Home Health ICD-9/ICD-10 Alert

Coding Changes: Stroke Coding Errors Will Skyrocket After October

Here's what you need to know to protect your reimbursement.

If you play a coding association game with your clinicians, when you say "stroke" they'll probably say "436" without missing a beat. And that could cost you money.

CVA codes are changing as of Oct. 1, and home health agencies won't have the usual 90-day grace period to make the transition from old codes to new ones. Your staff need to be prepared to hit the ground running, experts say.

Patients with cerebrovascular accidents (also known as CVAs or strokes) are among the most commonly seen diagnoses in home care. So coding strokes correctly can make a big difference in your cash flow. If you keep using 436, your fiscal intermediary will deny the claim.

Exception: If you are submitting a claim for an episode that began before Oct. 1, and you used the old diagnosis code on the original OASIS assessment, you may not have to change the code on the claim. Officials from the **Centers for Medicare & Medicaid Services** have indicated that as long as the end of episode claim is a "clean" claim and therefore accepted by the system, the agency will not have to change ICD-9 codes even when the end of episode occurs after Oct. 1, advises **Judy Adams** with the Charlotte, NC-based **LarsonAllen Health Care Group**. But if the claim has problems that prevent the system from accepting it, agencies may have to change to the new diagnosis codes for episodes spanning the Oct. 1 change date, she adds.

Old way: Diagnosis code 436 (Acute, but ill-defined, cerebrovascular disease) used to be a quick and easy solution to coding strokes. That code still exists after Oct. 1, but "they've pulled the [stroke] modifier language completely out of 436," explains **Lynda Dilts-Benson** with St. Petersburg, FL-based **Reingruber & Co.** Now if you need to code for most nonhemorrhagic stroke-related diagnoses, go to the 434 series of codes, experts say.

New way: Referring to the description at 436, especially the "excludes" note, will point you in the right direction, Adams suggests. The note will refer you to the new codes to use for CVAs.

Rather than a general three-digit code, the interchangeable terms "CVA" and "stroke" now have their own five-digit codes, advises coding expert **Prinny Rose Abraham** with **HIQM** in Minneapolis. The extra digits indicate the type of stroke diagnosis. This change makes the coding a little more complicated, and requires you to find out more about the patient's stroke before coding.

Clue in clinicians: After Oct. 1, there are more possible codes for CVAs.

1. 434.00 (CVA/stroke, thrombotic, without mention of cerebral infarction);
2. 434.01 (CVA/stroke, thrombotic);
3. 434.10 (CVA/stroke, embolic, without mention of cerebral infarction);
4. 434.11 (CVA/stroke, embolic);
5. 434.90 (Cerebral artery occlusion, unspecified,without mention of cerebral infarction); and
6. 434.91 (Cerebral artery occlusion, unspecified, with cerebral infarction).

The idea is that hospitals also will code strokes more specifically and this information will "trickle down" to agencies to make coding choices easier, says consultant **Lisa Selman-Holman** with Denton, TX-based **Selman-Holman & Associates**. Many referrals still will arrive with only the diagnosis of CVA or stroke, Selman-Holman tells **Eli**. If that is the only information you can find, 434.91 is the default CVA code, she explains.

Caution: Home care coders may be confused about when to use the 438 series of codes for late-effects of cerebrovascular disease versus the 434 acute codes, experts warn. That's because there are differing opinions about the subject.

When the Health Insurance Portability and Accountability Act required home health coders to follow ICD-9 CM coding guidelines beginning last Oct. 1, official coding groups such as the **American Health Information Management Association** expected home health coders to follow the coding convention that reserves the acute CVA codes for the initial treatment in the hospital, Adams explains.

But CMS had attached a case mix designation to acute CVA code 436 (and 434) that adds 20 points to the clinical dimension OASIS score. So other coders argue that the exception is still in effect and acceptable, because invalidating the use of the acute code in home health settings doesn't make sense until CMS revises its case mix to reflect the change, they maintain.

According to the original OASIS instructions, agencies may use the acute CVA codes as long as the patient is making progress with rehabilitation. When the patient's recovery plateaus, switch to late-effects codes. If the patient is discharged with goals met and later readmitted, the late-effect code is generally more appropriate, according to CMS.

Tip: Don't describe the same incident with both acute and late-effect CVA codes, Adams warns. But you can use both types of codes on the same claim if the patient has a new CVA and also late effects from a previous CVA, she explains.

Editor's Note: The CVA instructions from CMS are on page 6 at www.cms.hhs.gov/providers/hhapps/hhdiag.pdf.