Houston Healthcare has begun admitting to the inpatient stroke center. The CDI staff has reported that coded accts are missing the Glasgow Coma Scale (GCS) codes. Please make sure you are picking up these codes from:

* the ambulance report,
* ER report,
* nurse notes, etc
* at least once at the time of admission.

It is very important for HHC facility reporting that these be captured. Please familiarize yourselves with the coding guidelines on page 73-74 of the 2019 ICD-10-CMC Official Coding Guidelines in order to properly assign these codes.

The documentation of the coma scale may be documented by other clinicians involved in the care of the patient (EMT, nursing) and not only by the physician. The physician must have documented the associated diagnosis (why the GCS is being addressed) such as encephalopathy, stroke, overdose, etc.

When reporting the GCS, a code from each category is needed to complete the scale. At a minimum, report the initial score documented on presentation to your facility. This may be from EMT or from the ED. Only report the total score when there is no documentation in the record indicating the individual scores.

The 7th character indicates when the scale was recorded and should match for all three codes when reporting the individual scores.

Some of the GCS are MCC’s when grouped with certain diagnoses.

Example: R40.2214 (coma scale, best verbal response, none, 24 hours or more after hospital admission) is an MCC for a patient with an overdose, pneumonia, encephalopathy, and intestinal disorders along with many/most other selections of PDX.

It is important that these are reported appropriately since they can impact the DRG and SOI/ROM on some cases.

Here’s a couple of examples of when reporting the GCS would impact the DRG and/or SOI/ROM:

* Patient is found in their nursing home with labored breathing and ambulance is called. The patient is found to have a possible pneumonia and transported to the ED. The patient is confused and unable to respond to any questions and is nonverbal in the ambulance and does not open their eyes. Motor response is documented as abnormal by EMT. On discharge the patient is diagnosed with pneumonia (J18.9) and sent back to the nursing home. The coder should also assign R40.2211 (Coma scale, best verbal response, none, in the field [EMT or ambulance]), R40.2111 (Coma scale, eyes open, never, in the field [EMT or ambulance]), and R40.2331 (Coma scale, best motor response, abnormal, in the field [EMT or ambulance]). These codes result in MS-DRG 193 (Simple Pneumonia and Pleurisy with MCC.) The APR-DRG is 139 (Other pneumonia) with an SOI as 3-Major and ROM as 4-Extreme.
	+ If the GCS codes are taken away and only the total is reported (which was 3-R40.2431) the result is MS-DRG 195 (Simple Pneumonia and Pleurisy without CC/MCC) and APR DRG 139, Other Pneumonia with an SOI as 1-Minor and ROM as 1-Minor.
* Patient is brought into the ED with possible OD of heroin. The patient is found on presentation to the ED to be nonverbal, does not open eyes and has no motor responses. The patient is admitted to ICU and monitored and responds to treatment. The OD is determined to be accidental as the patient denies any suicidal intent or thoughts. Patient is discharged with accidental heroin OD. The coder should assign T40.1X1A (Poisoning by heroin, accidental (unintentional), initial encounter) as well as R40.2312 (Coma scale, best motor response, none, at arrival to emergency department), R40.2112 (Coma scale, eyes open, never at arrival to emergency department) and R40.2212 (Coma scale, best verbal response, none, at arrival to emergency department). These codes result in MS-DRG 917 (Poisoning and Toxic Effects of Drugs with MCC). The APR-DRG is 816 (Toxic effects of non-medicinal substances) with an SOI as 3-Major and ROM as 4-Extreme.
	+ If the individual GCS codes are taken away and only the total score reported R40.2212 the result is MS-DRG 918 (Poisoning and Toxic Effects of Drugs without MCC). APR-DRG is 816, Toxic effects of non-medicinal substances and an SOI as 1-Minor and ROM as 1-Minor.

If the patient expires in the ED before being admitted to an inpatient unit, coders will report the case as an outpatient encounter.

One code from each of the three subcategories (R40.21-, R40.22-, and R40.23-) is needed to complete the scale. Therefore, the clinician must document the patient’s visual, verbal, and motor status in the medical record.

When coding a patient’s visual status, look for documentation of how often the patient’s eyes are open and select the appropriate code:

* R40.211 (coma scale, eyes open, never)
* R40.212 (coma scale, eyes open, to pain)
* R40.213 (coma scale, eyes open, to sound)
* R40.214 (coma scale, eyes open, spontaneous)

Then, do the same for the patient’s verbal and motor skills. Physicians will need to document the patient’s best verbal and best motor response for coders to select the most appropriate code.

The clinician must also document the time in which the coma scale is recorded in order to assign the appropriate seventh character as 0 (unspecified time), 1 (in the field [EMT or ambulance]), 2 (at arrival to emergency department), 3 (at hospital admission), or 4 (24 hours or more after hospital admission).

**References:**

* AHA Coding Clinic, Fourth Quarter 2018 Page: 70
* AHA Coding Clinic, Fourth Quarter 2017 Page: 95
* ICD-10-CM Official Guidelines for Coding and Reporting FY 2019