

Clinical documentation improvements and general coding tips: Acute stroke

Coding acute stroke accurately requires the documentation to note the following:

1. Risk adjustable Dx from an outpatient setting must be “confirmed” diagnoses.

Uncertain Diagnoses

Outpatient: Do not code diagnoses documented as probably, suspected, likely, questionable, possible, still to be ruled out, or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reasons for the visit.

2. Acute Ischemic Stroke (ICD-10 code I63.*) should not be coded from an outpatient setting since confirmation of the diagnosis should be determined by diagnostics studies such as non-contrast brain CT or brain MRI, which would be ordered in an emergency room and/or inpatient setting.
3. ICD 10 Code Category I63.* generally requires causation and location of the stroke.
 - a. Non-specific ICD-10 codes I63.8 and I63.9 should not be used in an outpatient setting and avoided during an inpatient setting when site and cause should have been determined by diagnostic tests
4. Code Sequela of Cerebrovascular Disease/Stroke (ICD-10 code I69*) anytime post a diagnosis of any condition classifiable to ICD-10 codes I60 – I67*.
5. History of Stroke (ICD-10 code Z86.73) should be used when the patient is being seen in an out patient setting subsequent to an inpatient stay. In addition, this code should be used when the patient does not exhibit neurologic deficits due to cerebrovascular disease (i.e., no late effects due to stroke).

Resources

Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance In effect as of 03/20/2019.

Yew, K.S. & Cheng, E.M. (2015). Diagnosis of Acute Stroke. American Family Physician. Vol 91, number 8, www.aafp.org/afp.

Independence Blue Cross coding and documentation education materials are based on current guidelines, are to be used for reference only, and are not intended to replace the authoritative guidance of the ICD-10-CM Official Guidelines for Coding and Reporting as approved by the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). Clinical and coding decisions are to be made based on the following:

1. *The independent judgment of the treating physician or qualified health care practitioner.*
2. *The best interests of the patient.*
3. *The clinical documentation as contained in the medical record.*