Common IRF Coding Q&A

1. Question:
IRFs often struggle with the concept of trying to use only one code in the etiology field to best represent multiple trauma patients. An example of this would be a patient that has a fractured humerus, fractured ankle, fractured pelvis, kidney laceration, chest trauma resulting in pneumothorax, S/P trach and vent dependent.

Answer:
You must adhere to the guidelines and definitions as described in the IRF PAI Training manual in order to accurately complete the IRF PAI for the PPS. So after selecting the correct Impairment Group Code (IGC), you must select what the PRIMARY reason would be for the etiologic diagnosis. The other codes would be captured as comorbid conditions. This should not be difficult as there must also be supporting documentation by the physician as to why the patient requires inpatient rehabilitation. It should be evident as to what the primary issues to be addressed during a course of rehabilitation.

2. Question:
If a patient is admitted to rehabilitation for two conditions and one is coded as acute for the etiology diagnosis, should the other condition be coded as acute conditions under comorbidities section instead of coding a history of code?

Answer:
First you must select the reason for admission to rehabilitation – which is the impairment group code. Then you select the cause of the IGC – which is the etiologic diagnosis. There can only be 1 IGC and 1 etiologic diagnosis (and 1 main reason for admission to rehabilitation). If the patient has additional conditions, which are being monitored and treated, then code those conditions in the comorbid conditions section of the IRF PAI. Please note that if a patient has fractures that are present on admission and if the fractures are comorbid conditions, you code the V code for aftercare.

3. Question:
If a patient has a L3-L4 Laminectomy with diskectomy and fusion, what is the correct IGC and etiology diagnosis?

Answer:
You must first select the reason for the admission to rehabilitation - the impairment group code. Then select the etiologic diagnosis. Some suggested ICD-9-CM codes may include spinal stenosis, but this needs to be determined on an individual patient level and have supporting documentation by the physician as to what the etiology is. A surgical procedure on the spine is not sufficient reason for rehab admission. Usual reasons are persisting back pain that limits functional activities and/or neurologic deficit involving the spinal nerve roots and/or the motor/sensory pathways resulting
in paresis, impaired sensation, impaired sphincter function. Deconditioning is possible but should be rare.

4. **Question:**
Parkinson’s-patient has difficulty swallowing and unable to dislodge a bolus of meat in acute setting. During the patient’s stay, the patient is unable to take P.O. medications and declines physically and is admitted to rehabilitation, what is the admitting IGC and etiology diagnosis?

**Answer:**
If the patient is being admitted due to the Parkinson’s Disease, then the Impairment Group Code (IGC) is 3.2 (Parkinsonism) and the etiologic diagnosis is 332.x (Parkinsonism).

5. **Question:**
If a patient has bilateral joint replacement, there is not a specific code to reflect this in the ICD-9-CM coding schema. How should this be captured on the IRF-PAI?

**Answer:**
If a patient has bilateral joint replacements, the impairment group code for this should be selected. Per the IRF PAI Training manual, if the replacement were due to arthritis, the etiologic diagnosis would then be arthritis.

6. **Question**
On the etiology, when coding for multiple fractures, how should they be coded?

**Answer:**
Code to the worst fracture the patient has as the etiologic diagnosis. All remaining fractures should be coded with a V code in the comorbid conditions section of the IRF PAI.

7. **Question:**
Should chronic systemic conditions be listed in the comorbidities section of the IRF-PAI such as CHF, hypertension, COPD, Parkinson, etc. when the patient is on medication for these conditions?

**Answer:**
If the patient has chronic conditions and the condition is currently being monitored and/or treated for the condition (i.e., on medications) and this is documented in the medical record by the physician, then yes, these conditions should be coded as comorbid conditions. As far as coding additional diagnosis, you should be coding those elements required for the IRF PAI per the instructions in the IRF PAI Training Manual.
8. **Question:**
When do we code the V49 (status post amputation) codes as the etiologic diagnosis? Only for prosthetic training? According to the IRF-PAI training manual, we are to code the reason for the surgery as the etiologic diagnosis. (i.e. Spinal stenosis for a laminectomy, gangrene for amputee). What do we code when a patient comes back for prosthetic training?

**Answer:**
For the IRF PAI, you must first select the correct Impairment group code (IGC), then determine what it was that caused the Impairment. Thus for a patient with an amputation, select the amputation if that is the primary reason for admission, then select the cause of the amputation. This philosophy also holds true for the patient admitted (or readmitted) for prosthetic training.

9. **Question:**
Will the FI (fiscal intermediary) be looking at the IRF PAI or UB 92 to determine compliance with the 75% Rule?

**Answer:**
For compliance, the FI’s will be reviewing the IRF-PAI data and not the UB92.

10. **Question:**
There is a significant amount of confusion regarding assignment of multiple traumas. How do you know whether you should assign an impairment group code of Major Multiple Trauma? What does CMS mean when they say site or system?

**Answer:**
Appendix B, page 17 of the IRF PAI Training Manual states that this IGC (14) “includes trauma cases with more complex management due to involvement of multiple systems or sites.” Trauma cases do include a variety of mechanisms; the key is determining which deficit required the rehab. Page 25765 of the FR dated Friday, May 7, 2004, states: “[DRGs] 484, 485, and 486 were chosen to define major multiple trauma.” If a case falls under any of these DRGs in acute care, the case should be compliant toward the Major Multiple Trauma IGC. The final discretion is left to the FI.

**Example:**

Patient in a MVA can sustain damage to his trachea, liver, stomach, colon, or small intestine or to a combination of these areas. Each of these is considered a “site”. During the patient’s rehab stay, his physician will document medical management and monitoring of all of these sites. **Remember**, that your patient’s IGC is 14.1 only if he sustains injury to the brain and spinal cord. If the patient has a brain injury or spinal cord injury, **plus** multiple fractures or an amputation, assign him/her an IGC of 14.2, **Brain + Multiple Fracture/Amputation**, or IGC 14.3, **Spinal Cord + Multiple Fracture/Amputation**.
If your patient suffers a brain injury and only one fracture, assign IGC 02.21, *Traumatic, Open Injury,* or 02.22, *Traumatic, Closed Injury,* which reflect the traumatic brain injury (open injury or closed injury). The fracture should be coded as a comorbid condition using an after care for healing fracture code (V54.xx code).

One subclass under IGC 14 is 14.9, *Other Multiple Trauma.* Regarding this IGC, the training manual states it is: “Two or more ICD-9-CM codes for trauma to multiple systems or sites, but not brain or spinal cord”. If a patient has a femur fracture (which is an injury to the skeletal system) plus a lacerated liver, assign IGC 14.9 to the patient. The patient may have weight-bearing restrictions, as a result of the femur fracture, that will ultimately affect ADLs and ambulation. The liver laceration may require daily medications or periodic blood draws to monitor the healing process. This patient should be closely monitored by a physician or other rehabilitation staff member for right upper quadrant tenderness, infection, shock, hypotension, falling hematocrit level, or elevation of serum liver enzyme levels; these are just a few of the complications that may be identified throughout the rehabilitation stay. Remember that the documentation must support the need for medical management or therapeutic intervention for these problems. Throughout the patient’s stay, the providers should address these problems in progress notes and during team conference sessions.

It has been asked if skin can be considered a “site”. Even though skin is a site of the nervous system, there is no clear answer; instead, questions can help determine whether this is a site that affects the patient’s rehab stay. If a burn treatment unit is one of the specialty units at the IRF, and the patient has suffered burns over a significant portion of the body from a MVA, skin would most likely count as a site.

Usually cuts, bruises, and contusions of the skin would not be coded as a site because this would not require complex medical management. The training manual states “If only multiple fractures are present, code IGC under Orthopaedic Disorders as 08.4, *Major Multiple Fractures,* Even though this is not a compliant impairment under the 75% Rule, fractures can be bundled if a patient has multiple fractures that encompass “both lower limbs, a lower limb(s) with an upper limb, or a lower limb(s) with rib(s) and sternum.” Such a bundling would result in the assignment of a compliant etiologic diagnosis (ICD-9-CM code of 828.0, *Multiple fractures involving; both upper & lower limbs/rib/sternum, closed,* or 828.1, *Multiple fractures involving; both upper & lower limbs/rib/sternum, open,* to the case.

All four subclasses under Major Multiple Trauma are compliant with the 75% Rule. IGCs 14.1, 14.2, and 14.3 fall under RIC 18, and IGC 14.9 can be found under RIC 17.