CDI for Acute Inpatient Rehabilitation Facilities

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Learning Objectives

At the completion of this educational activity, the learner will be able to:

- Explain Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI) 60% rule and the role of CDIS
- Describe the Impairment Group Code (IGC), Rehab Impairment Category (RIC), and how these differ from MS-DRG and the MDCs
- Describe etiologic diagnosis, comorbidity tier, Functional Independence Measure (FIM), Case Mix Group (CMG) & quality indicators
- Understand how to utilize evidence in the medical record to formulate compliant rehab queries and educate the providers
- Understand the need to work collaboratively with PPS coordinators, therapists, coders, physicians, etc.
- Understand the difference between IRF-PAI and form UB-04
IRF-PAI 60% Rule

- Inpatient rehabilitation facilities patient assessment instrument
  - If an IRF admits >50% of Medicare Fee For Service (FFS) or Medicare Advantage (MA), it must then comply with the following:
    - At least 60% of the total inpatient population must have required intensive multi-disciplinary rehab services in 13 listed conditions
    - The calculation includes Medicare patients and others
    - Both primary and comorbid conditions are included
13 Qualifying Conditions for 60% Rule

1. Stroke
2. Congenital deformity
3. Spinal cord injury
4. Amputation
5. Brain injury
6. Multiple trauma
7. Hip fracture
8. Burns
9. Neurological disorders
10. Active arthritis*
11. Systemic vasculidities with joint inflammation
12. Severe or advanced osteoarthritis*
13. Knee or hip joint replacement*
Impairment Group Code

- **IGC**: Item 21 on IRF-PAI: Best describes the **primary reason** for the admission to IRF
- Similar to **principal diagnosis** used in acute care setting
- Be as specific as possible in selecting the IGC: It affects CMG, reimbursement, and ELOS
- For most cases, the IGC at discharge is the same as admission IGC
- **Exception**: If patient develops another impairment during the IRF stay that uses more resources than the admission IGC
Impairment Group Code cont.

Impairment Group Codes are grouped into 17 Categories

- 01. Stroke
- 02. Brain dysfunction
- 03. Neurological conditions
- 04.1. Spinal cord dysfunction (non-traumatic)
- 04.2. Spinal cord dysfunction (traumatic)
- 05. Amputation
- 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 (non-cardiac, non-pulmonary)
- 17. Medically complex
Rehabilitation Impairment Category

• RIC classifies patients with similar IGC into same category, IGC→RIC

• Think of RIC as similar to MDCs, there are 21 RICS

• RICs are the first level of classification for the payment (CMG) categories

• RIC is not recorded on the IRF-PAI but is assigned by the grouper software
Rehabilitation Impairment Category List

- 01: Stroke
- 02: Traumatic brain injury
- 03: Non-traumatic brain injury
- 04: Traumatic spinal cord injury
- 05: Non-traumatic spinal cord injury
- 06: Neurological conditions
- 07: Fracture of lower extremity
- 08: Replacement of lower extremity
- 09: Other orthopedic
- 10: Amputation of lower extremity
- 11: Amputation of non-lower extremity
- 12: Osteoarthritis
- 13: Rheumatoid, other arthritis
- 14: Cardiac
- 15: Pulmonary
- 16: Pain syndrome
- 17: Major multiple trauma w/o TBI or SCI
- 18: Major multiple trauma w/ TBI or SCI
- 19: Guillain Barre Syndrome
- 20: Miscellaneous
- 21: Burns
Etiologic Diagnosis

• The problem that led to the condition for which patient is receiving rehab

  – Example: A patient with acute ischemic stroke with left-sided hemiplegia received acute care and now admitted to rehab due to hemiplegia to help the patient adapt or regain motor function.

    ➢ IGC: Left-sided hemiplegia (IGC 01.1: Left Body Involvement [Right Brain])
    ➢ EDx: Acute Ischemic Stroke (ICD-10 code I63.9)

• This must be documented by the provider

• The codes are based on ICD-10 codes
Mr. Smith is a 70-year-old with complex medical history including TBI, CHF, CKD, multiple falls, admitted after a fall at home with displaced intertrochanteric fracture of the left femur. S/P ORIF of left femur prior to admission to acute inpatient rehabilitation.

• What is the IGC?
  – A. Hip Fracture
  – B. TBI
  – C. ORIF of left femur
    • Answer A 08.11 Status post unilateral hip fracture

• What is the etiologic diagnosis?
  – B. TBI
  – B. Fall
  – C. Displaced intertrochanteric fracture of the left femur
    • Answer C
IGC & Etiologic Diagnosis Practice Quiz cont.

This is a 65-year-old male with history of stroke and left residual weakness admitted to acute rehab after being involved in a MVA, patient was a passenger in the front seat & sustained a T4 compression fracture resulting in paraplegia.

• What is the IGC?
  – A. Left hemiplegia
  – B. Paraplegia
  – C. Fracture (other orthopedic)
    • Answer B 04.210 Paraplegia, unspecified

• What is the etiologic diagnosis?
  – A. Stroke
  – B. Compression fracture of the 4th thoracic vertebra, initial encounter
  – C. Paraplegia
    • Answer B
Comorbidity Tier

- Comorbid/secondary conditions a patient may have that are impacting the rehab are categorized into tiers

- Think of comorbidity tiers as similar to MS-DRG MCC/CC

- The tiers are as follows:
  - Tier 1 (B-Tier): Highest weighted tier
  - Tier 2 (C-Tier): Moderate weighted tier
  - Tier 3 (D-Tier): Lowest weighted tier
  - No tier is represented in the CMG with letter ‘A’

- The comorbid conditions must be accurately documented by the provider
Comorbidity Tier cont.

- The comorbid conditions must be coded with ICD-10 codes
- The codes must be entered on item 24 of the IRF-PAI
- You can enter up to 25 comorbid conditions
- The comorbid conditions could be present on admission or developed during the patient’s stay
- Any condition that occurred after the admission must also be entered on item 47 of the IRF-PAI
- Do not code any condition that occurred on the day or a day before discharge
Functional Independence Measure (FIM)

- FIM score instrument is a basic indicator of patient disability
- It’s used to track the changes in the functional ability of a patient
- The FIM admission assessment is done within 72 hours of start of Rehab
- The lowest score of any 24 hour period is recorded on the IRF-PAI by the 4th day
- Discharge FIM assessment score is collected within 72 hours prior to discharge
Functional Independence Measure cont.

• FIM comprised of 18 items, grouped into 2 subscales – motor and cognition.
• 12 out of 13 motor scores are used as final part of all the CMGs in all the RICs
• It helps to determine the reimbursement in all the RICs
• Cognition scores only help in determining reimbursement for RIC 01, Stroke and 02, Traumatic Brain Injury
• CDI need to review all the records to make sure that only the lowest FIM of the first 72 hours of admission are recorded in IRF-PAI
Functional Independence Measure cont.

- FIM instrument could be entered by any trained clinician (e.g., nurses, PT, OT, etc.)
- Remember, different environments or times of the day could affect patient’s function, please record the lowest rating
- The FIM focuses on what a patient is **doing or does** and not what the patient **should** be able to do
- It’s imperative that the CDIS review the nurses and therapists notes to make sure that the lowest scores were recorded
# FIM Motor Versus Cognition Items

## Motor Items
- Eating
- Grooming
- Bathing
- Dressing-upper body
- Dressing-lower body
- Toileting
- Bladder management-level of assistance
- Bladder management-accident frequency
- Bowel management-level of assistance
- Bowel management-accident frequency
- Transfers: bed, chair, wheel chair
- Transfers: Toilet + walk/wheel chair + Stairs
- Transfers: Tub *(Excluded in determining the CMG)*

## Cognition Items
- Comprehension
- Expression
- Social interaction
- Problem solving
- Memory
FIM Instrument Sample
Case-Mix Group (CMG)

- Distinct group(s) used in classifying patients based on clinical characteristics and expected resource needs

- CMG determines the reimbursement to IRF (similar to MS-DRG)

- It comprises of a **letter** and **4 digits**, e.g. **B0303** (Non-traumatic brain dysfunction with a B tier)

- IGC \( \Rightarrow \) RIC + FIM + Comorbid Condition \( \Rightarrow \) CMG
Case-Mix Group (CMG) cont.

- Impairment group code is used in determining CMG in all RICS
- FIM motor score is used in determining CMG in all RICS
- Cognitive Score only play a role for CMGs in RIC 01, Stroke, & RIC 02, Traumatic brain injury
- Age only play a role for CMGs in RIC 01, Stroke, RIC 04, Traumatic spinal cord injury, & RIC 08, Replacement of LE
Special CMGs

• 5 Special CMGs
  – Short stay, LOS < 3 days  → 5001
  – Expired, Orthopedic, LOS ≤ 13 days  → 5101
  – Expired, Orthopedic, LOS ≥ 14 days  → 5102
  – Expired, Non-Orthopedic, LOS ≤ 15 days  → 5103
  – Expired, Non-Orthopedic, LOS ≥ 16 days  → 5104
Quality Indicators (QIs)

- Quality indicators are now a big part of the IRF-PAI starting October 1, 2016

- Every IRF must accurately complete each section of the QI in a timely manner

- The CMS provides the guidelines and the rubric for scoring each section of the QI

- A facility will be assessed 2% penalty for the year if it fails to comply with any section of the QI

- CDI must pay attention to make sure every condition that is POA is documented as such
## Unadjusted Reimbursement Table FY 2018

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Case Sample 1

Mr. Johnson is a 68-years-old African American admitted with traumatic brain injury after a motor vehicle (Auto Vs Ped) accident. Patient was initially treated in the Intensive Care Unit and now admitted to acute Rehab for intensive multi-disciplinary rehabilitation therapy...

Assessment/Plan
1. Traumatic Brain injury
2. History of CHF, last know EF, 45%
3. Swallowing difficulty, speech therapist recommends pureed diet with thickened liquid
4. Gait instability
5. HTN
6. Migraine
Case Sample 1 cont.

Based on the above documentation, the provider was queried by the CDIS with regards to the swallowing difficulty and the type of CHF:

Provider’s response: **Dysphagia** (C Tier) and **Systolic CHF** (D Tier)

<table>
<thead>
<tr>
<th></th>
<th>Before the Query</th>
<th>After the Query</th>
</tr>
</thead>
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</tbody>
</table>
Sample Query

Patient Name___________________________________________________Date of Admission___________

Dear Dr. /Provider______________________________________________________________

Clinical documentations/information on the patient’s record indicates swallowing difficulty. For accurate Impairment Group Code, the Comorbidity tier, and the CMG assignment to reflect the level of rehabilitation services provided, could you please select all the diagnoses that apply to the patient based on your clinical judgement.

☐ Dysphagia

☐ Aphasia

☐ Aphagia

☐ Swallowing difficulty without further diagnosis

☐ Other (Please specify)_________________________________________________________

Signature_________________________________________Date_________Time__________

Clinical Documentation in the record___H & P , note the date____________________________________

Lab. Results_______________________________________________________________

Diagnostic Work Up____Modified Barium Swallow_________________________________________

Extended Length of Stay

Therapists/Nurses Documentation__Speech Therapist Note “Pt demonstrated moderate oropharyngeal dysphagia without aspiration sign and symptoms.”

Increase in resource utilization____Multi-disciplinary team________________________________________

Other__________________________________________________Name_________________________________________________(CDS) Date__________Time:___________________
Case Sample 2

Mr.------------- is a 63-years-old Caucasian male admitted to the acute Rehab due to paraplegia secondary to traumatic spinal cord injury at L1. Patient was initially admitted to the hospital on ---------2017 and transferred to the Rehab on ---------2017. Patient will require multi-disciplinary rehabilitation care in order to help him maximize his functional status before going home.

Assessment/Plan
1. Paraplegia
2. S/P fall
3. Intermittent AMS
4. History of HTN
5. DM2, on insulin sliding scale
6. History of cataract surgery
Case Sample 2 cont.

Based on the documentation of the history of DM2, insulin sliding scale, and the blood sugar level below, CDI queried the provider:

Provider's response: DM2 with Hyperglycemia

<table>
<thead>
<tr>
<th></th>
<th>Before the Query</th>
<th>After the Query</th>
</tr>
</thead>
<tbody>
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</table>
Sample Query 2

Patient Name___________________________________________________ Date of Admission__________

Dear Dr. /Provider______________________________________________________________

Clinical documentations/information on the patient’s record indicates abnormal blood sugar level and type 2 diabetes. For accurate Impairment Group Code, the Comorbidity tier, and the CMG assignment to reflect the level of rehabilitation services provided, could you please select all the diagnoses that apply to the patient based on your clinical judgement.

☐ Hyperglycemia

☐ Hypoglycemia

☐ Elevated blood sugar without clinical significance

☐ Type 2 Diabetes with diabetic complication (please specify the complication)

☐ Type 2 Diabetes without diabetic complication

☐ Other (Please specify)__________________________________________________________

Signature_________________________________________ Date_______ Time__________

Clinical Documentation in the record____Type 2 DM on prog. notes... (dates) ________________________________

Lab. Results__Accu Checks results 176mg/dl, 237mg/dl, 228mg/dl, 234mg/dl _________________________

Diagnostic Work Up_____________________________________________ Extended Length of Stay

Therapists/Nurses Documentation______________________________________________________________

Increase in resource utilization ________________________________________________________________

Other____Regular Insulin Lispro sliding scale, Last dose given, 4 units______________________________

Name_________________________________________________(CDS) Date__________ Time:______________
Case Sample 3

History of Present Illness
A 74-year-old female transferred from ... after she sustained a stroke. Patient was in the shower, started having left upper and lower extremity weakness. She was found to have right corona radiata stroke. Patient received TPA and started working with PT and OT. Patient continues to have left upper and lower extremity weakness.

Assessment/Plan
1. Right corona radiata stroke s/p TPA, continue ASA and Lipitor. PT/OT
2. HTN: continue losartan
3. HLD: continue Lipitor.
4. ESRD, appreciate Nephro dispo: acute rehab
Case Sample 3 cont.

CDI reviewed this record and noted that patient was on hemodialysis (HD) based on HD nurse’s documentation. Code N18.6 (ESRD) was reported by the coder but missed code Z99.2 (Renal Dialysis dependence). The mismatch was reconciled **N18.6 (A tier), Z99.2 (B tier)**

<table>
<thead>
<tr>
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<th>After Reconciliation</th>
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<td>Difference</td>
<td>-$5,810.96</td>
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</tbody>
</table>
Sample Case 4

This is a 79-year-old male admitted to acute care hospital for NSTEMI, UTI and PNA. S/P TURP. History of severe psoriatic arthritis, anemia, multiple falls, lives alone. Patient is extremely weak and would benefit from acute rehab to maximize his functional independence and safety. Will admit to Rehab once medically cleared.

Assessment/Plan
1. NSTEMI continue
2. Status Post TURP
3. Anemia
4. Multiple Falls
5. Psoriatic Arthritis
Sample Case 4 cont.

Based on the fact that patient was treated for PNA in the acute care hospital and the patient was still on IV Meropenem while in the Rehab, CDI queried the provider.

Provider documented Resolving PNA on the query form

<table>
<thead>
<tr>
<th></th>
<th>Before the Query</th>
<th>After the Query</th>
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</table>
Sample Query 3

Patient Name___________________________________________________ Date of Admission___________

Dear Dr. /Provider______________________________________________________________

Clinical documentations/information on the patient’s record indicates IV antibiotics treatment. For accurate Impairment Group Code, the Comorbidity tier, and the CMG assignment to reflect the level of rehabilitation services provided, could you please select all the diagnoses that apply to the patient based on the use of antibiotics and your clinical judgement.

☐ Prophylactic__________________________________

☐ Pneumonia (Please specify organism if known)________________________

☐ Urinary Tract Infection (Please Specify organism if Known)____________________

☐ Other (Please specify)______________________________________________

Signature_________________________________________ Date_________ Time__________

Clinical Documentation in the record__ Prog. note (date) Continue IV antibiotic order________________

Lab. Results__________________________________________________

Diagnostic Work Up_____________________________________________

Extended Length of Stay

Therapists/Nurses Documentation____________________________________________

Increase in resource utilization______________________________________________

Other__ IV antibiotic, Meropenem______________________________________________

Name________________________________________________ (CDS) Date__________ Time:___________________
Sample Case 5

This is a 68-year-old male admitted to acute inpatient due to severe sepsis and acute hypoxic respiratory failure. Patient was intubated on admission and extubated 4 days later. Patient with significant debility, and was admitted to acute rehab with encephalopathy.

Assessment/Plan

1. Acute Encephalopathy
2. Obesity
3. ESRD s/p renal transplant
4. HTN
5. Anemia

Continue with Rehab plan
Sample Case 5 cont.

Based on the documentation of obesity, CDIS reviewed the nurses' notes for the documentation of height, weight and BMI and found that patient's BMI was **42.5**. CDIS then queried the provider for morbid obesity.

Code **E66.9**, obesity (A tier), Code **E66.01**, morbid obesity (D-tier)

<table>
<thead>
<tr>
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<th>After the Query</th>
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</table>
Sample Query 4

Patient Name___________________________________________________Date of Admission___________

Dear Dr. /Provider______________________________________________________________

Clinical documentations/information on the patient’s record indicates obesity and high BMI. For accurate Impairment Group Code, the Comorbidity tier, and the CMG assignment to reflect the level of rehabilitation services provided, could you please select all the diagnoses that apply to the patient based on your clinical judgement.

☐ Obesity

☐ Overweight

☐ Morbid obesity due to excess calories

☐ Morbid Obesity due to other causes (Please Specify)______________________________

☐ Other (Please specify)_______________________________________________________

Signature_________________________________________Date_________Time_________

Clinical Documentation in the record___H& P (date), under assessment and plan “Obesity”_____
Lab. Results___BMI 42.5 documented on (mention the document and the date)______________________________
Diagnostic Work Up_____________________________________________Extended Length of Stay

Therapists/Nurses Documentation__Nutritional eval and follow up by the dietician. See the notes on (mention the dates) _____
Increase in resource utilization____Multi-disiplinary team_________________________________________
Other__________________________________________________Name________________________________________(CDS) Date__________Time:___________________
Sample Case 6

Mr. ... is a 67-year-old male admitted to acute rehab due to severe polyneuropathy secondary to Diabetes mellitus, type 2 and debility. Patient was transferred from acute hospital where he was treated for HHNS and stool C. diff. Past Medical history: DM2, HTN, Migraine, MI, CHF, CKD stage 3.

Assessment & Plan
1. Polyneuropathy
2. HTN
3. Debility
4. CHF
5. CKD, 3

Proceed with Rehab
Sample Case 6 cont.

In reviewing the record, the CDIS noted on the MAR that patient is still receiving vancomycin abx orally in addition to regular insulin and Lantus. CDIS then queried the provider to specify the reason for the abx.

Provider responded that abx is for the completion of C. Diff infection

<table>
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<tr>
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<th>After the Query</th>
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Sample Query 5

Clinical documentations/information on the patient’s record indicates IV antibiotics treatment. For accurate Impairment Group Code, the Comorbidity tier, and the CMG assignment to reflect the level of rehabilitation services provided, could you please select all the diagnoses that apply to the patient based on the use of antibiotics and your clinical judgement.

- [ ] Prophylactic
- [ ] Enterocolitis due to Clostridium Difficile
- [ ] Other bacteria infection (Please Specify organism if Known)
- [ ] Other (Please specify)

Signature_________________________Date_________Time________

Clinical Documentation in the record__H & P (date) “patient was treated for stool C.diff while in acute in patient.” ______

Lab. Results__________________________________________________

Diagnostic Work Up___________________________________________

Extended Length of Stay

Therapists/Nurses Documentation________________________________________________________

Increase in resource utilization______________________________________________

Other__Vancomycin antibiotic PO________________________________________________

Name_________________________________________________(CDS) Date__________Time:___________________
Sample Case 7

This is 86-year-old Caucasian male, S/P TURBT, transferred to acute rehab due to extreme weakness after receiving chemo therapy and radiation therapy. He will undergo physical and occupational therapy, further medical care and management.

Assessment/Plan
2. Gross hematuria as above
3. Gait instability
4. Long history of tobacco use in remission
5. Chronic Obstructive Pulmonary Disease, stable, handheld nebulizers prn
6. Status post recent pacemaker placement due to symptomatic bradycardia, stable
7. Anemia
Sample Case 7 cont.

After reviewing the record, CDI found the following CBC result: WBC 1.0 (normal 4-10.8), RBC 2.31 (Normal 4.6-6.20), Hgb. 7.7 (14.0-18.0), Hct. 24.3 (42.0-50.0), PLT. 57 (160-400). Patient was on chemo therapy. CDIS queried the provider for Pancytopenia. The provider responded: Chemotherapy induced pancytopenia.

<table>
<thead>
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</tr>
</thead>
<tbody>
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</table>
Sample Query 6

Patient Name___________________________________________________Date of Admission___________

Dear Dr. /Provider______________________________________________________________

Clinical documentations/information on the patient’s record indicates abnormal lab results and anemia. For accurate Impairment Group Code, the Comorbidity tier, and the CMG assignment to reflect the level of rehabilitation services provided, could you please select all the diagnoses that apply to the patient based on your clinical judgement.

☐ Pancytopenia

☐ Chemo Therapy Induced Pancytopenia

☐ Aplastic anemia

☐ Other Drug Induced Pancytopenia (Please specify the drug)______________________________________________

☐ Other (please specify)________________________________________________________

Signature_________________________________________Date_________Time__________

Clinical Documentation in the record _H & P noted that patient was on chemo therapy and radiation prior to admission to acute rehab_ Lab. Results___WBC 1.0 (normal 4-10.8), RBC 2.31 (Normal 4.6-6.20), Hgb. 7.7 (14.0-18.0), Hct. 24.3 (42.0-50.0), PLT. 57 (160-400). ___ Diagnostic Work Up______________________________________________

Extended Length of Stay

Therapists/Nurses Documentation______________________________________________

Increase in resource utilization____________________________________________________

Other________________________________________________________

Name___________________________________________(CDS) Date__________Time:___________________
FIM Motor Sample Error Affecting the CMG

Nurses documentation noted that the patient had bladder accident two consecutive nights, however, there was no FIM instrument completed by the nurses on those 2 nights.

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<th>After the correction</th>
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</table>
# Important Recap on CMG

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</tr>
<tr>
<td>FIM motor Score</td>
<td>Yes or No?</td>
</tr>
<tr>
<td>FIM Cognition</td>
<td>Yes or No?</td>
</tr>
<tr>
<td>Age</td>
<td>Yes or No?</td>
</tr>
</tbody>
</table>
Physician Responsibility & Engagement

• Postadmission Physician Evaluation (PAPE)
  – Must be completed by a rehabilitation physician within the first twenty-four hours of admission to IRF
  – Clearly document patient’s status on admission to rehab
  – Document important changes since preadmission screen (if any), if none, note no changes
  – Accurately document the reason for admission with supporting evidence
  – Document patient’s condition prior to admission and the current medical and functional conditions and comorbidities
Physician Responsibility & Engagement cont.

- Postadmission Physician Evaluation (PAPE)
  - Clearly link the medical conditions to functional decline or deficits
  - Clearly document the relevant treatments, time-frame and the expectation
  - Justify the interdisciplinary approach including the nurses’ interventions
  - Must hold at least three face-to-face visits each week; although not required, daily progress note is the best practice
  - Must lead a weekly interdisciplinary team conference to evaluate overall plan of care
CDI Summary of Responsibility

• Due to complexity of the rules and the guidelines for IRF:

• CDI must work with physicians, PPS coordinators, coders, and others to ensure accurate documentation & coding

• CDI must engage the physicians to educate them on the importance of accurate documentation

• Ensure that the IGC reflects the reason, the resource utilization and the continuity of care

• Make sure the etiologic diagnosis is accurate

• Query for any gap in documentation
IRF-PAI Versus UB-04

• IRF-PAI, an 18-page document that must be completed on every patient admitted to IRF

• Every item on the IRF must be accurately completed

• UB-04, used in submitting the bill to Medicare post discharge

• Cannot be processed unless the IRF-PAI is submitted

• The CMG on the IRF-PAI must match the one on UB-04

• Not everything on IRF-PAI is included in UB-04
GRATITUDE!

It is my pleasure to express my profound gratitude to Dr. Roshan Shetty (Senior Director, CDIS, Optum360)
Claudia Schenke-Sen, Service Area Director, SoCal, Optum360
Leon Choiniere, CFO, Dignity Health, St. Mary Medical Center, Long Beach
Entire CDIS staff in SoCal Service Area, Optum360/Dignity Health
Lani Garcia & the entire Rehab staff at St. Mary Medical Center, Long Beach
Thank you. Questions?

Anthony.Nkwuaku@dignityhealth.org
cdimadeeasy24@yahoo.com

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the program guide.