

Transcript of Conference Call 5-21-2009

MS. OPERATOR: Welcome, and thank you for standing by. At this time all participants are in a listen-only mode until the question-and-answer portion. If at that time you'd like to ask a question, please press star-1.

Today's conference is also being recorded. If you have any objections, please disconnect at this time.

And now I'll turn the call over to your host today, Ms. Henraya McGruder. Ma'am, you may begin.

MS. MCGRUDER: Good morning. My name is Henraya McGruder, and welcome to the Coverdell Program's first Infoshare conference call, featuring Mr. Barry Libman. Today we will hear a presentation on stroke coding issues. You have already received a copy of his PowerPoint presentation so that you may follow along with his talk.

If you are a coder and would like to receive continuing education credits for your participation on this call, please e-mail me at HM McGruder@cdc.gov. That's H-m-c-g-r-u-d-e-r-@c-d-c-dot-g-o-v. And I will then provide you with the appropriate documentation. Continuing education credits will only be provided through AHIMA and AAPC. No other CEU's will be offered at this time.

Now, I would like to introduce the speaker. Barry Libman is president and founder of Barry Libman, Incorporated, a 35-person firm, providing medical record coding, auditing and consulting services to hospitals and physician group practices throughout New England and the mid-Atlantic States. Before starting Barry Libman, Incorporated in 1998, Barry held a number of positions in the health information management field, working for hospitals, insurers, consulting firms, and regulatory bodies. Barry is recognized for his in-depth knowledge of coding and reimbursement issues. Barry is a graduate of Northeastern University, and received a master's in health care administration from Simmons College.

The next voice you hear will be that of Barry Libman.

Barry.

MR. LIBMAN: Thank you, Henraya for that gracious introduction.

The origins of this presentation on stroke coding issues really comes about from questions that were raised by the stroke coordinators in the different facilities from time to time about the data and about coding. The questions really entailed why cases are coded as they are, and how can the coordinators better understand how codes are assigned.

And with that in mind we're going to launch into a presentation I have prepared. It's kind of basic with respect to coding, but I hope it will provide some guidance and some understanding as to how coders prepare information contained in the medical record so you folks, the coordinators, can better understand that process.

At the moment, you're probably looking at a slide that says "Stroke coding issues."

And if we move to the very first slide after that, slide 2, it's going to describe some of the topics that we're going to discuss today. Which is basically how coding captures an episode of medical care and reflects what is done during that inpatient discharge; some of the rules and guidance that are very specific to how the coders assign codes with respect to the documentation in the record; some rules that are very specific to the clinical circumstances of stroke; some of the present-on-admission indicators, which is a new facet of reporting that has come up in the past few years that helps identify whether diagnoses that are reported were present on admission or in fact whether they develop during the hospital stay; and lastly, we're going to talk a little bit about the future of coding, which is one of my favorite topics, the advent of ICD-10.

Moving on to the next slide, entitled "The medical record," it's a good place to start because everything that we're working on here comes from the medical record. It's our source document. It's the concurrent communication tool for caregivers.

Clinicians don't often realize that even after they are done writing in the medical record, or creating that document, how many people depend on that information down the road. They often do not realize, and sometimes need education, to better understand that what may be obvious at the time -- you know, oftentimes clinicians on the floor, practically they know each other so well they can read each other's minds; they know what is going on with the patients -- but it is really very important to make sure that they actually get this information documented into the medical record for future reference for all the people that depend on that down the road.

It is worth noting that coding is based on explicit documentation. And the coders are really not allowed any interpretation of that data. They don't get to decide, well, this patient really did have pneumonia, even though no one could decide that that was the case. Again, no interpretation is allowed.

And it is the coder's job to report the diagnoses and procedures according to the documentation in the medical record. It would be as incorrect for a coder to omit information as it would be to report information that just wasn't documented in the medical record.

The next slide. The primary users of the medical record are the caregivers, and everyone else is secondary. The coders are secondary; the insurance companies; the CMS; patient accounts; statistical folks; attorneys; and what we call secondary users of varying sophistication, which are generally family members who now have access to the records, appropriately, and sometimes don't have a good understanding of what the documentation means in the record.

On the next slide, we're going to talk about coding rules and guidance. And there's really three steps there. One is coding conventions. And if you actually find a coding book and open it, you'll see that in the front of the book there are very specific guidelines about how the information is organized in the code book, what the punctuation means, because the punctuation has very specific guidelines as to how it is interpreted.

In a broader sense, the ICD-9 Official Coding Guidelines for reporting is given to us by the four cooperating parties: the National Center for Health

Statistics, CMS, American Hospital Association, and the American Health Information Management Association. They are the principal stakeholders in the assignment of these coding guidelines.

And you will see that you have a link with which to find the PDF file of the current coding guidelines, which is well worthwhile reading if you have an interest in doing so.

And secondly, the rules are given to us by the AHA, the American Hospital Association, Coding Clinic for ICD-9, which is really a refinement of some of the official coding rules. Some unusual circumstances that need clarification, or in response to questions raised by the coding community, these are often answered in a quarterly publication by the American Hospital Association.

The next slide. It's worth noting that adherence to these guidelines is really required under HIPAA. There is really no choice. Coding guidelines are hard and fast. And in case you thought otherwise, they are now a component of the HIPAA guidelines, which means that there really is not much discretion in how you use them.

Codes are dynamic. They are updated twice yearly. Most often they are updated on October 1st, but there is an opportunity to update codes midyear if necessary. And the updates for the coding process really occur through the

Coordination and Maintenance Committee meetings, which is held by the four cooperating parties at the CMS headquarters at the Department of Health and Human Services in Baltimore. It is public hearings, and people come forth and bring ideas for new codes. And the new codes largely reflect advances in medical science and technology.

Next we're going to discuss four aspects, which is really the coding rules relating to principal diagnosis; those reflecting rule out versus ruled out; how we handle uncertain diagnoses; and some that are very specific to stroke coding rules.

And on the next slide we have the definition of the principal diagnosis, which all coders can practically recite in their sleep. The principal diagnosis is the condition established, after study, to be chiefly responsible for occasioning admission of the patient to the hospital. And the second part of that is really that when two or more diagnoses -- and this actually happens quite often -- when two or more diagnoses equally meet the criteria for principal diagnosis, any one of those diagnoses may be sequenced first.

And I point this out because it is sometimes why the stroke coordinators, in assessing some of the data, while anticipating that stroke would be the principal diagnosis,

another equally important diagnosis may be principal and the stroke may be listed secondary.

On the next slide we're going to talk about the definition of secondary diagnoses. Secondary diagnoses are comorbidities, are conditions that affect the hospital, that affect the care given to the patient in the hospital, either in terms of evaluation, treatment, diagnostic studies, conditions that may extend the hospital stay, such as complications of care or things like C. difficile colitis or ventilator-acquired pneumonia, or in fact any diagnosis that increases nursing care or requires other sorts of monitoring, including those that require medication.

So something as simple as hypertension or hypothyroidism, for which the patient receives medication. It would be appropriate to report those as secondary diagnoses. Patients who have ostomies. And there are codes to show that their ostomy status is colostomy, presence of, patients who have difficulty hearing or have blindness. Those codes would be appropriate to report because they do in fact increase nursing care. And this rule actually allows and encourages us to do a complete coding for all these sorts of diagnoses, to better reflect the complexity of care a patient might require.

On the next slide we're going to talk about the difference between rule out versus ruled out for inpatient discharges. And diagnoses that are qualified by the term "rule out" are coded as if they are established for inpatient discharge. Ruled out, meaning past tense, the "d" on the word, ruled out, is never coded, because the condition has in fact been determined to not exist. And therefore, what one would code in those instances would be either an alternative diagnosis as the cause or perhaps the presenting symptoms.

Uncertain diagnoses, on the next slide. If the diagnosis documented at the time of discharge is described as probable, suspected, likely, questionable, possible, and still to be ruled out, the condition is coded as if it existed or as if it were established. And the reason for that is that, quite often, the resources utilized to actually reach the conclusion that they're not certain about the diagnosis would be the same as if the diagnosis were actually established and treated.

On the next page we're going to talk a little bit about coding rules specific to stroke. And one of the things that is very important to know is that as of October 1, 2004, the terms "cerebral infarction stroke," "cerebrovascular accident," was moved from code 436 to code 434.91. And the reason I point this out is that sometimes folks who have

actually memorized that a stroke was code 436 but actually missed the notification of that transfer may still be expecting to see code 436 to describe a stroke when in fact that is no longer the case.

Code 436 now is almost never used, because its definition is "acute but ill defined cerebrovascular disease," which is almost never documented. So code 436 is phased out. And we are going to talk a little bit about when that happened a little further in the presentation.

Next I want to talk about neurological deficits. For an admission during which a stroke has occurred, patients may present with, say, a hemiparesis or a weakness or something of that nature, and if this weakness resolves by the time the patient is discharged, then those residual effects are not coded, because in fact they have gone away by the time of discharge. However, if the neurological deficits are present at discharge, the deficit is reported at discharge. And that would be an example of hemiparesis, aphasia, dysphasia, or things of that nature.

And the codes that we would use to reflect those would actually be the actual code for that condition. So you would have a stroke as the principal diagnosis, but you would have a secondary diagnosis of, for example, 342.90, to

reflect the hemiparesis, or 784.3, to reflect the aphasia, and so on.

And we have described that, in comparison, on the next slide, as to how we code late effects of cerebrovascular disease. And late effects really come about by using code 438. And probably the best way to describe it is to talk about the continuum of care, where in the admission for the stroke during which the stroke occurred and there were residual effects, at the end of that, using hemiparesis as an example, you would code the stroke and the hemiparesis.

But once that patient leaves and moves on to a rehab facility or perhaps a long-term acute care facility, and may be admitted there for treatment of the late effect of the stroke, we would use a code from category 438. And you see that you would, based on the definition and the rule. These late effects include neurological deficits that persist after the onset of the initial condition that you would classify to 430 to 437, codes that you recognize as being for the acute stroke.

On the next slide, there is a code, an interesting code, that was established October 1, 2007, V12.54, which is the code "transient ischemic attack," a TIA, and "cerebral infarction without residual deficits." And this code was given to us because it was felt very important to be able to

describe a patient that may have had a stroke, had no residual effects, continues to have no residual effects, but the code V12.54 helps us to identify patients who have had these conditions and are at risk for certain other perhaps future strokes down the road. Just be aware that if you see this code, these are the circumstances that it describes, a patient who historically has had a stroke but has no residual effects.

We talked a little bit about Coding Clinic guidance and how Coding Clinic provides certain refinements to the coding process. And there are two significant Coding Clinics I would like to talk about, the one from the second quarter 2002 that describes, for inpatient discharges, it requires the attending physician to confirm the results of diagnostic testing in the progress notes or discharge summary. And this really solves the problem of whether or not a coder can or cannot code from a CT or an MRI scan. Findings, both of the actual scans and their significance, must be stated in the progress notes and consultations or in the discharge summary for the coder to actually code those conditions as if they occur.

And the other Coding Clinic worth knowing about is first quarter 2004. Which states that for inpatient discharges, documentation from a physician other than the

attending -- and that's the key phrase there -- may be used for coding purposes as long as the documentation does not conflict with the information written by the attending physician.

The attending physician is in charge of the case. And if the attending physician sees a note by a consultant, a resident staff or a covering physician and disagrees with that, you are required to code what the attending physician had documented. However, if the consultant, resident staff and covering physician provides additional information, it would be appropriate to use that information to code a more specific code for that case.

Something I would like to do is to show you how certain conditions are coded. And what I'm showing you on the next slide, entitled "ICD-9 CM index," is really a snapshot of some pages in the ICD-9 code book index. But I would like to explain the coding process first.

In coding, coders go to the code book and they look up the term that they're looking for in the index. And as you see below, there is a code that is assigned to it. And then they go to another portion of the book, the tabular portion, that provides further explanation and guidance on how those codes should be used and applied for certain clinical circumstances.

I'm going to show you several different pages of the code book that look a little bit the same. And it's because ICD-9 uses a process called multiple indexing, where, in one instance, you may look up the term "stroke," but because some people use the term "infarct," you will also see that you can look up "infarct" and often find some of the same range of codes. But on the page where we see "stroke," we see code 434.91. And as you go down the list of indented terms, you see "embolic," which is a little bit more specific, 434.11.

You see the term "healed," or "old," which is code V12.54, which we discussed a little earlier. And you see how the code book leads you to that. Further down we see the term "iatrogenic," which is often the code used when patients experience postoperative strokes.

One of the more interesting terms is the one below that, "stroke in evolution," which is actually assigned to the stroke code 434.91. Strokes in evolution are coded as though they occur. And again, that is very important about resource utilization. Ischemic strokes, 434.91. Below that, "late effect." And that leads you to late effect of cerebrovascular disease, which is the range of the 438 series codes. Progressive stroke is actually, as you would

recognize, the same code for that of a TIA, a transient ischemic attack.

So now you start to see how the code book index provides very specific direction as to what codes the coder might be led to assign.

On the next page you will see the term "infarct" as the main term. And below that you see the subterms and you see again "healed" or "old." And as you move down the list under "cerebral" what is worth noting is the term "aborted." Even an aborted stroke is coded as though it occurred. And that again is about resource utilization. And you will notice that the code for an aborted stroke is in fact the same code as that for a stroke in evolution in the previous slide. And both are coded as if the stroke occurred.

On the next page you see the main term "impending." An impending cerebrovascular accident or attack is only coded as though it were a TIA, which is a little different than how we coded the aborted or the in evolution.

And then you move down to "aneurysm, non-ruptured," 437.3. But "ruptured," code 430, which is the code for in fact a cerebral hemorrhage, as you can see from the main term below that.

On the next page, one of the more interesting codes as well is "occlusion of precerebral arteries." Those may be

carotid arteries, basilar arteries, vertebral arteries, but you will see that there is actually the opportunity where the fourth and fifth digits will tell us whether or not that stenosis or vascular disease has occurred with or without a cerebral infarction, zero for without and 1 for that with a cerebral infarction.

On the next slide we're going to talk a little bit about the addenda to the ICD-9 CM index. Every year -- and we mentioned twice a year -- new codes are given to us, but predominantly for the October 1st update. In addition to lists of new codes that are given to us in the Federal Register, there is also a document that is published called "The Addenda", which allows for certain changes that are made that may not be new codes but certain reclassification of codes.

The reason I bring this up, again, we're going to talk about October 1, 2004, when the term "strokes" and "cerebrovascular accidents" became moved from code 436 to 434.91. And the addenda, again, are worth reading on a yearly basis because you will see that oftentimes there are changes made to how cases are classified. And a significant change, as I've said probably too much at this point, occurred on October 1, 2004, with the change to that.

With respect to addenda, many changes occurred on October 1, 2007 that you may be aware of but, if not, I think it's worth going over. And as we talked about, you saw in the index "aborted strokes" were assigned to 434.91, and we were given the new code V12.54, as well as the term "stroke in evolution" to code 434.91. And I really keep going over this to drive home the point that coders need to be referring to the code book on an annual basis, and that memorization and dependence on end coders, although very useful, is often not the best approach sometimes. It is about specificity of process and referring to the book on a regular basis.

On the next slide I want to talk about an interesting and important new code, code V45.88, which became effective October 1, 2008. And this is really a very interesting application of the Coordination and Maintenance Committee process, where the American Academy of Neurologists asked two of their members, Drs. Joseph Broderick and Dawn Kleindorfer, to represent them in asking to have a new code created to help identify trends in the use of TPA, which was determined to be very important.

And Drs. Kleindorfer and Broderick gave a very compelling presentation about why a new code was needed, V45.88, to help identify trends in TPA. And the Coordination and Maintenance committee was so impressed by the

presentation that they actually fast tracked -- and it's very unusual for a code to be presented in March of a given year and implemented in October of the very same year.

And let's, on the next slide, look at code V45.88, which is actually kind of wordy but it is worth paying attention to: Status post-administration of TPA in a different facility within the last 24 hours prior to admission to a current, or the discharging, facility. And let me explain how that might work.

A patient may have a stroke and arrives at the first hospital. They are given treatment with TPA and then transferred to perhaps a stroke specialty hospital. At the second hospital, the specialty hospital treats the stroke and then discharges the patient. It would be this second hospital that is discharging the patient who would use code V45.88 to reflect that they treated a patient who received TPA in 24 hours prior to the admission to their facility. And I think the stroke coordinators will recognize that this is a very important type of patient to classify. And the coders would do this by using this code, V45.88, on their patient.

It is worth noting that this code is only used by the receiving facility and not by the transferring facility. And I would point out that if this code is relevant to you as

a reviewer, you should ask to see cases, or run reports, that would have the code on these cases. And if you find patients for whom you would expect to see it and you don't, it would be worth talking to the coding folks to understand perhaps why the code has not been applied to the case, something of that nature. But because the American Academy of Neurologists has asked that this code be given to us, it should be utilized by the second facilities that are reporting.

On the next page we are going to talk a little bit about the present-on-admission indicators, the POA indicators, that you may or may not be familiar with. I know the coders in the audience are quite familiar with this. The POA indicator is a character that is used and assigned to every diagnosis reported on an inpatient stay to help distinguish between, as I mentioned before, comorbidities, the preexisting conditions, that are present on admission and complications that may have occurred during the hospital stay. And for every diagnosis reported, the coder has to decide, is the condition present at the time the order for inpatient admissions occurs or was it not. And that is how the decision is really made.

The reason we talk about the POA indicator is that sometimes the stroke diagnosis that was present on admission

and may have a POA indicator of yes may not be reported as the principal diagnosis. And we are going to talk a little bit more about that at length down the road. And it would be okay that the stroke diagnosis not be reported.

Basically, on the next slide, you see a chart that explains the little characters that are used by the coders. "Yes," obviously, present on admission, at the time of admission; "no," it was not; "unknown," which is very rare that the character "U" is used; "clinically undetermined;" and sometimes there are certain diagnoses that do not require a POA indicator to be reported, and a blank would be left there. And there is in fact a list of these diagnoses that it is appropriate to not report POA. And the rules for applying the POA indicator are included in the Official Coding Guidelines, the PDF document I mentioned earlier in the presentation.

I want to give you a couple of examples. The sequencing is often simply based. The most resource-intensive diagnosis can be reported. Which is often simply a euphemism for that which has the highest reimbursement for that diagnosis. And I'm going to show you some examples using some Medicare weights.

For example, patient admitted with both a cerebrovascular accident and aspiration pneumonia, and both

were treated. Both equally meet the definition of principal diagnosis. If the aspiration pneumonia were reported as the principal diagnosis, the weight would be 2.0393. And if the cerebrovascular accident were reported, you would see that as principal and you would see the weight as 1.8. Reimbursement for the aspiration pneumonia is in fact higher; therefore it is likely the coder would report 2.0393 based on the circumstances of the case.

So I'm basically trying to provide some examples as to why sequencing may occur as it does, even though you might not expect it to be that way.

On the next slide we have an example of a patient who was admitted with both a cerebrovascular accident and respiratory failure and was placed on a ventilator. And here you see a dramatic difference in the reimbursement. If respiratory failure is made the principal diagnosis it has a weight of greater than 5. And if the cerebrovascular accident were reported, it would have a weight, again, of 1.8. So you begin to see some of the decision process that the coders face as they assign principal diagnosis.

Next I want to move on to ICD-10 a little bit, which is one of my favorite topics. The next slide you are looking at talks about the proposed rule, which was published August 22, 2008. And from time to time, you will notice that

when you see a presentation there is a slide missing. And in fact the next slide I am going to talk about is not in your presentation but will be available on the corrected version that Henraya will have a copy of, as well as will be provided on my Web site.

And those of you who are familiar with ICD-10 will realize that in fact the final rule has already been published. The final rule for ICD-10 was published on January 16, 2009, as part of the HIPAA administrative simplification law, which were modifications to the medical data code set.

The reason it was actually published through HIPAA was in fact to solve the issue of whether or not all insurers would be required to use ICD-10 or whether it would be simply Medicare. And by making it part of the HIPAA code set, a mandated code set, all insurers will be required to use ICD-10 as of October 1, 2013. So as of this moment right now, we are on track, doing preparation and education to prepare the workforce as to how to use ICD-10.

On the next slide, we talk a little bit about why ICD-10 is so great and why you should look forward to it. It offers so much greater specificity, greater sensitivity when refining and grouping reimbursement methodologies, refinement of clinical protocols. For one thing, it would allow us as a

country to match our data with the rest of the world. Most of the rest of the world is already using ICD-10 and making plans to move on to ICD-11.

And the last reason you should be really excited about the approach of ICD-10 is because it is mandated for implementation in 2013, we really have no choice. So it makes it easy to embrace the idea of a new coding system.

On the next slide I want to talk a little bit about some of the format. ICD-10 will have three to seven digits. They are alphanumeric. And the first thing you will realize from some of the examples we are going to go over is that the more characters you find in a diagnosis code, the greater the specificity of that diagnosis code.

And as you see below, for example, code I64 is "stroke not specified as a hemorrhage or infarction." So a three-digit code is simply a stroke, not very specific. But as you look below, you see code I62.01, which is a "non-traumatic acute subdural hemorrhage," a very specific sort of code.

The other category of specificity is in the area of late effects, where you see code I69.151, which is "hemiplegia following a non-traumatic intracerebral hemorrhage affecting the right dominant side." This is

showing us that ICD-10 gives us some specificity that we don't currently have contained within a single code.

Some other examples are on the next page for stroke. The codes for stroke will show us occlusion, whether it is a thrombosis or an embolism. But it will also show us which specific artery is suffering from this condition. And you see I63.0, "thrombosis of precerebral," I63.4, "embolism of a cerebral artery," things of that nature.

On the next slide we have "stroke, hemorrhage by site." And a very specific code, I60.2, a "non-traumatic subarachnoid hemorrhage from the anterior communicating artery." Other codes would be given to us that would show us the carotid artery having the same condition, the middle cerebral, anterior communicating, and posterior communicating arteries.

I61.5, "non-traumatic intracerebral hemorrhage, intraventricular." The other choices being "brain stem," "cerebellar" or "multiple sites."

And finally, I62.02, "non-traumatic subacute, subdural hemorrhage." And the other choices from some other codes that will be given to us would be, instead of "subacute," "that which is acute" or "that which is chronic."

On the next slide, it talks about late effect of stroke by type of stroke. So this would be telling us what

the late effects are by hemorrhage or infarction. And I know that there are a lot of folks interested in that because, for patients who may have an occlusive stroke, they may have certain kinds of late effects, whereas if they have a hemorrhagic stroke, additionally they may have late effects attributed to that. So you begin to see the benefit of that sort of specificity.

On the next slide, one of the things ICD-10 also has is a "code also" requirement. Earlier, you may recall that I mentioned that there are coding conventions, the rules in the front of the code book that talk about how certain language in the code book provides certain instruction to the coders. Here, in ICD-10, in the stroke category, we are going to be given the requirement to code also certain risk factors that are associated with stroke. The instructional term is very specific: Use an additional code to identify the presence of alcohol use, abuse, dependence, including that which is in remission; tobacco use or dependence, including history of, exposure to environmental tobacco smoke; hypertension; and things of that nature.

The distinction here is that the "code also" term is very specific. Because in ICD-9 right now we have terms that sometimes say to "code also if desired" or "code also if known." Here it is very specific. It is "code also." It is

a very unequivocal term and requires the risk factors to be reported.

On the next slide, I just want to talk briefly about the ICD-10 PCS, which is the procedural classification portion of ICD-10. And in fact, it is a little difficult to describe because it is very complex and very different from what we know from ICD-9. And partly it is difficult to describe because it is still under construction.

As you see, there are seven characters. They are alphanumeric and they describe sections. And sections would be things like med-surg will have its own table of procedure codes. Obstetrics will have its own table of procedure codes. Osteopathic medicine will, and chiropractic medicine, imaging, radiation, oncology. There will be a separate classification for mental health. And you start to see how it gets rather complex.

But I did want to, at the bottom, at least show you a snapshot of what these codes might look like. A CT scan of intracranial arteries using high osmolar contrast, and you see that there is a very specific detail that we do not currently have in ICD-9 with respect to how CT scans are provided.

On the next slide, I want to talk about ICD-10, some of the implementation issues. Because it is not going

to be an easy thing to do. Budgeting is a concern, the cost of making the change, which will include systems changes and personnel training. The Professional Society of the American Health Information Management Association has done some field testing of ICD-10. And the overwhelming response was that ICD-10 is not nearly as hard to use in the test groups as everyone thought it would be. And that is really good news, that that is how it is being received by folks who have been tested, as sort of the guinea pigs of the trial process.

The belief is really that training should occur about three to six months prior to October 1, 2013, and that the procedural classification will probably be the most difficult portion to learn. But I think, all in all, there is a lot to look forward to. There are tremendous employment opportunities and, if nothing else, tremendously more specific data that we will be able to utilize and refer back to.

In the next slide I wanted to talk a little bit about the next steps. Because one of the things that really comes about I think from this process, and one of the things I learned from putting the presentation together, was the notion of improving communication between coding staff and the stroke coordinators. And they are two groups of people working in a facility who should have, if not already met,

get to know each other, because they depend on each other. The stroke coordinators can help improve documentation up on the floors hopefully, and the coding staff can help explain to the coordinators why the data looks the way it does.

At this point, this is the end of my rather preliminary discussion of coding and stroke issues. I think we are going to move on to open the session up for some questions, and hopefully I will be able to answer your questions.

At this point, Henraya, I think we move to answering some questions.

MS. MCGRUDER: Yes. Thank you for that wonderful and informative presentation, Barry.

As Barry mentioned, this presentation is now open for questions.

MS. OPERATOR: Thank you, ma'am. I will give parties instructions on how to ask a question. If you would like to ask a question, you press star-1 and record your name. To withdraw your request, you press star-2. Once again, if you would like to ask a question at this time, please press star-1 and record your name.

One moment.

(Pause.)

MS. OPERATOR: And your first question comes from Jenna. Your line is open.

QUESTION: Hello. I was wondering if I could get a clarification about when the requirement for all insurers will be required.

MR. LIBMAN: That should be October 1, 2013 for ICD-10.

QUESTION: Right.

MR. LIBMAN: Your question is about ICD-10, correct?

QUESTION: Yes, ICD-10. Medicare's fiscal year of 2013, isn't it? So wouldn't it start with 2012, October 1?

MR. LIBMAN: The rule as written says 2013.

QUESTION: Okay.

MR. LIBMAN: So it would in fact be, as I understand it, Medicare's 2014 fiscal year. But the effective date, as I understand it, is October 1, 2013.

QUESTION: Okay. Thank you very much.

MR. LIBMAN: Sure.

MS. OPERATOR: The next question comes from Michael Tibbs. Your line is open.

QUESTION: Hello. I was wondering something even more basic than is in the presentation, as far as understanding how the coders gather the information for the

coding. Are they required or expected, or is it part of normal protocol, for them to read the entire chart and documentation, or do they just sample through?

MR. LIBMAN: Coders will read the entire medical record.

QUESTION: Okay.

MR. LIBMAN: But in fact, the most relevant documentation for reporting comes from the physician documentation.

QUESTION: Okay.

MR. LIBMAN: Discharge summaries, history and physical, emergency room record, progress notes. You get the idea. Consultations.

QUESTION: Sure.

MR. LIBMAN: The nursing notes are very helpful for gleaning certain kinds of specificity and perhaps initiating queries to the physicians if documentation is not as specific as we might hope it would be. But generally it is the physician documentation that serves as the source.

QUESTION: Okay, thank you.

MR. LIBMAN: Thank you.

MS. OPERATOR: The next question is from Stacy Roberts. Your line is open.

QUESTION: Thank you. My question is regarding the Coding Clinic Guidelines, 2004, Quarter One. I'm wondering if the Coding Clinic will be updated or expanded when the new ICD-10's go into effect, particularly with my ISM physician extenders being used for coding purposes.

MR. LIBMAN: I'm sure it will be. Let me say that optimistically. In fact, Coding Clinic is planning to become a document that will become relevant to the ICD-10 process. And I think that question you are describing -- Coding Clinic, which is published by the American Hospital Association, is actually a very receptive document. You can write to these folks and ask questions and they will report back to you, and sometimes very quickly incorporate important questions and findings and clarifications into their quarterly documents.

But I will make a note of that and see if we can learn the answer to that. I just can't speak on behalf of Coding Clinic, but I am sure they will take care of that. Thank you.

MS. OPERATOR: The next question is from Claudia Fitzgerald. Your line is open.

QUESTION: Hello, Barry. I have a question and was wondering if you could speak to the GD coding language, especially as it pertains to primary stroke services. The

coders at my hospital have been really helpful in terms of helping me understand the difference between patients that are admitted and discharged from the ED versus admitted and discharged as an inpatient, because the coding guidelines are different, especially "probable," "likely," et cetera.

MR. LIBMAN: That is correct.

QUESTION: Would you be able to expand on that? I don't think every facility's stroke coordinator is aware of that.

MR. LIBMAN: Yes, let me do my best here.

QUESTION: Thank you.

MR. LIBMAN: There are specific coding rules for inpatient cases, inpatient coding guidelines, and there are specific coding rules for outpatient. And one of the areas that they differ the most greatly is that in the area of uncertain diagnoses and the emergency department is considered an outpatient setting. So for patients who come into the emergency department and then leave the emergency department without being admitted are considered outpatients, outpatient coding rules would be applied.

So if the patient were seen, for example, with dizziness or slurring of speech and no diagnosis of a stroke was specifically made and perhaps the patient's issue resolved or they were transferred, you would code, if the

diagnosis were reported as a probable stroke or possible stroke, it would then be reported not as a stroke but in fact as the symptoms.

Whereas, in an inpatient setting, as we described, the terms "probable" and "possible" for an inpatient would result in the coding of that case as though it were a definitive stroke.

QUESTION: Thank you.

MR. LIBMAN: Thanks.

MS. OPERATOR: The next question is from Kim. Your line is open.

QUESTION: Yes, in regards to the code V45.88, TPA, is that code just specific to what we call "drip and ship," or was there a code created for TPA administration to increase the overall reimbursement, even if you didn't give the medication and shipped the patient out?

MR. LIBMAN: I believe it is meant to reflect, as you describe, the "drip and ship" patients, who come to the second facility, having arrived at the first for treatment of the stroke, and being given TPA.

QUESTION: Okay.

MR. LIBMAN: There are ICD-9 procedure codes to show the administration of the TPA.

QUESTION: Okay. And so this code was created so that --

MR. LIBMAN: This is a diagnosis code.

QUESTION: Yes, to help those facilities that are providing more intensive care in that 24-hour period.

MR. LIBMAN: Right. In fact, this code, V45.88, does not have an impact on reimbursement but is simply used as a flag to help identify those patients.

QUESTION: I got you. Okay. Thank you.

MS. OPERATOR: The next question comes from Amy. Your line is open.

QUESTION: Yes, hello. Thank you. Good presentation.

We have been instructed -- I'm a coder -- and we have been instructed, and I think I am going to say this correctly, that if a physician documents, even throughout the medical record, maybe even in the same discharge summary, for example, that a patient has carotid artery stenosis -- we'll use that as an example -- and they have an active acute stroke as well, but they do not specifically link those two, i.e., stroke was due to carotid artery stenosis, we are not to assign that fifth digit with the infarction. Do you agree with that?

MR. LIBMAN: Let me tell you what I would do, because I am pretty sure that there is no specific guideline given to us on that. I would code the stroke as a separate code, perhaps 434.91, and I would code the carotid artery stenosis without the fifth digit of 1 as a secondary. Because they are not specifically linking that stenosis to that stroke. I know that is a bit of controversial. Not everyone agrees with my approach on that. But I also think we do not have a guideline, which is what makes the approach on that.

And if I am incorrect on that, I would appreciate someone correcting me, if they are aware of a guideline or some rule that I just do not happen to be aware of. And if that is the case, we will certainly get that information out to the group. But that is how I would handle that case.

QUESTION: Okay. And I have not found specific instructions, and we do err to the conservative side. So it sounds like we are doing what you would recommend. Thank you.

MR. LIBMAN: Okay. Thank you.

MS. OPERATOR: The next question is from Michael. Your line is open.

(No response.)

MS. OPERATOR: Okay, we will go to the next question. There is another question, however they must have had their line on mute and their name was not recorded. Your line is open. Please state your name.

QUESTION: Hello, this is Susan.

MR. LIBMAN: Hello, Susan. Go ahead.

QUESTION: We have patients that come in, say, with a new case of slurred speech. And the doctor will put down "recrudescence of prior stroke" or "extension of prior stroke." How would that be coded?

MR. LIBMAN: You are saying this is an inpatient?

QUESTION: Yes. Is that coded as a new stroke?

MR. LIBMAN: I would think that is coded as a new stroke. I don't think we have guidance on or a means to otherwise reflect an extension of a stroke. So I would probably code that as a new stroke.

QUESTION: Okay. Thank you.

MS. OPERATOR: And once again, if you would like to ask a question, please press star-1. One moment.

(Pause.)

MS. OPERATOR: And sir, I show no further questions.

MR. LIBMAN: Well, great. Thank you very much. If you do have further questions, you can contact Henraya or you

also have my e-mail address on the last slide of the presentation. And feel free to even call or write with questions should that be the case.

I hope you found this helpful and informative, and I think maybe down the road, if this was well received, we may get to do more presentations of this nature.

MS. MCGRUDER: Yes. Thank you, Barry.

MR. LIBMAN: Okay.

MS. MCGRUDER: I just wanted to thank all of those that asked questions. They were all great questions. Thank you for your participation in our first Infoshare presentation.

As Barry said, CDC hopes to be able to provide more educational opportunities in the future. We hope that you use the information provided in this presentation in your future encounters with stroke patients.

If there are those that were unable to participate in today's presentation, an audio recording and transcript will be posted on the Division for Heart Disease and Stroke Prevention's Web site here at CDC, and information regarding that will be sent out to your State Coverdell managers at a future date. I will send out that link so that all interested persons can access the information.

Also, Barry has so graciously agreed to post his slides, as he mentioned during his presentation, on his Web site. And his Web site is www.barrylibmaninc.com. Again, that is www.barrylibmaninc.com.

Again, if you are a coder and would like to receive continuing education credits for your participation on this call, please e-mail me at Hmcgruder@cdc.gov. That's H-m-c-g-r-u-d-e-r@c-d-c-dot-g-o-v. I will then provide you with the appropriate documentation. Continuing education credits will only be provided through AHIMA and AAPC.

Again, thank you for your participation.

MS. OPERATOR: And this does conclude today's conference. You may now disconnect.

MR. LIBMAN: Thank you.

(Whereupon, the presentation was concluded.)