Inpatient rehab troubleshooter: Solutions to PPS’ most common problem spots
Dear reader:

It may seem to you that the start of the prospective payment system (PPS) brought more questions than answers. You may find yourself asking the following: “Am I filling out the assessment tool correctly? What should my facility’s compliance program look like? What do I need to know about ICD-9-CM codes?”

We wrote this special report to help you make sense of the complex issues surrounding PPS. The report covers topics such as correct coding guidelines for the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), accurately scoring your patients’ cognitive levels on the IRF-PAI, and establishment of a compliance program within your facility.

We hope you learn some useful tips from this report that make your job easier and improve the way that your facility deals with PPS.

Sincerely,

Anne Scadding
Managing Editor

**PPS Alert for Inpatient Rehab**

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When scoring the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), most clinicians are familiar with how to apply the different FIM™ instrument levels to patients’ varying physical abilities. But measuring cognitive function is another matter.

“Cognitive items are difficult to observe in the way that physical items can be observed,” points out Richard Linn, PhD, director of UDSMr, the Buffalo, NY–based organization that oversees the FIM instrument. For instance, if a patient can’t climb a set of stairs or even attempt this task, that’s relatively easy to score. But measuring a patient’s problem-solving ability is a bit more abstract, he says.

Starting off

There are five questions on the FIM instrument section of the IRF-PAI that relate to cognitive function—comprehension, expression, social interaction, problem solving, and memory. “They are all scored using the same scale and the same underlying philosophy—helper v. no helper, did you need an assistive device, and what’s the amount of time the other person needed to intervene with the patient,” explains Linn.

Unfortunately, many clinicians are not used to thinking in that manner when they evaluate cognitive activities. “It takes more time and effort to really think through the cognitive scoring because it’s more abstract and less overt,” he says.

Defining the levels of assistance

The FIM scoring levels of 1–7 describe the different amounts of help a patient might need to complete a task or activity. For an example of how to apply the levels to the cognitive function items, Linn uses the comprehension item:

• No helper. For levels 6 and 7 under the “No helper” heading, the scoring is quite simple. If a patient is completely independent in comprehension, he or she receives a score of 7, indicating complete independence.

For patients with hearing aids, visual aids, or other similar assistive devices that would assist them in comprehending, you would score them at a level 6, instead of a level 7.

“If a patient understands both auditory and visual directions but relies on a hearing aid or glasses to do so, the health care professional would score ‘modified independence,’ or 6,” explains Ann S. Lambert, OTR/L, MHSA, CPC, a senior manager with Baker Newman & Noyes in Portland, ME.

• Helper—Modified dependence. Though level 5, supervision, is self-explanatory, determining scores between level 4, in which the patient needs minimal assistance, and level 3, moderate assistance, can be tougher. All three levels require that the patient needs a helper (e.g., another person) for assistance to comprehend directions or conversation.

“For moderate prompting—level 3—the patient understands directions and conversation about basic daily needs 50%–74% of the time,” says Linn. So the patient would perform 50%–74% of the task of comprehending and the helper would take over from there. But minimal assistance translates to the patient comprehending these things 75% or more of the time before needing assistance.

• Helper—Complete dependence. Level 2 is labeled as maximal assistance on the FIM instrument, and it translates to a patient needing help or prompting from 25%–49% of the time—or that the patient is expending less than 50% of the effort, as Linn describes it. “As an example, they understand simple, commonly used spoken expressions or gestures such as ‘hello, how are you,’ or waving goodbye,” he says.

With level 1, total assistance, the patient is expending less than 25% of the effort, he says. So this person would need prompting or help—or would be unable—to understand even simple language.
Cognitive function  
continued from p. 3

- **Which to choose.** It’s important to keep in mind that you want to score the patient’s lowest level of functioning, or the most dependence you observe across all shifts, both day and night. “Sometimes therapy sees someone doing very well, but later in the day they need a lot of help,” says Linn. “You want to score the lowest level of functioning because that reflects the patient’s burden of care.”

**Who is able to rate the IRF-PAI?**  
There’s nothing set in stone as to who can score this section of the IRF-PAI, advises Linn. “Clearly you’re not required to have someone who has training as a speech-language pathologist to rate the cognitive items, since the FIM instrument is meant to be discipline-free.”

For example, a rehabilitation provider not trained in the nuances of language can certainly determine whether her patient needed prompting or assistance in communicating their needs related to placing a dinner order.

Many team members can be involved in cognitive rating—not just the occupational and speech therapists, advises Lambert.

“It therefore, it’s important for the team to check rating reliability on a regular basis,” she says. “Peer reviews are a great way to do this.”

Try conducting rating explanations in team meetings, advises Linn. “It might be helpful for cognitive team members to explain [to others] why they ended up

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**Scoring social interaction and problem solving**

Out of the five cognitive function questions on the FIM™ instrument, social interaction and problem solving may be the hardest to score. After all, it’s not easy to see evidence of patients using these abstract skills.

“If you think about them, they’re not something you can give an easy test to measure,” explains Richard Linn, PhD, director of UDSMr, the Buffalo, NY–based organization that oversees the FIM instrument. Here’s what he has to say about each item:

- **Problem solving.** This item is sometimes hard for clinicians to pin down because it’s being done mentally, says Linn. That’s why the help of other staff members comes into play for this item.

“It takes a little bit more input from members of the team,” he says. “You really have to observe the patient’s interactions and behaviors across all patient settings” to get an accurate rating on this item of the FIM instrument.

- **Social interaction.** When you’re rating social interaction, you’re also rating something a little beyond the typical definition of cognition, says Linn. You want to determine whether a relatively independent patient acts appropriately around staff, family members, and other patients—or whether the patient might need medication or staff guidance to control inappropriate behaviors.

“Look at how they deal behaviorally with having to wait for breakfast or needing to go to the bathroom and having to wait for assistance,” advises Linn. You’ll want to observe the patient across a wide range of contexts to figure out whether patients’ interaction skills are appropriate or whether they need prompting, supervision, or redirection, he advises.

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with a rating of 4 or 5.” If there’s dissension in the ranks, team members can work out the correct rating and come up with a group consensus. “It makes for very good consistency across disciplines,” he adds.

**For what it’s worth**

Obviously, accurate rating on all areas of the IRF-PAI ensures that your facility is reimbursed according to the amount of resources required to properly care for a patient, says Lambert. But the five cognitive function items do enter directly into the payment calculation—at least for some of the 100 case-mix groups (CMGs).

In general, the criteria that determine a patient’s CMG come from the patient’s impairment group, his or her FIM motor score, and then the patient’s cognitive score and age.

“The FIM cognitive is providing extra information in some cases, but it’s a lesser variable in the case-mix group,” says Linn.

This happens primarily because most patients selected for intensive inpatient rehab possess cognitive functions high enough for them to profit from such interventions, he explains.

The scores affect payment in only 15 CMGs, adds Lambert. According to her, there are three stroke CMGs, three CMGs for traumatic brain injury, two for nontraumatic spinal cord injuries, three for lower extremity joint replacement, two for osteoarthritis, and two for major multiple trauma with brain or spinal cord injuries. The FIM cognitive score doesn’t directly affect payment in any other CMGs.

Because they’re not as obvious as patients’ physical capabilities, it’s no surprise that cognitive functions can be more difficult to measure. Still, it’s essential that you rate them correctly on the IRF-PAI to accurately reflect the care a patient needs.

“It takes a bit more scrutiny to really understand the level at which a person is engaging in cognitive functions,” says Linn, “but it’s a critical issue.” He adds that review of the cognitive ratings in the UDSMR database indicates that most clinicians are rating the cognitive items appropriately.

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**Confused about assessment reference dates?**

Under the prospective payment system, providers are required to submit the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) at both admission and discharge. The schedule for completing, encoding, and transmitting the IRF-PAIs can be confusing.

The Centers for Medicare & Medicaid Services, in its training materials for fiscal intermediaries, outlined the following schedule that providers should remember:

1. **Admission IRF-PAI**
   - Observation period—days one through three
   - Assessment reference date—day three
   - Completion date—day four
   - Encoded date—day 10
   - Transmission date—this is the same date that applies to the transmission of the discharge IRF-PAI

2. **Discharge IRF-PAI**
   - Assessment reference date—the date of discharge or the discontinuation of Medicare Part A services (counted as day one).
   - Completion date—day five following discharge or discontinuation of Part A services.
   - Encoded date—day seven following the completion date. (This should be counted from the completion date, which serves as the first day of the counting sequence.)
   - Transmission date—day seven following the encoded date. (The encoded date represents the first day in the sequence.)
Now’s a good time to start auditing your claims
Implement an audit program soon to make sure you’re in compliance

Now that the prospective payment system (PPS) isn’t brand new to inpatient rehabilitation facilities anymore, you’re probably getting a handle on the process of assessing patients and billing under the new payment system. But if something has been going consistently wrong in your claims submission practice, you’ll want to discover it now before the errors pile up.

Why conduct an audit?
“In the future, a medical review person from the PRO [peer review organization] or the fiscal intermediary will be coming out to your facility looking to second-guess you and the scores in your IRF-PAI [Inpatient Rehabilitation Facility Patient Assessment Instrument],” says David Ross, CPA, director of reimbursement and internal auditing for Kessler Rehabilitation Corporation in West Orange, NJ. But by starting some internal auditing now, you’ll be one step ahead of them.

Plus, if you can use all the staff involved in your data collection process in your self-audit, it becomes a learning tool, advises Angie Phillips, PT, president and chief executive officer of Images, a rehab services consulting firm based in Amarillo, TX. “Not only are you ensuring that you’re compliant—or making every effort to be compliant—but you’re also helping other people in your organization see where you’re falling down in the system,” she says.

It’s basically about making sure your claim agrees with the information in your system and that the medical record documents that the services billed were provided, explains Ross. “Also, you want to ensure that anything that could have been billed for is included on the bill,” he adds.

Who can help
When reviewing your claims to make sure they match the information recorded on your IRF-PAI, consider conducting a peer review, he advises. “You don’t want your internal auditor to be the first to do a test on it primarily because it contains things that are more subjective from a clinician’s point of view,” he says. The people involved in the audit process need to have a thorough understanding of the clinical side of the business.

Also remember that coding staff are great for self-audits because they are the most skilled at identifying what can and can’t be coded. They also sometimes may pick up on things that should be coded but weren’t—for instance, if there’s a comorbidity present that would affect reimbursement but the clinician didn’t document it well, a coder may recognize that. “A coder can then do a query process that asks for clarification from the physician—‘Am I inferring the right thing from this and if so, can you document it for me?’” says Phillips.

Claims audit focus
According to Ross and Phillips, there are six major areas you’ll want to look at when you conduct an internal billing audit under PPS:

1. Short-stay outliers. There’s a special case-mix group (CMG) for those patients who arrive at your facility but then leave unexpectedly and have a total stay of fewer than three days so your facility doesn’t get overpaid for their care.

Since this is a new concept under PPS, facilities may not be used to billing in this way. And because it’s well known that the Centers for Medicare & Medicaid Services (CMS) doesn’t like to hand out overpayments, it’s best if you eyeball your claims and make sure short-stay outliers are classified as such.

2. Interrupted stays. These can be hard to catch, according to Ross, and they also represent a new way of billing under PPS. In the case of an interrupted stay—where the patient is admitted to your facility, leaves for a while, and then returns within a three-day period—billers will submit only one claim for the patient’s stay, and not two as they had done in the past, Ross warns.

“Don’t shortchange yourself by only submitting a claim
for the first half of the stay,” he says. In the case of a true interrupted stay, Medicare will reject the second claim—and you may not get paid appropriately for the services you provided. For example, if a patient went out for a short time to an acute care hospital and you submitted a bill for only the first half of his or her stay, you’d get the transfer payment instead of the full payment, says Ross.

3. Services rendered by others.
Another concept that’s not new but still gives rehab facilities a difficult time is accounting for services rendered by another provider that need to be included on your bill. For example, take the patient who needs to visit an acute care hospital for services not available at your rehab facility.

“The rehab hospital needs to capture the charges on the bill, even though under PPS you may or may not get any additional payment,” advises Ross. If it is an outlier situation—i.e., a patient who exceeds the PPS reimbursement rate by a substantial amount of money—accounting for those services will ensure that you receive all of the reimbursement you are entitled to, he says. Even if it is not an outlier situation, you want to make sure you note the full charges for the services rendered to ensure that future rates set by CMS reflect the care provided.

4. Discharge status. An additional factor Ross recommends you look at while performing self-audits is the patient’s discharge status as listed on the claim. Of course, the ultimate goal for a patient in a rehab facility is to go home—but some patients will be transferred to acute-care hospitals or nursing homes after their rehab stay.

“When that happens, there could be a Medicare transfer payment reduction associated with the stay,” says Ross. If you code that the patient is going home on your claim but he or she is really going to a hospital or nursing home, you’re going to get overpaid. When Medicare catches it, you’ll be opening yourself up to medical review, warns Ross.

5. The FIM™ instrument. The 18 elements of the FIM instrument factor highly in putting a patient into the correct case-mix group (CMG) for reimbursement, says Phillips. “There are actually 14 different CMGs for stroke, and which one patients end up in is determined by their motor score and cognitive score from those 18 function elements,” she says.

Scoring the 18 elements correctly and putting the patient into the correct CMG will allow your facility to provide the resources that will benefit that patient the most. “It’s also an area where if we’re not using good processes, we could be making mistakes and falling out of compliance,” she says.

6. Information 24/7. One of the other things that facilities struggle with is making sure the information scored on the IRF-PAI includes how the patient functions 24 hours per day, says Phillips. “We want to make sure we look at what’s happening after 5 p.m. and before 7 a.m.,” she advises. “We have to look at how well the patient is doing with physical therapy, occupational therapy, nursing staff, and with their families.”

Another caution from Phillips: The common myth that the first day is always the worst for the rehab patient. That’s not always the case, she says. So when your facility performs a self-audit, make sure staff don’t assume that the first day of a patient’s stay is necessarily going to be the lowest-scored on the FIM instrument.

According to Phillips, it’s too early to tell which will be the most common errors on inpatient rehab PPS claims. But if you begin auditing your claims now, you can not only reinforce the importance of compliance to your staff, but you can also work out any kinks in your PPS system—before CMS or your fiscal intermediary steps in to do it for you.
Time and time again, industry experts hammer the point home. In order to succeed under the inpatient rehab prospective payment system (PPS), you need to code the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) accurately.

For those with little exposure to coding prior to PPS, the process may seem daunting. But you must be familiar with the ICD-9-CM coding system to accurately record patients’ etiological diagnosis and comorbidities on the IRF-PAI.

Do you need a primer when it comes to rehab coding? Industry experts recommend that you remember the following key points:

1. **Code to the greatest specificity.** Whether you’re recording the ICD-9-CM code for comorbidities or the etiological diagnosis, it’s important to code to the greatest specificity possible.

   For professional coders, this concept is not new. However, it may be causing some rehabilitation providers troubles.

   The Centers for Medicare & Medicaid Services (CMS) regularly releases PPS guidance—in the form of frequently asked questions and answers—on its Web site.

   One of its most recent questions notes that rehab providers should use the most specific ICD-9-CM code available to indicate patient conditions. ICD-9-CM codes can range from three digits to five digits, says Michelle Dougherty, RHIA, a practice manager with the American Health Information Management Association (AHIMA).

   “For a coder, this is nothing new,” says Dougherty. “We have been taught to code to the highest level of specificity. By using all of the digits available, it means that you are most accurately reflecting the diagnosis.”

   For example, consider the codes for a patient who has diabetes. The first three digits of the code—250—indicate that the person is diabetic. Following the decimal point, however, the fourth and fifth digit may reflect greater detail about the person’s condition.

   ICD-9-CM code 250.4 indicates that the patient suffers from diabetes with renal complications. A fifth digit may indicate whether the diabetes is controlled with insulin, does not require insulin, or is not controlled at all, Dougherty says.

   “The digits become very important for communicating the specifics of the disease,” Dougherty says. “You always want to assign the highest number of digits available.”

2. **Understand the nuances of rehab coding.**

   Coding for rehabilitation services is unique in that some of the coding guidelines used in acute-care settings do not necessarily apply, says Patricia Trela, a manager at Deloitte & Touche, an accounting firm in Boston.

   “Okay, you can start every therapy session with the Star Spangled Banner?”

Illustration by Dave Harbaugh
The IRF-PAI requires you to list the patient’s etiological diagnosis (item 22), which is the underlying condition that caused admission to the rehab setting. This differs from the listing of the principal diagnosis used in other settings.

However, while this code is unique to rehab, coders must still follow the coding guidelines when it comes to the UB-92. This means that the codes required on the UB-92—the principal diagnosis—will be a V code that differs from the etiological code.

3. Use all available resources. So how do you go about finding the most specific code? You need to access all existing information. You will want to consult the IRF-PAI Training Manual and the final rule for guidance.

It may be best, however, to go directly to the source and consult ICD-9-CM codebooks, Trela says. You can consult the book’s alphabetical listing for the condition that you want to code.

Then, you can go to the code book’s tabular listing to find the code that describes the condition to its greatest level of specificity.

It’s also a good idea to consult a medical records professional who may work within your facility. You will want to take advantage of all professional resources available.

This includes accessing The Coding Clinic, the American Hospital Association’s publication that regularly gives guidance on using ICD-9-CM codes. If you belong to AHIMA, you may also want to consult its Web site at www.ahima.org for specific rehab coding guidance, including its “Communities of Practice.” The Coding SCC: Physical Medicine/Rehabilitation is helpful for rehab coders.

You may also want to consider purchasing an electronic encoder, a product offered by several companies. Make sure the product you purchase is programmed to recognize rehabilitation coding.

Coding for rehab impairment categories

As part of the prospective payment system (PPS), the Centers for Medicare & Medicaid Services (CMS) established 21 rehabilitation impairment categories (RICs).

Under PPS, the coders assign patients a rehab impairment group code, says Patricia Trela, a manager at Deloitte & Touche in Boston. The coder then enters the code into the IRVEN software, which converts it and places the patient into one of 21 RICs.

The issue can become clouded if the patient suffers from one or more conditions. For example, a patient may have had a stroke and then more recently fell and fractured his or her hip.

When it comes time to choose the impairment group category, you need to choose the code that indicates the primary reason the patient is being treated at your facility. In this case, that means choosing the code that reflects the hip fracture.

“You need to look at the primary reason for admission,” says Trela. “The patient may have had a stroke [previously], but he or she wouldn’t be admitted unless it was for the hip fracture.”

Although impairment group categories are listed in the final rule, the best resource for choosing the correct category may be the Inpatient Rehabilitation Facility Patient Assessment Instrument Training Manual, Trela says. The manual’s listings make it easier to choose the correct code.
Where can you find a reliable coding person?

With the demands of inpatient rehabilitation’s prospective payment system (PPS), you may realize that your facility needs more help.

You may want to look at data-entry staff—employees who can help with the added coding demands that PPS brings. Industry experts offer these suggestions:

1. **Look for experience.** How do you find such a person and what type of qualifications should the candidate possess? It may sound simple, but first off you need to make sure your prospective employee has some experience with coding, says Sheryl Smith, vice president of administration at Rehab Therapy Works in Clearwater, FL.

“It cannot be someone from a temporary agency,” she says. “It has to be a person who is very well trained and has to be cognizant of the information that they are putting in [to the system], and who has to be able to recognize when something is [off] kilter.”

“Even though your coders aren’t typically therapists, they should have a working knowledge of the definitions of the CPT and ICD-9 codes,” says Jerry Goldstein, president of the National Association of Rehab Providers and Agencies and chief financial officer of Lake Center for Rehabilitation in Leesburg, FL.

Finding these people can be tricky. If you are on the lookout for a new coder, make sure to specify in your advertisement exactly what you need. Carefully spell out that the candidate needs specific coding experience in relation to the rehab industry. Asking pointed, specific questions during interviews will allow you to see which candidate has the “right stuff.”

Although hiring the person with the most experience is usually the best bet, Smith says her facility has done some on-the-job training for people who want to move into this profession.

“Typically they are not already employees here. They are on-the-job trained for other employment situations [within our facility],” she explains. “We do some testing and training with the junior college in the area, which sends us students.”

2. **Perform internal testing.** Besides testing and training given at the school, Smith’s facility also gives an internal test to make sure the candidate has the right amount of knowledge to do the job. Applicants take the tests on a computer in about 20 to 30 minutes. Most questions are hypothetical, asking the candidate what to do if certain situations arise regarding modifiers and what codes should be used for certain diagnoses.

In order to get into the data-entry chair, each candidate must get every question correct. Those who do not pass the first time can review the material and take the test again. Besides the internal test, data-entry applicants should also pass a state certification test before they get hired at Smith’s facility.

Candidates do not have to take this test in order to be hired, but it does weigh heavily in their favor if they do, she says.

Goldstein doesn’t utilize tests for his employees, nor does he initially look for candidates outside his facility. He chooses people already in the company who have proven their mettle doing other office jobs. Most of his coders have started in the front office, so his office manager plays a key role in the early training of the data-entry worker.

“We have a solid office manager who teaches and trains the front officer workers the different front office procedures,” Goldstein says.

 “[The procedures] include handling money at the desk, checking with the insurance company on verifications, and getting information back and forth correctly and accurately from the physician’s office. We seek employees who are detail-oriented and don’t make a lot of mistakes.”
Do you have a question about the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) or other specifics of the prospective payment system?

If so, don’t despair. The Centers for Medicare & Medicaid Services (CMS) continues to provide a variety of resources to ensure provider success under PPS.

• **Q&As.** CMS regularly releases frequently asked questions—and answers—it receives from providers. Providers will find questions specific to the IRF-PAI, as well those that address billing, software, and coding issues.

For example, some providers may be wondering whether it’s okay to change a previously recorded admission assessment item score based on information that results from the discharge IRF-PAI.

According to CMS the answer—in general—is no. However, there is one exception to this. Providers are allowed to retroactively change item 39 L on the IRF-PAI, which is the walk/wheelchair question.

• **The IRF-PAI training manual.** CMS released its first version of the training manual in late 2001 and provided updates to the manual earlier this year.

• **The IRF-PAI help line.** UDSMR, the Buffalo, NY–based organization that oversees the FIM instrument, also staffs the help line established by CMS to help providers with their IRF-PAI questions. You can contact the help line by

  - **phone:** 866/216-8089
  - **fax:** 866/216-8090
  - **e-mail:** HELP@IRFPAI.com

*Editor’s note: Go to [www.rehabregs.com/ppsrc](http://www.rehabregs.com/ppsrc) and click on “Inpatient Rehab” to access the updated list of Q&As, the IRF-PAI training manual and its updates.*
There are a variety of resources available that can help you train your staff, keep you up-to-date on the latest rehab news, and provide essential information. The following is a listing of helpful resources for rehab providers:

1. **Staff training.** A new, 20-page pamphlet, “Inpatient Rehab PPS: What you need to know” outlines items that will help your staff complete the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), submit accurate claims to get the reimbursement you deserve, and describe best practices your facility should follow for success. The guide is published by Opus Communications, publisher of **PAIR**. Call customer service at 800/650-6787 to order.

2. **Free e-mail newsletter.** **RehabRegs**, a free, weekly, e-mail newsletter keeps you up-to-date with the latest changes affecting rehab providers and the industry. To subscribe, go to [www.bcmarketplace.com](http://www.bcmarketplace.com) and click on “Free e-zines.” Then choose “RehabRegs,” to subscribe to the e-mail newsletter, which is brought to you by Opus Communications.

3. **RehabRegs Web site.** Go to [www.rehabregs.com](http://www.rehabregs.com) to access a Web site devote to the latest rehab industry news. Click on the “PPS Resource Center” and then choose “Inpatient Rehab” to download the final rule outlining PPS, Centers for Medicare & Medicaid Services program memorandums, the IRF-PAI and other helpful tools.

4. **The CMS’ Inpatient Rehab Facility PPS Web site.** Go to [www.bcfa.gov/medicare/irfpps.htm](http://www.bcfa.gov/medicare/irfpps.htm) to find CMS’ main Web page outlining PPS. The site includes training materials, software downloads, the IRF-PAI Training Manual, frequently asked questions and answers, and is updated regularly.

5. **American Medical Rehabilitation Providers Association.** Go to [www.amrpa.org](http://www.amrpa.org) to read the latest news from this organization, which represents industry providers. The Web site includes contact information, updates on new regulations, and links to resources and other helpful items.

6. **UDSMR.** Go to [www.udsmr.org](http://www.udsmr.org) to find the latest in PPS news from this Buffalo, NY–based organization that oversees the FIM™ instrument. UDSMR provided the IRF-PAI Training Manual and its updates for CMS, as well as frequently asked questions about the IRF-PAI. Its Web site provides PPS resources and helpful links to research material, resources, and other products and services.

7. **Outpatient rehab providers newsletter.** This 12-page monthly publication, **Briefings on Outpatient Rehab Reimbursement and Regulations**, offers tips and advice pertaining to clinical issues, reimbursement, and compliance with CMS regulations. Call customer service at 800/650-6787 to subscribe to the newsletter, which is published by Opus Communications.