Stroke icd 10 guidelines

As the largest outsourcing coding provider in the country, we have identified trends and received unique information from our programmers throughout the transition to ICD-10. We share these ideas with the wider community through our biweekly blog series ICD-10 Fast Tips. The theme of this series is cured based on trending themes in our online question-and-answer system, which services more than 1,200 of our HIM professionals. Our subject matter experts have an average of 20 years of experience and are considered leaders in their field. This week's post comes from the National Compliance and Quality Control Manager, Melissa McLeod, CDIP, CCDS, CCS, CPC-1, and AHIMA Approved ICD-10 Trainer. After our last few blogs where we covered a number of complex coding topics, ones that have spinal synthesis and aneurysm repair (I know I've heard you all moan again), we thought it was time for an easy topic. So let's talk neuroscience! Neurology isn't too bad in the coding world, but there are a few little snippets we'd like to share with you all as we continue to navigate through ICD-10. So here we go! Fragment 1 When one-sided weakness is clearly documented as associated with stroke, it is considered synonymous with hemiparesis/hemiplegia. Pause... say what? When did that happen? When is anything synonymous in coding?? The 1st quarter 2015 coding clinic explains to us: The question is: An 88-year-old male patient is hospitalized in high school for a brain infarction. In its final diagnostic statement, the provider documented acute brain infarction involving the right hemisphere with left-sided (non-dominant) weakness. How should left-handed weakness be encoded due to an acute cerebral infarction when there is no specific mention of hemiplegia/hemiparesa? Answer: Assign code I63.9, brain infarction, uncertain, as the main diagnosis. Assign the code G81.94, Hemiplegia, uncertain affecting the left non-dominant side, as an additional diagnosis. When one-sided weakness is clearly documented as associated with stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be considered as hemiparesis/hemiplegia unless it is associated with any other brain disorder or injury. Okay, what about residual weakness after CVA? The 1st quarter 2015 coding clinic explains to us: The patient is a 72-year-old male hospitalized due to gastrointestinal bleeding. The provider documented that the patient had a history of acute brain infarction with residual right-sided weakness (dominant) and ordered the evaluation through physical and occupational therapy. What is the appropriate purpose of the code for residual weakness, as a result of the old CVA without mentioning hemiplegia/gemipares? hemiplegia/gemiparesa? Assign code I69.351, Gemiplegia and hemiparesis after a brain infarction affecting the right dominant side, for residual right-sided weakness due to a cerebral infarction. When one-sided weakness is clearly documented as associated with stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be considered as hemiparesis/hemiplegia unless it is associated with any other brain disorder or injury. Fragment 2 term Parkinson's indicates that a person has symptoms similar to Parkinson's disease. This does not necessarily mean that a person has Parkinson's disease. In Parkinson's disease, brain cells that produce dopamine die. Symptoms such as tremor, stiffness, and slow motion are caused by lack of dopamine. According to the National Parkinson's Foundation, it is possible to have Parkinson's Parkinson's disease, with only 85 percent of all Parkinson's syndrome due to Parkinson's disease In both ICD-9-CM and ICD-10-CM indices see the instruction after the main term Parkinson's disease indicates that the underlying term Of Parkinson's should be referenced. This may lead the coder to conclude that Parkinson's disease and Parkinson's disease are synonymous with terms, but it is not. It is necessary to take care to follow the index and tablya, especially when coding the complications of Parkinson's disease and Parkinson's disease. Fragment 3 Central Pain Syndrome (G89.0) and Chronic Pain Syndrome (G89.4) are different from the term chronic pain, and therefore codes should be used only when the provider has specifically documented this condition. Central pain syndrome is defined by the National Institute of Neurological Disorders and Stroke (NINDS) as a neurological condition caused by damage or dysfunction of the central nervous system. Central pain syndrome can occur as a result of stroke, multiple sclerosis, neoplasm, epilepsy, CNS injury or Parkinson's disease. ICD-10-CM classifies the central pain syndrome to code 89.0 (Central Pain Syndrome). Chronic pain syndrome is a chronic pain associated with significant psychosocial dysfunction. Psychosocial problems can include depression, drug addiction, complaints that are disproportionate to physical findings, anxiety and other manifestations. You should encode this condition only when the doctor specifically documents it. Chronic pain syndrome is reported with the code G89.4 (Chronic Pain Syndrome). Well, you've got it! A few small fragments to help you in coding in the field of neurology. Now we can't let you all come out so easily next time... maybe it's time to address some OB/GYN coding? For my moans there... We hear you! Want to get articles like this in your inbox? On JustCoding News: Landline! Fast Fast The ICD-9-SM and ICD-10-CM stroke and coma codes shows a lot in common and some important differences. As ICD-10 stroke codes organized 2013 ICD-10-CM Table of Diseases organizes cerebrovascular disease codes as follows: I60-I62: Nontraumatic intracranial hemorrhage (i.e., spontaneous subarachnoid, intramuscular, or subdural hemorrhage) I63 Infarction of the brain (i.e.. I65-I66: Occlusion and stenosis of the brain or pre-cerebral vessels without infarction I67-I68: Other cerebrovascular diseases I69: Sequelae cerebrovascular diseases (late effect) Note that some neurological manifestations of cerebrovascular disease such as transient ischemic brain attacks and associated syndromes (G45), are classified elsewhere. Greater specificity for strokes ICD-10-CM bar codes are more specific than their ICD-9-CM counterparts. First, the I60-I62 codes indicate the location or source of the hemorrhage, as well as its laterality. For example, the code ICD-10-CM I60.11 refers to a non-traumatic subarachnoid hemorrhage from the right middle cerebral artery. A CT scan usually indicates a specific location of hemorrhage, said Alice zentner, RHIA, director of audit and education at TrustHCS in Springfield, Mo. Hopefully the doctor will bring this information forward in his or her progress notes, she says. Secondly, the code category I63 defines the following: The cause of ischemic stroke (e.g. thrombosis, embolism, or indefinite) Specific location and lateral occlusion (i.e. specific artery) For example, the code ICD-10-CM I63.331 denotes a cerebral infar infarction due to thrombosis of the right posterior cerebral artery. zentner says that programmers should be able to differentiate the following terms when presenting code from the category I63-I65: Stenosis-narrowing of the Artery Occlusion-Full or partial obstacle Thrombus-Solid mass platelets or fibrin, which forms and remains in the blood vessel (stationary blood clot) Embolism-Blood clot that travels from the place where it is formed to another place in the body Coders should also be able to distinguish between the brain and pre-series arteries because ICD-10-CM codes make this difference, says James S. Kennedy, MD, CCS, CDIP, Managing Director of FTI Consulting in Atlanta. Pre-reebal arteries include vertebrae, basilar and carotid arteries and their branches. The brain arteries include the anterior, middle and posterior cerebral arteries and their branches. Third, the code category I69 determines the type of stroke that caused the sequels, as well as the residual state itself. For example, the code I69.01 denotes cognitive deficit after non-traumaticl hemorrhage. In ICD-9-SM, code 438.xx simply refers to a residual condition, not a type of stroke that State. Coders can report code from category I69 in combination with state, state, category I60-I67, if the patient has a current cerebrovascular disease and deficiency from old cerebrovascular disease. The coding guidelines also state that neurological deficiencies caused by stroke may occur at the beginning of a stroke or occur at any time after the onset of stroke. Please note that I69 codes are exempt from POA reporting. When a patient has a history of cerebrovascular disease without any neurological deficits, programmers must report code No. 86.73 (personal history of transient ischemic attack, and brain infarction without residual deficit) and code for brain infarction without residual deficit (not code I69), according to the 2012 ICD-10-CM guidelines. Reporting bilateral hemorrhage If the patient has suffered bilateral non-traumatic intracerebral hemorrhage, programmers should report code I61.6 (non-traumatic intracerebral hemorrhage, multiple localized). Conversely, if a doctor documents bilateral non-traumatic sites of subarachnoid hemorrhage, coders must report ICD-10-CM encodings for each party. The ICD-10-CM guidelines state that if a patient has a two-way condition and there is no two-way ICD-10-CM code, coders must assign separate codes to the left and right sides. For example, in rare cases that the patient suffers non-traumatic subarachnoid hemorrhage of both anterior artery binders, prescribe as: I60.21, non-traumatic subarachnoid hemorrhage from the right anterior connection of the artery I60.22, non-traumatic subarachnoid hemorrhage from the left anterior artery However, coders should note that the code categories I65-I66 include bilateral subarachnoid hemorrhage from the left anterior artery However, coders should note that code categories I65-I66 include bilateral subarachnoid hemorrhage from the left anterior artery However, coders should note that bilateral subarachnoid hemorrhage from the left anterior artery however, coders should note that bilateral subarachnoid hemorrhage from the left anterior artery however, coders should note that the I65-I66 coder includes bilateral subarachnoid hemorrhage from the left anterior artery however, coders should note that Coders should note that I65-I66 codes are encodes. Therefore, if the patient has bilateral stenosis of the vertebral arteries, programmers should prescribe I65.03-not I65.01 and I65.02 to indicate the right and left vertebral arteries, respectively. Reporting intraoperative and post-proctusical strokes as opposed to ICD-9-CM, ICD-10-CM highlights the following: Intraoperative stroke during cardiac surgery (I97.810) or during another surgery (I97.811) Postprodedural stroke during cardiac surgery (I97.820) or during another surgery (I97.821) If a stroke occurs in surgery, a request is required, to determine if a stroke occurred during or after surgery, Kennedy said. The most notable difference between the ICD-9-CM code 780.01 (coma) and its ICD-10-CM counterpart (R40.2 category) is that the latter includes the Glasgow Coma Scale (GCS), a neurological which captures the patient's conscious condition for initial and subsequent evaluation. It really shows the patient's condition and the severity of the event, says Sentner. If reported at different intervals, it shows the patient's progress and response to treatment. Coders can report GCS with any relevant disease. Coma scales should be sequenced after the code is diagnosed (s). GCS can be coded on the basis of a cumulative score (code (code GCS is a total score), or based on its individual components. The R40.24 code is appropriate when only the overall score is documented, not individual components. When individual components are documented, coders can report GCS based on components. However, they must report the code from each of the following subcategories: R40.21: Eye reaction (eyes never open or eyes open to pain, sound or spontaneous) R40.22: Best verbal response (clarity of words inappropriate, R40.23: Best Motor Response (voluntary and involuntary responses (expansion, flexion, abnormal, obeyed commands) If a doctor does not document GCS or documents, only a portion of his coders must report R40.244 (another coma, without a documentary Glasgow coma score, or with a partial assessment). The codes R40.21-R40.23 require the seventh character to indicate when the scale has been recorded (i.e. an unspecified time in the SCOR field, on arrival at ED, when hospitalized, or 24 hours or more after hospitalization). Coders must report codes for all three components, and they must ensure that the seventh character matches all three, Kennedy said. Coders should also note that hospitals can report GCS at multiple intervals and that doctors and ambulance documentation should support the appointment of the code, he says. Amenities who have an injury registry certainly want to report on these codes, says Sentner. If the center wants to follow the patient and see how he or she progresses, they may want to report multiple codes. It is important to inform ED physicians about the documentation of coma scales and new codes. Hospitals should consider revising templates so they can include this information, she says. Individual symptoms and combined code coders should look for the ICD-10-CM Alphabet Index for codes that automatically include a coma in their descriptions. For example, the code E11.641 refers to type 2 diabetes with hypoglycemia with coma. The purpose of the ICD-10-SM R40.20 code (coma, uncertain) as an additional code would be appropriate, as the combined code E11.641 includes a coma (symptom) as an integral component. Editor's Note: Access to the latest version of the ICD-10-CM and 2012 ICD-10-CM Guidelines, online. This article was originally published in the September issue of coding compliance briefings. Email your questions to Senior Editor-in-Chief Michelle A. Leppert, PDA, mleppert@hcpro.com. Want to get articles like this in your inbox? Subscribe to JustCoding News: Landline! Stationary! stroke coding guidelines icd 10. get with the guidelines stroke icd-10 codes