



**American Hospital
Association**

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October 31, 2005

Herb Kuhn, Director
Center for Medicare Management
Mail Stop C5-15-12
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 20041

Dear Mr. Kuhn:

On behalf of the American Hospital Association's (AHA) 4,800 hospital, health system and other health care organization members, including approximately 1,200 inpatient rehabilitation hospitals and units, we are submitting the attached formal recommendations to standardize and simplify the ICD-9-CM coding requirements for reporting diagnoses, signs, symptoms and complaints for patients receiving inpatient rehabilitative services.

The AHA formed a Rehabilitation Coding Workgroup, a representative group of rehabilitation clinical coding experts from the hospital field, to identify areas where rehabilitation hospitals and units have specific clinical coding problems, and then work toward developing solutions. The Workgroup was fortunate to obtain input from Uniform Data System for Medical Rehabilitation (UDSMR), the Medicare contractor that assists with completion of the Inpatient Rehabilitation Facility Patient Assessment Instrument. In addition, we had invaluable input from the American Health Information Management Association, representing more than 45,000 specially educated health information management professionals who work throughout the health care field.

We believe our recommendations can significantly relieve the administrative burden on our rehabilitation hospitals and units, as well as ensure that the Centers for Medicare & Medicaid Services receives consistently coded information.

If you have questions or concerns regarding our recommendations, please call me or Nelly Leon-Chisen, director of coding and classification, at 312-422-3396.

Respectfully,

Carmela Coyle
Senior Vice President, Policy



Recommendations from the Inpatient Rehabilitation Facility Coding Workgroup

Background

Since the creation in January 2002 of the Medicare inpatient rehabilitation facility prospective payment system (IRF-PPS), inpatient rehabilitation facilities have been required to collect data using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI). The IRF-PAI requires facilities to assign an ICD-9-CM code for the etiologic diagnosis indicating the condition which caused the impairment, and for which the patient is receiving rehabilitation. Additional codes also are submitted to identify any other comorbid conditions present and ICD-9-CM codes are reported using the UB-92 claim form.

The "etiologic diagnosis" is a specific element of the IRF-PAI data set, with a specific definition, but 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.

About the Workgroup

The American Hospital Association (AHA) convened a Rehabilitation Coding Workgroup, a representative group of rehabilitation clinical coding experts, to identify specific clinical coding problem areas for rehabilitation facilities and work toward developing solutions. The Workgroup represented large, medium and small rehabilitation units and freestanding rehabilitation hospitals, and health systems from different geographical areas. The Workgroup was fortunate to be assisted by Uniform Data System for Medical Rehabilitation (UDSMR), the Medicare subcontractor that assists with the completion of the IRF-PAI via the CMS Help Desk, and the American Health Information Management Association (AHIMA), representing 45,000 specially educated health information management professionals who work in every segment of the health care field.

The Workgroup's mission was to identify specific clinical coding (ICD-9-CM) problem areas for rehabilitation facilities and then develop solutions. Input on ICD-9-CM problem areas was sought from Workgroup members as well as other AHA members. Workgroup members were asked to list their questions and develop proposed solutions. The questions then were sorted based on whether they related to ICD-9-CM coding on the UB-92 claim form or completion of the IRF-PAI.

The Workgroup had one face-to-face meeting in March 2005 and several follow-up conference calls. Additional discussions and fine-tuning of the proposed solutions were conducted via e-mail. Decisions were made through a general consensus process.

Recommendations

ICD-9-CM Coding on IRF-PAI vs. UB-92

We understand the need to maintain a separate etiologic diagnosis field (with separate and distinct instructions) for the reporting of etiologic diagnosis in order to meet the requirements of the IRF-PPS. However, we believe that specific changes can be implemented to simplify the process of reporting secondary diagnoses or comorbidities on both the IRF-PAI and the UB-92. Simplifying the process also will ensure that the Centers for Medicare & Medicaid Services (CMS) is supplied with consistent and reliable coded data.

- 1. Etiologic diagnosis should remain a separate field with its own definition and its own instructions.** The definition of etiologic diagnosis, as well as the selection of the ICD-9-CM code for this field, should remain consistent with the IRF-PAI training manual.
- 2. The reporting of comorbid or secondary conditions on the IRF-PAI should be allowed regardless of when these conditions developed during the rehabilitation facility stay, so long as they meet the Uniform Hospital Discharge Data Set (UHDDS) definition for additional diagnoses as noted in the *Official Guidelines for Coding and Reporting*.** 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. 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.”
- 3. The reporting of secondary diagnoses should be consistent between the UB-92 (following the *Official Guidelines*), and the IRF-PAI to allow ease of reporting, consistency of coding practices, comparability of data, and more complete reporting of the patient’s clinical picture.**

The reporting of all appropriate secondary conditions would identify any potential quality of care issues if complications or problems develop and the patient is

discharged without having addressed or resolved that problem. If there is a need to identify whether a particular comorbidity has developed on the day of discharge or the day prior to discharge, an additional field could be added to the IRF-PAI to identify these situations.

Secondary or comorbid conditions should be reported regardless of whether they have an impact on reimbursement. This will assure that a complete clinical picture of the patient is provided, and that CMS receives all clinical variables to use in potential future rate setting. Instructions can be provided to prioritize those conditions affecting reimbursement.

- 4. The application of the ICD-9-CM codes on the IRF-PAI should be as consistent as possible with the ICD-9-CM classification instructions and guidelines.** Without this consistency, there is confusion as to what codes should be assigned. Facilities then are faced with the dilemma of violating coding rules or foregoing additional reimbursement to which they may be properly entitled. More importantly, because of this confusion, CMS most likely is receiving incorrect – or at least inconsistent – data.

Examples include:

- Osteoarthritis of multiple joints – The training manual recognizes all the applicable ICD-9-CM codes for osteoarthritis while the 75% Rule does not. The 75% Rule only recognizes the codes for osteoarthritis of individual joints and not the codes for osteoarthritis of multiple sites. However, according to the ICD-9-CM classification, if a patient has osteoarthritis of multiple sites, a single code should be reported with a fifth digit of “9” to indicate multiple sites.
- ICD-9-CM rules require that diabetic manifestations be reported using category 250 first, followed by the manifestation (e.g. renal, gangrene, etc.), but the IRF-PAI etiologic diagnosis instructions require the code for the manifestation rather than the 250.xx code.

Example: 250.7x DM w peripheral vascular disease,
 443.81, peripheral angiopathy in diseases classified
 elsewhere,
 785.4.gangrene

Under current definitions, the IRF-PAI would show code 785.4 reported as the etiological diagnosis as the reason for the amputation, and codes 250.70 and 443.81 would be reported as co-morbid conditions. 785.4 would not be reported as a co-morbid condition as it is no longer present.

- Hemiplegia due to prior cerebrovascular accident – For example, a patient who has fractured a hip is admitted for inpatient rehabilitation, and has a comorbidity of a right or left hemiplegia due to a prior stroke. ICD-9-CM requires that the comorbidity be coded using codes 438.20, 438.21 or 438.22. Code 342.9x, Hemiplegia, unspecified, should not be assigned when the hemiplegia/hemiparesis is a late effect of cerebrovascular disease. However, the IRF-PPS only recognizes 342.9x, Hemiplegia, unspecified, under Appendix C – List of Comorbidities, as affecting a payment tier.
 - Dysphagia due to a prior stroke – Similar to the issue above for hemiplegia due to prior stroke, a patient could be undergoing inpatient rehabilitation due to a fractured hip. The patient had a previous stroke and was left with the residual of dysphagia. ICD-9-CM requires that this be coded with the combination code 438.82. Code 787.2 should not be assigned when the dysphagia is a late effect of cerebrovascular disease. However, the IRF-PPS only recognizes 787.2, Dysphagia under Appendix C – List of Comorbidities, as affecting a payment tier.
5. **When it is not possible for CMS to change the requirement for reporting of an etiologic diagnosis to be consistent with the ICD-9-CM instructions, explicit written clarification should be issued to all inpatient rehabilitation facilities regarding these exceptions.** As in the example listed earlier regarding diabetic manifestations, if it is not possible to change the reporting sequencing to be consistent with ICD-9-CM instructions to sequence the 250.xx code before the manifestation code, then we suggest that CMS provide additional education.
6. **Coding changes, as well as identification of comorbidity list changes should be communicated to facilities in a separate, easy to identify document.** These changes currently are included in documents related to computer logic changes or the IRF-PPS final rule; as such, the coding changes are easily missed and not always routed to the appropriate individuals within the facility.

Remaining Issues

A number of additional questions about ICD-9-CM coding as reported on the claim form came up during the Workgroup's deliberations. These were compiled and presented at the September 2005 meeting of the *Coding Clinic* Editorial Advisory Board. Once resolved, the questions will be published in a future issue of *Coding Clinic for ICD-9-CM*. As you may recall, all coding advice in this publication is approved by the Cooperating Parties. The Cooperating Parties are comprised of the National Center for Health Statistics, CMS, AHIMA and AHA.

The Workgroup hopes that the advice to be published in *Coding Clinic* along with the recommendations to CMS as outlined in this document, will help ease the administrative burden for rehabilitation facilities, ease the coding confusion, and improve the quality of rehabilitation administrative data in this country.

Herb Kuhn, Director

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