LOUISIANA HOSPITAL ASSOCIATION

Coding Overview
January 15, 2008

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Overview of IRF Coding

- IRF are required to collect data using the IRF PAI
  - PAI documentation is MANDATORY for payment
  - Must assign an ICD-9-CM code for the etiologic diagnosis indicating the condition which caused impairment and for which the patient is receiving rehab.
  - The ICD-9-CM coding guidelines do not provide instructions for the completion of this data element
  - The *Official Guidelines for Coding and Reporting* govern the selection and application of ICD-9-CM codes on the claim form.
  - The discrepancy between the ICD-9-CM codes submitted on the IRF-PAI and the codes submitted on the claim form has resulted in confusion and substantial administrative burden for facilities.
Overview of IRF Coding for the PAI

- What is Impairment Group Codes (IGC)?
- What is Case-Mix Group (CMG)?
- What is Rehabilitation Impairment Category (RIC)?
- What is Debility IGC?
- What is Medically Complex IGC?
- When should I use the Debility IGC versus the Medically Complex IGC?
Overview of IRF Coding for the PAI

- Which should be assigned first: the Impairment Group Code or the Etiologic Diagnosis?

- Should a complication be coded as a comorbid condition?

- Are the ICD-9-CM codes listed as Etiologic Diagnoses in appendix B of the IRF PAI Training Manual all-inclusive?
A percentage of an IRF’s total inpatient population must match one or more of 13 medical conditions specified:

1. Stroke
2. Spinal cord injury
3. Congenital deformity
4. Amputation
5. Major multiple trauma
6. Fracture of femur (hip fracture)
7. Brain injury
8. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson’s disease
9. Burns
10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)
13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:

- 1. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

- 2. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

- 3. The patient is age 85 or older at the time of admission to the IRF.
<table>
<thead>
<tr>
<th>UB92 vs. IRF-PAI Coding</th>
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<tbody>
<tr>
<td>📈 Uniform Hospital Discharge Data Set (UHDDS)</td>
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<tr>
<td>📈 Etiologic Diagnosis</td>
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<tr>
<td>📈 Principal Diagnosis</td>
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<tr>
<td>📈 Complications</td>
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How to select a principal diagnosis

◆ Principal diagnosis should always be a code from the V57.xx series of codes
  • V57.89

◆ Codes should not be assigned for conditions that are not confirmed

◆ The IRF is considered a post acute care facility, coding guidelines for post acute care should be followed

◆ Following the V57.xx code, the code reported should represent the reason the patient is admitted to the IRF
How to select a secondary diagnosis

- Following the V57.xx code, report a code that best describes the reason the patient is admitted to the IRF.

- Additional conditions that affect patient care in terms of required: clinical evaluation; or therapeutic treatment; or diagnostic procedures, or extended length of hospital stay; or increased nursing care and/or monitoring.

- All conditions that coexist at the time of admission, that develop subsequently or that affect the treatment received and/or length of stay.

- Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

- For patients with multiple medical conditions, report codes regardless of the affect on payment; Sequence the codes for the most significant diagnoses first.
How to select a secondary diagnosis

**Previous conditions** – If the physician has included a diagnosis in the final discharge summary or face sheet, it should ordinarily be coded. History codes may be used as secondary codes if the historical condition or family history has an impact on current admission.

**Abnormal Findings** - Abnormal findings from diagnostic tests are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the attending physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the abnormal finding should be added.
No IGC or Etiologic Diagnoses on the UB-04

Complications

Comorbid or Secondary Diagnosis

- How do these affect the IRF-PAI?
- Current IRF-PAI instructions do NOT allow the reporting of comorbid conditions that have been identified on the day of discharge or the day prior to discharge.

- UHDDS - The UHDDS defines other diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay.” The Guidelines interpret this as additional conditions that affect patient care in terms of requiring “clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring.”

Specific Examples
<table>
<thead>
<tr>
<th>Deadly IRF Documentation Sins</th>
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<tbody>
<tr>
<td>1. Physicians not selecting the admission IGC</td>
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<tr>
<td>2. Physicians do not provide enough supporting documentation for the selected admission IGC and any comorbid conditions</td>
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<tr>
<td>3. Medical record coders do not adopt the IRF PPS philosophy of coding</td>
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Importance of Accurate Coding

- Case mix group assignment
- Payment tier assignment
- Medical necessity
- Recovery Audit Contractor (RAC)- Independent contractor hired by CMS to recover Medicare overpayments–
- The 75% rule–Presumed compliance
  - If facility does not meet presumed compliance
    - Fiscal Intermediary could perform review of both Medicare and non-Medicare cases
The goal to pay your claims correctly is DOCUMENTATION. This is KEY. Documentation supports medical necessity.

According to the CMS Manual there are two basic requirements that must be met:

- The services must be reasonable and necessary (in terms of efficacy, duration, frequency and amount) for treatment of the patient’s condition and

- It is necessary to furnish the care on an inpatient hospital basis, rather than a less intensive facility such as a SNF, or an outpatient basis
Why is Documentation Important?

- Serves as a means to identify the patient, justify the treatment, support the diagnoses, document the patient’s progress and results of treatment.
- Provides continuity of patient care and serves as a means of communication among peers.
- Assist in protecting legal interests of patients, healthcare professionals and healthcare facilities.
- Determines coding for the UB92 and IRF-PAI.
- Ensures accurate reimbursement when the documentation is clear, concise, complete, consistent and legible.
To obtain accurate credit for all resources utilized as well as the patient’s true medical situation, it is imperative that all documented diagnoses that meet the UHDDS coding guidelines are coded.

- The only way the hospital can capture this is if it is documented

Incomplete documentation and coding can potentially have financial implications

All providers need to make a concerted effort to ensure that diagnoses are consistent

- If diagnosis has changed from previous date or from another provider’s entry, then document this
With the advent of the IRF PPS, CMS has stated:

“One principle governing appropriate Medicare payment and utilization of Medicare inpatient services is that there must be documentation establishing that the inpatient services furnished to the patient meet the requirements set forth in section 1862 (a) of the Act (for example, are reasonable and necessary for the diagnosis or treatment of illness or injury) (412.606(a) and (c)).”

“A patient’s clinical status for a given time period, as indicated by a completed patient assessment instrument, must be verifiable and consistent with the clinical information independently or separately recorded in the patient’s clinical record. Otherwise, inaccurately completed patient assessments might be used to classify patients into CMGs that would, in turn, form the basis for Medicare payment for medically inappropriate or unnecessary services.”
When performing chart audits, we typically see great documentation of the following:

- patient’s past medical history
- events that brought the patient to the hospital
- details of the hospital course

Poor documentation of:

- physician history and physical is unclear as to why the patient is being admitted to rehabilitation
- reason for admission to the hospital does not always match the reason for admission to rehabilitation
Physician Documentation

The physician H&P must include:

- documentation of all relevant conditions that affect the rehabilitation stay
- it must distinguish clearly between past medical history (PMH) and comorbid conditions
- Any condition documented as suspected, probable, or unconfirmed may not be listed as an active condition on the IRF PAI
- The admission IGC should clearly state the reason for admission to rehabilitation. (Preferably, the physician will write the specific name of one of the eighty-five impairment groups.)
- It likewise should state the condition that led to the impairment (etiologic diagnosis) and any other concurrent conditions that will affect the patient’s rehabilitation stay (comorbid conditions).
- For example, if a patient’s deficits are related to an etiology such as encephalopathy, the documentation might read, “Patient admitted to rehabilitation with general weakness, cognitive deficits, and ADL and gait dysfunction due to non-traumatic brain dysfunction caused by encephalopathy.”
Physician Documentation

Additional suggestions for documentation of three common documents:

- Referral
- H&P
- Progress Notes
Physician Documentation

- Physicians need to be very specific when documenting a condition.
- Physicians need to ensure that all conditions and diagnoses discussed during the interviews/sessions are documented.
  - Do not ignore the importance of some diagnoses.
- Ancillary staff needs to become more aware of their documentation.
  - Documenting patient is “fine” while physician on same day is documenting something different.
  - Do not ignore the importance of documenting complaints (nose bleeds, dysuria, etc.)
Documentation is not just up to the physician:

- Rehab Nurse
- Therapies
- Interdisciplinary Team
Common Audit Findings Regarding Documentation

- The documentation for the beneficiaries admitted with a primary diagnosis of joint replacement did not support the need for an IRF setting as beneficiaries were medically stable without co-morbidities that would support the need for the level of physician involvement required to be in an IRF.

- Also noted were several admissions following a surgical procedure and the documentation did not support the need for an IRF setting.

- If the beneficiary was unable to tolerate the three hours of therapy, the records did not explain why or that the IRF setting was required because of the co-morbidities/medical complications (not well documented either).
What are the most common reasons for denial?

- Failure to submit the requested documentation
- Lack of documentation that would support Medicare Regulations for Documentation and Medical Necessity
- Failure to complete or submit the PAI
### Understanding Impact of Documentation

<table>
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<tr>
<th>Unable to Code</th>
<th>Able to Code</th>
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<tbody>
<tr>
<td>Multi-System organ failure</td>
<td>Liver Failure, Renal Failure</td>
</tr>
<tr>
<td>Severe respiratory distress</td>
<td>Respiratory failure</td>
</tr>
<tr>
<td>Hemodynamically unstable</td>
<td>Hypotension, CHF</td>
</tr>
<tr>
<td>Will hydrate</td>
<td>Dehydration, hypovolemicia</td>
</tr>
<tr>
<td>Rhythm stable today</td>
<td>Ventricular tachycardia</td>
</tr>
<tr>
<td>Has had delusions in past</td>
<td>Currently delusional</td>
</tr>
<tr>
<td>Unable to void</td>
<td>Urinary retention</td>
</tr>
<tr>
<td>Has had hallucinations</td>
<td>Visual hallucinations, auditory hallucations during admission</td>
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Coder Clinical Knowledge

- Education on clinical knowledge is a must
- Clinical semantics/physician semantics must be clarified to determine appropriate principal diagnosis
- Know when to query the physician and what questions to ask
  - Query Process – a method of communication used by coders to request clarification of patient diagnoses or procedures from the physician
  - Helps avoid assumptions!
  - If not documented; patient did not have it or it was not done!
Physician Query Process

Some guidelines for the physician query process include the following:

1. Ask only questions that are drawn from the clinical documentation that the physician has provided in the patient’s record.

2. Ask only open-ended questions if possible. If not, provide reasonable choices for the physician, so it does not appear that you are showing preference for a particular response.

3. Never make any clinical assumptions - clinical documentation is solely the job of the physician.

4. Present the facts from the medical record and identify why clarification is needed.

5. Remember the role in the coding/billing function is to translate the physician’s documentation into billable "coding" language.

6. Like any translator, it is appropriate to ask for clarification, but the coder needs to stick to as strict and literal as possible interpretation of the physician’s documentation.
Physician Query Process

- Patient name
- The admission date
- The medical record number
- The name and contact information of the coding professional
- A specific question and rationale for the question
- A place for the physician to document his or her response
- A place for the physician to sign and date his or her response
Recommendations

- Perform coding reviews
  - Have an external audit done ASAP
  - Do periodic internal audits
- Review current query processes
- Organize “physician – coder” meetings
- Give coders access to billing system
- Consider developing H&P template
  - includes all possible IGCs
  - include an area for past medical history and a separate area for current conditions affecting the rehabilitation stay