

Home Health ICD-9/ICD-10 Alert

Coding 101: New PPS Guidelines Help Clear UP Your Stroke Coding Confusion

Tip-off: Late effects coding can take more than one code.

Getting the case mix points your agency deserves for stroke patients has been complicated in the past, but the revised prospective payment system makes stroke reporting much more clear-cut. Here's the latest word on coding for strokes to make sure you're keeping up-to-date with the changes.

Remember Stroke Coding History

When the **Centers for Medicare & Medicaid Services** introduced the original home health PPS back in 2000, it based payment for new strokes or cerebrovascular accidents on reporting the acute care code, says clinical consultant **Judy Adams, RN, BSN, HCS-D**, with **LarsonAllen** in Charlotte, NC.

However, coding rules limited the use of acute stroke codes to inpatient acute care settings, Adams says. So, to receive reimbursement for the resource-intensive care generally required for a new stroke patient, home health agencies needed to follow CMS, but listing the acute codes went against the coding rules.

Old way: In order to list an acute care code for a home health patient, CMS required agencies to meet three conditions, says **Trish Twombly, RN, BSN, HCS-D, CHCE**, director of coding with **Foundation Management Services** in Denton, TX. If your patient met the following conditions, then you could list an acute stroke code in the payment slot (M0230 or M0245):

- The patient was receiving therapy;
- There was no interruption in therapy from when the patient started at the hospital (for example) to when the patient started receiving therapy through home care; and
- The patient was progressing with therapy.

Until 2004, coders used 436 (Acute but ill-defined cerebrovascular disease) to report unspecified CVAs. But revisions to 436 excluded any condition classifiable to 430-435 (Cerebrovascular disease), so home health coders began using one of the 434.xx codes to reflect the more specific cause of the stroke. Code 434.91 (Cerebral artery occlusion, unspecified; with cerebral infarction) became the default code when the cause of the stroke wasn't specified.

Enjoy Easier Stroke Coding With Revised PPS

As of Jan. 1, under the revised PPS, CMS aligns its payment directions with the coding rules, Adams says.

New way: The 430-437 codes are no longer appropriate for services provided in the home health setting, and CMS has removed all of the acute stroke codes from the case mix list, Adams says. Now home health coders should look to the 438.xx (Late effects of cerebrovascular disease) codes for their stroke patients with late effects. These codes are now PPS case mix codes under the Neuro 3, Stroke, category.

Potential challenge: What if you're treating a stroke patient who has no residuals? As of Oct. 1, you can report a new

code, V12.54 (Personal history of transient ischemic attack [TIA], and cerebral infarction without residual deficits), for these patients, Twombly says.

But don't place a code in M0246 across from V12.54, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, consultant and principal of **Selman-Holman & Associates** in Denton, TX. There are two main reasons for this:

- The underlying condition for the V12.xx code is the acute CVA code, which is not a case mix code; and
- The V12 codes are not on the list of V codes provided by CMS that have potential underlying case mix diagnoses.

However, a patient with a history of CVA or TIA without residuals still needs skilled care for teaching as well as observation and assessment because he is at risk for other TIAs and strokes, says Selman-Holman.

Hint: Look under "Late, effects" in the alphabetical index when searching for the appropriate code to describe residual effects of a CVA, Adams says. You'll find an expansive list of residuals listed under "cerebrovascular disease (conditions classifiable to 430-437)."

The Alphabetic List refers you to the 438.xx category for stroke late effects. Some of these codes are actually combination codes -- meaning that two problems are covered by one code.

The late effects of stroke codes combine information to identify a residual condition and to indicate that it is the late effect of a stroke, Adams says. As a result, many late effects of stroke require only one code. These include cognitive deficits (438.0), specific speech and language deficits (438.10-438.12, 438.19), hemiplegia/hemiparesis (438.2x), monoplegia of upper limb (438.3x), and monoplegia of lower limb (438.4x).

Sequencing tip: Other 438 codes require a second code, says Selman-Holman. You can determine which ones require a second code because the 438 code will instruct you to use an additional code. This also turns out to be a hint in sequencing -- sequence the 438 code before the residual deficit, she adds.

Avoid This Stroke Mistake

Not all stroke late effects codes are combination codes, warns Twombly. Some late effects CVA codes require two codes. Read the code descriptions carefully to be sure you see the instruction that reminds you to use an additional code.

For example: If your patient has blurred vision as the residual effect of a CVA, you would look in the late effects section of your coding manual and find 438.7 (Disturbances of vision), Twombly says. Immediately underneath this entry, you'll see a note advising you to use an additional code to identify the visual disturbance. In this case, blurred vision would be your second code, so you would list 368.8 (Other specified visual disturbances).

Another example: Your patient has general muscle weakness as the result of a stroke. This is not a case of weakness in the dominant side, such as hemiplegia, Twombly says. Here, you would instead list 438.89 (Other late effects of CVA) and follow this with 728.87 (Muscle weakness).