Objectives

At the completion of this lesson the learner will be able to:

- List the frequently used neurology diagnoses
- Document the specificity required to support accurate and complete coding of diagnoses
Documentation Overview

While the actual number of neurologic diagnoses has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis and acuity of cardiac patients.

**Neurologic Diagnosis Documentation Overview:**

- Document location with greater specificity—occluded vessel, location of stenosis, spinal level, bleeding vessel
- Document comorbidities with detail that will show their impact on patient condition even if it is not the primary problem
- Document the clinical findings/indicators to support the diagnosis documented
- Document a clear LINK between underlying condition and related, secondary or causal illness whenever appropriate
- Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis
Section 1: ICD-10 Diagnostic Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Neurology providers are responsible for a wide array of diagnoses and procedures. By identifying those used most frequently and those with high ICD-10 impact this module will:

- Provide specific knowledge for a common core of diagnoses
- Identify concepts of ICD-10 specificity to apply to any diagnoses

**Diagnoses included in this training include:**

- Headache/Migraine
- Alzheimer’s Disease
- Seizures, Convulsions
- Epilepsy and Seizures
- Alterations of Consciousness
- Cerebral Vascular Disease
- Neoplasms of the Brain and Spine
- Sequela
- Intracranial Hemorrhage
- General Pain

*Note: This training module is not intended to be an all-inclusive training tool to teach the provider every coding nuance within ICD-10*
The documentation for Headaches and migraines is very similar, requiring:

- **Frequency**
- **Complications**
- **Characteristics**

Examples of headache and migraine diagnoses include:

- *Menstrual migraine, not intractable, without status migrainosus*
- *Migraine with aura, not intractable*
- *Chronic cluster headache, intractable*
- *Acute post-traumatic headache, intractable*
Documenting Headaches

- Identify the type:
  - Vascular
  - Associated with sexual activity
  - Primary cough
  - Exertional
  - Stabbing
  - Cluster, tension, or paroxysmal hemicranias

- Specify when episodic or chronic
- State if acute or chronic
- Include information regarding any post-concussional syndrome
- Drug-induced
  - Provide information regarding the associated medication.
- Complicated
  - Clarify as primary thunderclap or new daily persistent
- Differentiate between a migraine and a headache
- Note when a headache is secondary to a lumbar puncture
Documenting Migraines

• Indicate the type of migraine (e.g., hemiplegic, ophthalmoplegic, menstrual, cyclical vomiting, periodic headache syndrome, etc.)

• Specify when the migraine is intractable (e.g., poorly controlled, pharmacoresistant, treatment-resistant, refractory)

• Clarify the presence or absence of:
  – An aura
  – Status migrainosus
  – Cerebral infarction
Documenting Post-Operative Complications

Complications with a procedure or a device requires the same specificity of documentation regardless of the initial cause or patient presentation:

1. Clearly defining the complication either of procedure or device
2. Identifying the complication as causal to the patient presentation
3. Clearly identifying if this was an expected or unexpected outcome
Alzheimer’s Disease/Dementia

Diagnosis of Alzheimer’s disease is characterized primarily by onset:

- Alzheimer’s disease with early onset
- Alzheimer’s disease with late onset
- Alzheimer’s disease, unspecified

Diagnosis of dementia is characterized by the presence or absence of behavioral disturbance

- Dementia with behavioral disturbance
- Dementia without behavioral disturbance

**NOTE:** Delirium should be designated as acute or subacute and physiologic cause defined if known
# Seizures, Convulsions

**Documentation of seizure diagnoses contain the following principles:**

- Type
- Cause
- Control
- Presence of status epilepticus

**Seizures not diagnosed as a disorder or recurrent (i.e., non-epileptic) should specify the condition as being:**

- Febrile specify simple or complex.
- New onset.
- Single seizure or convulsion.
- Post traumatic or hysterical
- Autonomic

**Examples:**

- *Absence epileptic syndrome, not intractable, with status epilepticus*
- *Juvenile myoclonic epilepsy, intractable, without status epilepticus*
- *Epileptic seizures related to ETOH, drugs, stress*
- *Simple partial seizures developing into generalized seizures*
Documenting Epilepsy and Seizures

- Specify epilepsy as being localization-related or generalized
- Indicate the presence or absence of intractability and status epilepticus
- Describe seizures as having a localized onset, being simple partial, or complex partial
- Identify any special epileptic syndromes (e.g., seizures related to alcohol, drugs, sleep deprivation, etc.)
- Include descriptions of poorly controlled, pharmaco-resistant, treatment resistant, and refractory

Also see documentation tips for seizure and convulsions
Alterations of Consciousness

ICD-10 documentation of level of consciousness has expanded, beyond the previous single option of coma to include:

Somnolence
Stupor
Coma

1. Documentation of *each category* of best response
   - Eye Opening, Best Verbal Response, Best Motor Response

2. Capture of GCS timing
   - In the field
   - At arrival to the ED
   - At Hospital Admission
   - 24 hours or more after admission
Cerebral Vascular Disease

Documentation of cerebral vascular disease and infarction should include:

1. Documentation of Traumatic vs. Non-Traumatic origin
2. Identify the affected vessel e.g. vertebral, anterior and posterior communicating, middle cerebral, carotid, bifurcation, etc.
3. Document laterality (right or left)
4. Document any underlying conditions e.g. atrial fibrillation, hypertension, atrial flutter, etc.
5. Link test results and findings to the related diagnosis e.g. MRA showing ruptured right vertebral artery aneurysm to subarachnoid hemorrhagic stroke
6. Document the cause of the condition e.g. hemorrhage, thrombosis, occlusion, stenosis, etc.
7. Documentation of presence or absence of infarct
8. Document any Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
9. Provide information regarding tPA administration in a different facility within 24 hours of admission to the current facility.
10. Sequela

Examples:
• Cerebral infarction due to embolism of right anterior cerebral artery
• Cerebral infarction due to unspecified occlusion or stenosis of left vertebral arteries
• Non-traumatic subarachnoid hemorrhage from anterior communication artery
Neoplasms

Neoplasms will be defined location and behavior - Location specificity should include:

- Laterality
- Specificity
- Any overlapping sites
- Document site, state morphology e.g. benign, in situ, malignant, uncertain behavior, document the stage and any metastatic sites.
- Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
- Reason for the patient’s current admission/encounter, or when the patient is admitted for a specific treatment related to the neoplasm, e.g. chemo, surgical removal, radiation therapy

Examples:

- C713- Malignant neoplasm of parietal lobe
- C6962- Acoustic Schwarroma
- C700- Malignant neoplasm of cerebral meninges
Neoplasms

Primary vs. Metastatic Sites
Coding for treatment of primary sites differs from that of treatment directed at secondary or other sites

- Document primary site
- Document malignancies
- Identification of direction of treatment

Documenting histology of neoplasms
- The documentation of a specific histology helps to direct coding of neoplasm diagnosis
- Document that a neoplasm cannot be determined after histology study to be Malignant, benign, or uncertain behavior.
- Clinical information by acknowledging the cytology, pathology or histology findings in the notes
- When histology is known, document clearly
- Neoplasm complication:
  - These are conditions that complicates the neoplasm, they are either adverse reaction to neoplastic treatment or the progression of neoplastic disease e.g. neoplastic anemia, pathological fracture due to a neoplastic process, vomiting secondary to chemo.
  - Clearly document the reason for the encounter, the conditions that requires treatment e.g. dehydration, anemia
  - Specify any drug causing adverse effects and the adverse effects of treatments e.g. anemia secondary to anemia
Sequela

Documenting sequela of a neurovascular event requires more precise documentation:

1. Sequela is identified as a result of:
   - Infarct, nontraumatic hemorrhage, or other neurovascular disease that must be identified

2. Conditions to identify
   - Hemiplegia, hemiparesis, monoparesis, other paralytic syndrome
   - Location of limb involvement

3. Speech and language deficits must be identified as:
   - Aphasia, dysphagia, dysarthria, fluency disorder
Cranial Hemorrhage

Diagnoses of cranial bleeds can be documented by identifying the following:

*Origin of the event, area of impact and specific location of bleed*

Example: Non-traumatic intracranial bleed of brain stem
General Pain

- Document acuity (acute vs. chronic)
- Document location of the pain
- Identify the cause of the pain
- Specify if patient was admitted for:
  - Pain management
  - Pain Control
  - Psychological pain
Section 2: ICD-10 Procedure Documentation Recommendations

ICD-10 Diagnostic Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Review of ICD-10 Procedure Code Structure

ICD-10 Procedure documentation: More granular and precise

Focus for Providers: Understand concepts coders capture rather than memorize every detail

- Procedure documentation can be thought of on multiple axes
- Each axis captures an increased amount of provider documentation in respect to the service or procedure provided
Axis 1: Starting point for coding procedures.
Provides the coder with the initial criteria to class information and narrows available codes

Examples for neurology include:
- Radiation Oncology - Radiosurgery of Brains
- Medical and Surgical - Biopsy of the Thalamus

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Axis 2: Body System

**Body System**: is the next axis for understand ICD-10 coding. As the Axes increase so does the specificity of documentation AND coding.

Depending on the section identified the axis may be:

- Body System
- Physiologic System
- Anatomic Region

**Examples of Axis 2:**

- Central nervous system
- Peripheral nervous system
- Upper vein
- Lower vein
Axis 3: Root Operation

Root Operation determines the purpose of a procedure. There are 31 specific types of root operations that are in 9 groups:

1. Procedures that take out some or all of a **body part**
2. Procedures that take out **solids/fluids/gases** from a body part
3. Procedures involving **cutting or separating** only
4. Procedures that **put in/** put back or **move** some/all of a body part
5. Procedures that **alter the diameter/route of a tubular body part** - can be performed only on tubular body parts
6. Procedures that always involve a **device**
7. Procedures involving **examination only**
8. Procedures that **define other repairs**
9. Procedures that **define other objectives**
Axis 3: Root Operation

Neurology Examples of Axis 3-Root Operation:
Excision- removal of brain tumor
Inspection- Craniotomy
Revision- Adjustment of neurostimulator lead

Documenting for Axis 3:
• Don’t attempt to memorize the coding verbiage for each root operation
• Ensure documentation of the procedure has a clear objective/purpose
• Ensure one of the 9 groupings of operations can be identified
Axis 4: Body Part

**Axis 4:** Very specific and detailed, procedure dictates the specificity of documentation:

- A body part
- Some of a body part
- Area around a body part
- In or On a body Part
- Conduction mechanism (brain or heart)

**Neurology Examples of Axis 4:**

- Brain
- Thalamus
- Cerebellum
- Medulla Oblongata
- Trochlear Nerve
- Facial nerve

INCREASING SPECIFICITY
Axis 4: Body Part

Documenting for Axis 4:

• Be as specific as the body part and procedure allow
• If there is laterality capture right, left or bilateral
• If there is distance capture proximal and distal
• Multiple procedures in the same organ or vessel need to have clear documentation
Axis 5: Defined based on access location, method and types of instrumentation used:

- **Open**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site
- **Percutaneous**—Entry, by puncture or incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach procedure site
- **Percutaneous endoscopic**—Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to reach and visualize procedure site
- **Via natural or artificial opening**—Entry of instrumentation through natural or artificial external opening to reach procedure site
- **Via natural or artificial opening endoscopic**—Entry of instrumentation through natural or artificial external opening to reach and visualize procedure site
- **Open with percutaneous endoscopic assistance**—Cutting through skin or mucous membrane and other body layers necessary to expose procedure site, and entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and other body layers necessary to aid in performance of the procedure.
- **External**—Procedures performed directly on skin or mucous membrane and procedures performed indirectly by application of external force through skin or mucous membrane
Axis 6: Device

Axis 6: Devices left in place at the completion of a procedure require a code.

Examples include:
- Infusion device
- Monitoring device
- Neurostimulator lead
- Radioactive elements

Device Placement for Procedures:
It is important to document specifically what type of device is placed, and also how it is placed. Qualifying codes will often capture additional details about a device placement.
Axis 7: Qualifier

Axis 7: Defines “qualifier” or an additional attribute of the procedure when appropriate.

- Not all procedure codes require qualifiers
- Data adds specific, clarifying information that is not contained in another axis

**Examples of Qualifiers:**

- Procedures including biopsy for diagnostic purposes
- Identifies source of tissue if placed during a procedure: autologous, non-autologous
- Identifies source of blood product: frozen vs. fresh
Blood Transfusions

The single data point captured in ICD-9 for blood transfusion was the occurrence of the transfusion. With ICD-10 there are multiple data points that will be captured:

1. Type of cells transfused (RBC or Frozen RBC)
2. Document location or infusion site (Peripheral artery, Peripheral vein, Central Vein, Central Artery)
3. Document the approach
4. Specify if Autologous or non-Autologous

Important Note:
The receipt of transfusions has to be acknowledged by the provider
Putting It All Together:

- 00930ZZ - Drainage of Epidural Space, Open Approach, No Qualifier, No Device
- 00933ZZ - Drainage of Epidural Space, Percutaneous Approach, No Qualifier, No Device
- 00934ZZ - Drainage of Epidural Space, Percutaneous Endoscopic Approach, No Qualifier, No Device
- 00930ZX - Drainage of Epidural Space, Open Approach, Diagnostic, No Device
- 00933ZX - Drainage of Epidural Space, Percutaneous Approach, Diagnostic, No Device
- 00934ZX - Drainage of Epidural Space, Percutaneous Endoscopic Approach, Diagnostic, No Device
- 009300Z - Drainage of Epidural Space, Open Approach, Drainage Device, No Qualifier
- 009330Z - Drainage of Epidural Space, Percutaneous Approach, Drainage Device, No Qualifier
- 009340Z - Drainage of Epidural Space, Percutaneous Endoscopic Approach, Drainage Device, No Qualifier
Documentation Conclusion

- Documentation and coding of diagnoses have greater alignment with ICD-10.
- Following these documentation recommendations will assist in meeting the greater specificity demands of ICD-10.

Neurologic Diagnosis Documentation Overview:

- Document location with greater specificity—occluded vessel, location of stenosis, spinal level, bleeding vessel
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