

Clinical Documentation and Coding Tips

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Additional Resources — Clinical documentation and coding tips

IBX risk adjustment webpage

www.ibx.com/codingtips

ICD-10 website

www.cms.gov/medicare/coding-billing/icd-10-codes

ICD-10-CM Official Guidelines for Coding and Reporting and codes are subject to annual updates.

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Clinical documentation and coding tips

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Introduction — Clinical documentation and coding tips

Accurate clinical documentation and diagnosis coding are key to telling a patient's complete clinical story. This **Clinical Documentation & Coding Tips booklet** was compiled by Independence Blue Cross (IBX) from definitive coding guidelines to provide practical, specific guidance to help providers improve documentation clarity and coding accuracy for commonly reported and clinically complex conditions. **Conditions include cancer, chronic kidney disease, dementia, depression, embolism and thrombosis, fractures, morbid obesity, myocardial infarction, and stroke.**

Tips for each condition feature key documentation elements and coding reminders to support appropriate code selection, accurately reflect disease acuity and status, and explicitly demonstrate evaluation, treatment, or management at each encounter/visit — helping ensure that medical records fully represent the care delivered.

Clinical documentation tips

- **Do not report conditions that are unconfirmed:** For example: "Possible," "rule out," "suspected."
- **Each progress note must be able to stand alone:** Show clinical documentation for each diagnosis addressed.
- **Confirm, document, and code chronic conditions at least once a year:** For example: Transplant status, amputation status, dialysis status, chemotherapy status, artificial opening status/maintenance.
- **Always appropriately diagnose to the highest level of specificity:** Demonstrate the level of complexity for the patient encounter.
- **Conditions must be addressed and documented within the progress note to be considered "diagnosed."**
- **Medical record documentation should support the presence of the disease/condition and include the provider's assessment and plan for management of the disease/condition.**

M.E.A.T. Criteria

Monitor	• Signs and symptoms • Disease progression and/or status
Evaluate	• Response to treatment(s) • Test results • Medication effectiveness
Assess/ Address	• Counsel and/or discussion • Records review • Refer to specialist
Treat	• Stop or start medication • Diagnostic and/or therapy • Patient education and/or follow-up schedule

T.A.M.P.E.R.

Treatment

Assessment

Monitor/**M**edicate

Plan

Evaluate

Referral

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Clinical documentation and coding tips

Cancer

Cancer is a complex group of diseases characterized by the uncontrolled growth and spread of abnormal cells in the body. These cells can invade and damage surrounding tissues and organs. Cancer can arise in various forms, depending on the type of cells involved, and is often categorized by its origin:

- **Carcinomas:** Originate from epithelial cells.
- **Sarcomas:** Originate from connective tissues.
- **Leukemias:** Originate from blood-forming tissues.
- **Lymphomas:** Originate from the immune system.

ICD-10 documentation guidance for cancer

To ensure accurate documentation, follow these guidelines:

General documentation requirements	• Document to the highest specificity and severity, including laterality when relevant. • Clearly differentiate whether the neoplasm is: — Benign — In-situ — Malignant — Of uncertain histologic behavior — Laterality
For malignant neoplasm	• Document the primary site (original site of the cancer). • Document any secondary sites (locations where cancer has spread). • Include details of current treatments which may involve: — Chemotherapy — Radiation — Hormonal Therapy — Surgery — Watchful Waiting — Refusal of Treatment
When malignant neoplasms are no longer active	If the neoplasm has been excised or eradicated and the patient is not receiving further treatment: • Use a code from category Z85 (Personal history of malignant neoplasm). • This applies only if the patient is not receiving **active treatment** and there are **no indications of current disease.**

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Documentation best practices

For Metastatic Neoplasms	Invalid documentation	Proper documentation
Ensure documentation includes both the **primary site** and **secondary sites**, along with the patient's current treatment. **Note:** Refer to ICD-10 Official Guidelines for Coding and Reporting 1.C.2.l for proper sequencing of the main diagnosis.	**Z85.3** *"History of breast cancer, no recurrence, cont. current Tamoxifen tx"* **Why it is invalid:** The patient is still being treated with Tamoxifen, so this condition should be documented as **active cancer**, not history.	**C50.-** *"Breast cancer, no recurrence, continue current Tamoxifen treatment."*

Note: A dash (-) indicates that additional characters are required to complete the code.

References

- Centers for Medicare & Medicaid Services. Contract-Level 15 Risk Adjustment Data Validation Medical Record Reviewer Guidance In effect as of 01/10/2020. Version 2.0.
- AAPC. (2026). *ICD-10-CM Expert 2026: Diagnosis codes for providers & facilities*. AAPC.
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Clinical documentation and coding tips

Chronic kidney disease

Chronic kidney disease (CKD) is a multisystem disease characterized by a progressive loss of kidney function, primarily measured through the glomerular filtration rate (GFR). CKD is diagnosed when there is evidence of:

- **Kidney damage (e.g., urine albumin > 30 mg/g creatinine), and/or**
- **A sustained decrease in kidney function (eGFR < 60 mL/min/1.73 m^2) for more than three months.**

The staging of CKD is based on the assessment of GFR levels

CKD staging based on eGFR (mL/min/1.73 m^2) levels		
Stage 1	Kidney damage with normal or high GFR	≥ 90
Stage 2	Kidney damage with mild decrease in GFR	60-89
Stage 3a	Moderate decrease in GFR (mild-moderate)	45-59
Stage 3b	Moderate decrease in GFR (moderate-severe)	30-44
Stage 4	Severe decrease in GFR	15-29
Stage 5	Kidney failure	< 15

ICD-10 documentation guidance for CKD

- Include the patient's most recent GFR lab results in the documentation.
- For patients currently receiving dialysis, document: Dependence on Renal Dialysis – Z99.2.
- For patients with a kidney transplant, document the transplant status at least once annually: Z94 (Kidney Transplant Status).

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Documentation best practices

Specific comorbidities and ICD-10 documentation examples:

Use an additional code to document the stage of CKD

I12.0	Hypertensive CKD with stage 5 CKD or end-stage renal disease (ESRD)	I12.9	Hypertensive CKD with stage 1 through 4 CKD, or unspecified CKD

Use an additional code to document the stage of CKD

E08.22	Diabetes mellitus due to underlying condition with diabetic CKD	E10.22	Type 1 diabetes mellitus with diabetic CKD
E09.22	Drug or chemical induced diabetes mellitus with diabetic CKD	E11.22	Type 2 diabetes mellitus with CKD

Use an additional code to identify: Type of heart failure (I50.-) and stage of CKD

I13.0	Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD, or unspecified kidney disease	I13.11	Hypertensive heart and CKD without heart failure and stage 5 CKD, or ESRD
I13.10	Hypertensive heart and CKD without heart failure and stage 1 through stage 4 CKD, or unspecified kidney disease	I13.2	Hypertensive heart and CKD with heart failure and stage 5 CKD, or ESRD

Note: A dash (-) indicates that additional characters are required to complete the code.

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- AAPC. (2026). *ICD-10-CM Expert 2026: Diagnosis codes for providers & facilities*. AAPC; Sections I.A.15; I.C.9.a3; and I.C.14.
- National Institute of Diabetes and Digestive and Kidney Diseases. (n.d.). Identify & evaluate patients with chronic kidney disease. U.S. Department of Health and Human Services, National Institutes of Health. https://www.niddk.nih.gov/health-information/professionals/clinical-tools-patient-management/kidney-disease/identify-manage-patients/evaluate-ckd

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Clinical documentation and coding tips

Dementia

Dementia is a progressive and degenerative neurological disorder that affects cognitive functions such as memory, thinking, language, and behavior. It is a group of symptoms resulting from the damage or death of brain cells.

Dementia is classified into three main categories based on its etiology.

1. **Vascular Dementia (F01.-). Caused by infarction or other cerebrovascular disease.**

F01.50	Vascular dementia
F01.518	Vascular dementia with behavioral disturbances
F01.3	Mixed vascular dementia

2. **Dementia in Diseases Classified Elsewhere (F02.-). Requires Etiology/Manifestation coding, with the etiology coded first. Examples include:**

G20	Parkinson's Disease	G30.1	Alzheimer's Disease with Late Onset
G30.0	Alzheimer's Disease with Early Onset	G31.83	Dementia/Neurocognitive Disorder with Parkinsonism or Lewy Bodies

3. **Dementia, Unspecified (F03.-). Used to represent dementia Not Otherwise Specified (NOS).**

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ICD-10 documentation guidance for dementia

Behavioral disturbances may accompany dementia and are classified as follows:

1. **Agitation.** Includes: Restlessness, rocking, pacing, exit-seeking, profanity, shouting, threatening, anger, aggression, combativeness, or violence.
2. **Other behavioral disturbances.** Includes: Sleep disturbances, social disinhibition, or sexual disinhibition. Use additional code Z91.83 to document wandering (if applicable).
3. **Psychotic disturbance.** Includes: Hallucinations, paranoia, suspiciousness, or delusional state.
4. **Mood disturbance.** Includes: Depression, apathy, or anhedonia.
5. **Anxiety.** As stated in the record.

Dementia severity levels

Mild	**F01.A-** **F02.A-** **F03.A-**	Clear functional impact on daily life, primarily affecting **instrumental activities**. The patient is no longer fully independent/requires occasional assistance with daily life activities.
Moderate	**F01.B-** **F02.B-** **F03.B-**	Extensive functional impact on daily life with impairment in **basic activities**. No longer independent and requires frequent assistance with daily life activities.
Severe	**F01.C-** **F02.C-** **F03.C-**	Clinical interview may not be possible. **Complete dependency** due to severe functional impact on daily life with impairment in basic activities, including basic self-care.

Note: A dash (-) indicates that additional characters are required to complete the code.

Documentation Best Practices

When documenting dementia, consider the following criteria:

- **Category/Type:** F01, F02, F03
- **Severity:** Mild, Moderate, Severe
- **With or Without Behavioral Disturbances**

Important note: For vascular dementia and dementia in diseases classified elsewhere, **code first** the underlying physiological condition.

References

- Centers for Medicare & Medicaid Services. Contract-Level 15 Risk Adjustment Data Validation Medical Record Reviewer Guidance In effect as of 01/10/2020. Version 2.0.
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- National Institute on Aging. (2023, April 5). Alzheimer's disease fact sheet. U.S. Department of Health and Human Services, National Institutes of Health. https://www.nia.nih.gov/health/alzheimers-and-dementia/alzheimers-disease-fact-sheet

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Clinical documentation and coding tips

Depression, unspecified vs. major depressive disorder, single episode, unspecified

For a diagnosis of major depressive disorder, symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Although individuals with mild depression may appear to function normally, the condition can still be present. Additionally, symptoms must not be attributable to substance use or another medical condition.

ICD-10 documentation guidance for major depressive disorder

Coding major depressive disorder accurately requires the documentation to note the following:

- Symptoms present for at **least 2 weeks**
- Specify if it is a **single episode** or **recurrent episode; and further indicate severity: Mild, moderate, severe (with or without psychotic features)**

Note if the episode is in partial or full remission. **Partial remission indicates that the condition is still being managed and/or treated.**

ICD-10-CM codes for depression

The code **F32.A** (Depression, unspecified) has been created, and the narrative at category **F32** has been revised to "Depression." Previously, ICD-10-CM defaulted to "Depression, not otherwise specified (NOS)," reported with **F32.9** (major depressive disorder, single episode, unspecified).

F32.0	Major depressive disorder, single episode, mild	**F32.5**	Major depressive disorder, single episode, in full remission
F32.1	Major depressive disorder, single episode, moderate	**F32.8**	Other depressive episodes • F32.81 Premenstrual dysphoric disorder • F32.89 Other specified depressive episodes
F32.2	Major depressive disorder, single episode, severe without psychotic features		
F32.3	Major depressive disorder, single episode, severe with psychotic features	**F32.9**	Major depressive disorder, single episode, unspecified
F32.4	Major depressive disorder, single episode, in partial remission	**F32.A**	Depression, unspecified

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Depression, unspecified vs. major depressive disorder, single episode, unspecified — Clinical documentation and coding tips

Documentation best practices

- If the documentation does not meet the specificity as noted in the above list, then the diagnosis can only support Depression, unspecified (F32.A).
- Always appropriately document to the highest degree of specificity: Type and episode.
- Avoid documenting in past medical history (PMH) if the individual is receiving current treatments, including prescribed medication and/or receiving counseling/therapy.
- If member has a diagnosis of depression and a diagnosis of anxiety and if there is a causal relationship between the two conditions, then documentation must establish the relationship by stating depression "with," "due to," or "related to" anxiety to capture the code that encompasses both diagnoses (F34.1 or F41.8).

References

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Clinical documentation and coding tips

Embolism and thrombosis

Location: Deep vein thrombosis (DVT) occurs when a blood clot forms in the deep veins, usually in the legs, while pulmonary embolism (PE) occurs when a clot breaks off and travels to the lungs, blocking an artery.

ICD-10 documentation guidance for embolism and thrombosis

Coding active and/or current embolism and thrombosis accurately requires the documentation to note the following:

Type of embolism or thrombosis	PE • Is it acute? — With acute cor pulmonale? — Without acute cor pulmonale? • Is it a provoked or unprovoked PE? • Is it chronic?	Other specified site
Anticoagulation treatment	Length of treatment • If treatment is greater than three months, and there is no clear documentation of rationale for why, then assume medication is prophylaxis/preventative and code as history of. • There is only one code to utilize while under long-term treatment: Z79.0-. *Note: Use additional code, if applicable, for long-term (current) use of anticoagulants.*	

Note: A dash (-) indicates that additional characters are required to complete the code.

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Documentation best practices

- Code acute PE only while the patient is anticoagulated and only for up to three months (document duration in your note).
- After three months, anticoagulant medication is often used for prevention only. Therefore, continue coding acute PE past three months only if clinically appropriate.
  - I26.99 Other pulmonary embolism without acute cor pulmonale
    Assessment and plan (A/P): Patient continues on an anticoagulant two months into three-month course for subsegmental PE. Asymptomatic, continue monitor international normalized ratio (INR).
  - Z86.711 Personal history of pulmonary embolism
    A/P: Patient with unprovoked PE five months ago. Currently asymptomatic, normal exam will continue full six months anticoagulation.
- Code acute DVT only while the patient is anticoagulated and only for up to six months (document duration in your note).*
  - Continue coding acute DVT past six months only if clinically appropriate.
  - I82.432 Acute embolism and thrombosis of left popliteal vein
    A/P: Patient continues warfarin two months into six-month course for left popliteal DVT. Asymptomatic, continue monitor INR.
  - Z86.718 Personal history of other venous thrombosis and embolism
    A/P: Patient with unprovoked DVT seven months ago. Currently asymptomatic, normal exam will continue full 12 months anticoagulation.
- Chronic DVT criteria: Repeat radiologic studies (ultrasound, CT, etc.) confirms persistent clot > four weeks.
  - Specify Chronic DVT
  - Code I82.5-
    - 5th character for Vein involved
    - 6th character for Right, Left, bilateral, or unspecified
    - Code I82.532 Chronic embolism and thrombosis left popliteal vein
  - Code Z79.01 long-term (current) use anticoagulants
    - A/P: Continued swelling, pain, DVT six months ago L popliteal vein.
    - Ultrasound reveals chronic DVT. Continue anticoagulation and compression stocking, refer to vascular surgery.

*Use additional code, if applicable, for long-term (current) use of anticoagulants.

Note: A dash (-) indicates that additional characters are required to complete the code.

References

- Centers for Disease Control and Prevention. (2025, March 5). About venous thromboembolism (blood clots). U.S. Department of Health and Human Services. www.cdc.gov/blood-clots/about/index.html
- Centers for Medicare & Medicaid Services. Contract-Level 15 Risk Adjustment Data Validation Medical Record Reviewer Guidance In effect as of 01/10/2020. Version 2.0.
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Clinical documentation and coding tips

Fractures

Fracture types

Traumatic fractures

A traumatic fracture is caused by a sudden, forceful impact, for example due to a motor vehicle accident, fall, or sports injury.

- 7th characters: Traumatic fracture categories have additional options for the 7th character.
- Multiple fractures: These should be sequenced according to the severity of the fractures.
- Open vs. closed: If the fracture is **not indicated as open or closed**, it should be coded as **closed**.
- Displaced vs. non-displaced: If the fracture is **not indicated as displaced or non-displaced**, it should be coded as **displaced**.

Pathologic fractures

A pathologic fracture occurs when a bone breaks in an area weakened by another disease process, for example, due to osteoporosis or a neoplasm.

ICD-10 documentation guidance for fractures

The **7th character** is required for all codes within fracture categories, as instructed in the **Tabular List**.

- The 7th character **must occupy the 7th position** in the code.
- Use a **placeholder "X"** to fill empty characters if needed.

7th character definitions	
A – Initial encounter	• Use **A** for each encounter where the patient is receiving **active treatment**. • **Active treatment** refers to interventions such as surgical procedures, emergency department care, or placement of a cast. • **Important:** The assignment of the 7th character is based on **active treatment**, not whether it is the **first visit** with the provider.
D – Subsequent encounter (routine healing)	Use **D** for follow-up care during the **healing or recovery phase**.
S – Sequela	Use for complications or conditions that arise as a direct result of the original injury (i.e., a residual effect that occurs after the acute phase of an illness or injury has passed, a complication of the original illness).

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Documentation best practices

7th character example	• A patient falls at home and has an X-ray confirming a fracture. The patient is placed in a cast. • The **active treatment** is the placement of the cast, so **A** is assigned.
D – Subsequent encounter (routine healing) example	• A patient returns for a follow-up visit after a cast was placed. The physician orders an X-ray to check healing, and no adjustments are made. • Since no treatment was rendered, this is a **subsequent encounter**, so **D** is assigned.
S – Sequela example	Contracture due to cast and prolonged immobilization.

References

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Clinical documentation and coding tips

Morbid obesity and BMI

Morbid obesity can be defined by the following

- Having a body mass index (BMI) of 40 or greater.
- Having a BMI of 35 or greater along with one or more co-morbidities, such as:
  - Hypertension
  - Dyslipidemia
  - Type 2 diabetes
  - Coronary artery disease

ICD-10 documentation guidance for morbid obesity and BMI

A diagnosis of morbid obesity requires the following:

- BMI **must** always be reported with a documented weight-related diagnosis.
- Never convert a BMI code into a weight diagnosis. The provider **must** document the weight diagnosis for the BMI to be abstracted.
- A provider may state that a patient is morbidly obese even if the BMI is less than 40 but greater than 35.

Documentation best practices

- If the provider documents obesity with a BMI of 45, then obesity should be abstracted.
- If a BMI of 52 is noted with no weight-related diagnosis, the provider should be queried. If no weight diagnosis is documented, the BMI cannot be reported.
- BMI is a screening tool and does not define a person's body fat or health.
- The provider's weight-related diagnosis is the only acceptable documentation for coding morbid obesity.

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ICD-10-CM codes for overweight and obesity

E66.01	Morbid (severe) obesity due to excess calories	**E66.3**	Overweight
E66.09	Other obesity due to excess calories	**E66.8**	Other obesity
E66.1	Drug-induced obesity	**E66.9**	Obesity, unspecified
E66.2	Morbid (severe) obesity with alveolar hypoventilation		

ICD-10-CM codes for BMI

Z68.2-	BMI 20–29, adult	**Z68.4-**	BMI 40 or greater, adult
Z68.3-	BMI 30–39, adult		

Note: A dash (-) indicates that additional characters are required to complete the code.

References

- Centers for Medicare & Medicaid Services. Contract-Level 15 Risk Adjustment Data Validation Medical Record Reviewer Guidance In effect as of 01/10/2020. Version 2.0.
- AAPC. (2026). *ICD-10-CM Expert 2026: Diagnosis codes for providers & facilities*. AAPC.
- AAPC. (2026). *ICD-10-CM Expert 2026: Diagnosis codes for providers & facilities*. AAPC; Section I.A.15.

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Clinical documentation and coding tips

Myocardial infarction

A myocardial infarction (MI), commonly known as a heart attack, occurs when blood flow to the heart muscle is severely reduced or completely blocked, leading to damage or death of the heart tissue.

This blockage is often caused by a buildup of fat, cholesterol, or other substances that form plaques in the coronary arteries. MIs are classified into different types based on their underlying cause, such as spontaneous coronary artery occlusion (type 1) or secondary to an imbalance in oxygen demand and supply (type 2).

ICD-10 documentation guidance for MI

Documenting by type or unspecified MI	• Specify the type of MI (e.g., type 1, type 2, type 4, or type 5) or clearly indicate if the MI is unspecified. • Accurate documentation is crucial for assigning the correct ICD-10-CM code.
Acute MI	• An **acute MI** is defined as an MI that is **equal to or less than four weeks old**, even if the patient is transferred to another acute care setting or post-acute care setting. • Document the **date of onset** and the **location of the MI** for accurate coding.
Encounters after the fourth week of the initial MI	• If care is **related to the MI**, assign an appropriate **aftercare Z-code** (e.g., Z48.812 for surgical aftercare of the circulatory system). Do not use the MI code from category I21. • If the MI is **old or healed** with no continued symptoms or treatment, assign ICD-10 code I25.2 (old MI). • If a **subsequent MI** occurs within the four-week timeframe of the initial MI, follow the coding rules in the next section.
Subsequent MIs	• A **subsequent MI** is defined as a new MI occurring within the **four-week time frame** of the initial MI. • Coding guidelines for subsequent MIs: — Do **not** assign a code from category **I22** for subsequent myocardial infarctions unless both the initial and subsequent MIs are **type 1** or **unspecified**. — For a **subsequent type 2 acute MI**, assign only **ICD-10 code I21.A1**. — For a **subsequent type 4 or type 5 acute MI**, assign only **ICD-10 code I21.A9**. • If a **subsequent MI of one type** occurs within four weeks of an MI of a **different type**, assign the appropriate codes from category **I21** to identify each type. Do **not** use a code from category **I22**.

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Documentation Best Practices

- Document the **date of onset, to the best of your knowledge**, and the **specific location** of the MI.
- Provide the **highest level of specificity and severity** to ensure accurate ICD-10 code assignment.
- Use precise terminology to describe the patient's condition, including specific diagnoses, symptoms, or reasons for the encounter.
- Assign codes from category **I22** only if both the initial and subsequent MIs are **type 1** or **unspecified**.
- For type 2, type 4, or type 5 subsequent MIs, use the appropriate code from category **I21**.

References

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- AAPC. (2026). *ICD-10-CM Expert 2026: Diagnosis codes for providers & facilities*. AAPC.
- AAPC. (2026). *ICD-10-CM Expert 2026: Diagnosis codes for providers & facilities*. AAPC; Sections I.A.15; I.C.9.e.
- Mills, Lorie B. Susan Sweeney, Laura Little, Abhinav Goyal. "Red Flags for Myocardial Infarctions Coding and CDI." Journal of AHIMA, no. 7 (Jul-Aug): 54-55.

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Clinical documentation and coding tips

Stroke

A stroke, also known as a cerebrovascular accident (CVA), occurs when blood flow to a part of the brain is interrupted or reduced, preventing brain tissue from receiving oxygen and nutrients.

This can lead to brain cell death within minutes. Strokes can be classified into several types, including ischemic strokes (caused by a blockage in blood flow) and hemorrhagic strokes (caused by bleeding in or around the brain).

A transient ischemic attack (TIA), often called a "mini-stroke," is a temporary period of symptoms similar to a stroke but does not cause permanent damage.

ICD-10 documentation guidance for stroke

Acute ischemic stroke (ICD-10 code I63.-) and hemorrhagic stroke (ICD-10 codes I60.- through I62.-)	• **Key point:** Strokes should not be coded in outpatient settings because a confirmed diagnosis requires diagnostic studies (e.g., non-contrast brain CT or brain MRI), which are typically conducted in an emergency room or inpatient setting. • **Documentation requirement:** ICD-10 codes under categories I60.-, I61.-, I62.- and I63.- require documentation of both the **causation** and **location** of the stroke. • Code to the highest level of specificity. Do not assign unspecified stroke codes (e.g., **I63.9**) or non-specific codes (e.g., **I63.8**) when provider documentation or diagnostic findings support a more specific cerebral infarction code.
Unconfirmed stroke diagnoses in outpatient settings	• Document to the **highest degree of certainty** for that encounter/visit. This might include symptoms, signs, abnormal test results, or the primary reason for the visit. • Terms like "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out" indicate that coding has not been done to the **highest degree of certainty**.
History of stroke (ICD-10 code Z86.73)	Use this code when: • A patient is seen in the outpatient setting after a confirmed diagnosis of a stroke but is **not currently experiencing a CVA** and shows no residual deficits. • A patient had a TIA that has completely resolved.

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Sequela of cerebrovascular disease/stroke (ICD-10 code I69.-)	• These codes are used to document the **long-term effects (residuals)** of a stroke. • **Key documentation requirement:** Providers must explicitly link the residual condition (e.g., hemiplegia, speech deficits) with the stroke to justify the use of a sequela code. • Details to include: — Specify the residual condition. — Indicate the affected side (dominant or non-dominant).
TIA (ICD-10 code G45.9)	• TIA, often referred to as a "mini-stroke," is coded separately from cerebral infarction. • Unlike a stroke, a TIA does not cause permanent brain damage. Use code **G45.9** to document a diagnosed TIA.

Note: A dash (-) indicates that additional characters are required to complete the code.

Documentation Best Practices

- Accurate coding for stroke requires specific documentation of the **type**, **location**, and **cause** of the stroke.
- Avoid vague or non-specific codes when diagnostic details are available.
- For **outpatient settings**, focus on coding **confirmed conditions** or **symptoms** rather than unconfirmed or suspected diagnoses.
- Distinguish between active stroke, resolved TIA, and residual sequelae for proper coding and documentation.

References

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- Yew KS, Cheng EM. Diagnosis of acute stroke. Am Fam Physician. 2015 Apr 15;91(8):528-36. PMID: 25884860.

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Clinical documentation and coding tips

Telehealth

Telehealth services occur when a patient uses technology to receive care remotely, either through real-time audio and/or video communication or non-real-time methods. The modality used must be documented for each date of service.

Synchronous visit

Interactive, real-time communications, which include telephone connection or a combination of telephone and video connection.

Asynchronous visit

- Often known as "store and forward."
- Electronic transmission of medical information to a practitioner who can evaluate outside of real-time or at a later date.

Each telehealth encounter must specify if using audio only or audio/visual within the chart for that date of service.

CPT®/HCPCS* Code	Modifier	Modifier Description
Various	95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system
99441-99443	93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system

References

- Centers for Medicare & Medicaid Services. (2025). Telehealth & remote monitoring (MLN901705). U.S. Department of Health and Human Services. https://www.cms.gov/files/document/mln901705-telehealth-remote-monitoring.pdf
- Center for Connected Health Policy. (n.d.). Pennsylvania state telehealth laws and policies. Retrieved from www.cchpca.org/pennsylvania/

*Healthcare Common Procedure Coding System (HCPCS)

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