff members.
- Maintains a current knowledge of PPS regulations related to participation requirements for inpatient rehabilitation facilities.
- Maintains current knowledge of IMPACT Act and quality reporting requirements for the IRF setting.

**Qualifications:**

- Qualifications vary depending on facility and job duties. This role can be filled as a clerical role or clinical aspects can be added to the role requiring a nurse or other clinician.

# APPENDIX C: SAMPLE IRF AUDIT TOOLS

## AUDIT TOOL 1

| CASE #: Patient Name: MRN#: | Admit Date: | |
|---|---|---|
| Attending Physician: | Discharge Date: | |
| Diagnosis: | Discharge Disposition: | |
| **Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)—110.1.5** | **Y/N/NA** | **Comment** |
| IRF-PAI forms included in the medical record? | | |
| **Admission Orders—110.1.4** | **Y/N/NA** | **Comment** |
| Physician admission orders written? | | |
| **Medical Necessity—110.2.1** | **Y/N/NA** | **Comment** |
| Does the patient require active and ongoing intensive therapeutic intervention of multiple therapies, one of which must be PT or OT? | | |
| **Medical Necessity—110.2.2** | **Y/N/NA** | **Comment** |
| Does the patient require intensive rehab. therapy of at least 3 hrs./day @ least 5 days/week or 15 hrs. w/in 7 consecutive days, beginning with the admission date? | | |
| Will the patient be able to undergo face-to-face sessions 3 days/week with the physiatrist (may be noted in progress notes)? | | |
| **Pre-Admission Screening - 110.1.1** | **Y/N/NA** | **Comment** |
| Conducted by a physiatrist within 48 hours of admission? (DATE AND TIME) | | |
| If not, has the screening been updated to document the pt.'s medical & functional status within 48 hrs.? | | |
| **Does the pre-admission screen include: (BOLD anything not documented)—Check off list not acceptable** | | |
| Prior level of function? Expected level of improvement? Expected length of time necessary to achieve the level of improvement? Risk for clinical complications? Conditions that caused the need for rehabilitation? Treatments required (including prosthetics/orthotics)? Expected frequency & duration of treatment? Anticipated discharge disposition? Anticipated post-discharge treatments? Other Information relevant to the care needs of the pt.? | | |

| CASE #: Patient Name: MRN#: | | |
|---|---|---|
| **Post-Admission Physician Evaluation—110.1.2**<br>*(Dated, timed and authenticated physician eval. must be retained in the patient's IRF medical record).* | **Y/N/NA** | **Comment** |
| Evaluated by a physiatrist w/in the first 24 hours of the admission?<br>*May not serve as one of the three face-to-face visits in the first week.* | | |
| Support medical necessity of admission | | |
| Include relevant changes since preadmission screening? | | |
| Include a documented H&P exam, as well as a review of the pt.'s prior & current medical & functional conditions & comorbidities? | | |
| **Individualized Overall Plan of Care (IOP)—110.1.3** | **Y/N/NA** | **Comment** |
| Reviewed by a physiatrist within the first four days of admission?<br>*(May be completed at the same time as the post-admission eval. as long as all required elements are included).* | | |
| **Does the IOP include: (BOLD anything not documented)** | | |
| Medical prognosis? Anticipated interventions (expected intensity/ frequency/duration)? Functional outcomes? Discharge destination? Expectations based on the pt.'s impairments, functional status, and complicating conditions? | | |

| CASE #: Patient Name: MRN#: | | |
|---|---|---|
| **Interdisciplinary Team Approach—110.2.5** | **Y/N/NA** | **Comment** |
| Conducted at least once a week? | | |
| **Is the interdisciplinary team is in attendance and is comprised of the following disciplines with their name and professional designations: (BOLD any not documented)** | | |
| Physiatrist? RN? SW/CM? and Therapists from each discipline involved (PT, OT, ST). | | |
| Assess the individual's progress towards goals-potential barriers? | | |
| Monitor and revise treatment plans? | | |

## SAMPLE AUDIT TOOL #2

| | | | |
|---|---|---|---|
| | | **Review Date:** | |
| **Patient Name:** | **Patient Name:** | **Admit Date:** | |
| **Attending Physician:** | | **D/C Date or expected:** | |
| **Any critical findings on chart audit? No_____ Yes _____ Specify Area:_____** | | **CMG Proposed:** | |
| **Pre-Admission Screening** | | **Y/N/NA** | **Comment** |
| | Acute care admit date | | |
| | Acute care Hospital | | |
| Conducted by a clinician within 48 hours of admission? (DATE AND TIME) | | | |
| If not, has the screening been updated to document the pt's medical & functional status within 48 hrs? | | | |
| Does the pre-admission screen include: (circle anything not documented) | | | |
| Prior level of function? Expected level of improvement? Expected length of time necessary to achieve the level of improvement? Risk for clinical complications? Conditions that caused the need for rehabilitation? Treatments required (including prosthetics/orthotics)? Expected frequency & duration of treatment? Anticipated discharge disposition? Anticipated post-discharge treatments? Other information relevant to the care needs of the pt? | | | |
| Has a rehabilitation physician reviewed the pre-screening information, concurred with the findings, and confirmed the appropriateness of the admission? **(DATE AND TIME)** | | | |
| **COMMENTS:** | | | |

## SAMPLE AUDIT TOOL #3

| Finding Code: | | PATIENT SUMMARY |
|---|---|---|
| Patient Name: | | |
| MRN | | |
| Admission Date | | |
| Discharge Date | | |
| LOS | 0 | |
| Interrupted Stay? (Y/N) | | |
| | | |
| CMG Billed | | |
| CMG Description | | |
| LOS for Billed CMG | | |
| CMG Audited | | |
| | | TEAM CONFERENCE |
| Billed Impairment Group | | DATE |
| Description | | ATTENDEES: |
| Audited Impairment Group | | NOTES WRITTEN BY: |
| | | |
| Billed Etiologic Dx | | DATE |
| Description | | ATTENDEES: |
| Audited Etiologic Dx | | NOTES WRITTEN BY: |

| | | Y/N/NA | | | | Comments |
|---|---|---|---|---|---|---|
| | **Attending physician** | | | | | |
| 1 | Is the primary or secondary diagnosis covered under Medicare's 60% rule? | | 0 | 0 | 0 | |
| 2 | Admission information (IRF PAI # 12-19) are completed accurately | | 0 | 0 | 0 | |
| 3 | Pre-admission screening conducted to document patient's benefit from admission? | | 0 | 0 | 0 | |
| 4 | Treatment plan established and reviewed by physician or does documentation support a treatment plan? | | 0 | 0 | 0 | |
| 5 | Team conferences conducted at least every two weeks with sign-off from every team member? | | 0 | 0 | 0 | |
| 6 | Nature and degree of expected improvement and estimate LOS documented? | N/A | 1 | 0 | 0 | |
| 7 | Documentation of patient's improvements are sustainable and measured against condition at time of admission? | N/A | 1 | 0 | 0 | |
| 8 | Impairment group (PAI form # 21), etiological diagnosis, and date of onset (PAI form # 22-23) are accurately completed | | 0 | 0 | 0 | |
| 9 | Tiered comorbid conditions (PAI form # 24) are accurately completed and documented | | 0 | 0 | 0 | |
| 10 | Functional modifiers (PAI form # 29-38) are accurately completed | | 0 | 0 | 0 | |
| 11 | Motor score (sum of PAI form # 39 A, B, C, D, E, F, G, H, I, J, L, M ) AND Cognitive Score (sum of PAI form # 39 N, O, P, Q, R) are accurately completed | | 0 | 0 | 0 | |
| 12 | Discharge information (PAI form # 40-47) are accurately completed | | 0 | 0 | 0 | |
| 13 | Was length of stay appropriate? | | 0 | 0 | 0 | |
| 14 | No issues/concerns that might question appropriateness of admission? | | 0 | 0 | 0 | |
| 15 | Three hours of rehab provided over five days with active patient participation? | | 0 | 0 | 0 | |
| #N/A | (N/A=Not Applicable) | 2 | 2 | | | |
| # Y | (Y=Met Requirements) | 0 | | 0 | | |
| # N | (N= Did not meet requirements) | 0 | | | 0 | |
| | Total Items Reviewed From Audit | 2 | | | | |
| | | **FIM SCORE** | | | | **Comments** |

| | | | | | | |
|---|---|---|---|---|---|---|
| FIM | 39A. Eating (0.6) | | 0.6 | | | |
| | 39B. Grooming (0.2) | | 0.2 | | | |
| | 39C. Bathing (0.9) | | 0.9 | | | |
| | 39D. Dressing—Upper (0.2) | | 0.2 | | | |
| | 39E. Dressing—Lower (1.4) | | 1.4 | | | |
| | 39F. Toileting (1.2) | | 1.2 | | | |
| | 39G. Bladder (0.5) | | 0.5 | | | |
| | 39H. Bowel (0.2) | | 0.2 | | | |
| | 39I. Bed, Chair, WC (2.2) | | 2.2 | | | |
| | 39J. Toilet (1.4) | | 1.4 | | | |
| | 39K. Tub, Shower (0) | | | | | |
| | 39L. Walk/WC (1.6) | | 1.6 | | | |
| | 39M. Stairs (1.6) | | 1.6 | | | |
| | 39N. Comprehension | | | | | |
| | 39O. Expression | | | | | |
| | 39P. Social Interaction | | | | | |
| | 39Q. Problem Solving | | | | | |
| | 39R. Memory | | | | | |
| MOTOR TOTAL: | | 13.40 | 12 | 0 | 0 | |
| COGNITIVE TOTAL: | | 0.00 | 0 | | | |
| AUDIT | 39A. Eating | | 0.6 | | | |
| | 39B. Grooming | | 0.2 | | | |
| | 39C. Bathing | | 0.9 | | | |
| | 39D. Dressing—Upper | | 0.2 | | | |
| | 39E. Dressing—Lower | | 1.4 | | | |
| | 39F. Toileting | | 1.2 | | | |
| | 39G. Bladder | | 0.5 | | | |
| | 39H. Bowel | | 0.2 | | | |
| | 39I. Bed, Chair, WC | | 2.2 | | | |
| | 39J. Toilet | | 1.4 | | | |
| | 39K. Tub, Shower | | | | | |
| | 39L. Walk/WC | | 1.6 | | | |
| | 39M. Stairs | | 1.6 | | | |
| | 39N. Comprehension | | | | | |
| | 39O. Expression | | | | | |
| | 39P. Social Interaction | | | | | |
| | 39Q. Problem Solving | | | | | |
| | 39R. Memory | | | | | |
| MOTOR TOTAL: | | 13.40 | 12 | 0 | 0 | |
| COGNITIVE TOTAL: | | 0.00 | 0 | 0 | 0 | |

| Post-Admission Physician Evaluation | Y/N/NA | Comment |
|---|---|---|
| **Performed in the first 24 hours of the admission?** | | |
| **Does the post-admission physician evaluation:** | | |
| Include comparison of pt's current condition to the pre-admission screening documentation? | | |
| Begin development of the pt's expected course of treatment (which will help to form the POC)? | | |
| Include any relevant changes that have occurred since admission? | | |
| Include a documented history and physical exam? | | |
| Include a review of the pt's prior and current medical and functional conditions & comorbidities? | | |
| DATE AND TIME OF HOSPITAL ADMISSION | | |
| DATE AND TIME OF H&P | | |
| DATE AND TIME OF PAPE | | |
| COMMENTS: | | |

| Other Requirements/Audit Tools | Y/N/NA | Comment |
|---|---|---|
| **Physician admission orders written?** | | |
| **Therapy commenced within 36 hours of admission?** | | |
| Is the pt receiving at least three hours of therapy/day at least five days/week, or at least 15 hours within a seven-consecutive day period? | | |
| **Are total therapy minutes provided accurately identified as individual, concurrent, group, or co-treatment?** | | |

## PHYSICAL THERAPY

**Week 1** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 1 Total _____
**Week 2** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 2 Total _____
**Week 3** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 3 Total _____
**Week 4** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 4 Total _____

## OCCUPATIONAL THERAPY

**Week 1** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 1 Total _____
**Week 2** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 2 Total _____
**Week 3** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 3 Total _____
**Week 4** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 4 Total _____

## SPEECH THERAPY

**Week 1** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 1 Total _____
**Week 2** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 2 Total _____
**Week 3** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 3 Total _____
**Week 4** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 4 Total _____

## PHYSICIAN PROGRESS NOTES

**Week 1** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 1 Total _____
**Week 2** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 2 Total _____
**Week 3** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 3 Total _____
**Week 4** Date (min) Date _____ _____ _____ _____ _____ _____ _____ Week 4 Total _____

**Other Comments / Recommendations / Concerns**

## PATIENT PROGRESS

| Date | Eat | Groom | Bath | UE | LE | Toilet | Bed/Chair Xfer | Toilet Xfer | Tub/Shower Xfer | Gait | Dist. Walk | AD Level |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |

# APPENDIX D: SAMPLE QUERIES FOR INPATIENT REHABILITATION FACILITY CODING

*The following were created utilizing the AHIMA Query Toolkit.* [1]

***Altered Mental Status Clarification Query***

Dear Dr. Doolittle:

Altered Mental Status has been documented on the History and Physical for patient Wylie, Tomcat. Could the diagnosis be further specified?

**Clinical Indicators:** **drowsiness, poor decision-making, hallucinations**

**Risk Factors:** **dehydration, hypoxia**

Based on the clinical indicators please use your clinical judgment to determine if the diagnosis of Altered Mental Status can be further specified.

Please select an option below and document in the progress notes.

- Acute encephalopathy
- Toxic encephalopathy
- Psychosis
- Delirium
- Other explanation
- Unable to determine
- No further clarification needed

***Heart Failure Clarification Query***

Dear Dr. Strange:

Heart failure unspecified has been documented on the History and Physical for patient Susie Q. Could the diagnosis be further specified?

**Clinical indicators:** **shortness of breath, fatigue, anasarca**

**Risk factors:** **hypertension, obesity, coronary artery disease**

Based on the clinical indicators please use your clinical judgment to further specify the diagnosis of heart failure.

Please choose an option below and document in the progress note.

- Acute systolic heart failure
- Acute diastolic heart failure
- Chronic systolic heart failure
- Chronic diastolic heart failure
- Acute combined systolic/diastolic heart failure
- Unable to determine
- No further clarification needed

***Hip Fracture Clarification Query***

Dear Dr. Right:

Right hip fracture is documented on the History and Physical for patient clarification. Could this diagnosis be further specified?

Please further specify the site of the fracture. Choose an option below and document in the progress note.

- Base of neck
- Epiphysis
- Trochanteric
- Intertrochanteric
- Subtrochanteric
- Subcapital
- Unable to determine

***Note***

1. AHIMA. *AHIMA Query Toolkit*. 2017. http://bok.ahima.org/PdfView?oid=302140.