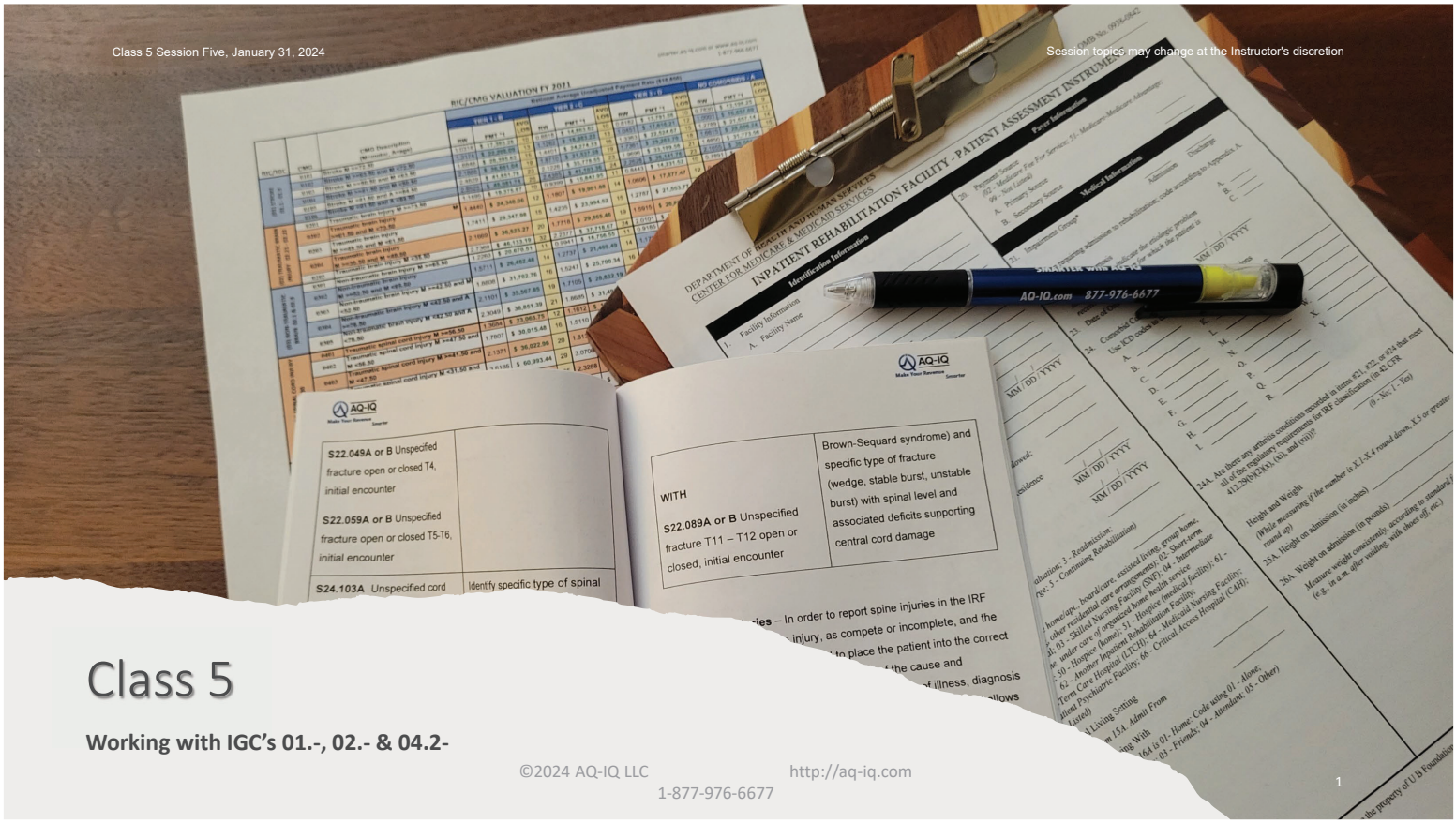
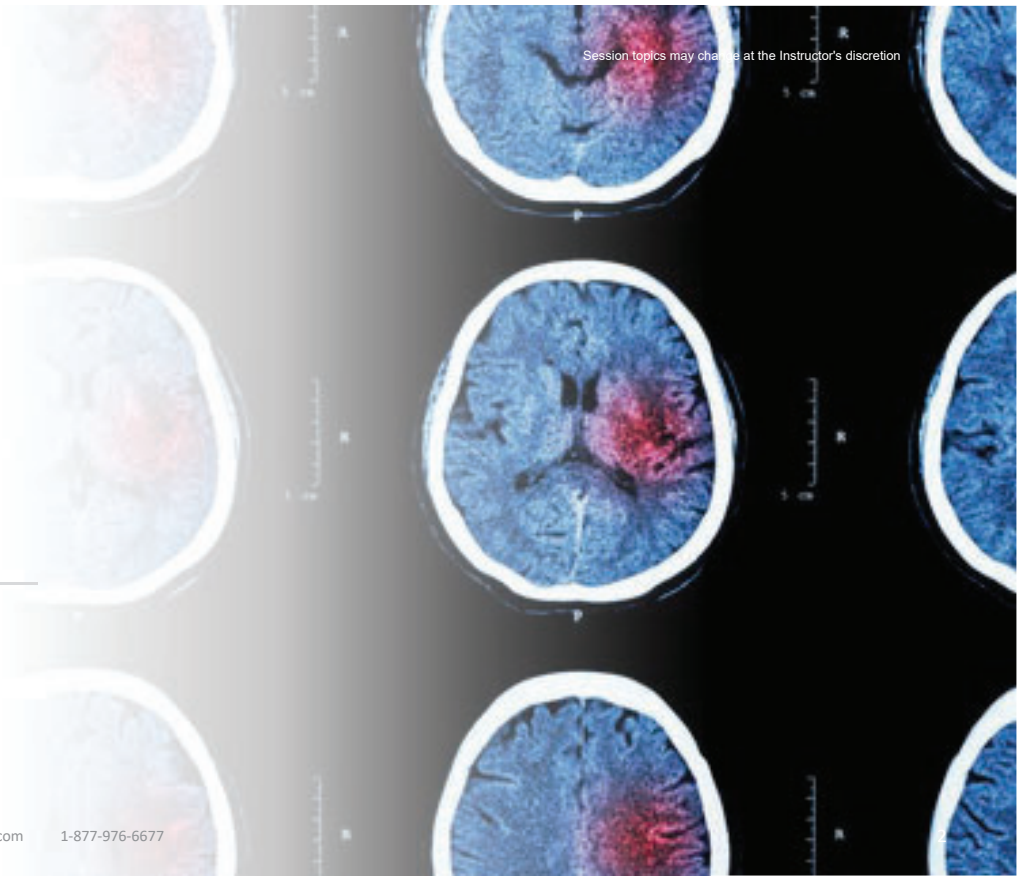


Class 5

Working with IGC's 01.-, 02.- & 04.2-

Class 5 Session Five, January 31, 2024

Session topics may change at the Instructor's discretion

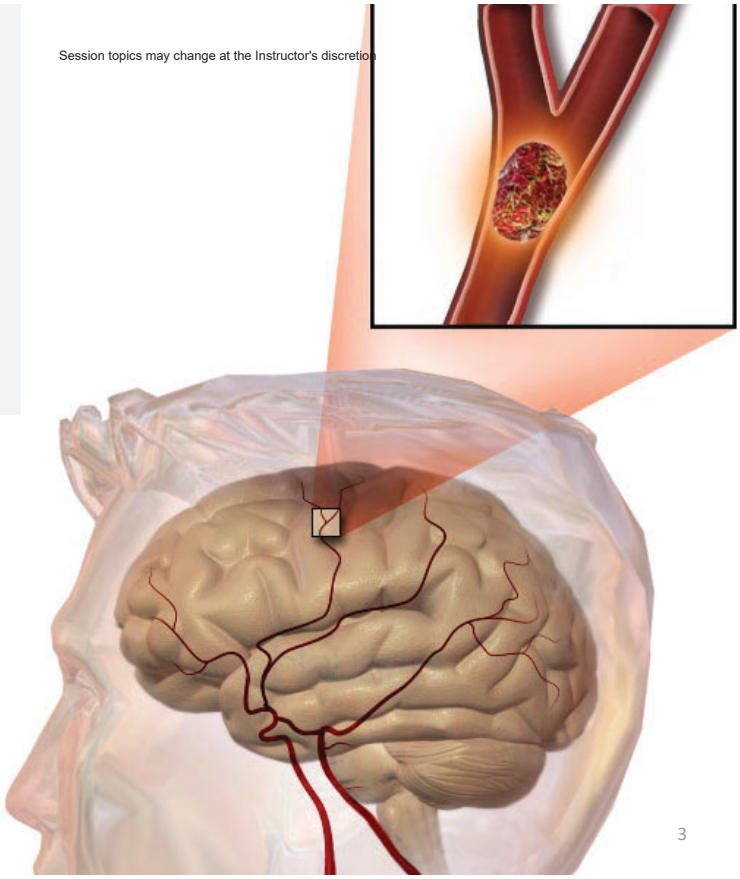


IGC 01 - Stroke

Stroke: IGC Options

IGC – *"the primary reason for admission to the rehabilitation program"*

- 01.1 Left body involvement Right brain
- 01.2 Right body involvement Left brain
- 01.3 Bilateral involvement
- 01.4 No paresis
- 01.9 Other stroke



IGCs By the Letter – Stroke (I)

New Strokes (I61.x; I63.x)

- **"I"** – Code based on artery location and cause
- New Residuals/Stroke Etiologic:
  - **"R"** Stroke Scores; Dysphagia; Ataxia; Dysarthria; Apraxia; Some Cognitive
  - **"G"** Paralytic Syndromes: Hemiplegia; Monoplegia

New Post Operative / Intraoperative Stroke - I97.-

- Residuals the same as other new strokes

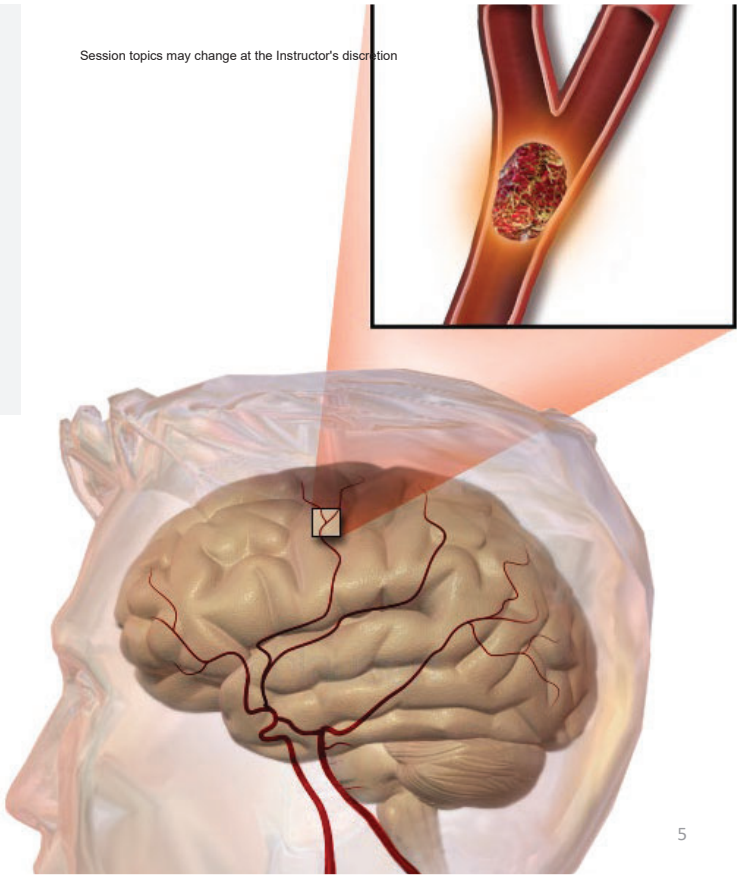
Former/Old Stroke

All residuals reported as I69.-based on identified cause and residual - i.e. I69.092 Facial Weakness following non-traumatic SAH.

Typical Etiologic Options - Stroke

Etiologic – *"The etiologic problem that led to the impairment for which the patient is receiving rehabilitation" CMS*

- I60.x – SAH (Non-traumatic)
- I61.x – Intracerebral Hemorrhage (Non-Traumatic)
- I62.x – Other Intracranial Hemorrhage (Non-Traumatic)
- I63.x – Cerebral Infarction



IRF-PAI: Stroke Etiologic Examples

- I63.011 due to thrombosis of right vertebral artery
- I63.131 due to embolism of right carotid artery
- I63.212 due to occlusion or stenosis of left vertebral artery
- I97.810 Intraoperative during cardiac surgery
- I97.821 Post-procedural CVA
- I63.9 Unspecified CVA
- I69.359 Hemiplegia following CVA
- I69.051 Hemiplegia following non-traumatic SAH affecting right dominant side
- I97.x Post operative stroke

Stroke Diagnosis Documentation - SAH

Hemorrhagic

1. **SAH (specify by artery and laterality)**
   - Carotid Siphon and Bifurcation
   - MCA
   - Anterior Communicating (no laterality)
   - Posterior Communicating
   - Vertebral
   - Basilar (no laterality)
   - Other/Unspecified
     - **Further specify by:**
       - Right
       - Left
       - Not Specified

Stroke Diagnosis Documentation – Intracerebral Hemorrhage

2. **Intracerebral Hemorrhage (specify by location)**
   - Cortical (central lobe)
   - Subcortical Hemisphere (deep intracerebral)
   - Brainstem
   - Cerebellum
   - Intraventricular
   - Multiple Localized
   - Other/Not Specified

Stroke Diagnosis Documentation – Intracranial Hemorrhage

3. **Other Intracranial (location, severity)**
   - Subdural
     - Acute, subacute, chronic
   - Extradural (epidural)
   - Not Specified

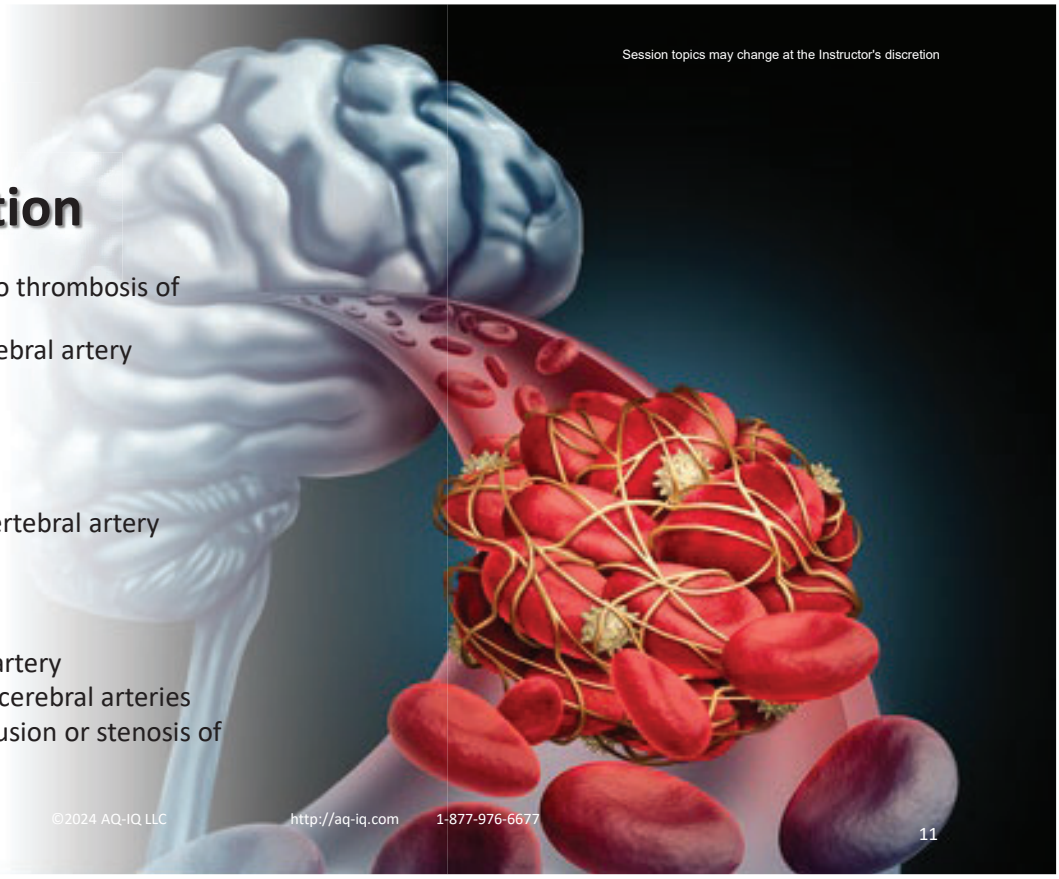
Stroke Diagnosis Documentation – Cerebral Infarction

- **Thrombosis (artery, laterality)**
- **Embolism (artery, laterality)**
- **Occlusion or Stenosis (artery, laterality)**

Also

- **Post Operative Stroke**

ICD-10-CM Cerebral Infarction



- I63.0- Cerebral infarction due to thrombosis of Precerebral arteries
  - I63.00- Unspecified precerebral artery
  - I63.01 - Vertebral artery
    - I63.011 Right
    - I63.012 Left
    - I63.013 Bilateral
    - I63.019 Unspecified vertebral artery
  - I63.02- Basilar artery
  - I63.03 - Carotid artery
    - Specify Laterality
  - I63.09- Other Precerebral artery
- I63.1- ..due to embolism of Precerebral arteries
- I63.2- ..due to unspecified occlusion or stenosis of Precerebral arteries

Documenting and Coding for Strokes

CAUSE, LOCATION, RESIDUAL

Sequela (Residual)

- *Side is important! Dominant versus Non- Dominant should be clear;*
- *Codes from I69 used for sequela;*
- *May be assigned with codes from I60-I67;*
- *For current and old deficits from old CVA*

Sequelae of Stroke on the IRF-PAI

- **I69.0**- NT Subarachnoid Hemorrhage
- **I69.1**- NT Intracerebral Hemorrhage
- **I69.2**- Other NT Intracranial Hemorrhage
- **I69.3**- Cerebral Infarction
- **I69.8**- Other Cerebrovascular Diseases
- **I69.9**- Unspecified Cerebrovascular Diseases

Stroke Sequela – UB-04

- **Also I69.x (Typically PDx and comorbidities on the UB-04)**

Documenting:
Diplegia
Hemiplegia
Paraplegia
Quadriplegia
Monoplegia

- **State Associations** (Cause and Effects)
  - **Cause:** i.e. Cerebral Palsy, Stroke, Other
  - **Effects**: i.e.. Cauda equina syndrome, Myositis ossificans of right shoulder d/t paraplegia
- **Type**
  - **Hemiplegia:** Spastic, Flaccid,
  - **Paraplegia:** Complete, Incomplete
  - **Quadriplegia:** Complete, Incomplete, Level (C4)
- **Affected Side** (dominant v. non-dominant), Specified Limb(s)

Identifying the Affected Side

Best practice = Identifying the Dominant side <u>BUT:</u>

We have a RULE!

- **Ambidextrous - Default = Dominant**
- **Left affected - Default = Non-Dominant**
- **Right affected - Default = Dominant.**

Without the Affected/Dominant Sides those cases that fall into IGC 01.9 may fail 60%.

Qualifying Strokes

60 % IGCs for Strokes

- 01.1 Left body involvement Right brain (Compliant)
- 01.2 Right body involvement Left brain (Compliant)
- 01.3 Bilateral involvement (Compliant)
- 01.4 No paresis (Compliant)
- 01.9 Other stroke (Compliant with restrictions)

01.9 "Other Stroke" Exclusions

Record fails with these etiologic diagnoses

- **Unspecified Intracranial Hemorrhage** (I62.9)
- **Any Monoplegia of Upper Limb** (I69.031-039, I69.131-139, I69.231-239, I69.331-339, I69.831-839, I69.931-939)
- **Monoplegia Lower Limbs of Unspecified side** (I69.049, I69.149, I69.249, I69.349, I69.849, I69.949)
- **Hemiplegia Unspecified side** (I69.059, I69.159, I69.259, I69.359, I69.859, I69.959)
- **Other Paralytic Syndrome, unspecified side** (I69.069, I69.169, I69.269, I69.369, I69.869, I69.969)

Stroke 60% Example

I69.13-	MONOPLEGIA following NT-ICH affecting UPPER LIMB Use 6th Character (1) RIGHT DOMINANT side (2) LEFT DOMINANT side (3) RIGHT NON-DOMINANT side (4) LEFT NON-DOMINANT side (9) Unspecified side

ICD-10	I-10 Description
I69.14-	MONOPLEGIA following NT-ICH affecting LOWER LIMB Use 6th Character (1) RIGHT DOMINANT side (2) LEFT DOMINANT side (3) RIGHT NON-DOMINANT side (4) LEFT NON-DOMINANT side (9) Unspecified side
I69.15-	HEMIPLEGIA and HEMIPARESIS following NT-ICH affecting LOWER LIMB Use 6th Character (1) RIGHT DOMINANT side (2) LEFT DOMINANT side (3) RIGHT NON-DOMINANT side (4) LEFT NON-DOMINANT side (9) Unspecified side
I69.16-	OTHER PARALYTIC SYNDROME following NT-ICH affecting LOWER LIMB Use 6th Character (1) RIGHT DOMINANT side (2) LEFT DOMINANT side (3) RIGHT NON-DOMINANT side (4) LEFT NON-DOMINANT side (5) BILATERAL sides (9) Unspecified side

Putting it All Together #1

85 y/o female admitted to acute hospital with right side hemiplegia (G81.91/I69.351), facial droop (R29.810/I69.392) and slurred speech (R47.81/I69.328). Found to have cerebral infarction due to stenosis of the left vertebral artery (I63.212) causing these deficits. Patient has multiple medical comorbidities including type 2 diabetes (E11.22 w/CKD), hypertension and stage 3 chronic kidney disease (I12.9 + N18.3).

Motor Score 36

What's Your Answer?

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Putting it All Together #2

64 y/o Ms. Jones had a Left-sided stroke (I63.9) with right upper extremity monoplegia (G83.21/I69.331), dysphagia (R13.10/I69.391) and dysarthria (R47.1/I69.322). During the rehab course, Ms. Jones had COPD exacerbation (J44.1) and was admitted into the acute hospital for 4 days. Ms. Jones is now being readmitted to the IRF for continuation of her rehab.

Motor Score 28

What's Your Answer?

IRF-PAI

- IGC:
- Etiologic Diagnosis(es):
- Tier:
- Age:
- Motor Score:
- CMG:
- 60%, WHY:

UB04

- Principal:
- CC/MCC:
- DRG:

Putting it All Together #3

Miss Shapely, 72 years old, is admitted into the acute setting with increasing Left-sided weakness, she reports having a stroke about 2.5 years ago. Workup for new stroke was negative. Left-sided hemiplegia (I69.354) worsening. Patient admitted for Increasing Left-sided Hemiplegia following stroke in 2019 for which she was previously in rehab.

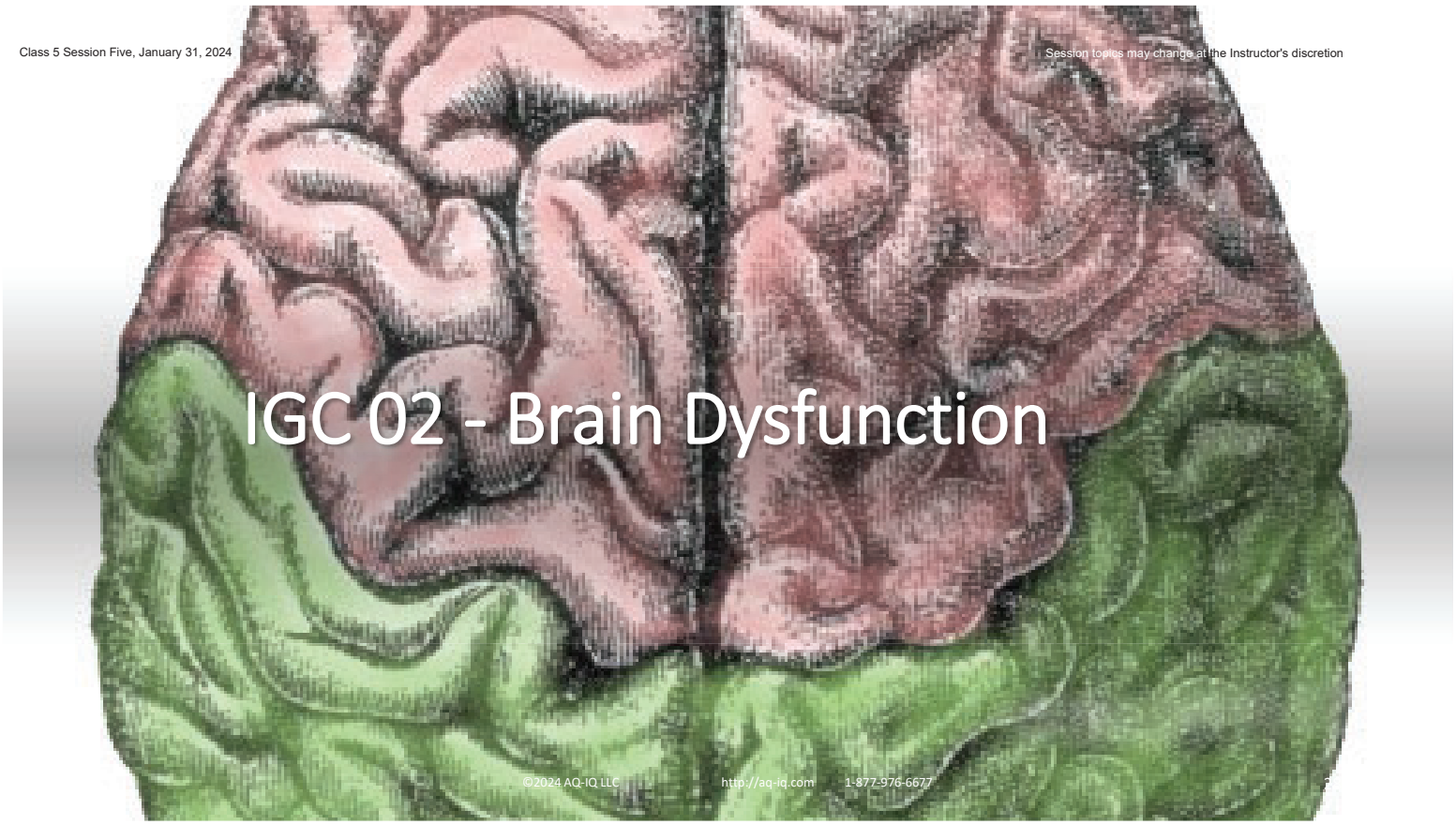
Motor Score 42

What's Your Answer?

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Case Study 4 – Breakout

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:



IGC 02 - Brain Dysfunction

Brain Dysfunction – IGC Options

- 02.1 Non-traumatic
- 02.21 Traumatic, Open injury
- 02.22 Traumatic, Closed injury
- 02.9 Other Brain

IGCs By the Letter – Non-Traumatic Brain (C, D, G, R)

- **G"** – Encephalitis, Encephalopathy (By Cause)
- **Seizures** –
  - **"G" Epileptic / Recurrent**; **Unspecified Seizure Disorder** or
  - **"R" Post Traumatic; Convulsive NOS; Seizure NOS**
- Brain Neoplasms - **"C'** Malignant; **"D"** Benign, Uncertain or Unspecified

Words Matter, It's a Clue –

- **G = Neurologic**
- **R = Sign. Symptom, Abnormal Test**
- **Could make a difference in IGC/Medical Necessity**

IRF-PAI: NT Brain Etiologic Examples

- G92 Toxic Encephalopathy
- A39.0 Meningococcal meningitis
- G40.309 Generalized Idiopathic Epilepsy Seizures
- C71.0 Malignant Neoplasm of brain cerebrum, except lobes and ventricles (supratentorial NOS)

IGCs By the Letter –Traumatic Brain (S)

- **IGC 2.21 and 2.22 will only have etiologic diagnoses starting with the S and all need 7th (i.e. A, B, D, S).**
  - Include Fractures (Open and Closed by specific anatomic location on the head i.e. vault)
  - Intracranial injuries by specific injury type (i.e. contusion, laceration, hemorrhage), location (i.e. subarachnoid, subdural) and loss of consciousness level when known.

Words Matter, It's a Clue –

- **Identification of LOC and specifics of injury(ies) may make or break 60%**

IRF-PAI: Traumatic Brain Etiologic Examples

- Fractures and Injuries of the head S06.-
- 7th Character typically A could be B, C, D, S - others exist but rarely used (refer to 7th character list)

Principal Diagnosis Examples

Non-Traumatic

- G92- Toxic Encephalopathy (if resolved report symptom)
- A39.0 Meningococcal meningitis
- G40.309 Generalized Idiopathic Epilepsy Seizures
- C71.0 Malignant Neoplasm of brain cerebrum, except lobes and ventricles (supratentorial NOS)

Traumatic

- S06.5X2D Traumatic subdural hemorrhage with 45-minute LOC
- S02.91XD Open skull fracture with contusion and laceration of cerebrum

Ch 19 Guidelines – Injuries (I.C.19.b)

Report each injury separately

Traumatic Injury codes are NOT used to describe **complications of surgical wounds**

Most serious injury sequenced **1st**.

Minor injuries part **of more severe** NOT reported.

Qualifying - Brain Dysfunction

60 % IGCs Brain Dysfunction

- 02.1 Non-traumatic (Restrictions)
- 02.21 Traumatic, Open injury (Restrictions)
- 02.22 Traumatic, Closed injury (Restrictions)
- 02.9 Other Brain (Not compliant)

Etiologic Diagnoses that fail 60% - NT Brain

D21.0- Benign Neoplasm of connective tissue and other soft tissues of head, face, neck

G30.0- Alzheimer's with early onset
G30.1- Alzheimer's with late onset
G30.8- Other Alzheimer's
G30.9- Alzheimer's Unsp

G31.1- Senile degeneration of brain , NEC

Etiologic Diagnoses that fail 60% - Traumatic Brain

- Some injuries without LOC with and without other injuries

60% Traumatic Brain Injury – Disqualifying Codes

- **Contusion and laceration of cerebrum, unspecified no LOC**
  - **Traumatic Hemorrhage of cerebrum, unspecified no LOC**
  - **Unspecified Intracranial injury no LOC**
- **Reported with codes below or alone:**
  - **Unspecified fracture of skull – open/closed; or,**
  - **Unspecified open wound of unspecified part of head**

Loss of Consciousness Options

- Without loss of consciousness
- 30 min or less
- 31-59 min
- 1 hour to 5 hours 59 minutes
- 6-24 hours
- Greater than 24 hours w/ return to pre-existing conscious level
- Greater than 24 hours w/o return to pre-existing conscious level
- With any duration with death due to brain injury prior to regaining consciousness
- With any duration with death due to other cause prior to regaining consciousness
- With LOC status unknown
- With LOC unspecified duration

IRF Considerations – 60%

- **PASS – TBI (unsp) w/ LOC, Hemorrhage w/ LOC, Specified Fractures (location/ laterality), Burns of specified sites with specified degree, etc.**

Inconsistent Failures

- **Traumatic Brain (Open)** FAILS for diagnosis codes listed in categories S01, S02 and S06 with brain injury w/o LOC, Unspecified open wound of head
- **Traumatic Brain (Closed)** FAILS for diagnosis codes listed in categories S01, S02 and S06 with brain injury w/o LOC; and Concussion, Contusion, Laceration and Hemorrhage of Brain, Brain Hemorrhage
  - w/o LOC or LOC unspecified duration,

CHAT IT OUT - Putting it All Together #5

Patient found on the side of I-75 150 feet away from his motorcycle. Patient reports he doesn't know if he lost consciousness, he remembers the crash and the ambulance ride. He has comorbidities of asthma (J45.909), HTN (I10), Collar bone fracture (S42.001A), open right 3rd, 4th and 5th (S62.302B, S62.304B, S62.306B) metacarpal fractures, a 6" laceration on the right side of his face (S01.81XA) and broken zygomatic bones (S02.402A). He was found in acute with a SAH (S06.6XAA) and SDH (S06.5XAA) which required surgical intervention. Currently he is being admitted to rehab with cognitive issues. Patient developed pneumonia (J18.9) while in acute, still on antibiotic.

Motor Score: 30

What's Your Answer?

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

PUT IT ALL TOGETHER (CHAT) #6

A 62-year-old patient was admitted to acute care hospital on September 7. After workup it was determined that she had an Internal Carotid artery aneurysm (I72.0) and severe anemia (D64.9). The patient went in for surgical intervention and had NSTEMI (I97.791, I21.4) during surgery and required additional interventions now with dysphagia (R13.10). Admitted to rehab with significant cognitive slowing (R41.89) in a debilitated state.

Motor Score :36

What's Your Answer?

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

YOU PUT IT ALL TOGETHER (CHAT) #7

45-year-old patient admitted with worsening vision bilateral eyes (H54.3), acute workup showed a 2 cm malignant tumor between the corpus callosum (C71.8). Tumor was pressing on all sides of the union causing vision changes, slurred speech (R47.81), and confusion and was removed by Dr. Shorty on January 5. Patient is being admitted to inpatient rehab for cognitive retraining and ADL's, symptoms persisted post surgery.

Motor Score: 43

What's Your Answer?

IRF-PAI

- IGC:
- Etiologic Diagnosis(es):
- Tier:
- Age:
- Motor Score:
- CMG:
- 60%, WHY:

UB04

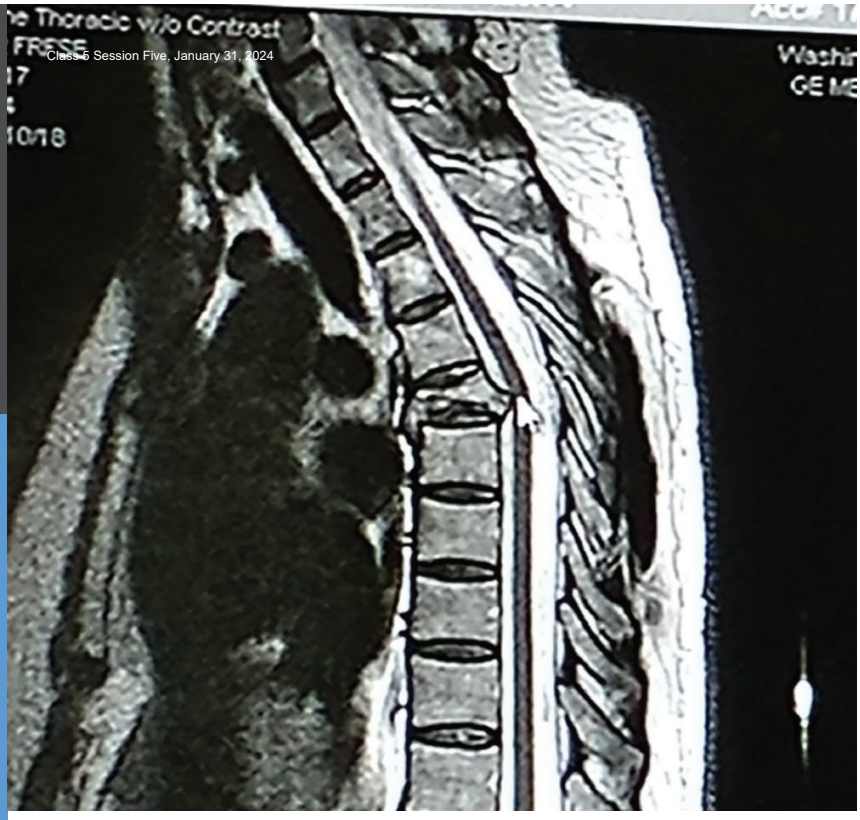
- Principal:
- CC/MCC:
- DRG:

Documenting Brain Injuries

- **Indicate if Traumatic/Non-Traumatic/During or Post Procedural**
- Identify any **associated wounds or skull fractures with detailed locations and severity**
- **Location of injury(is)** (Diffuse/Focal)
  - Brainstem: Cerebral –State Laterality (i.e., Right/Left Cerebrum); Extradural/Epidural; Intracranial-State Laterality (i.e., Right/Left Internal Carotid)
- **Type of injury**
  - Concussion; Contusion; Hemorrhage; Laceration; Traumatic Cerebral Edema
- **Skull Fracture(s) with details of location**, Open/Closed, Healing (Normal/Non-Union/Sequela)
- **Identify level of consciousness at time of injury, if known and Glasgow Coma Scale**
  - None/unknown (specify "none" or "unknown"); Specify time range; Greater than 24 hours indicate if return to pre-existing conscious level.

Case Study 8 – Breakout

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:



IGC 04- Spinal Cord Dysfunction

IGC/Etiologic Match – Non-Traumatic Spine

IGC – "the primary reason for admission to the rehabilitation program"
Etiologic – "The etiologic problem that led to the impairment for which the patient is receiving rehabilitation" CMS

- 04.110 Para, Unspecified
- 04.111 Para, Incomplete
- 04.112 Para, Complete
- 04.120 Quad, Unspecified
- 04.1211 Quad, Incomplete C1-4
- 04.1212 Quad, Incomplete C5-8
- 04.1221 Quad, Complete C1-4
- 04.1222 Quad, Complete C5-8
- 04.130 Other NTSCI

- NTSCI: Conditions that impact the cord – Spondylosis or disk disorders with myelopathy, neoplasms, certain myelitis, intraspinal abscess, ruptured aortic aneurysm (if cord impacted)
- Residual weakness is not an automatic, what are the deficits!
- Includes natural consequences

IGCs By the Letter –Non-Traumatic Spine (C, D, G, M)

- **M** - Vertebral Disk Disorders with myelopathy; spondylosis with myelopathy; Subluxations and Spinal Stenosis
- **G** – Myelitis; Intra-spinal Abscess;
- **C-D** Neoplasms of the spine (C= Malignant by level; D = Benign, Unspecified or Uncertain by level)

Words Matter, It's a Clue –

- **DEFICITS Support CORD**
- **Symptoms rather than causes fail 60%.**

Class 5 Session Five, January 31, 2024
Session topics may change at the Instructor's discretion

Etiologic Diagnosis Examples

- **C70.1 Malignant neoplasm of spinal meninges**
- **G06.1 Intra-spinal abscess and granuloma**
- **I71.1 Aortic Aneurysm ruptured thoracic**
- **M47.10 Other spondylosis with myelopathy, unspecified site**
- **M50.00 Cervical disc disorder with myelopathy, unspecified cervical region**
- **M99.30 Osseous Stenosis in Neural Canal, Head region**
- **M48.00 Spinal Stenosis, Unspecified Site**

IGC/Etiologic Match –Traumatic Spine

IGC – "the primary reason for admission to the rehabilitation program"
Etiologic – "The etiologic problem that led to the impairment for which the patient is receiving rehabilitation" CMS

- **04.210 Para, Unspecified**
- **04.211 Para, Incomplete**
- **04.212 Para, Complete**
- **04.220 Quad, Unspecified**
- **04.2211 Quad, Incomplete C1-4**
- **04.2212 Quad, Incomplete C5-8**
- **04.2221 Quad, Complete C1-4**
- **04.2222 Quad, Complete C5-8**
- **04.230 Other NTSCI**

- TSCI: Traumatic injuries that that impact the cord – displaced C-3 fracture with complete cord lesion.
- Residual weakness is not an automatic, what are the deficits!
- Includes natural consequences

IGCs By the Letter –Traumatic Spine (All S Here)

- **Mostly S10.-; S20.- and S30.-**
- Spinal Level and Specific Injury Needed
- **Cord Injury 7th Characters**
  - A Initial Encounter
  - D Subsequent Encounter
  - S Sequela
- **Fractures Mostly S12.-; S22.-; S32.-**
  - A Closed, Initial Encounter
  - B Open, Initial Encounter
  - D Subsequent Encounter
  - G Fracture with delayed healing
  - K Fracture with non-union
  - S Sequela

Words Matter, It's a Clue –

- **DEFICITS Support CORD**
- **Fractures alone as etiologic may not support IGC.**

Etiologic Diagnoses that cause TSCI to Fail

- M48.00-M48.08-Spinal Stenosis, all regions
- M99.20-M99.29-Subluxation stenosis of neural canal of all regions
- M99.30-M99.39-Osseous stenosis of neural canal of all regions
- M99.40-M99.49-Connective tissue stenosis of neural canal of all regions
- M99.50-M99.59-Intervertebral disc stenosis of neural canal of all regions
- M99.60-M99.69-Osseous and subluxation stenosis of intervertebral foramina of all regions
- M99.70-M99.79-Connective tissue and disc stenosis of intervertebral foramina of all regions

Principal Diagnosis Examples

- Quadriplegia
- Paraplegia
- Aftercare OR 7th Character D

Qualifying - Spine

60% Traumatic & Non-Traumatic Spine

IGC 04.110-04.130 NTSCI

- Not Compliant
  - Stenosis (ANY spinal region)
- **Remaining: Cause of stenosis-**
  - Spondylosis with Myelopathy (Identify Spinal Level)
  - Intervertebral Disc Disorders with Myelopathy (Identify spinal level)
  - Certain Neoplasms (Identify site)
  - Intraspinal abscess and granuloma
  - Acute/Subacute myelitis

04.210-04.230 TSCI

- Many Combo codes – Describe every injury, cause, impacted spinal level, residuals, history of present illness in detail! Lack of specificity doesn't fly!
- Clarify "Cord" deficits.
- "Weakness" is not enough.
- Unspecified fractures (location) with unspecified injuries - FAIL

UDSMR Impairment Group	UDSMR Impairment Group Code (Item 21)	RIC	Presumptive Compliance Exclusions	Etiologic Diagnosis	ICD-10	I-10 Description	What Should Be Documented
Spinal Cord Dysfunction	04.110 Paraplegia, Unspecified 04.111 Paraplegia, Incomplete 04.112 Paraplegia, Complete 04.120 Quadriplegia, Unspecified 04.1211 Quad, Incomplete, C1-C4 04.1212 Quad, Incomplete, C5-C8 04.1221 Quad. Complete , C1-C4 04.1222 Quad, Complete, C5-C8 04.130 Other Non-traumatic Spinal Cord Dysfunction (will be excluded from 60% with certain diagnoses identified in red)	NTSCI (05)	ALL IGCs NOT Presumptive without qualifying comorbidity if the etiologic diagnosis is listed above and in the table in RED	Spinal stenosis in cervical region	M48.0-	Spinal stenosis in **CERVICAL** REGION (if deficits include weakness) Use 5th character (1) **OCCIPITO-ATLANTO-AXIAL** REGION (2) **CERVICAL** REGION (3) **CERVICOTHORACIC** REGION	*if cause of stenosis (i.e. spondylosis/disc disorder) is known, best practice warrants stating it and coding the causative condition rather than the resulting stenosis. -Identify condition/type of stenosis: Spinal; Subluxation stenosis of neural canal; Osseous stenosis; Connective tissue; Intervertebral disc stenosis; Osseous and subluxation stenosis; Connective tissue and disc stenosis -Specify location and specific spinal region.
					M99.2-	SUBLUXATION stenosis in **NEURAL CANAL** Use 5th character (0) **HEAD** REGION (1) **CERVICAL** REGION	
					M99.3-	OSSEOUS stenosis in **NEURAL CANAL** Use 5th character (0) **HEAD** REGION (1) **CERVICAL** REGION	
					M99.4-	CONNECTIVE TISSUE stenosis in **NEURAL CANAL** Use 5th character (0) **HEAD** REGION (1) **CERVICAL** REGION	
					M99.5-	INTERVERTEBRAL DISC stenosis in **NEURAL CANAL** Use 5th character (0) **HEAD** REGION (1) **CERVICAL** REGION	
					M99.6-	OSSEOUS and SUBLUXATION stenosis in **INTERVERTEBRAL FORAMINA** Use 5th character (0) **HEAD** REGION (1) **CERVICAL** REGION	
					M99.7-	CONNECTIVE TISSUE and DISC stenosis of **INTERVERTEBRAL FORAMINA**	

Things to look for in a Spinal Cord Case

- The focus of treatment must be a true spinal cord.
- Deficits for a patient with spinal cord damage must be documented.
- Spinal cord dysfunction is the highest reimbursing impairment group code, these cases should be documented clearly as such.

Spinal Cord Caveats

- If a patient comes to rehab for a natural consequence of an old spinal cord injury, that patient will be accepted again as a spinal cord injury.

- For Example:
- A patient comes to rehab for a traumatic spinal cord injury with paraparesis of the lower extremity, requiring a wheelchair afterwards. That patient becomes depressed and rarely moves from his living room and wheelchair and subsequently develops a stage 4 ulcer of the right buttocks, which is removed, and that patient sent back to rehab. This patient will be brought into rehab under a traumatic spinal cord injury again even though no additional trauma or spinal cord dysfunction was involved, this was a natural consequence of that initial injury.

Uncle Bill's Back Surgery

Spine	*Neuro*	*Ortho*
• Patient with L1-L3-spine fusion and laminectomy. • Incomplete cord lesion at L1 • Neurogenic bowel and bladder, • Lower extremity incomplete bilateral paraparesis. • Peripheral weakness bilateral feet/toes.	• Patient with L1-L3 spine fusion and laminectomy. • Lower extremity bilateral paresthesias. • Radiculopathy and left foot drop • Peripheral weakness bilateral feet/toes.	• Patient with L1 to L3 spine fusion and laminectomy. • Constipation • Bladder Incontinence • Difficulty Walking • Weakness

These don't fit? Consider Pain or Debility.

Putting it All Together #9

42 y/o patient with worsening lower extremity patchy paresthesias, he states this started about two weeks ago when he noticed erectile dysfunction (N52.9). Patient has severe spondylosis with myelopathy at L1, L2, and L3 (M47.16). Patient was admitted to the hospital on 5/8 for a Lumbar Laminectomy with decompression and fusion however noted deficits remained following surgery and diagnosed also with neurogenic bladder(N31.9) as a result. Patient was also found to have obtained a UTI (N39.0) with pseudomonas (B96.5) secondary to numbness in that area and not voiding properly.

Motor Score: 31

What's Your Answer?

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Putting it All Together #10

34 y/o patient with a history of back pain starting about 15 years of age, patient has been a long-time football player since childhood. Patient was admitted with bowel (R15.9) and bladder incontinence (R32) and spasticity (R25.9), as well as numbness and weakness from bilateral hips progressing slowly to his toes. Patient was not a surgical candidate, diagnosed with paraparesis of bilateral legs (G82.20) and is admitted to rehab for strengthening and transfer training.

Motor Score: 42

What's Your Answer?

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Putting it All Together #11

Following fall patient suffered T1-T3 fractures (S22.019A, S22.029A, S22.039A) with thoracic cord compression at T1 (S24.101A) complicated by acute respiratory failure (hypoxic) (J96.01), COPD exacerbation (J44.1), pulmonary embolism (I26.99), Left-sided pleural effusion (J90), urinary tract infection (N39.0) with E.coli (B96.20), neurogenic bowel (K59.2) and bladder (N31.9).

Motor Score 42

What's Your Answer?

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Case Study 11(long case) – Breakout

IRF-PAI	UB04
• IGC: • Etiologic Diagnosis(es): • Tier: • Age: • Motor Score: • CMG: • 60%, WHY:	• Principal: • CC/MCC: • DRG:

Session 5 Assignments

Connect with Kristine and take the quiz for CE Credit

Post in the group what is your favorite thing to do when you are not an IRF Superhero