Rehabilitation coding

by Ralph Renteria, RHIT and
Dawna M. Toews, MBA, RHIT, CCS

What is rehabilitation coding?

An IRF is an inpatient rehabilitation facility or part of a rehabilitation hospital, which provides an intensive rehabilitation program to inpatients. IRF provides nursing care to inpatients on a 24-hour basis, under the supervision of a doctor and a registered professional nurse. IRF covers daily charges for room and board, ancillary charges, routine charges and charges for other services ordinarily covered in a general hospital.

The intent of this article is to introduce and explain the process of the post-acute care coding at the acute inpatient rehabilitation setting. The type of coding used and how it differs from the acute inpatient hospital coding will be explained.

Historical information

The Center for Medicare and Medicaid Services (CMS) requires the Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF-PAI) to be completed as part of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) effective January 1, 2002. The data are gathered to determine the payment for each Medicare Part A fee-for-service patient admitted to an inpatient rehabilitation unit or hospital.

The rehabilitation unit or hospital must provide intensive inpatient rehabilitation services to an inpatient population that includes patients being treated for:

- Stroke
- Congenital deformity
- Spinal cord injury
- Amputation
- Brain injury
- Major multiple trauma
- Hip fracture
- Burns
- Polyarthritis (including rheumatoid)

These diagnoses must make up 75% of the population and patient services must include: Physician monitoring and some rehabilitation nursing, therapies, psychosocial and orthotic and prosthetic services.

The development of the Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities was begun in 1993 at the VA Medical Center in Los Angeles when Functional Related Groups (FRGs) were used as a possible basis for payment. The Secretary of Health and Human Services established Case Mix Groups (CMGs) and classifications. In 2001 the Final Rule for the inpatient rehabilitation PPS was published.

The IRF-PAI must be completed before transmittal to CMS. Federal regulations require that data must be collected and entered into the data collection software within a specific time period. If the patient's stay is less than three calendar days, the staff of the rehabilitation facility must complete the IRF-PAI admission items but do not have to complete all the discharge IRF-PAI items. When coding short lengths of stay, it is permissible to use the same scores at discharge that were used on admission.

How to code an IRF account

Determine the ICD -9-CM code that best describes the primary reason for the patient's admission to the rehabilitation program.

At the acute rehabilitation coding setting, the focus is on the *aftercare* of the patient and services. For example, there are four general types of conditions that are diagnosed in the post acute care facility: Aftercare following treatment of an acute disease or injury; late effects of an illness or injury; chronic conditions; and, acute illnesses. Late effect codes and V-codes are used to identify aftercare following initial treatment of a condition. For example, if a patient suffered a stroke and was admitted at the acute hospital, the principal diagnosis code would be 434.91 (CVA). When the patient is discharged to a rehabilitation hospital, the initial rehabilitation aftercare code would be V57.89 (rehabilitation procedure code) and would be applied as the principal diagnosis as well as 438.20 (Late effect of CVA) as the secondary diagnosis. Comorbidities are also coded and included in the abstract. The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) is used to influence the calculations of Case Mix Groups (CMG) that determines payment. Coding of diagnosis in the post-acute rehabilitation setting adheres to the same established ICD-9 coding guidelines and conventions as the acute hospitals.

Under the inpatient rehabilitation facility prospective payment system (IRF PPS), a case-mix is an adjusted payment for varying numbers of days of IRF care and is made using one of 93 Case Mix Groups (CMG). On Medicare claims these CMGs are represented as Health Insurance Prospective Payment Systems (HIPPS) codes. HIPPS codes are determined based on assessments made using the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI).

The Impairment Group Code (IGC) consists of a two-digit number that indicates the major impairment group and is followed by a decimal and 1-4 additional digits that identify the subgroup. Some IGCs have no subgroups and are indicated with the two-digit number. Avoid using Impairment Code 13 as this is a non-specific IGC. Usually the IGC will be the same at admission and discharge. If there is a change during the stay the IGC should be changed at discharge to reflect the shift in patient care focus. The CMG used for payment is based on the IGC assigned to the patient at admission and is not affected by the change of the IGC at discharge. Please note the IRF Training Manual (01/16/2002 version) at www.cms.gov/inpatientrehab for detailed information regarding Impairment Group Codes.

Another interesting difference in IRF-PAI coding is that the date of onset of the condition must be entered. If the patient is admitted for care of a stroke, enter the date of the most recent stroke. If care is for aftercare of surgery, enter the date of the surgery. If the patient is admitted for

aftercare of a neurological condition enter the date of exacerbation of the neurological condition. If admission is for aftercare of a traumatic injury enter the date of injury. Aftercare of arthritis should have the date of diagnosis entered for the date of onset. The date of birth is entered for congenital deformities or developmental disabilities. For a medical complex condition enter the date of admission to an acute hospital for the care of that condition.

In the world of health information \management, it is well known that coding is of vital importance to the needs of the hospital and for the various services it provides; billing/reimbursement, statistical data, research, performance improvement as well as medical necessity of treatment. When coding at the acute inpatient hospital setting, the coding at the general hospital is focused on the principal diagnosis and codes the *initial* admission of why the patient was admitted/hospitalized. The acute coding function is performed through a review process of the medical record, selection of diagnosis and procedure codes, assignment of codes, sequencing of codes and finally entry of coded data into a database (abstracting). Reimbursement for the acute hospitals is primarily based on a diagnosis related group (DRG) payment method.

Coding an encounter for an inpatient rehabilitation facility focuses on the coding the aftercare code as the principal diagnosis. This is followed with up to ten ICD- 9-CM codes for comorbid conditions. Comorbidity has the same definition at an IRF facility as at an acute care hospital. Enter ICD-9-CM codes for conditions diagnosed during admission assessment or anytime during the stay. Conditions recognized or diagnosed the day prior to the day of discharge or on the day of discharge should not be coded. As with acute care coding, the more complete and accurate the documentation is the more accurately the payment system can reflect patient resources used by the IRF over time.

Another aspect of the coding function that helps with coding accuracy and reimbursement is working closely with case management on a daily basis. This practice ensures that the coder is kept in the loop with any new diagnosis or co-morbidities that may affect reimbursement and the length of stay. This is also a very useful way to query a physician when a questionable diagnosis is present. The case manager working with a patient may happen to notice a change in the patient and report it which may result in contacting the physician to evaluate and diagnose.

In conclusion, rehabilitation coding versus the general acute hospital coding are two very unique types of coding that deliver the same information and data to the needs of their respective facilities and the patient's physician. First of all, in the rehabilitation setting, there are very few procedures performed; insertion of a PICC line, blood transfusion and dialysis, etc., compared to major surgeries and procedures in the acute hospital. Coding in the rehabilitation setting is focused on the rehabilitation of the patient and the main reason the patient is in the rehabilitation facility. The ICD-9-CM codes are entered into the encoder to communicate the reason for the inpatient stay at an inpatient rehabilitation facility to receive aftercare for those diagnoses listed at the beginning of this article.

Please note that this is not a comprehensive article encompassing all aspects of abstracting, coding and billing of an IRF encounter. You are encouraged to visit the Web site at www.cms.gov/InpatientRehavFacPPS in order to obtain a complete document of all aspects pertinent and required by CMS in the coding of an IRF encounter. Another excellent source of

information pertaining specifically to IRF-PAI coding is found in various *Coding Clinic* issues from the American Hospital Association (AHA).

References
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Ralph Renteria, RHIT, is the HIM Manager at San Joaquin Valley Rehabilitation Hospital.
Dawna M. Toews, MBA, RHIT, CCS, is the Associate Director, Hospital Coding for the Northern California Region, Kaiser Permanente.