The Struggles and Triumphs of ICD-10-CM Implementation together with Changes to the 60% Presumptive Compliance Criteria

Ruth A. Leigh, RN, CRRN, CDIP, CCS
AHIMA Approved ICD-10-CM/PCS Trainer

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Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements.

Examples for general educational purposes only and subject to change. See CMS IRF PAI Training manual and Official Coding Guidelines for complete instructions.

This is NOT an ICD-10 Coding 101 presentation.

Intended audience: YOU.
The focus is on IRF presumptive compliance & capturing specificity of conditions, not a lesson in ICD-10 coding.
Facility Highlights

- 55 bed acute rehabilitation unit (5 units)
- CARF accredited: Comprehensive Inpatient, Stroke and Brain Injury Programs
- Medical Director: Board Certified in Physical Medicine & Rehabilitation, Board Certified in Spinal Cord Injury (3 PM&R’s, Hospitalists, Independent Internal Medicine Physicians)
- Over 30% of nurses possess CRRN (100+ nurses)
- Therapists with advanced certifications, including NDT and Dysphagia
- Brain Injury team comprised of Certified Brain Injury Specialists
- Dedicated brain injury unit
- The only acute rehabilitation facility in the area designed and built exclusively for inpatient rehabilitation
- > 84% of patients are discharged to home or community-based setting

Learning Objectives

- Discuss changes to the 60% Presumptive Compliance Criteria
- Identify ICD-10 rehab coding nuances between the UB and IRF-PAI
- Describe collaborative staff opportunities to improve 60% Presumptive compliance capture and improved ICD-10 coding

Goal: Ensure continued patient access while improving/maintaining 60% presumptive threshold with accurate and specific coding through supportive documentation
**IRF Documentation, Coding, & Reporting**

### Targeted Focus Areas

**Coverage Requirements**
- Reasonable & Necessary (admission justification - medical & functional needs est. need for IRF level of services)
- Capturing burden of care - medical complexity (severity of illness)

**Classification Criteria**
- 60% Presumptive Compliance Threshold

**Health Information Management & Billing**
- Abstracting, coding, & reporting of the claim to support treatment rendered; IRF-PAI & UB Claim ICD-10-CM coding
- Clinical Documentation Improvement (CDI)

**Reimbursement Analysis**
- Reviews / claim audits, proper reimbursement including accuracy, tiered comorbid reporting (revenue integrity); IRF-PAI analysis: RIC, comorbid tiering, FIM® rating practices

**Other Reporting**
- National Quality Measures (NHSN/CDC, CMS)
- State/hospital requirements

### Classification Criteria - 60% Presumptive Compliance

**Background: Compliance Percentage**

- At least 60% of an IRF's total inpatient population must be diagnosed with one or more of 13 medical conditions for that hospital to be classified as a rehabilitation facility and paid under the IRF PPS
- The Medicare Administrative Contractor (MAC) uses data from a specific time period - the compliance review period - to calculate the facilities compliance percentage.

The MAC has the discretion to perform random sample of medical record reviews an any time.
The MAC computes a percentage by either:

- **The Presumptive Method**
  - Under this method, the compliance threshold is met if a facility’s Medicare Part A FFS and Medicare Advantage population for the 13 specified compliance threshold conditions is at least 50% or more of the facility’s total inpatient population.
  - Using a CMS software program that analyzes the IRF PPS impairment group codes and the etiologic diagnosis and comorbidity codes (ICD-9-CM) or as of October 1, 2015, ICD-10-CM codes on the IRF-PAIs submitted to CMS during a specific compliance review time period.
  (For compliance review periods beginning on or after October 1, 2015, MACs may perform an additional mini-review of arthritis cases to ensure that such cases meet all regulatory requirements for inclusion in the IRF’s presumptive methodology compliance percentage); or

- **A Review of Medical Records** – Review of a random sample of medical records that represent the IRF cases treated during the compliance review time period.

### Classification Criteria - 60% Presumptive Compliance

#### 13 Conditions

1. Stroke
2. Spinal cord injury
3. Congenital deformity
4. Amputation
5. Major multiple trauma
6. Fracture of femur (hip fracture)
7. Brain injury
8. Neurological disorders including:
   - Multiple sclerosis
   - Motor neuron disease
   - Polyneuropathy
   - Muscular dystrophy
   - Parkinson’s disease
9. Burns

The following have specific additional criteria:

10. Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies
11. Systemic vasculidities
12. Severe or advanced osteoarthritis
13. Knee or hip joint replacement, or both
Classification Criteria - 60% Presumptive Compliance

REASONABLE and NECESSARY:
Meeting the Admission Criteria

- Its our job to know admission and classification criteria, not our referral sources of whom they can or should refer
- Focus placed on medical necessity (medical and functional needs)

REMEMBER:
• 60% of cases must meet a specified diagnosis, BUT
• 100% of cases must meet reasonable and necessary criteria

Classification Criteria - 60% Presumptive Compliance

Changes to the 60% Presumptive Compliance Criteria

The 60% Presumptive Compliance List Changes...

For compliance review period 1 (C1) list - With ICD-9-CM transition to ICD-10-CM same 60% presumptive conditions continue (no codes were to be ‘removed’ – only transition from ICD-9 to ICD-10)

Example - Cost reporting period: Jan 1-Dec 30
Review period (~ 4 months): Sept 1 – Aug 30

Sutter Health
Sutter Rehabilitation Institute
For compliance review periods 2 (C2) list - begins with the IRF-specific cost review period beginning on or after October 1, 2015, CMS

1. Removed ICD codes from the presumptive compliance listing:
   • Certain unspecified/nonspecific/not otherwise specified codes
   • Arthritis diagnosis codes
   • Miscellaneous codes
   • S/p amputation
   • Prosthetic fitting and adjustments diagnosis codes
   • Certain congenital anomaly diagnosis codes, etc

2. Removed specific IGCs from presumptive compliance (05.x Upper limb amputation, 06.1 Rheumatoid arthritis, 06.9 Other arthritis)

3. Increased conditions that would exclude a case from presumptive compliance - exclusionary IGC/etiologic condition pairing
   (ex: IGC 8.11 Unilateral Hip Fracture with Etiologic conditions: Unspecified femoral neck fracture = record fails/ not counted as a 60%er)

Classification Criteria - 60% Presumptive Compliance

Classification Criteria: A 60% Presumptive Compliance qualifying condition can possibly count under the following:

**Consideration:** IGC/Etiologic Dx - MUST MAKE SENSE TOGETHER!
Must be a certain specified Impairment Group Code listed in CMS files*
*IGC/Etiologic condition pairing: “Record fails” exclusions exist with IGC 1.9 Stroke, Traumatic/Non-traumatic Brain Dysfunction, certain Neurologic Conditions, Hip Fractures, Traumatic/Non-traumatic Spinal Cord Dysfunction, Major Multiple Trauma, etc

**Consideration:** Must cause significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation... (consider b documentation for this condition is “co-primary” focused)

Other conditions/ diagnosis may count under/ after medical records review*

**Age >85yr with specified joint repl. IGCs**
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html
So what’s the problem?

60% Rule Impact: ICD-9-CM code lists translated into ICD-10-CM using the General Equivalence Mappings (GEMs) tool

Impacts Compliance Review Period - 2

S06.5X9A Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter and S06.5X0A Traumatic subdural hemorrhage without loss of consciousness, initial encounter, if recorded in the etiologic diagnosis fields with Impairment Group Code 2.22 Traumatic Brain Dysfunction, will exclude the case from counting under the presumptive methodology for the 60 percent rule.
### ICD-10-CM IRF Coding Nuances & 60%er's

#### Traumatic Brain Injury

### PROBLEM: UNSPECIFIED CODES INTENDED REMOVED

From Exclusionary IGC/Etiologic Pairing List... (Compl. Rev Period 2)

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>GEM</th>
<th>ICD-10</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>852.29</td>
<td>SDH FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED</td>
<td></td>
<td>S06.5X0A</td>
<td>Traumatic subdural hemorrhage without loss of consciousness, initial encounter</td>
<td>REMOVED</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>S06.5X0A and S06.6X0A, if recorded in the etiologic diagnosis fields with Impairment Group Code 2.22, will exclude the case from counting under the presumptive methodology for the 60 percent rule.</td>
</tr>
</tbody>
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### IMPACT: RESULTING ISSUE

(Should still count?)

Regarding Exclusionary IGC/Etiologic Pairing List... (Compl. Rev Period 2)

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</tr>
</thead>
<tbody>
<tr>
<td>852.20</td>
<td>SDH FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED</td>
<td></td>
<td>S06.5X0A</td>
<td>Traumatic subdural hemorrhage without loss of consciousness, initial encounter</td>
<td>REMOVED INADVERDENTLY?</td>
</tr>
<tr>
<td>852.21</td>
<td>SDH FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH NO LOSS OF CONSCIOUSNESS</td>
<td></td>
<td>S06.5X0A</td>
<td>Traumatic subdural hemorrhage without loss of consciousness, initial encounter</td>
<td>REMOVED INADVERDENTLY?</td>
</tr>
<tr>
<td>852.26</td>
<td>SDH FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION</td>
<td></td>
<td>S06.5X9A</td>
<td>Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter</td>
<td>REMOVED INADVERDENTLY?</td>
</tr>
</tbody>
</table>

Crosswalks to same ICD codes

S06.5X0A and S06.6X0A, if recorded in the etiologic diagnosis fields with Impairment Group Code 2.22, will exclude the case from counting under the presumptive methodology for the 60 percent rule.
S06.5X9A Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter

S06.5X9D Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, subsequent encounter

S06.5X9A Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter (only if occurs while in rehab or active treatment continues – unlikely scenario)

S72.321A Displaced transverse fracture of shaft of right femur, initial encounter
**Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, initial encounter**

**CMS Presumptive Compliance List: Count's here!**

**CMS Exclusionary Pairing List: Doesn't count here**

**RECOMMENDATIONS / ACTION**

**ACTION**

- Education on physician documentation on specificity of Traumatic Brain Injury - loss of consciousness documentation (acute care records, ER records, Glasgow Coma Scale)
  - Physician education
  - IRF PAI coordinator
  - Medical coder
  - Preadmission screener

- Use the Compliance-1 and Compliance-2 fields in the UDS-PROi® software

- Manual Count (manual records review)
  - Use the 60% Presumptive Compliance YES/NO checkbox (UDS-PROi® field 118) to track this information

- Use the Compliance-1 and Compliance-2 fields in the UDS-PROi® software

**CONSIDERATIONS...**

**ACTION**

- Key: Know the rules – impacts compliance review period 2!

- These ICD-10 codes which are excluded when paired with 2.2X TBD BUT may count as qualifying co-morbidities in other cases...

- There are four CMS 60%er lists
  - 2 Impairment Group Code exclusionary etiologic pairing listing
  - 2 presumptive methodology pre- and post-review periods that begin on or after Oct 1, 2016

- Make sure you code/report TBI + skull fracture code also when present

- Pay attention to 7th character injury/ fracture codes you are reporting on PAI

**ICD-10-CM IRF Coding Nuances & 60%er’s**

### Traumatic Brain Injury

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<thead>
<tr>
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<th>CONSIDERATIONS...</th>
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<tbody>
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<td><strong>ACTION</strong></td>
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<tr>
<td>Education on physician documentation on specificity of Traumatic Brain Injury - loss of consciousness documentation (acute care records, ER records, Glasgow Coma Scale)</td>
<td>Key: Know the rules – impacts compliance review period 2!</td>
</tr>
<tr>
<td>- Physician education</td>
<td>These ICD-10 codes which are excluded when paired with 2.2X TBD BUT may count as qualifying co-morbidities in other cases...</td>
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<td>- IRF PAI coordinator</td>
<td>There are four CMS 60%er lists</td>
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<td>- 2 Impairment Group Code exclusionary etiologic pairing listing</td>
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<td>- Preadmission screener</td>
<td>- 2 presumptive methodology pre- and post-review periods that begin on or after Oct 1, 2016</td>
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<td>Use the Compliance-1 and Compliance-2 fields in the UDS-PROi® software</td>
<td>Make sure you code/report TBI + skull fracture code also when present</td>
</tr>
<tr>
<td>Manual Count (manual records review)</td>
<td>Pay attention to 7th character injury/ fracture codes you are reporting on PAI</td>
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<tr>
<td>• Use the 60% Presumptive Compliance YES/NO checkbox (UDS-PROi® field 118) to track this information</td>
<td>CMS – address in next final rule?</td>
</tr>
</tbody>
</table>
**ICD-10-CM IRF Coding Nuances & 60%er’s**

**Traumatic Brain Injury**

**Physician Queries**

**ICD-10: Loss of Consciousness**

**PROBLEM: UNSPECIFIED CODES REMOVED**

**Expected Further specificity (Compl. Rev Period 2)**

**IGC: Orthopedic Disorders - 08.11 Status Post Unilateral Hip Fracture**

Record **Fails if** Etiological Diagnosis Code (Item 22) Matches Any Code Listed

- **S72.001A** Fracture of unspecified part of neck of right femur, initial encounter for closed fracture
- **S72.002A** Fracture of unspecified part of neck of left femur, initial encounter for closed fracture
- **S72.009A** Fracture of unspecified part of neck of unspecified femur, initial encounter for closed fracture
- **S72.001B** Fracture of unspecified part of neck of right femur, initial encounter for open fracture type I or II
- **S72.001C** Fracture of unspecified part of neck of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC
- **S72.002B** Fracture of unspecified part of neck of left femur, initial encounter for open fracture type I or II
- **S72.002C** Fracture of unspecified part of neck of left femur, initial encounter for open fracture type IIIA, IIIB, or IIIC
- **S72.009B** Fracture of unspecified part of neck of unspecified femur, initial encounter for open fracture type I or II
- **S72.009C** Fracture of unspecified part of neck of unspecified femur, initial encounter for open fracture type IIIA, IIIB, or IIIC
Fracture specificity, documentation, & coding for IRF-PAI Etiologic Diagnosis reporting

ICD-10-CM IRF Coding Nuances

Injuries/Fractures

7th Character for Fractures (general concepts*)

A: Initial encounter for closed fracture

Define - Active treatment - used while the patient is receiving active treatment for a condition (emergent encounter, surgery, evaluation and continuing treatment by the same or new provider)

HINTS:

1. IRF-PAI: For injury and fracture cases, typically use the 7th character “A” initial encounter code for etiologic condition.
   - IRF-PAI Item #22 - Etiologic Condition: report the condition responsible for the impairment (IGC)

2. IRF-PAI: Use 7th character “A” for comorbid condition IRF-PAI Item #24 when fracture/injury occurred while in rehab or when condition meets “active treatment” definition above while in rehab (i.e., surgery)

3. UB-04/claim: Use 7th character “A” for UB-04/claim for principal or secondary condition(s) when treatment for the condition meets “active treatment” definition above while in rehab (i.e., surgery)

Confusing? Key: Know when to use what
ICD-10-CM IRF Coding Nuances

Injuries/Fractures

7th Character for Fractures (general concepts*)

D: Subsequent encounter for fracture with routine healing

Define - Subsequent care (routine care during healing or recovery phase; active treatment has been completed)

HINTS:
1. IRF-PAI: Use for IRF-PAI Item #24 comorbid condition(s) when condition is an additional condition(s) not already reported/represented in IGC/etiologic condition
2. UB-04 claim: Principal diagnosis - report the condition responsible for rehab admission
   • Use 7th character of “D” for aftercare/ recovery & healing of injury
3. UB-04 claim: Secondary diagnosis - report additional conditions addressed during rehab admission
   • Use 7th character of “D” aftercare/ recovery & healing of injury

*NOTE: Follow official coding guidelines
(still many questions/clarifications not yet addressed regarding IRF coding...)

ICD-10-CM IRF Coding Nuances

Injuries/Fractures

7th Character for Fractures (general concepts*)

S: Sequela

Define - Late effect (complications or conditions that arise as a direct result of a condition, no time limit)

HINTS:
1. IRF-PAI Item #22 - Etiologic Condition: Refer to IRF-PAI Training Manual for examples of when to use sequela injury codes
2. IRF-PAI Item #24 - Comorbid Condition(s): Follow coding guidelines
3. UB-04: Specify sequela first, followed by injury code
   • Add 7th character “S” to injury code, not sequela
   • Use on IRF-PAI and IRF UB claim when meets definition
   • IRF-PAI Item #22 - Etiologic Condition Training manual for example of when to use sequela injury codes

*NOTE: Follow official coding guidelines
(still many questions/clarifications not yet addressed regarding IRF coding...)
ICD-10-CM IRF Coding Nuances

Fractures

7th Character for Fractures

A: Initial encounter for closed fracture* **
D: Subsequent encounter for fracture with routine healing* (most freq reported on PAI)
G: Subsequent encounter for fracture with delayed healing* (most freq reported on UB)
K: Subsequent encounter for fracture with nonunion*
P: Subsequent encounter for fracture with malunion*
S: Sequela * **

Open Fractures

B: Initial encounter for open fracture type I or II or NOS **
C: Initial encounter for open fracture type IIIA, III, or IIIC
E: Subsequent encounter for open fracture type I or II with routine healing
F: Subsequent encounter for open fracture type IIIA, III, or IIIC with routine healing
H: Subsequent encounter for open fracture type I or II; with delayed healing
J: Subsequent encounter for open fracture type IIIA, III, or IIIC with delayed healing
M: Subsequent encounter for open fracture type I or II with nonunion
N: Subsequent encounter for open fracture type IIIA, III, or IIIC with nonunion
Q: Subsequent encounter for open fracture type I or II with malunion
R: Subsequent encounter for open fracture type IIIA, III, or IIIC with malunion

* Used for pathologic fractures
** If condition falls under 60%, most likely 7th character - see CMS list for complete details: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalRehabFacPS/Criteria.html

ICD-10-CM IRF Coding Nuances

Hip Fracture

ICD-10-CM IRF Coding Nuances

8.11 Unilateral Hip Fracture
Displaced Intertrochanteric fracture right femur, initial encounter
Principal: S72.141D
Displaced Intertrochanteric fracture right femur, subsequent encounter for closed fx with routine healing
Secondary: W19.XXXD
Unspecified fall, subsequent encounter

Key: Report specificity (60%) and correct encounter type
# ICD-10-CM IRF Coding Nuances & 60%er's

## Fractures

<table>
<thead>
<tr>
<th>RECOMMENDATIONS / ACTION</th>
<th>CONSIDERATIONS... ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve hip fracture specificity, documentation, &amp; coding for IRF Etiologic Diagnosis reporting</td>
<td>Know which unspecified ICD-10 codes are excluded when paired with 08.11 Hip Fracture (Compl. Rev Period 2) - these same cases we’ve always treated – continued access.....</td>
</tr>
</tbody>
</table>
| Education on specificity of hip fracture (acute care records: radiology, ER, op reports)  
  - Physician education (referral source)  
  - IRF PAI coordinator  
  - Medical coder  
  - Preadmission screener | Understand and pay attention 7th character code assignment you are reporting for all injuries/fractures |
| Use the Compliance-1 and Compliance-2 fields in the UDS-PROi® software | Multiple fractures – most descriptive codes should be used (femoral neck, acetabular, skull have specific 60% presumptive codes) |
| Manual Count (manual records review)  
  - Use the 60% Presumptive Compliance YES/NO checkbox (UDS-PROi® field 118) to track this information | |

## Spinal Cord Injury

**PROBLEM: UNSPECIFIED CODES REMOVED**

Expected Further specificity (Compl. Rev Period 2)

Impairment group: Spinal Cord Dysfunction: Traumatic - 04.2xxx

Record Fails if Etiological Diagnosis Code (Item 22) Matches Any Code Listed

<table>
<thead>
<tr>
<th>Excerpts from CMS listing only</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10</td>
</tr>
<tr>
<td>S14.2XXA</td>
</tr>
<tr>
<td>S24.2XXA</td>
</tr>
</tbody>
</table>

**Choice (A + B)**

- S24.102A | Unspecified injury at T2-T6 level of thoracic spinal cord, initial encounter |
- S22.029B | Unspecified fracture of second thoracic vertebra, initial encounter for open fracture * |
- S22.039B | Unspecified fracture of third thoracic vertebra, initial encounter for open fracture |
- S22.049B | Unspecified fracture of fourth thoracic vertebra, initial encounter for open fracture |
- S22.059B | Unspecified fracture of T5-T6 vertebra, initial encounter for open fracture |

*Below Choice A +B is a more likely case scenario, however ‘open’ fracture scenario above used for emphasis

- S24.102A | Unspecified injury at T2-T6 level of thoracic spinal cord, initial encounter |
- S22.029A | Unspecified fracture of second thoracic vertebra, initial encounter for closed fracture
### ICD-10-CM IRF Coding Nuances & 60%ers

**Spinal Cord Injury**

**Combination codes and 60%ers**

<table>
<thead>
<tr>
<th>Admissions Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance 1</td>
<td>Initial Rehabilitation</td>
</tr>
<tr>
<td>Compliance 2</td>
<td>Initial Rehabilitation</td>
</tr>
<tr>
<td>Compliance 3</td>
<td>Initial Rehabilitation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code 1</td>
<td>A</td>
</tr>
<tr>
<td>Code 2</td>
<td>B</td>
</tr>
</tbody>
</table>

**Etiologic Reported:**

- **S24.102A** A Unspecified injury at T2-T6 level of thoracic spinal cord, initial encounter
- **S22.029B** B Unspecified fracture of second thoracic vertebra, initial encounter for open fracture

**Sutter Health Sutter Rehabilitation Institute**

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### ICD-10-CM IRF Coding Nuances & 60%ers

**Spinal Cord Injury**

**Combination codes and 60%ers**

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<tr>
<td>Compliance 3</td>
<td>Initial Rehabilitation</td>
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<tr>
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<tr>
<td>Code 1</td>
<td>A</td>
</tr>
<tr>
<td>Code 2</td>
<td>B</td>
</tr>
</tbody>
</table>

**Etiologic Reported:**

- **S24.102A** A Unspecified injury at T2-T6 level of thoracic spinal cord, initial encounter
- **S22.029B** B Unspecified fracture of second thoracic vertebra, initial encounter for open fracture
- **S22.021B** B Stable burst fracture second thoracic vertebra, initial encounter for open fracture

**Sutter Health Sutter Rehabilitation Institute**
Spinal Cord Injury Classification

American Spinal Injury Association (ASIA) classification – no codes based on scale. BUT spinal cord injuries may be coded by complete vs. incomplete (which relates to Asia scale).

Ex: Spinal Cord Injury > incomplete lesion > cervical > C3 > initial encounter
   S14.153A Incomplete lesion at C3 level of cervical spinal cord, initial encounter

Ex: Spinal Cord Injury > complete lesion > lumbar > L1 > initial
   Fracture of Lumbar Vertebra > First > Closed > Initial
   S34.111A Complete lesion of L1 level of lumbar spinal cord, initial encounter
   S32.019A Unspecified fracture of first lumbar vertebra, initial encounter for closed fracture

and/or

Clinical classification – ICD-10-CM codes include:
- Anterior Cord Syndrome
- Central Cord Syndrome
- Posterior Cord Syndrome
- Cauda Equina Syndrome
- Brown-Sequard Syndrome

Ex: S14.123A Central cord syndrome at C3 level of cervical spinal cord, initial encounter

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**ICD-10-CM IRF Coding Nuances & 60%er’s**

### Spinal Cord Injury

#### RECOMMENDATIONS / CONSIDERATIONS...

<table>
<thead>
<tr>
<th>ACTION</th>
<th>CONSIDERATIONS...</th>
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<tbody>
<tr>
<td>Improve SCI specificity, documentation, &amp; coding for IRF Etiologic Diagnosis reporting</td>
<td>KEY: Know the rules – impacts compliance review period 2!</td>
</tr>
<tr>
<td>Utilizes Classification System  - Clinical Classification  - ASIA Impairment Scale</td>
<td>There are four CMS 60%er lists  - 2 Impairment Group Code exclusionary etiologic pairing listing  - 2 presumptive methodology pre- and post- review periods that begin on or after Oct 1, 2016</td>
</tr>
<tr>
<td>Education on specificity of SCI (acute care records: radiology, ER, op reports)  - Physician education (referral source)  - IRF PAI coordinator  - Medical coder  - Preadmission screener</td>
<td>Pay attention to 7th character injury/ fracture codes you are reporting on PAI</td>
</tr>
<tr>
<td>Use the Compliance-1 and Compliance-2 fields in the UDS-PROI® software</td>
<td>Make sure you code/report SCI code + fracture when present</td>
</tr>
</tbody>
</table>
PROBLEM: UNSPECIFIED CODES REMOVED

Expected Further specificity (Compl. Rev Period 2)

Impairment group: Spinal Cord Dysfunction: Non-traumatic - 04.1xxx

Record Fails if Etiological Diagnosis Code (Item 22) Matches Any Code Listed

Excerpts from CMS listing only

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>ICD Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M48.00</td>
<td>Spinal stenosis, site unspecified</td>
</tr>
<tr>
<td>M48.02</td>
<td>Spinal stenosis, cervical region</td>
</tr>
<tr>
<td>M48.03</td>
<td>Spinal stenosis, cervicothoracic region</td>
</tr>
<tr>
<td>M48.04</td>
<td>Spinal stenosis, thoracic region</td>
</tr>
<tr>
<td>M48.05</td>
<td>Spinal stenosis, thoracolumbar region</td>
</tr>
<tr>
<td>M48.06</td>
<td>Spinal stenosis, lumbar region</td>
</tr>
</tbody>
</table>

Nonspecific, vague codes. CODE to specificity
(same conditions that failed under ICD-9 = nothing new)

Scenario:
Rehab PM&R H&P

Rehab Impairment: Nontraumatic Spinal Cord Dysfunction (60%er)
- Cervical Spinal Stenosis
- s/p Cervical multilevel anterior cervical instrumentation and C5-T2 fusion and decompression
- continued postop significant bilateral upper ext. weakness/numbness, radiculopathy

Hospitalist day 2 of rehab stay documents:
- Cervical spinal stenosis, s/ cervical fusion

IRF PAI Biologic code: M48.02 Cervical Stenosis ❌ (exclusionary pairing = now fails as 60%er)

BUT.....

Prior acute records: brief post operative report
Post Procedure Diagnosis: Cervical spondylosis with myelopathy, stenosis
Procedure Performed: Cervical decompression fusion instrumentation
(M47.12 Cervical spondylosis with myelopathy ✔️)
ICD-10-CM IRF Coding Nuances & 60%er’s

Scenario continued:

This specific etiologic diagnosis reported with IGC Nontraumatic SCD would have qualified this case as a 60%er, BUT it was not captured by nor queried/documented by rehab physician:

- preadmission screener
- rehab physician
- rehab hospitalist
- coder (can’t code from previous encounters)
- PPS coordinator, Program Director, etc

Key: Review Back/Lamin/Synovial Stenosis case carefully. A physician must document diagnosis within current admission

Review details of case
Cervical/Lumbar/Thoracic - Spinal stenosis WITH myelopathy, intervertebral disk disease, degenerative disk disease, disk displacement, hemiated disk, spondylosis, spondylolisthesis (with or without neurogenic claudication is not distinguished in ICD-10)

Collaborative TEAM Efforts

NEED MORE DATA! SHARE MORE DATA!

COMMUNICATION IS CRITICAL
IRF documentation, coding, and reporting accuracy is multifaceted and is contingent upon IRF PPS knowledge and documentation of such from the following key team members:

1. Program Director
2. Clinical Liaison(s) – preadmission screening
3. Physician’s – H&P, progress note, and UC summary documentation
4. Multidisciplinary Team (RN, PT, OT, ST, SW, CM, Pharm, Neuropsych, Chaplain, Dietician, Therapeutic Rec...)
5. Coder – IRF-PAI vs. UB coding, HIM, Clinical Documentation Specialist (CDI program)
6. IRF-PAI Coordinator (PPS Coordinator, PD, Prog Secretary)
7. Billing Dept
Collaborative TEAM Efforts

Communication: Collaborative staff opportunities to improve 60% Presumptive compliance capture and improved ICD-10 coding.

Physician Queries

Please address these top two priorities:

1. Diabetes, glucose, physician query parameters concensus vs inkind preferences. When to query elevation in glucose levels in diabetic patients. Minimum glucose of _______ (Dr. Matthews mentioned >180). Dr. Yabes asked with that? Fasting only? over “3 occurrences”?

2. Impairment group, Pre admission screen vs H&P inconsistency. Solutions for volume of impairment group queries:
   1. Review preadmission screen impairment group/diagnostic diagnosis and make comment of any inconsistency (www.sutter.com/physician-applications.com), “or”
   2. Continuously with physician query, in
   3. Rehab Physician to document the impairment group code and diagnostic diagnosis to be reported within their H&P assessment/diagnosis list (best practice).

Impact: relevant impairment groups can lead to different Case Mix Group (CMG), payment, collaborations, documentation inconsistency, team treatment plans, inconsistencies.

clinical indicators...
Stroke - type (occlusion/ embolic/ thrombotic/ hemorrhagic), location, side affected, artery involved, dominance.

Etiologic: Left embolic intracerebral infarction, with right hemiparesis

TBI - traumatic brain injury diagnosis and loss of consciousness duration, (include any fractures)

Etiologic: Traumatic Subarachnoid hemorrhage with 1 hour loss of consciousness
**Collaborative TEAM Efforts**

**SPINAL CORD DYSFUNCTION** (motor/sensory/nerve deficits)

**NON-TRAUMATIC**
- 04.110 Paraplegia, Unspecified
- 04.111 Paraplegia, Incomplete
- 04.112 Paraplegia, Complete
- 04.120 Quadriplegia, Unspecified
- 04.1211 Quadriplegia, Incomplete C1-4
- 04.1212 Quadriplegia, Incomplete C5-8
- 04.1221 Quadriplegia, Complete C1-4
- 04.1222 Quadriplegia, Complete C5-8
- 04.130 Other Non-Traumatic Spinal Cord Dysfunction
  - (Lumbar Spinal Stenosis with Myelopathy)

**TRAUMATIC**
- 04.210 Paraplegia, Unspecified
- 04.211 Paraplegia, Incomplete
- 04.212 Paraplegia, Complete
- 04.220 Quadriplegia, Unspecified
- 04.2211 Quadriplegia, Incomplete C1-4
- 04.2212 Quadriplegia, Incomplete C5-8
- 04.2221 Quadriplegia, Complete C1-4
- 04.2222 Quadriplegia, Complete C5-8
- 04.230 Other Traumatic Spinal Cord Dysfunction

**SCI** – diagnosis, specific cord injury, and primary deficit (include any spinal fractures)

**Etiologic:** CSCI with central cord syndrome, with incomplete quadriparesis

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**Collaborative TEAM Efforts**

**AMPUTATION**
- 05.1 Unilateral Upper Limb Above the Elbow
- 05.2 Unilateral Upper Limb Below the Elbow
- 05.3 Unilateral Lower Limb AKA
- 05.4 Unilateral Lower Limb BKA (may fail presumptive if certain else assigned)
- 05.5 Bilateral Lower Limb AKA
- 05.6 Bilateral Lower Limb BKA
- 05.7 Bilateral Lower Limb BKA
- 05.9 Other Amputation – upper extremity

**ARTHRITIS**
- 06.1 Rheumatoid Arthritis
- 06.2 Osteoarthritis
- 06.9 Other Arthritis

**PAIN SYNDROMES**
- 07.1 Neck Pain
- 07.2 Back Pain
- 07.3 Extremity Pain
- 07.9 Other Pain

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**NOTE:** The highlighted items may be representative of an active primary or secondary diagnosis, incabbit and/ or univentricular heart disease, and/ or multi-vascular complications with additional cardiopulmonary baseline and clinical parameters.
Collaborative TEAM Efforts

Orthopaedic Disorders

- 08.11 Unilateral Hip Fracture
- 08.12 Bilateral Hip Fracture
- 08.2 Femur (Shaf) Fracture
- 08.3 Pelvic Fracture (IGC doesn't count but can with specified Dx)
- 08.4 Major Multiple Fractures (IGC doesn't count but can with specified Dx)
- 08.51 Unilateral Hip Replacement
- 08.52 Bilateral Hip Replacement
- 08.61 Unilateral Knee Replacement
- 08.62 Bilateral Knee Replacement
- 08.71 Knee and Hip Replacement (same side)
- 08.72 Knee and Hip Replacements (different sides)
- 08.9 Other Orthopaedic

Fracture – exact anatomical location, type, open/closed, side, displaced/nondisplaced, (encounter)

Etiologic: Left displaced, intertrochanteric femur fracture, open

Collaborative TEAM Efforts

Rehab Impairment Group Worksheet – Inpatient Rehabilitation

Cardiac

- 09 Cardiac

Pulmonary (chronic pulmonary disorder/sufficiency)

- 10.1 COPD
- 10.9 Other Pulmonary

Debility

- 16 Debility (Non-Cardiac / Non-Pulmonary)

Other Disabling Impairments

- 16 Other Disabling Impairments

Developmental Disability

- 15 Developmental Disability

Burns

- 11 Burns (may fall presumptive if certain site assigned)

Congenital Deformities

- 12.1 Spinal Fusion (may fall presumptive if certain site assigned)
- 12.9 Other Congenital Deformities (may fall presumptive if certain site assigned)

Medically Complex

- 17 Diabetic Complications
- 17.2 Neurovascular
- 17.3 Nephropathy with Retinopathy / Peripheral Pri

Note: The highlighted green text represents a designated presumptive qualifying condition, while blue text represents conditions not counting towards rehabilitation compliance threshold.
**Medical Complexity, Classification Criteria, & needed Physician Documentation**

- **LATERALITY** (left/right/bilateral, dominance, upper/lower)
- **PRECISE ANATOMICAL SITE/LLOCATION OF AREA INVOLVED** (especially fractures, hemorrhages)
- **SPECIFY SEVERITY DETAILS** (acute/chronic, exacerbation, degree, late effects of, morbidity)
- **SPECIFY DURATION** (loss of consciousness duration)
- **SPECIFY TYPE** (traumatic/non-traumatic, pathologic, dislocated/comminuted, disruption, systolic/diastolic)
- **ADDRESS SUPPORTING/RESULTINGongoing deficits** (hemi/para/quadri-paresis/plegia, myopathy, myelopathy - motor, sensory, functional, dysphagia)
- **LINK EFFECTS/MANIFESTATIONSTO CAUSAL CONDITION** (ex: polyneuropathy related to ___________, other___________)

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**Fracture Site**
- Specific anatomical location
- Displaced vs. non-displaced
- Type: Comminuted, Transverse, Compression, Oblique, etc.
- Laterality: Left/Right/bilateral
- Pathologic-cause: Osteoporosis, Neoplasm, Degenerative condition
- Open vs closed: (Gustilo classif. # open)

**Brain Injury**
- Specific anatomical location and injury type, severity
- With/without skull fx
- Specific anatomical location
- Loss of consciousness DURATION
- Laterality: Left/Right/bilateral

**CVA/Infarction**
- Laterality: Left/Right/bilateral
- Type: Thrombosis, Embolism, Occlusion or stenosis
- Arteries: Cerebral (anterior, cerebellar, middle, posterior), Precerebral (basilar, ophthalmic, vertebral)

**TBI**
- Specific anatomical location and injury type, severity
- Central cord syndrome
- Anterior lesion of cord
- Cauda equina
- Brown-Sequard syndrome
- Other spec SCI
- With/without vert fx
- Specific anatomical location and involvement

**Complete vs incomplete lesion of cord**

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**Take-Aways:**
- SPECIFICITY IS CRITICAL (ICD-9 or ICD-10)
- DOCUMENT DETAILS OF CONDITIONS
- QUERY PHYSICIAN WHEN NEEDED
### Queries: Description of ICD-10 Documentation Gap Categories - Inpatient Rehab

<table>
<thead>
<tr>
<th>Gap Category</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviation</td>
<td>Spell out abbreviations used in documentation</td>
<td>Acute kidney insufficiency instead of AKI, acute on chronic renal failure instead of AoCRF</td>
</tr>
<tr>
<td>Acuity / Onset</td>
<td>Acute or sub-acute or chronic, recurrent</td>
<td>Acute vs. chronic respiratory failure, acute kidney injury, acute diastolic CHF, acute blood loss anemia</td>
</tr>
<tr>
<td>Associated Conditions / Manifestations</td>
<td>Related medical condition of a primary medical condition, related deficits and/or manifestations</td>
<td>Ischemic heart disease with or without angina, DM with nephropathy, urinary tract infection with bacteremia, Clostridium difficile colitis, Streptococcus pneumoniae, Pseudomonas Aeruginosa UTI, Polyneuropathy due to DM type II</td>
</tr>
<tr>
<td>Causal Agent / Organism / Procedure related</td>
<td>External agents / organisms that causes the medical condition</td>
<td>C. Diff colitis, Streptococcus pneumoniae, Pseudomonas Aeruginosa UTI, Polyneuropathy due to DM type II</td>
</tr>
<tr>
<td>Comorbidities or Complications</td>
<td>Presence of one or more additional medical conditions co-occurring with a primary one</td>
<td>Congestive heart failure with hyperlipidemia, Non-union of right IT femoral fracture, CVA with left hemiparesis, dysarthria, and cognitive deficit, Uncontrolled DM type II with Hypoglycemia</td>
</tr>
<tr>
<td>Confirmation</td>
<td>Confirm presence of medical conditions based on clinical documentation / indicators</td>
<td>SIRS vs. UTI vs. urosepsis</td>
</tr>
<tr>
<td>Depth</td>
<td>Measure the depth of a wound / skin ulcer</td>
<td>Skin ulcer is 1/4 inch in depth</td>
</tr>
<tr>
<td>Device</td>
<td>Type of device used in a medical procedure</td>
<td>Type of femoral head implant</td>
</tr>
<tr>
<td>Duration</td>
<td>Associated time related to condition</td>
<td>Traumatic closed subdural hematoma with 1 hour loss of consciousness</td>
</tr>
<tr>
<td>Initial vs. Subsequent</td>
<td>Initial vs. Subsequent</td>
<td>Lumbar L2 fracture, initial vs. subsequent onset</td>
</tr>
<tr>
<td>Etiology / Cause</td>
<td>Cause of the medical condition</td>
<td>Aspiration vs. community acquired pneumonia, diagnosis for significantly reduced hematocrit level</td>
</tr>
<tr>
<td>Frequency</td>
<td>How often the medical condition occurs</td>
<td>Frequency of alcohol use or asthma attack</td>
</tr>
<tr>
<td>Laterality / Localization</td>
<td>Left or right, bilateral or unilateral, dominant/non-dominant</td>
<td>Left or right femoral head fracture, CVA with left hemiparesis, dominant side</td>
</tr>
<tr>
<td>Root Operation</td>
<td>Main focus of the procedure and is based on the objective of the procedure</td>
<td>Excision vs. resection vs. detachment vs. destruction vs. extraction</td>
</tr>
<tr>
<td>Severity / Degree / Involvement</td>
<td>Mild, moderate, severe</td>
<td>Mild vs. severe malnutrition, Motard obesity</td>
</tr>
<tr>
<td>Sequence</td>
<td>Late effects of</td>
<td>History of CVA with residual left non-dominant hemiparesis</td>
</tr>
<tr>
<td>Site - Anatomical</td>
<td>The body part where the medical condition occurs, precise anatomical location</td>
<td>Site of acute MI, brain tumors, C1-2 fracture, OA, and URI, Intertrochanteric femoral neck fracture</td>
</tr>
<tr>
<td>Stage / Phase</td>
<td>Clinical progression of the medical condition</td>
<td>Stage 1 – 4 of cancer, Stage 1 – 5 of CKD, Stage 2 coccyx pressure ulcer</td>
</tr>
<tr>
<td>Type</td>
<td>Added definition of the medical condition</td>
<td>Penile / cardiac / permanent / transient arthritis, type 1 or 2 diabetes, acute nodular CCHF, oropharyngeal dysphagia, Non-traumatic subarachnoid hemorrhage</td>
</tr>
</tbody>
</table>

---

### ICD-10-CM IRF – PAI / UB Coding Examples

#### IRF PAI Codes

**Impairment Group Code: 1.2 Stroke, Right Body Involvement**

**A** 63.332 Left posterior cerebral artery thrombosis with infarction

**B**

**C**

**Comorbidities**

- G81.11 Spastic hemiplegia affecting right dominant side
- R13.11 Dysphagia, oral phase
- R47.1 Dysthria

**Complications** (also reported as comorbidities)

- I69.354 Hemiparesis following cerebral infarction affecting left nondominant side – FROM OLD CVA (H/O with residual affect present at the time of new onset CVA affecting right side)

#### UB codes

**Admitting diagnosis**

- I63.332 Left posterior cerebral artery thrombosis with infarction

**Principal diagnosis**

- I69.351 Late effects of Left posterior cerebral artery thrombosis with infarction with spastic right dominant hemiparesis

**Secondary / additional diagnosis**

- I69.391 Dysphagia following cerebral infarction, late effects
- I69.312 Dysphagia following cerebral infarction
- I69.354 Hemiparesis following cerebral infarction affecting left nondominant side

---

**Queries: Description of ICD-10 Documentation Gap Categories - Inpatient Rehab**

**TEAM UPDATES**

IRF PAI Codes UB codes

Impairment Group Code: 1.2 Stroke, Right Body Involvement

**A** 63.332 Left posterior cerebral artery thrombosis with infarction

**B**

**C**

**Comorbidities**

- G81.11 Spastic hemiplegia affecting right dominant side
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- I69.354 Hemiparesis following cerebral infarction affecting left nondominant side – FROM OLD CVA (H/O with residual affect present at the time of new onset CVA affecting right side)

Whether ICD-9 or ICD-10, impact: IRF 60% presumptive compliance, IRF PPS comorbid tier reporting (MCR reimbursement and est. LOS), reporting of severity of illness and burden of care, supports justification of admission, quality reporting.
# ICD-10-CM IRF - PAI / UB Coding Examples

## IRF PAI Codes

<table>
<thead>
<tr>
<th>Impairment Group Code:</th>
<th>UB codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.4 Major Multiple Fractures</td>
<td>Principal diagnosis</td>
</tr>
<tr>
<td><strong>Biologic</strong></td>
<td></td>
</tr>
<tr>
<td>A S72.141A Displaced transverse fracture of shaft of right femur, initial encounter for closed fracture</td>
<td></td>
</tr>
<tr>
<td>B S82.441A Displaced spiral fracture of shaft of right fibula, initial encounter for closed fracture</td>
<td></td>
</tr>
<tr>
<td>C S44.322A Displaced transverse fracture of shaft of humerus, left arm, initial encounter for closed fracture</td>
<td></td>
</tr>
</tbody>
</table>

## Comorbidities

| S42.122D Displaced fracture of acromial process, left shoulder, closed subsequent encounter |
| W19.XXXD Unspecified fall, subsequent encounter |

## Complications (also reported as comorbidities)

- If all fractures were present on admission to IRF
- If all fractures were present on admission to IRF

---

## ICD-10-CM IRF - PAI / UB Coding Examples

<table>
<thead>
<tr>
<th>Impairment Group Code:</th>
<th>UB codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>04.210 Traumatic Spinal Cord Injury – Paraplegia Incomplete</td>
<td>Admitting diagnosis</td>
</tr>
<tr>
<td><strong>Biologic</strong></td>
<td></td>
</tr>
<tr>
<td>A S24.152A Other incomplete lesion at T2-T6 level of thoracic spinal cord, initial encounter</td>
<td></td>
</tr>
<tr>
<td>B S22.050A Wedge compression fracture or T5-T6 vertebra, initial encounter</td>
<td></td>
</tr>
</tbody>
</table>

## Comorbidities

| V43.52XD Car driver injured in collision with other type care in traffic accident, subsequent encounter |

## A: Initial encounter

| D: Subsequent encounter |
| S: Sequela |

## Complications (also reported as comorbidities)

- Code and report any other SCI deficits (for PAI - not inherent to IGC/etiology) such as neurogenic bowel and bladder

---

*Example of where initial PAI etiologic condition can be recorded, however base on facility P&P*
**Resources / Tools**

**Key Considerations**
- Team understanding of IRF PPS coding concepts
- Ensure final IRF-PAI codes and UB codes are consistent / tell the same story (esp. with ICD-10 injury specificity codes, and now with UB principal dx. reporting (no more V57.89))
  - Update initial codes with final codes (may have more details/specific coding)
  - Minimize coding errors
  - Ensure accurate CMI/CMG reimbursement
  - Ensure continued patient access with improving/maintaining 60% presumptive threshold
- Concurrent coding/team conference documentation?
  - Capture complications/ tiered conditions, clarifications, is team on the same page - primary rehab focus
- PPS coordinator/coder collaboration
  - Communication tool
- MD queries / query process
• UDS-PRO® reports
  – Etiologic Diagnosis by Impairment Group Code Listing
  – Percentage of Cases by Comorbid Tier
  – Presumptive Eligible Estimation Report
• CMS data files
  – Presumptive compliance list – C1 and C2
  – Presumptive IGC exclusionary list – C1 and C2
  – Tiered conditions

HELPFUL IRF RESOURCES

Additional IRF Information
CMS publications related to the IRF PPS

Clarifications for IRF Coverage Requirements
Website: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html

Information for IRF PPS claims and the matching process with the IRF-PAI

IRF Quality Reporting Program