Primary Impairment is More Than Just a Code

By Dr. Pamela Smith, President and CEO ITHealthTrack. Inc.

Dr. Pamela Smith

Impairment group codes had humble beginnings. A similar coding system was used by the Boston Hospital Utilization Project or Boston HUP and considered by the National Task Force for the Development of a Uniform Data Set for Medical Rehabilitation. Another similar set of codes was developed through a survey conducted by the California Association of Rehabilitation Facilities to examine rehabilitation programs. Codes developed by these groups were reviewed by Task Force members and incorporated into the Uniform Data Set for Medical Rehabilitation. Codes were used to classify patients into similar groups so that programs and outcomes could be studied in a meaningful way. Today, impairment group codes are used as a component of the Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS) after study by the RAND Corporation, under contract from the Centers for Medicare and Medicaid Services.

The Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI) Training Manual defines primary impairment as the condition requiring admission to rehabilitation. It is item 21 on the IRF-PAI form and is entitled Impairment Group Code or IGC. It can be assigned by the PPS coordinator, the physician, the coder or through a collaborative process and is the first step in establishing reimbursement because IGCs map to Rehabilitation Impairment Categories or RICs. Next, patients are divided into Case Mix Groups or CMGs based on functional assessment scores completed by clinical staff. Impairment group codes are integral to establishing 60% Rule compliance and placing patients into homogeneous groups to assess functional outcomes. While playing such a key role in prospective payment and measuring program performance, the IGC is just as significant to clinical practice. The IGC has the potential to provide a framework for initial and ongoing assessments, align interventions with IRF-PAI coding, focus the team around the reason for admission and improve coordination of care.

In order to fulfill its potential, the IGC needs to be identified in a reliable manner and as early in the admission process as possible. Ideally, a preliminary IGC should be assigned at the time of pre-admission screening, enabling clinicians to be aware of the primary reason for admission even before a history and physical, nursing and therapy initial evaluations are completed. Identifying the proper IGC can be a very simple process for some patients, but other cases offer a great challenge. A patient with worsening Parkinson's symptoms and gait instability who falls and fractures a bone could mistakenly be coded as orthopedic, rather than neurologic. A patient with severe neuropathies who falls and fractures a hip that is repaired with a hemiarthoplasty offers a challenge for coding IGC with clinicians considering joint replacement, hip fracture or neurologic (where of course, joint replacement should not be used). A patient with a history of chronic obstructive pulmonary disease (COPD) who experiences sepsis and respiratory failure and who is placed on a ventilator poses a quite a challenge when symptoms also indicate critical illness myopathy. In these cases, team involvement in assigning the IGC is almost always necessary.

Wikipedia defines a code as a "rule for converting a piece of information into another form or representation." Assigning the IGC requires that clinicians be able to cross-walk the information in both directions. Information from the medical record, including history of present illness and past medical and surgical history, needs to be evaluated to assign an IGC. Conversely, when a clinician sees an IGC, it should trigger an impression of a patient's potential problems and needs. It is a representation of a clinical picture. While the IGC provides no indication of the severity of impairments or resulting disabilities, it does suggest a set of potential impairments and disabilities to the experienced clinician. As such, the IGC offers a framework for beginning the process of assessment and treatment.

When patients are admitted with multiple impairments, identification of primary impairment provides a method of prioritizing assessments and interventions. Without being aware of what has been identified as the primary impairment by the physician or designee, clinicians may interpret information derived from their assessments from their own perspective and assign the primary impairment differently. As a result, assessments, interventions and daily documentation could be approached from varied perspectives. Once provided with this key piece of information, clinicians can begin to view the patient through a common lens. When beginning an assessment, an experienced clinician who is aware of the primary impairment brings to the session an anticipation of related impairments and activity limitations. There is a hypothetical presentation gained though education and clinical experience that forms a framework for assessment, goal setting and care planning. After the initial assessment is completed, hypothetical information can be validated or rejected and an individualized plan of care can be developed. The framework is an essential component of the process, especially when there is a complex clinical presentation.

The tine test of reliable impairment group coding is that the treatment plan and coding are synchronized. When clinicians are aware of the primary impairment, they are able to align interventions with IRF-PAI coding. The medical record will then present consistent information between data reported on the IRF-PAI form and all other aspects of documentation. If the primary impairment is neurologic, then the treatment plan should be focused around motor and sensory retraining and/or recovery as opposed to conditioning and endurance, as seen in debility. If the primary impairment is traumatic spinal cord injury, then the treatment plan is aimed at adaptation and compensation, as opposed to pain management as seen in orthopedic cases. It is apparent to an auditor experienced in rehabilitation if there is a discrepancy between coding and care planning.

The primary impairment should appear on every initial assessment. It serves to gather the team around the reason for admission. It sets a direction for a group of people who are intent on achieving a common goal, but who come from a variety of educational and clinical backgrounds. Given the shortage of nurses and therapists and great variation in working schedules, primary impairment can be an anchor or a means of grounding clinicians to the mission at hand. One nurse working the weekend can hand off a patient to a weekday nurse and maintain the reason for admission through a code and what those digits represent. Shorter lengths of stay also force clinicians to focus on the reason for admission and to achieve goals resulting from that reason as efficiently as possible. For example, knowing the reason for admission and the typical length of stay for a patient may influence a therapist to use a functional approach to treatment as opposed to an adaptive or other compensatory approach.

When the entire team is aware of the primary impairment, coordination of care is improved. There is consistency between medical, nursing and therapy approaches to care, and the interdisciplinary care plan is in harmony. Nurses providing carry-over for strategies learned in therapy are sensitive to the intent of the admission and are better able to provide guidance that is consistent with therapy interventions. Therapists are in tune to health issues considered comorbid conditions being treated by physicians and nurses and can assess pertinent health parameters during therapy sessions. Finally, physicians or others who facilitate team conference can draw together the team around a common purpose and center discussion of the treatment plan, goals and discharge plans on the purpose of admission.

Primary impairment has evolved from the time of the National Task Force for Development of a Uniform Data Set for Medical Rehabilitation when it was used to classify patients for outcomes reporting to present day PPS with its requirements for medical necessity. It has taken on a new clinical role. It is a number that represents a reason that an individual with activity limitations was admitted to an intensive inpatient rehabilitation program with strict demands on the program, the clinicians and the patient. It's not just a code, it's a mission.

AMRPA