Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Claims-Based Outcome and Payment Measures Resources and Use of the NIH Stroke Scale

Questions and Answers

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Webinar attendees asked the following questions and subject-matter experts provided the responses. Questions and answers may have been edited.

Question 1: There is a list of seven fact sheets. I cannot locate the last two fact sheets: National Institutes of Health (NIH) Stroke Scale and background. Where are these located?

The pathway to the fact sheets, including the NIH Stroke Scale, can be found on slide 13. Go to *Qualitynet.org*, Hospitals-Inpatient, Claims-Based and Hybrid Measure, and then select Mortality Measures in the left-side navigation pane. Select the Resources tab; you will find the NIH Stroke Scale fact sheet there. The mortality measures fact sheet should also be on that tab. Measure background information for any of the other measure groups (complication, payment, readmission, etc.) are also located on the Resources tab.

Question 2: Who can document the NIH Stroke Scale score?

Information on who can document the NIH Stroke Scale is available in the ICD-10-CM Official Guidelines for Coding and Reporting*.

According to the guidelines, "NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient" ICD-10-CM Official Guidelines for Coding and Reporting, page 17).

*ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification.

Question 3: When does the NIH Stroke Scale need to be documented? On day of admission, within 12 hours? Which is The Joint Commission standard for the comprehensive stroke programs?

For the purposes of the enhanced CMS 30-day ischemic stroke mortality measures, the initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71). If multiple stroke scale scores are reported, hospitals should use a Present on Admission (POA) code to coincide with the initial assessment.

Question 4: **Does the stroke diagnosis need to be POA of "Yes" or "No"?**

To be in the stroke mortality measure, a stroke diagnosis must be in the principal discharge diagnosis field. ICD-10-CM codes for the NIH Stroke Scale are available as secondary diagnosis codes since October 2016.

If multiple NIH Stroke Scales are documented on your claim, associating the initial NIH Stroke Scale score with the POA of "Yes" is recommended.

Question 5: **Slide 16. What is included in the background fact sheet? And, where is it located? Are the resources—for example, fact sheet for the NIH Stroke Scale—in the *QualityNet* website? And if so, where?**

The measure background fact sheet provides an overview of outcome measures, their development, and importance. The mortality measures fact sheet contains information on the mortality measures, including the purpose of the measures, 2018 measure updates, and programs in which they are currently implemented.

On slide 13, the measure background/mortality measure fact sheet is located on the Resources tab of each of the measures. Go to the Mortality Measures tab; the measure background and mortality measures fact sheets are available on the Resources tab. The NIH Stroke Scale fact sheet is located on the Resources tab, as well.

Question 6: **When clicking on the Hospital Specific Report (HSR) User Guide for July 2018 public reporting, I am getting an error message. I'm not sure if this is on our end or yours. I can access the other links.**

The most likely reason why you are getting an error message when you try to download the HSR User Guide, is probably due to the browser you're using. The *QualityNet* website works best when you use the Internet Explorer browser. If you're potentially using Chrome or something else, that may be the reason why you're getting the error message.

Question 7: **Slide 17. Where is the infographic found and where is the general fact sheet you referred to in your first slide?**

All the measure background fact sheets can be found on the Resources tab of any of the measure groups. These resources can be found on slide 13. If you go to the Resource tab, for any of the measure groups, you will find both infographics there.

Question 8: **Slide 25. Regarding the mock HSRs on the NIH Stroke Scale, has this HSR been released already or is it coming in the future?**

Yes. The HSR containing information on the NIH Stroke Scale codes was released on May 4, 2018. There is no specific HSR for the NIH Stroke Scale; but there is a stroke mortality HSR that contains information on the NIH Stroke Scale codes. You can access the stroke mortality HSR on the Mortality Measures page on *Qualitynet*.

Question 9: **Slide 27. When outpatient services performed within 72 hours of a hospitalization are bundled to the inpatient admissions for payment purposes, does the counter for readmissions within 30 days post discharge use the bundled outpatient service date as start date for a readmission event?**

Yes. When you have a bundled claim, the claim from date is used. If that occurs within a 30-day claim period, then it certainly will be considered to be a readmission outcome. The full-bundled claim will be used, specifically looking at the claim from date within that claim.

Question 10: **Under what tab is the HSR User Guide located?**

There’s an HSR tab for every measure. If you go the Mortality Measures page, an HSR tab is located within that measure. If you go to the Readmission Measures page, an HSR tab is located within that measure. Once you go to that HSR tab, then you should be able to find the HSR User Guide. The pathway is on slide 22.

Question 11: What disciplines are allowed to document the NIH Stroke Scale for coding to abstract?

Information on who can document the NIH Stroke Scale is available in the ICD-10-CM Official Guidelines for Coding and Reporting. According to the guidelines, “NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient” (ICD-10-CM Official Guidelines for Coding and Reporting, page 17).

Question 12: If you do not have a full electronic health record (EHR), how is the stroke scale picked up?

EHRs are not relied on to document the NIH Stroke Scale. The revised stroke mortality measure will use claims information (ICD-10-CM codes) to determine the severity of a stroke on the NIH Stroke Scale.

Information on who and how to document the NIH Stroke Scale is available in the ICD-10-CM Official Guidelines for Coding and Reporting.

ICD-10-CM codes for the NIH Stroke Scale have been available as secondary diagnosis codes since October 2016. Specifically, 43 new codes were introduced. NIH Stroke Scale scores range from 0 to 42, with higher values indicating more severe strokes (0 indicating no stroke symptoms, 1–4 minor stroke, 5–15 moderate stroke, 16–20 moderate to severe stroke, and 21–42 severe stroke).

According to the ICD-10-CM coding and reporting guidelines, “NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient” (ICD-10-CM Official Guidelines for Coding and Reporting, page 17).

Question 13: **Can you tell me where to find or what specific ICD-10 codes are used for the stroke mortality measure?**

CMS released the ICD-10-CM Official Guidelines for Coding and Reporting for fiscal year (FY) 2018. The document is available online here.

ICD-10-CM codes for the NIH Stroke Scale have been available as secondary diagnosis codes since October 2016. Specifically, 43 new codes were introduced. NIH Stroke Scale scores range from 0 to 42, with higher values indicating more severe strokes (0 indicating no stroke symptoms, 1–4 minor stroke, 5–15 moderate stroke, 16–20 moderate to severe stroke, and 21–42 severe stroke).

Question 14: **Do coders have to determine if the NIH is utilized and apply ICD-10, as applicable?**

Yes, coders must determine if the NIH Stroke Scale is utilized and apply ICD-10-CM codes on the claim.

Information on who can document the NIH Stroke Scale is available in the ICD-10-CM Official Guidelines for Coding and Reporting. According to the guidelines, "NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient" (ICD-10-CM Official Guidelines for Coding and Reporting, page 17).

ICD-10-CM codes for the NIH Stroke Scale have been available as secondary diagnosis codes since October 2016. Specifically, 43 new codes were introduced. NIH Stroke Scale scores range from 0 to 42, with higher values indicating more severe strokes (0 indicating no stroke symptoms, 1–4 minor stroke, 5–15 moderate stroke, 16–20 moderate to severe stroke, and 21–42 severe stroke).

The initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71). If multiple stroke scale scores are reported, hospitals should use a POA code to coincide with the initial assessment.

Question 15: **Do you know if critical access hospitals (CAHs) will have the NIH Stroke Scale measure reported in HSR?**

Yes, CAHs receive their HSRs. Specifically, the stroke mortality HSR contains information on the NIH Stroke Scale. This HSR has been available on *Qualitynet* since May 4, 2018.

Question 16: **What should coders use for patients transferring into the facility? The initial score at the transferring facility or the score when they arrive at our hospital?**

A coder should document the first NIH Stroke Scale given to a patient at the coder's facility. The claims are bundled, and the measure is calculated using the first NIH Stroke Scale score from the first admitting hospital.

Question 17: **Will lack of NIH affect payment?**

Currently, lack of NIH Stroke Scale will not affect payment. The NIH Stroke Scale will be included in the risk adjustment model of the revised stroke mortality measure for payment determination in FY 2023 using data starting June 2018. This means that the NIH Stroke Scale scores will influence your risk standardized mortality rate.

Question 18: **What type of strokes is the NIH Stroke Scale used on? Ischemic, subarachnoid hemorrhage (SAH), intracerebral hemorrhage (ICH), or all?**

The NIH Stroke Scale is used to determine the severity of acute ischemic strokes.

Question 19: **Are there NIH Stroke Scale HSRs available on *QualityNet* now?**

There are no specific HSRs for the NIH Stroke Scale. However, the stroke mortality HSR contains information on the NIH Stroke Scale scores. That HSR is currently available on *QualityNet*.

Question 20: **Only ten to thirty percent of hospitals are coding or reporting the NIH Stroke Scale POA. Is that correct? We do the NIH Stroke Scale. Can it be that coders are not including it?**

Yes, the percentage of hospitals that are coding the scale is based on those that have included it in the claims. Many hospitals may administer the NIH Stroke Scale, but it is not captured by coders in claims. For those, the score will not be included in the measure calculation.

Question 21: **How will the stroke metric be captured in the claim?**

Information on who can document the NIH Stroke Scale is available in the ICD-10-CM Official Guidelines for Coding and Reporting. According to the guidelines, "NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient" (ICD-10-CM Official Guidelines for Coding and Reporting, page 17).

ICD-10-CM codes for the NIH Stroke Scale have been available as secondary diagnosis codes since October 2016. Specifically, 43 new codes were introduced. NIH Stroke Scale scores range from 0 to 42, with higher values indicating more severe strokes (0 indicating no stroke symptoms, 1–4 minor stroke, 5–15 moderate stroke, 16–20 moderate to severe stroke, and 21–42 severe stroke).

The initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71). If multiple stroke scale scores are reported, hospitals should use a POA code of "Yes" to coincide with the initial assessment.

The mortality measure is calculated using claims from the index hospitalization, as well as historical claims for risk adjustment. See here for the measure technical report and here for the paper on the enhanced stroke mortality measure.

Question 22: **We receive stroke patient transfers from our telestroke program. The sending hospital provides an NIH Stroke Scale prior to treatment with tissue plasminogen activator (TPA). Can we capture that initial score at the outside hospital prior to our direction to administer TPA?**

A coder should document the first NIH Stroke Scale given to a patient at the coder's facility. The claims are bundled, and the measure is calculated using the first NIH Stroke Scale score from the first admitting hospital.

Question 23: **Where in the medical record should the NIH Stroke Scale be documented? Should it be in the emergency department (ED) record?**

Yes, the NIH Stroke Scale score can be added into the ED record. The stroke scale should be documented wherever it is first assessed and documented.

Question 24: **Is the measure to ensure the hospitals are using the scale or to see how well the different scores do on mortality? The NIH Stroke Scale score may change during the stay.**

The intent in using the NIH Stroke Scale is to risk adjust the stroke mortality measure for a patient's stroke severity. The initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71). If multiple stroke scale scores are reported, hospitals should use a POA code to coincide with the initial assessment.

Question 25: **Has the adding of the NIH Stroke Scale by the coders already started?**

Yes, ICD-10-CM codes for the NIH Stroke Scale have been available as secondary diagnosis codes since October 2016. CMS will implement the modified stroke measure using the NIH Stroke Scale obtained from claims data, using discharges from July 1, 2018 to June 30, 2021, for payment determination in FY 2023. For more details, see the FY 2018 Inpatient Prospective Payment System Final Rule.

Question 26: **How will a missing NIH Stroke Scale affect the severity adjustment?**

CMS has not announced how missing NIH Stroke Scale scores will be accounted for in measure calculations. However, missing an NIH Stroke Scale score will limit the measure's ability to adequately assess the case mix of a hospital.

Question 27: **If the risk-standardized mortality rate (RSMR) at a hospital is higher than the raw mortality rate, would that be an indicator that risk factors may not be captured in documentation in the claim?**

The underreporting of risk factors could increase a hospital's RSMR, regardless of the observed rate. If a hospital does not comprehensively capture information on how sick their patients are, then it is possible that their hospital effect will be larger than it would be if they included all risk factors; in turn, a larger hospital effect would increase their predicted mortality rate. To elaborate:

- The RSMRs are calculated as the ratio of the number of "predicted" deaths to the number of "expected" deaths, multiplied by the national observed mortality rate. For each hospital, the numerator of the ratio is the number of deaths within 30 days predicted based on the hospital's performance with its observed case mix. The denominator is the number of deaths expected based on the nation's performance with that hospital's case mix.
- This approach is analogous to a ratio of "observed" to "expected" used in other types of statistical analyses. It conceptually allows for a comparison of a hospital's performance given its case mix to an average hospital's performance with the same case mix.
- It is not appropriate to directly compare a hospital's raw mortality rates to the RSMRs.

For details on the statistical methodology, please refer to Section 2 and Appendix A of the 2018 Condition-Specific or Procedure-Specific Mortality Measures Updates and Specifications Reports available on *QualityNet*. Go to *Qualitynet.org*, Hospitals-Inpatient, Claims-Based and Hybrid Measure; and then select Mortality Measures in the left-side navigation pane. Select the Measure Methodology tab.

Question 28: If there are multiple NIH Stroke Scales documented, which one do we log on the claim?

The initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71).

If multiple stroke scale scores are reported, hospitals should use a POA code of "Yes" to coincide with the initial assessment.

Question 29: What is considered the initial NIH Stroke Scale as documented by the medical provider?

The initial NIH Stroke Scale is the first stroke scale administered.

Information on who and how to document the NIH Stroke Scale is available in the ICD-10-CM Official Guidelines for Coding and Reporting.

According to the guidelines, "NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient" (ICD-10-CM Official Guidelines for Coding and Reporting, page 17).

The initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71). If multiple stroke scale scores are reported, hospitals should use a POA code to coincide with the initial assessment.

Question 30: Are CAHs required to do the NIH Stroke Scale on admission?

Yes, CAHs are included in the measure calculations, and therefore the NIH Stroke Scale should be recorded.

Question 31: **Does the provider actually have to document the entire NIH Stroke Scale examination in the record or can they just document the total NIH Stroke Scale for it to be abstracted by the coder?**

The coder only needs to document the total NIH Stroke Scale score for recording in claims.

Question 32: **Does the Resources section provide the impact on reimbursement rates related to NIH Stroke Scale reporting?**

No, the Resources section on *Qualitynet* only provides information on mortality measures and the NIH Stroke Scale.

Question 33: **If our HSR shows the NIH Stroke Scale score as "[c] N/A" does that mean it's not applicable? And, does it mean that we did not code it when we should have?**

N/A means not applicable because the NIH Stroke Scale was not available in ICD-10 codes prior to October 2016.

Missing NIH Stroke Scale scores are noted as " . "

Question 34: **Please clarify which NIH Stroke Scale you want to capture. Is it the NIH Stroke Scale on arrival or the last one before discharge?**

The initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71). If multiple stroke scale scores are reported, hospitals should use a POA code to coincide with the initial assessment.

Question 35: **I just looked at our HSR data and noticed that "N/A" is noted in the NIH Stroke Scale column. My understanding is that the medical records department is abstracting that information. Where on the claim should this information be recorded so that it is captured?**

N/A means not applicable because the NIH Stroke Scale was not available in ICD-10 codes prior to October 2016.

Missing NIH Stroke Scale scores are noted as " . "

Information on who can document the NIH Stroke Scale is available in the ICD-10-CM Official Guidelines for Coding and Reporting. According to the guidelines, "NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient" (ICD-10-CM Official Guidelines for Coding and Reporting, page 17).

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The initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71). If multiple stroke scale scores are reported, hospitals should use a POA code to coincide with the initial assessment.

The NIH Stroke Scale score is entered as a secondary diagnosis code in claims.

Question 36: **What evidence is used to indicate documenting the NIH Stroke Scale improves outcomes?**

Several studies have demonstrated that the first stroke severity score is one of the strongest predictors of mortality in ischemic stroke patients (see, e.g., Fonarow et al. 2012; Nedeltchev et al. 2010; Smith et al. 2010).

Benefits of incorporating the NIH Stroke Scale into the risk-adjustment models include the following:

- Aligning with clinical guidelines
- Improving the discrimination of the stroke mortality measure, which allows for more rigorous risk adjustment
- Improving face validity of the measure
- Maintaining low burden for hospitals

Question 37: **For the NIH Stroke Scale ICD-10 coding on claims, does it have to be one of the first ICD-10 codes listed on the claim? For example, if it is listed as the 43rd diagnosis code on the claim, will CMS still recognize it?**

ICD-10-CM codes for the NIH Stroke Scale should be listed as **secondary diagnosis codes**.

The initial NIH Stroke Scale should be documented (ICD-10-CM Official Guidelines for Coding and Reporting, page 71). If multiple stroke scale scores are reported, hospitals should use a POA code to coincide with the initial assessment.

Question 38: **Where is the stroke scale entered on the claim?**

The NIH Stroke Scale score is entered as a secondary diagnosis code in claims.

Question 39: **The coding guidelines do not tell the coders how to handle transfers. How do we stay consistent with this across hospitals?**

A coder should document the first NIH Stroke Scale given to a patient at the coder's facility. The claims are bundled, and the measure is calculated using the first NIH Stroke Scale score from the first admitting hospital.

Question 40: **Where are the coding instructions found for abstracting the NIH Stroke Scale?**

Information on who can document the NIH Stroke Scale is available in the ICD-10-CM Official Guidelines for Coding and Reporting. According to the guidelines, "NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient" (ICD-10-CM Official Guidelines for Coding and Reporting, page 17).

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