



Stroke Coding Issues

Presentation to:

NorthEast Cerebrovascular
Consortium

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Stroke Coding Issues

■ Outline

- Medical record documentation
- Coding rules
- Reimbursement implication of MS-DRGs
- Present on Admission
- ICD-10-CM

■ Goals

- Identify the shared interests
- Explain why the coded information looks as it does
- Identify opportunities for improvement

The Medical Record

- Concurrent communication tool for care giving
- What may be obvious at the time needs to be *explicitly* stated for later reference
- Coding is based on explicit documentation
- It is a coder's job to report diagnoses and procedures according to documentation in the medical record
- *If it is not documented; it did not occur*

The Medical Record

- Primary users are care givers; all else are secondary.
- Who else depends on the information in the record?
 - Medical records and coding
 - Patient accounts
 - Internal and external quality monitoring
 - CMS and other insurers
 - Statistics and research
 - Attorneys
 - Secondary users of varying sophistication

Coding Rules and Guidance

- ICD-9-CM Official Guidelines for Coding and Reporting
- Current guidelines effective for discharges October 1, 2008
- Developed and approved by the cooperating parties for ICD-9-CM
 - National Center for Health Statistics
 - CMS (formerly Health Care Financing Administration)
 - American Hospital Association
 - American Health Information Management Association
- <http://www.cdc.gov/nchs/dataawh/ftpserv/ftpicd9/icdguide08.pdf>

- AHA Coding Clinic for ICD-9-CM: A Quarterly Publication of the Central Office on ICD-9-CM
 - American Hospital Association

Coding Rules and Guidance

- Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).
- Codes are dynamic – updated twice yearly
- Changes to reflect advances in medical science and technology

Coding rules

- Principal diagnosis
- “Rule out” versus “ruled out”
- Uncertain diagnoses
- Stroke-specific coding rules

Principal Diagnosis

- The condition established *after study* to be *chiefly responsible* for admission of the patient to the hospital.
- When two or more diagnoses equally meet the criteria for principal diagnosis
 - as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and
 - the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction,
 - any one of the diagnoses may be sequenced first.

Secondary Diagnosis/Comorbidities

- Conditions that affect the episode of hospital care, including:
 - Clinical evaluation
 - Therapeutic treatment
 - Further evaluation by diagnostic studies, procedures, or consultation
 - Extended length of hospital stay
 - Increased nursing care and/or other monitoring

“Rule out” versus “ruled out”

■ For Inpatient Discharges

- Diagnoses qualified by the term “rule out” are coded as if established for inpatient episodes of care
- “Ruled out” is never coded - code the established alternative diagnosis or presenting symptom or other precursor condition.

Uncertain Diagnoses

- If the diagnosis documented at the time of discharge is qualified as
 - “probable”
 - “suspected”
 - “likely”
 - “questionable”
 - “possible”
 - “still to be ruled out”
- Code the condition as if it existed or were established

Coding rule specific to stroke

- Cerebral infarction/stroke/cerebrovascular accident (CVA)
 - Terms often used interchangeably to refer to a cerebral infarction.
 - Stroke, CVA, and cerebral infarction NOS are all indexed to the default code 434.91, Cerebral artery occlusion, unspecified, with infarction.
 - Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used when the documentation states stroke or CVA.

Coding rule specific to stroke

- Neurological deficits
 - not coded if resolved at the time of discharge
 - if present at discharge, the deficit is reported at discharge (e.g., hemiparesis, aphasia, dysphagia, etc)

Late effect of CVA

- Category 438, Late Effects of Cerebrovascular disease
 - These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to 430-437

History of CVA or TIA

- V12.54 Transient ischemic attack (TIA), and cerebral infarction without residual deficits
 - Assign code V12.54 (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.
 - New code as of 10/1/07

Coding Clinic guidance

- Coding Clinic 2002 Q2

For Inpatient Discharges, requires the attending physician to confirm the results of diagnostic testing in the progress notes or discharge summary. (*Do not code from radiology or laboratory reports.*)

- Coding Clinic 2004 Q1

For Inpatient Discharges, documentation from a physician other than the attending may be used for coding purposes as long as the documentation does not conflict with information written by the attending physician.

ICD-9-CM index

Stroke 434.91

Apoplectic (see also disease, cerebrovascular, acute) 436

Brain see infarct, brain

Embolic 434.11

Healed or old V12.54

Hemorrhagic - see Hemorrhage, brain

Iatrogenic 997.02

In evolution 434.91

Ischemic 434.91

Late effect – see Late effect(s) (of) cerebrovascular disease

Postoperative 997.02

Paralytic – see Infarct, brain

Progressive 435.9

Thrombotic 434.01

ICD-9-CM index

Infarct, Infarction

Brain (stem) 434.91

Embolic (see also Embolism, brain) 434.11

Healed or old without residuals V12.54

Iatrogenic 997.02

Lacunar 434.91

Postoperative 997.02

Puerperal, postpartum, childbirth 674.0

Thrombotic (see also Thrombosis, brain) 434.01

Cerebral (see also Infarct, Brain) 434.91

Aborted 434.91

Embolic 434.11

Thrombotic 434.01

ICD-9-CM index

Impending

Cerebrovascular accident or attack 435.9

Aneurysm,

Brain,

Nonruptured 437.3

Ruptured 430

Hemorrhage, hemorrhagic (nontraumatic)

Brain 431

Cerebral 431

Subarachnoid 430

Subdural 432.1

ICD-9-CM Tabular List

- 433 Occlusion and Stenosis of Precerebral Arteries
- The following fifth-digit subclassification is for use with category 433
 - 0 **without** mention of cerebral infarction
 - 1 **with** cerebral infarction
- Ex.
 - 433.10 carotid artery stenosis without mention of cerebral infarction
 - 433.11 carotid artery stenosis with cerebral infarction

Addenda to the ICD-9-CM Index Effective 10-1-04

- As of 10/1/04, the terms stroke and cerebrovascular accident are assigned to code 434.91
- Prior to that date the terms were assigned to code 436

Addenda to the ICD-9-CM Index Effective 10-1-07

Accident, accidental - see also condition
cerebrovascular (current) (CVA) (see also
Disease, cerebrovascular, acute) 434.91

aborted 434.91

healed or old V12.54

*note: code V12.54 is used to report history of
stroke with no residual deficits*

Stroke 434.91

in evolution 434.91

New Code V45.88 (effective 10/1/08)

In March 2008, the AAN proposed a unique code to the ICD-9-CM Coordination and Maintenance Committee

- Intended to identify trends in the use of TPA
- Created to better track those patients who receive TPA especially within the 24 hours prior to the hospital admission.
- American Academy of Neurology; Joseph Broderick, MD and Dawn Kleindorfer, MD

New Code V45.88

- V45.88 Status post administration of tPA (rtPA) in a different facility w/in the last 24 hours prior to admission to current facility
- Code first the condition requiring tPA administration (e.g., CVA, MI)
- Only coded by the receiving facility and not the transferring facility
- Applies even if the patient is still receiving the tPA at the time they are received into the current facility

Medicare Severity DRGs: MS-DRGs

- Complete restructuring of the DRG system (745 DRGs in FY 2008 replacing 538)
- MS-DRG categories split by
 - With Major CC
 - With CC
 - Without CC or MCC
 - (some exceptions)

Medicare Severity DRGs: MS-DRGs

Selected Major CCs

- Quadriplegia
- Severe malnutrition
- Toxic encephalopathy
- Acute systolic congestive heart failure
- Acute diastolic congestive heart failure
- Pneumonia
- Acute renal failure
- End stage renal disease
- Decubitus ulcers
- Cardiogenic/septic shock
- Fractures/burns
- Sepsis/severe sepsis

Medicare Severity DRGs: MS-DRGs

- A few CCs to keep in mind:
 - COPD exacerbation
 - Urinary Tract Infection
 - Hyponatremia
 - Chronic systolic heart failure
 - Chronic diastolic heart failure
 - Atrial flutter

MS-DRGs – relative weights

Acute ischemic stroke w/ use of thrombolytic agent ...

- DRG 061 ... w/ MCC (wt. 2.8717) (alos 8.9)
- DRG 062 ... w/ CC (wt. 1.9537) (alos 6.3)
- DRG 063 ... w/o CC/MCC (wt. 1.5143) (alos 4.5)

MS-DRGs – relative weights

Intracranial hemorrhage or cerebral infarction ...

- DRG 064 ... w/ MCC (wt. 1.8450) (alos 7.5)
- DRG 065 ... w/ CC (wt. 1.1760) (alos 5.2)
- DRG 066 ... w/o CC/MCC (wt. 0.8439) (alos 3.7)

MS-DRGs – relative weights

Nonspecific CVA & precerebral occlusion w/o infarct ...

- DRG 067 ... w/ MCC (wt. 1.3873) (alos 5.8)
- DRG 068 ... w/o MCC (wt. 0.8457) (alos 3.4)

- DRG 069 Transient ischemia (wt. 0.7157) (alos 3.0)

MS-DRGs – relative weights

Nonspecific cerebrovascular disorders ...

- DRG 070 ...w/ MCC (wt. 1.8246) (alos 7.9)
- DRG 071 ...w/ CC (wt. 1.1361) (alos 5.6)
- DRG 072 ...w/o CC/MCC (wt. 0.7650) (alos 3.5)

Present on Admission (POA)

- Distinguish between co-morbidity (pre-existing conditions) and complications
- Is the condition present at the time the order for inpatient admission occurs?
- The stroke diagnosis that was present on admission may not be reported as the principal diagnosis

POA indicators

POA Indicator Code	Code Translation	Explanation
Y	Yes	Present at the time of inpatient admission
N	No	Not present at the time of inpatient admission
U	Unknown	Documentation is insufficient to determine if condition was present on admission
W	Clinically undetermined	Provider is clinically unable to determine if condition was present on admission or not
Blank space	Unreported/Exempt	A list of ICD-9-CM codes will be published as exempt for this indicator

POA example

Effect of sequencing on reimbursement when both diagnoses are present on admission

Example: patient admitted with both CVA 434.91 and aspiration pneumonia 507.0

- Aspiration pneumonia 507.0, Y, DRG 177 (**wt. 2.0393**)
(alos 9.1)
CVA 434.91, Y
- CVA 434.91, Y, DRG 64, (**wt 1.8450**) (alos 7.5)
Aspiration pneumonia 507.0, Y

POA example

Effect of sequencing on reimbursement when both diagnoses are present on admission

Example: patient admitted with both CVA 434.91 and respiratory failure 518.81 and is on a ventilator

- Respiratory failure 518.81, Y, DRG 207 (**wt. 5.1055**) (alos 15.1)
CVA 434.91, Y
w/ ventilator >96 hours 96.72
- CVA 434.91, Y, DRG 64 (**wt 1.8450**) (alos 7.5)
Respiratory failure 518.81, Y
w/ ventilator >96 hours 96.72

ICD-10-CM

- Proposed rule published:
 - 49796 Federal Register / Vol. 73, No. 164 / Friday, August 22, 2008
 - <http://edocket.access.gpo.gov/2008/pdf/E8-19298.pdf>

“We propose October 1, 2011 as the compliance date for ICD–10–CM and ICD–10–PCS code sets for all covered entities.”

ICD-10-CM

- ICD-10 offers much greater specificity and clinical information resulting in
 - Improved ability to measure health care services
 - Increased sensitivity when refining grouping and reimbursement methodologies
 - Enhanced ability to conduct public health surveillance
 - Decreased need to include supporting documentation with claims

ICD-10-CM Diagnoses

- ICD-10-CM has 3-7 digits (alphanumeric)

Examples:

- I64 Stroke not specified as hemorrhage or infarction
- I62.01 Non-traumatic acute subdural hemorrhage
- I69.151 Hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting right dominant side

ICD-10-CM Specificity

- Stroke - occlusion by thrombosis or embolism, by artery

Examples:

- I63.0 Cerebral infarction due to thrombosis of precerebral arteries
- I63.4 Cerebral infarction due to embolism of cerebral arteries
- I65.2 Occlusion and stenosis of carotid artery, not resulting in cerebral infarction

ICD-10-CM Specificity

- Stroke hemorrhage by site

Examples:

- I60.2 Non-traumatic subarachnoid hemorrhage from anterior communicating artery
- I61.5 Non-traumatic intracerebral hemorrhage, intraventricular
- I62.02 Non-traumatic subacute subdural hemorrhage

ICD-10-CM Specificity

- Late effect by type of stroke

Examples:

- I69.051 Hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage affecting right dominant side
- I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side

ICD-10-CM Specificity

- Requirement to “code also” risk factors
- Instructional term: Use additional code to identify presence of:
 - Alcohol use, abuse or dependence, including in remission
 - Tobacco use or dependence, including history of use
 - Exposure to environmental tobacco smoke, including occupational exposure
 - Hypertension

ICD-10-PCS Procedures

- ICD-10-PCS has 7 digits (alphanumeric)
 - Eliminated letters O and I to avoid confusion with 0 and 1

- Structure
 1. Section
 2. Body System
 3. Root Operation
 4. Body Part
 5. Approach
 6. Device
 7. Qualifier

Example:

- B32R0ZZ CT Scan of Intracranial arteries using high osmolar contrast

ICD-10-CM – Implementation Issues

- Budgeting
- Personnel training
- Documentation improvement
- Hardware and software changes
- Data conversion

Questions?

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