Eli's Rehab Report

Inpatient Insights: Catch 2 Key Changes CMS is Brewing for IRF PPS in 2014

Big ouch: Arthritis cases fall under further scrutiny.

It's never too early to prepare for next year's inpatient rehab facility prospective payment system changes. The **Centers for Medicare and Medicaid Services** released its proposed IRF PPS rule for 2014 and is wrapping up its comment period on July 1.

CMS proposes a two percent increase to IRF payments as well as two notable changes that could have a big impact on your facility operations: fewer presumptive compliance codes and more quality measures.

Brace Yourself: Presumptive Compliance ICD-9 List to Be Decimated

As has been the case for several years, sixty percent of your patients must demonstrate the need for IRF-level rehab for you to get paid at the higher IRF PPS rates. Most notably, these patients must have at least one of 13 conditions (listed by CMS) that require intensive rehab.

While the 60 Percent Rule and the 13 conditions are set to stay the same, CMS wants to tighten the diagnostic coding standards that qualify patients for these 13 conditions.

How it works: CMS determines your IRF's compliance to the 60 Percent Rule either via medical review or the "presumptive" method. Under the presumptive method, CMS compares your patients' diagnosis codes with a "presumptive compliance" list of ICD-9 Codes. For 2014, CMS proposes to remove certain codes from the presumptive compliance list, arguing, "the described conditions would not prove compliance in the absence of additional facts that would have to be pulled from a patient's medical record."

"The codes removed typically require additional facts to support compliance, and these would be in the medical record," says **Angie Phillips, PT,** president of **Images & Associates** in Irving, TX. "As always, IRFs must be sure that the documentation in the medical record from the preadmission assessment throughout the stay is sufficient to support the admitting diagnosis and the need for an inpatient rehabilitation stay.

Biggest hit: Industry experts are most concerned about the removal of the arthritis codes.

"The impact of the presumptive compliance code revisions depends on each provider, but those who admit more arthritis cases will be more directly affected," notes **Doug Baer,** vice chair of the **American Medical Rehabilitation Providers Association** (AMRPA), and president/CEO of **Brooks Rehabilitation** in Jacksonville, FL. "That could lead to some patients having their access denied, which is another one of our concerns."

Clarification: The proposed rule does not remove arthritis as an IRF-level rehab condition it only removes it (and the other aforementioned ICD-9 Codes) from the list for "presumptive" eligibility. That means these cases would be subject to a medical record review method, instead.

"This change would, however, make the arthritis cases more difficult to qualify," Baer points out. "So, providers really need to assess how many arthritis cases they have, which would be essentially subject to review."

The second-biggest hit to the presumptive compliance codes is the proposed removal of "non-specific" ICD-9 Codes. CMS' rationale behind removing so many unspecified ICD-9 Codes was to prepare for the transition to ICD-10 (whose coding methodology is innately more specific).

Note: "While non-specific codes were removed, IRFs can still qualify these patients under presumptive rules by using more specific codes," Phillips clarifies.

"IRFs need to study how they're coding now, compared to the proposed rule and the codes set to be eliminated," Baer recommends. "If they are using some unspecified codes, they should look for ways to be more specific."

Example: "CMS proposes to remove 438.20 (Late effects of cerebrovascular disease, hemiplegia affecting unspecified side), but, 438.21 and 438.22, (Late effects ... affecting dominant and non-dominant sides) will remain," Phillips points out. "So, IRFs need to really focus on coding specificity and the documentation to support more specific codes."

Stay on Top of New Readmission Quality Measure

You're now familiar with the IRF Quality Reporting Program and documenting quality measures related to pressure ulcers and catheter-associated urinary tract infections. (For more information see related story in Eli's Rehab Report, Vol. 19, No. 11, Make Your IRF's Quality Reporting Rock Solid.) For 2014, CMS wants to keep the pressure ulcer and CAUTI measures and add three new ones:

- Percent of patients who were assessed and appropriately given seasonal influenza vaccine;
- Influenza vaccination coverage among healthcare personnel; and
- All cause unplanned readmissions within 30 days of discharge from IRFs.

With regard to the influenza vaccine the burden for the IRF would be more of a documentation and data capture issue, Phillips says, noting that many freestanding IRFs already have adopted flu vaccine practices.

Important: The readmissions quality measure is the one that rehab industry leaders are most concerned about.

"AMRPA is very active and supportive of the quality reporting effort," Baer says. "However, the measure related to readmissions is a particular concern because it is complex, and it could have potential long-term implications for IRFs."

In other words, rehab providers could begin changing the patterns of people they admit if readmissions are high for certain cases.

Good to know: "Whether IRFs realize it or not, unplanned readmissions are already being monitored, and these are reported on the PEPPER (Program for Evaluating Payment Patterns Electronic Report) report," Phillips says. At the same time, you'll want to consider communicating and collaborating more with post-discharge providers in ways to help limit unnecessary returns to the hospital, she adds.

Tip: Start implementing strong discharge planning and follow-up processes now. These steps should "assure that patient needs are met and that the patient and family are well prepared for discharge and understand the post-discharge plan and service needs," Phillips says."