FY10 Rehabilitation Coding
and
IRF PPS Update

Audio Seminar/ Webinar
September 24, 2009

Practical Tools for Seminar Learning
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Faculty

Patricia Trela, RHIA

Patricia Trela is the director of HIM and rehabilitation services for Diskriter Inc., a consulting firm providing HIM services for rehabilitation facilities. Prior to joining Diskriter, she was principal of her own consulting firm, PATrela Consulting, in Quincy, MA. Ms. Trela has over 25 years experience in the health information management (HIM) profession, and specializes in healthcare billing, coding, and reimbursement issues with a focus on rehabilitation facilities. Previously, she was a consultant with various HIM consulting firms. Ms. Trela was a member of the task force that developed the Functional Independence Measure (FIM) and is currently a member of the UDSMR National Advisory Council. She facilitates the AHIMA Coding Physical Medicine and Rehabilitation COP.
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FY10 Rehabilitation Coding and IRF PPS Update

Agenda

- ICD-9-CM Code updates for the inpatient rehabilitation provider setting
- FY 2010 Inpatient Rehabilitation Facility Prospective Payment System
  - Changes to IRF coverage requirements
  - 60% rule calculation changes
- Coding Challenges for the IRF PAI
- What’s In the Future for IRF

Changes to ICD-9-CM
Effective 10/01/09
**New Codes - Gouty Arthropathy**

- **274.00** Gouty arthropathy, unspecified
- **274.01** Acute gouty arthropathy
- **274.02** Chronic gouty arthropathy w/ o mention of tophus (tophi)
- **274.03** Chronic gouty arthropathy with tophus (tophi)
  - Gout with tophi NOS

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**New Code - Antineoplastic Chemotherapy Induced Anemia**

- **285.3** Antineoplastic chemotherapy induced anemia

  Excludes: Anemia due to drug NED-code to type of anemia
  - Anemia in neoplastic disease (285.22)
  - Aplastic anemia due to antineoplastic chemotherapy (284.89)
New Index Changes - Epilepsy

345 Epilepsy and recurrent seizures
Note: use the following fifth-digit subclassifications with categories 345.0, 345.1, 345.4-345.9

1. with intractable epilepsy
   Add pharmacoresistant (pharmacologically resistant)
   Add poorly controlled
   Add treatment resistant
   Add refractory (medically)

New Code - Chronic Pulmonary Heart Disease

* 416.2 Chronic pulmonary embolism
   • Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61)
   • Excludes: personal history of pulmonary embolism (V12.51)
New Codes - Late Effects of Cerebrovascular Disease

438.1 Speech and language deficits
• 438.13 Dysarthria
• 438.14 Fluency disorder
  Stuttering

New Codes - Venous Embolism and Thrombosis

• 453 Other venous embolism and thrombosis
  • Excludes Note Deleted
  • Expansion of this category to differentiate between acute and chronic embolism and thrombosis and to specify additional sites (thorax, neck, upper extremities)
  • If not specified as acute or chronic, the default code is acute
## New Codes - Influenza Due to Certain Identified Influenza Viruses

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>488</td>
<td><strong>Influenza Due to Certain Identified Influenza Viruses</strong></td>
</tr>
<tr>
<td></td>
<td>Excludes: influenza caused by unspecified influenza viruses (487.0-487.8)</td>
</tr>
<tr>
<td>488.0</td>
<td>Influenza due to identified avian influenza virus</td>
</tr>
<tr>
<td></td>
<td>Avian influenza</td>
</tr>
<tr>
<td></td>
<td>Bird flu</td>
</tr>
<tr>
<td></td>
<td>Influenza A/ H5N1</td>
</tr>
<tr>
<td>488.1</td>
<td>Influenza due to identified novel H1N1 influenza virus</td>
</tr>
<tr>
<td></td>
<td>2009 H1N1 [swine] influenza virus</td>
</tr>
<tr>
<td></td>
<td>Novel 2009 influenza H1N1</td>
</tr>
<tr>
<td></td>
<td>Novel H1N1 influenza</td>
</tr>
<tr>
<td></td>
<td>Novel influenza A/ H1N1</td>
</tr>
<tr>
<td></td>
<td>Swine flu</td>
</tr>
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</table>

## Tabular Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>707.0</td>
<td>Pressure ulcer</td>
</tr>
<tr>
<td>707.03</td>
<td>Lower back</td>
</tr>
<tr>
<td></td>
<td>Added Coccyx</td>
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</tbody>
</table>
Tabular Changes

733 Other disorders of bone and cartilage
- 733.1 Pathologic fracture
  Added Chronic fracture

Tabular Changes

780 General Symptoms
- 780.0 Alteration of consciousness
  Added excludes notes
  Excludes: Alteration of consciousness due to intracranial injuries (850.0 - 854.19)
  Skull fractures (800.00 - 801.99, 803.00 - 804.99)
Tabular Changes

780.9 Other general symptoms
   • 780.93 Memory loss
      Revised and added excludes notes
      Excludes: Memory loss due to:
      Intracranial injuries (850.0 - 854.19)
      Skull fractures (800.00 - 801.99, 803.00 - 804.99)
      Mild memory disturbance due to organic brain damage (310.8)

Tabular Changes

784.5 Other speech disturbance
   • 784.51 Dysarthria
      Excludes: Dysarthria due to late effect of cerebrovascular accident (438.13)
   • 784.59 Other speech disturbance
      Dysphasia
      Slurred speech
      Speech disturbance NOS
Tabular Changes

- Intracranial Injury, Excluding those with skull fracture (850-854)
  Add: Includes: Traumatic brain injury without skull fracture
- 854.00 Intracranial injury of other unspecified nature
  Revise: Includes: Injury:
  - Brain NOS
  - Intracranial
  - Traumatic brain NOS

New V Codes to Note

- V15.52 History of traumatic brain injury
  Excludes: personal history of cerebrovascular accident (cerebral infarction) without residual deficits (V12.54)
- V80 Special screening for neurological, eye and ear diseases
- V80.0 Neurological conditions
  - V80.01 Traumatic brain injury
  - V80.09 Other neurological conditions
Comorbidities - Payment Tiers

• Added Tier 3 Comorbidities
  • 285.3 Anemia due to antineoplastic chemotherapy
  • 416.2 Chronic pulmonary embolism
  • 488.0 Flu due to identified avian virus
  • 488.1 Flu due to identified H1N1 virus

FY 2010 Inpatient Rehabilitation Facility Prospective Payment System
**FY 2010 IRF PPS Pricer Changes**

**Standard Federal Rate**

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<th>2010</th>
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<tr>
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<td>$12,958</td>
<td>$13,661</td>
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Outlier threshold amount **$10,652**

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<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$9,972</td>
<td>$10,652</td>
</tr>
</tbody>
</table>

**FY 2010 Changes**

- **CMG Changes**
  - Changes to Relative Weights
  - Changes to Average Length of Stay
- **Updates based on FY 2008 IRF Claims and FY 2007 Cost Report data**
FY 2010 Changes

- Pre-Admission screening
- Close medical supervision by qualified personnel
- Coordinated interdisciplinary team approach to care

FY 2010 Changes

- A 3 to 10 day evaluation period post admission no longer allowed
- Word “multidisciplinary” replaced by “interdisciplinary”
- Interdisciplinary team meetings at least once per week
Polling Question #1

At your facility, is the documentation of the pre-admission assessment currently retained in the medical record?

* 1 Yes
* 2 No

Pre-Admission Screening

- Clinician conducting the screening must be appropriately trained and qualified
- Each prospective patient’s condition and medical history is reviewed - is patient likely to benefit from intensive IRF program
- Documentation of screening retained in IRF medical record
**Pre-Admission Screening**

- If performed more than 48 hours prior to admission must be updated in person or by phone within 48 hours of admission
- Must be documented in the patient’s medical record to update medical and functional status
- Pre-admission screening conducted only by telephone without review of acute care hospital records by licensed clinical staff is not acceptable

**Post-Admission Physician Evaluation**

- Review of the medical history and validate patient’s condition on admission
- Supports medical necessity of admission
- Includes documentation to understand rationale for admission decision
- Documentation retained in the medical record
**Individualized Overall Plan of Care**

- Must be completed by end of fourth day following admission
- Must be retained in the medical record

**Close Medical Supervision**

- IRFs must furnish:
  - Rehabilitation nursing
  - Physical therapy
  - Occupational therapy
- As needed
  - Speech-language pathology
  - Social services
  - Psychological services (including neuropsychology)
  - Orthotic and prosthetic services
Close Medical Supervision

- Rehab physician – reassessment of patient’s functional goals at least 3 times per week and document these visits in the medical record
- IRF’s may increase frequency of physician visits if it best serves their patient population

Coordinated Interdisciplinary Team Approach

- Periodic clinical documentation in medical record
- Team conferences at least once a week - must be documented
- Team must include:
  - Rehabilitation physician
  - Registered nurse with rehab experience
  - A social worker or case manager
  - Therapist with current knowledge of the patient from each discipline treating the patient
Coordinated Interdisciplinary Team Approach

- First team conference within first week of the patient’s admission to the IRF
- Rehab physician must document concurrence with all decisions made at each meeting
- Documentation must include progress toward goals
- Documentation retained in IRF medical record

Intensive Rehabilitation Therapy

- 3 hours per day at least 5 days per week
- Therapy must begin within 36 hours of midnight of the day of admission
- Therapy evaluations satisfy the requirement
Intensive Rehabilitation Therapy

- Intensive rehabilitation therapy could be shown if patient benefits from at least 15 hours of therapy for 7 consecutive days starting from day of admission
- Patient’s periodic need for this program must be well documented in the medical record

Intensive Rehabilitation Therapy

- Group therapy should be an adjunct to individual therapy
- If group therapy better meets patient needs on limited basis, rationale should be documented in the medical record
60 Percent Rule Calculations

- 60% of IRF inpatient population must require rehab services for one or more of 13 specified conditions
- If 50% of IRF’s inpatient population is Medicare, presumptive method can be used
  - Computer software used to examine IRF PAI
  - If one of 13 conditions is present, patient is counted in IRF’s compliance percentage

60 Percent Rule Calculations

- Computer software computes presumptive compliance percentage (total number meeting compliance divided by total number of IRF PAI's submitted by IRF)
- If Medicare Part A patients less than 50% of total inpatient population, a sample of medical records from the IRF’s total inpatient population
Polling Question #2

Are Medicare Part A, Fee for Service patients less than 50% of your total inpatient population?

*1  IRF Freestanding Facility - Yes
*2  IRF Freestanding Facility - No
*3  IRF Hospital Unit - Yes
*4  IRF Hospital Unit - No

60 Percent Rule Calculations

• Medicare Part C (Medicare Advantage) Patients will be included in this calculation
• IRF must submit IRF PAI for each Medicare Part C patient admitted or discharged from IRF on or after October 1, 2009
• If facility does not submit an IRF PAI for each Medicare Part C patient—facility forfeits ability to have these patients included in compliance calculations
Coding Challenges for the Patient Assessment Instrument (PAI)

Impairment Group 14 - Major Multiple Trauma

- **14.1** Brain + Spinal Cord
- **14.2** Brain + Multiple Fractures/Amputation
- **14.3** Spinal Cord + Multiple Fractures/Amputation
- **14.9** Other Multiple Trauma
Impairment Group 16 - Debility

- Etiology for IGC 16
  - Should not be Debility
  - Look for why the patient has become debilitated
- Do not use IGC 16 when patient meets criteria for another IGC

Impairment Group 17 - Medically Complex Conditions

- Reason for admission is for medical management
- Therapy is secondary to the medical management
- May not be able to tolerate 3 hours of therapy a day
What’s In the Future for IRF?

Audits - Are You Prepared?

- Recovery Audit Contractor (RAC)
- Medicaid Integrity Contractor (MIC)
Polling Question #3

Do you plan on having an outside audit to prepare for the RAC?

* 1 IRF Freestanding Facility - Yes
* 2 IRF Freestanding Facility - No
* 3 IRF Hospital Unit - Yes
* 4 IRF Hospital Unit - No

Post Acute Care Initiatives

- Post Acute Care: Patient Assessment Instrument and Payment Reform Demonstration (RTI International)
  Medicaid Integrity Contractor (MIC)
  • CARE Tool
- Bundling
  • SHAPE - Study of Hospital and Post-acute care episodes
Resource/Reference List

- ICD-9-CM Official Guidelines for Coding and Reporting, Effective October 1, 2009

- ICD-9-CM Index and Tabular addenda
  http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

- Federal Register, Friday, August 7, 2009
  Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal FY 2010; Final Rule pp. 39762-39838

- AHIMA Coding Physical Medicine Rehabilitation Community of Practice
  www.ahima.org

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    October 1, 2009

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    October 22, 2009

Physician Practice E/ M Guidelines
    November 10, 2009
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Resource/ Reference List


http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

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