IMPROVING IRF PATIENT ASSESSMENTS USING DECISION SUPPORT TECHNOLOGY

WHITE PAPER

MediServe
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EXECUTIVE SUMMARY

The inpatient rehabilitation facility patient assessment instrument (IRFPAI) determines reimbursement for inpatient rehabilitation providers. Unfortunately, the instrument is complex and easily misused. As a result, providers may not receive appropriate reimbursement. This paper focuses on the benefits of applying clinical decision support to the IRFPAI, which includes more accurate assessments of patient functionality and increased revenue for inpatient rehabilitation providers.

MediServe conducted an analysis to measure the effect standardized IRFPAI assessment would have on inpatient rehabilitation facilities or units (IRFs/IRUs). The analysis included 27 IRFs/IRUs across the United States, covering a patient population of nearly 37,500 Medicare patients. The rating process built into the MediLinks Inpatient software solution was used to assess the impairment measurement of patients. Patient assessments from up to three years before the implementation of the MediLinks Inpatient software solution were compared to assessments up to three years after the implementation of MediLinks Inpatient. The average of the before and after periods were compiled and compared to quantify the results of switching from a typical scoring process to a process that adds additional structure to the IRFPAI.

Adding more rigor and discipline to the process positively impacted the accuracy of patient assessment and reimbursement. Results of the analysis showed an average Medicare reimbursement increase of $928 per patient.

$928 AVERAGE INCREASE IN MEDICARE REIMBURSEMENT
INTRODUCTION

Out of all the factors that go into determining the financial return for patient care delivered, the IRFPAI plays a pivotal role in the reimbursement for patient care delivered in inpatient rehabilitation. The IRFPAI was designed to evaluate functional ability per the PAI Manual. Based on the analysis, we found that providers struggle with inconsistencies in documentation and inaccurate measurement of the true burden of care. As a result, providers do not receive sufficient reimbursement for the care they’ve provided.

Accurate patient assessment and the impact it has on revenue have always weighed heavily on the shoulders of anyone who has a financial interest in delivering patient care in the inpatient rehabilitation care industry. The purpose of this analysis was to explore the benefits of adding additional rigor and discipline into the IRF patient assessment process. The analysis evaluated the benefits of using clinical decision support technology to assess patient function and its contribution to both patient care and management of accurate payment for IRFs/IRUs. Healthcare standards demand consistency and repeatability of assessments that support clinically necessary care often challenged by medical necessity audit/review. The risk of full denials rests in this level of accuracy. Meeting payer requirements, specifically Medicare, is becoming more difficult to manage using traditional processes. As a result, many inpatient rehab providers have already implemented automated assessments, or have begun experimenting with automation in their workflow, to help them successfully maintain high standards of quality patient care while lowering its cost.

As the cost of care continues to rise, margins tighten and expectations for high-quality care increase, inpatient rehabilitation providers must adapt their workflow to survive in the future environment of healthcare. How the IRF industry reacts to these changes and challenges will ultimately determine where the industry will go from here. To survive in the future, providers must manage both revenue and costs while adapting to changing requirements.
Understanding how Medicare pays inpatient rehabilitation providers can be complex. The IRFPAI measures the patient burden of care. It was adopted as part of the payment methodology for the Prospective Payment System (PPS) reimbursement in IRFs/IRUs. It relies on a combination of 12 of the 13 motor and five cognitive domains, and sometimes age, to measure the burden required for a patient to complete daily activities. The tasks are rated on a seven-point ordinal scale that range from total assistance to complete functional independence. Scoring is completed by therapists, nurses and other clinicians. Functional items that are scored include: eating, grooming, toileting, bed to chair transfer, stairs, problem solving and memory, just to name a few. Providers are required to report the burden or assistance required for a patient to complete functional tasks at the time of admission and discharge. The patient’s admission scores are used to determine the reimbursement for the patient’s care.

IRFPAI ASSESSMENT CHALLENGES

More than eighty-five percent of CMGs rely on the weighted motor score alone. Therefore, accurately assessing these scores is critical to classifying the patient appropriately. The primary challenge with accurate assessment of a patient’s function is the complexity involved in arriving at the patient’s final score. When a clinician assesses the patient’s eating ability, for example, they must first consider four baseline items: utensil use, how eating occurs and what types of food are eaten along with...
their ability to chew and swallow; before they can even begin to assess the 13 criteria items for eating. How many clinicians are able to recall all the variant factors that are used in assessing a patient’s eating ability when applying a number on the PAI? These factors are critical in determining the appropriate score.

Due to the fast-paced environment and the many demands placed on them, clinicians tend to focus on the score itself rather than each scoring criteria. In other words, the complexity of the scoring process is at odds with the practicality of performing the assessments. As a result, variability is introduced into the scoring process.

Clinicians tend to be optimistic in their perception of the patient’s functional ability and as a result, the assessments themselves become skewed. We believe this may be due to the compassionate nature of clinicians who want their patients to perform better and give them the benefit of the doubt at the time of assessment. They are trained to have their mindset on “minimal,” “moderate” or “maximal assistance,” as an applied rehabilitation jargon, rather than on the components of assistance required to complete each of the individual tasks. Unfortunately this distorts the patient’s true burden of care and negatively impacts Medicare reimbursement.

Another challenge providers face with scoring is assigning certain IRFPAI items to the discipline that specializes in the treatment. This is a common practice that is used to reduce the effort of scoring on the clinician. For example, occupational therapists assess dressing, physical therapists assess locomotion, speech therapists assess swallowing, nursing assesses bladder, and so on. It is also important to continually assess patients regardless of the time of day because patient performance varies throughout the day and night. In other words, the effort required to care for the patient and keep them safe requires input throughout the day and night from all participating caregivers; not just those assessing the patient during optimum performance times. As the analysis has shown, overcoming these challenges in today’s environment is possible using clinical decision support technology.

**ADDIMG STRUCTURE TO THE ASSESSMENT PROCESS**

Guiding clinicians through the IRF patient assessment process with clinical decision support significantly improves scoring accuracy, reduces subjectivity and protects revenue. Instead of focusing on the functional scores themselves, participants in the analysis were required to assess each scoring criteria. In fact, the functional scores were automatically determined based on the assessment of each scoring criteria. This more rigorous method of assessment removes a degree of subjectivity because the clinician can focus on the patient’s true ability and no longer worry about what the numerical score should be.

### CMS EATING CRITERIA

1. **Does patient need help when eating meals or administering parenteral or enteral nutrition?**
2. **Does the patient need an assistive device to eat?**
3. **Does the patient take more than the reasonable time to eat?**
4. **Is there a concern for safety?**
5. **Does the patient require modified food consistency?**
6. **Does the patient administer tube feedings independently?**
7. **Does the patient perform half or more of eating tasks?**
8. **Does the patient need only supervision, cuing or coaxing?**
9. **Does the patient need help to apply an orthosis?**
10. **Does the patient need help to cut food, open containers, pour liquids or butter bread?**
11. **Does the patient require total assistance to eat such as the helper holding the utensil and bringing all food and liquid to mouth?**
12. **Does the patient need total assistance with tube feedings?**
13. **Does the patient only need incidental help such as placement of utensils in his or her hand or occasional help to scoop food onto fork or spoon?**
BACKGROUND

The MediLinks Inpatient software solution is designed to target the specific challenges inpatient rehabilitation providers encounter with the Prospective Payment System (PPS).

MediLinks was used in the analysis to demonstrate the results of adding more rigor and discipline into the scoring process and the impact it would have on assessing the true burden of care and payment.

Twenty-seven IRFs/IRUs across the United States were included, covering a patient population of nearly 37,500 Medicare patients. The following standards were used to calculate the impact on patient CMI and reimbursement:

- Applied CMS fiscal year 2012 CMI values
- Standard base pay for CMS fiscal year 2012
- Exclusive to Medicare Part A non-MCO patients
- Excluded transfer patients and short stays

The scoring process built into the MediLinks Inpatient software solution was used by all 27 facilities to assess the impairment measurement of patients throughout the analysis. Scoring assessments from up to three years before the implementation of the MediLinks Inpatient software solution were compared to assessments up to three years after the implementation of MediLinks Inpatient. The averages of both the before and after time periods were compiled and compared to see what kind of results were accomplished by switching from a typical scoring selection to a process that applies clinical decision support to the IRFPAI.
By adding additional rigor and discipline into the IRFPAI assessment, the analysis proved that clinical decision support technology has a positive impact on the management of patient assessment and reimbursement.

On average, across all rehabilitation impairment categories (RICs), there was a $928 reimbursement increase per Medicare patient. The increase in revenue is a result of capturing a more accurate burden of care. By using the methodology built into MediLinks Inpatient, all clinicians were able to consistently assess the patient’s condition by focusing on the scoring criteria, rather than the resulting number. The scores at admission indicated the need for a higher level of care, appropriately resulting in a higher average reimbursement per case. Additionally, all decisions that support the score are documented and enable clear conditional support toward the submitted scores.

As the results have shown, applying clinical decision support to the IRFPAI process resulted in a more accurate assessment of the patient’s burden of care and helped improve revenue. It is recommended that providers utilize clinical decision support when assessing their patients’ function so they too can more accurately reflect the resources and intensity provided at an IRF/IRU standard.

MediLinks made it possible for therapists and nurses to contribute to the documentation process and provide a much more accurate picture of the patient’s true burden of care.

- Nancy Hughes, Manager of Case Management, St. Luke’s Rehabilitation Institute
OVETCOMING THE CHALLENGES OF IRF PATIENT ASSESSMENT

Applying clinical decision support to the IRFPAI not only adds discipline and rigor to the scoring process, but also provides an effective practice that helps inpatient rehab providers overcome the challenges of the IRFPAI. Clinical decision support allows clinicians to become more patient-centric and provides the intelligence and the ability to be most effective at the patient level of care.

Going forward, IRFs will be driven by business and clinical intelligence. Utilizing automated processes throughout the unique IRF workflow will not only help meet the demands of ever-changing regulatory requirements, it will provide the intelligence, or information, needed to drive practices that will result in success. It is crucial to identify how change can create opportunity for growth while recognizing that continuing and holding on to old practices will erode the potential for success and decrease the ability to survive in the changing healthcare industry.

CONCLUSION

There are many electronic medical records (EMR) or health information systems (HIS) available in the market today that are capable of capturing the patient data required in an acute care hospital. However, many of these systems do not grasp the breadth and depth of Medicare’s IRF Conditions of Participation (COP) and mandated Code of the Federal Register (CFR) laws to demonstrate excluded status and the other unique challenges faced by inpatient rehabilitation providers. Mediserve’s solutions are specifically designed to meet the unique needs and challenges that exist in an IRF/IRU level of care.

The MediLinks Inpatient solution utilized in this analysis of 37,500 Medicare patients was designed to specifically improve the consistency and accuracy of patient functional scoring at admission and discharge. MediLinks Inpatient solutions assist leadership in helping clinicians determine appropriate burden of care measurement by determining a more accurate CMG to reflect the cost and resources required to rehabilitate the patient in an IRF/IRU setting.
ABOUT MEDISERVE

MediServe’s rehabilitation software solutions are designed to optimize the value of patient care in today’s healthcare environment by automating the ineffective and inefficient processes that are inherent in a highly regulated, work-intense environment. With more than 20 years of experience and industry expertise, MediServe’s solutions address the highly regulated workflow, compliance and documentation needs that are unique to the rehabilitation environment and produce results that significantly improve compliance, outcomes, revenue and efficiency.

To learn more about MediServe’s rehabilitation solutions, or to see a demo of our solutions, please visit MediServe.com or call us at 800.279.8456.

REFERENCES

1. MediLinks Database of participating facilities: Patient population consisted of 37,363 Medicare patients.

2. Standard deviation of $871

3. IRFPAI Manual, page III-12