

# Coding and Documentation Guide: Cerebrovascular Accident in Outpatient Settings

Accurate coding and documentation are fundamental to the risk adjustment process and crucial to representing each patient’s complex health profile. Bright HealthCare’s coding and documentation guides equip coders and medical staff with the information needed to support complete and accurate coding and documentation.

## Documentation best practices

- Documentation must be provided. Coders cannot assume diagnoses exist based on medication lists or physician orders.
- All conditions that coexist at the time of the encounter and require or affect patient care, treatment, or management should be documented and coded.
- Coders cannot code current conditions from problem lists, medical history, or superbills.
- Providers should document any cerebrovascular accident (CVA) late effects to the highest specificity, including:
  - The cause-and-effect relationship of CVA and related deficits
  - Specific deficits, such as hemiplegia/hemiparesis, cognitive deficits, facial weakness, etc.
  - Laterality and whether the side affected is dominant or non-dominant
- Acute CVA should only be documented **during the initial episode of care**. Post-discharge, providers should document “history of CVA” with or without residual or late effects.
- Coders must ensure clinical documentation for all diagnoses using the MEAT tool (monitor, evaluate, assess, treat). One or more MEAT detail is required for each condition requiring or affecting patient care.

| Monitor  | Evaluate  | Assess  | Treat  |
|--|---|---|--|
| Signs<br>Symptoms<br>Disease progression<br>Disease regression           | Test results<br>Medication effectiveness<br>Response to treatment<br>Physical exam findings | Test ordered<br>Counseling<br>Record review<br>Discussion   | Medication<br>Therapies<br>Referral<br>Other modalities  |
| <b>MEAT Examples: CVA Late Effects</b>                                   |   |   |  |
| Left hemiparesis following old CVA –<br>No improvement since last visit. | Right hemiparesis due to recent CVA –<br>Right upper extremity without movement, baseline.  | Residual left hemiparesis due to history of CVA –<br>Discussed orthotic for night wear to counteract the progressive contracture. | Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side –<br>S/P stroke. Patient is being followed by neurology. |

# Coding and documentation examples

## Case study #1: Complete documentation

**Gender:** F **DOB:** MM/DD/1955

### History of present illness

64-year-old male presents to clinic for evaluation after stroke. Patient reports that on 5/29/2020, he had symptoms of right-sided weakness and slurred speech. Stroke was confirmed with tests at local hospital. Patient reports that since stroke, he has right arm weakness. Patient on Plavix and statin without side effects.

### Medications

Atorvastatin – 20 mg, po qhs  
Clopidogrel – 75 mg, po od  
Aspirin 162 – 325 mg, po od

### Physical examination

Mental status: Awake, alert, oriented x 3, good comprehension and repetition  
CN exam: 2-12 grossly intact  
Motor strength: 2/5 strength to RUE, 5/5 to LUE, 5/5 strength to BLE, normal bulk and tone  
Sensory exam: Intact by all modalities  
Reflexes: 2+ throughout, bilaterally symmetric  
Plantar response: Down going toes bilaterally  
Gait: Unsteady

### Assessment & plan

Patient has right upper extremity weakness, resulting from stroke.  
Patient will be referred for PT and OT. Recommend to continue Plavix and statin.

**Reason for encounter is clearly documented.**

**Assessment and plan clearly states that patient has weakness due to stroke.**

**Documentation includes MEAT details: referral, medication.**

**Documentation supports monoplegia of upper limb following cerebral infarction affecting right dominant side (I69.331).**

## Case study #2: Missed opportunity

**Gender:** M **DOB:** MM/DD/1966

### History of present illness

Pt is here for second opinion regarding recent stroke; he is here to discuss treatment options and to review medications prescribed by previous provider. Wife does report a few TIAs a couple of weeks ago, states he had some slurring of words, states Saturday he could not move his left arm.

### Current medications

Aspirin 81 MG EC tablet; take 81 mg by mouth  
Atorvastatin (LIPITOR) 80 MG tablet; take 80 mg by mouth  
Lisinopril (PRINIVIL, ZESTRIL) 5 MG tablet; take 5 mg by mouth  
Metoprolol succinate (TOPROL-XL) 25 MG 24 hr tablet; take 75 mg by mouth

### Past medical history

Stroke x 2

### Physical exam

General appearance: Alert, in no acute distress  
HEENT: Eyes normal inspection  
Neck: Normal inspection, trachea midline  
Respiratory: Normal lung sounds bilaterally, no respiratory distress  
CVS: Chest non-tender, heart sounds irregular rate and rhythm  
Abdomen/GU: Non-tender  
Rectal: Exam deferred  
Back: Normal inspection, no CVA tenderness  
Skin: Warm, dry, intact, no rash or petechia  
Extremities: Normal inspection, non-tender, normal range of motion  
Neuro: Oriented x4, speech seems fairly clear. There is no significant aphasia at this time.  
Psych: Negative for anxiety and depression

**Note that patient could not move his left arm, a clinical indicator of late effects from recent stroke.**

### Assessment & plan

Recent CVA

- Reviewing recent hospital records show ischemic stroke, status post-thrombectomy. Recommend he stay on anticoagulation.
- Refer to PT for balance and strength.

**Note referral to PT under recent stroke, a clinical indicator of late effects of stroke. Query provider for clarification.**

**Documentation supports personal history of stroke, without residual deficits (Z86.73).**

# Coding for CVA in outpatient settings

## Acute CVA

Coding an acute CVA is not appropriate in an outpatient setting; therefore do not use ICD-10-CM codes from category I60–I68 for outpatient settings. Codes from category I60–I68 should not be abstracted from problem lists or past medical history because post-discharge, the event is no longer considered acute.

## History of CVA (with and without late effects)

The appropriate code for “history of” CVA with no lasting effects is personal history of cerebral infarction without residual effects (Z86.73).

Assign the appropriate code from category I69, late effects/sequelae of cerebrovascular disease, when there is documentation of history of CVA with residual deficits. There must be clear documentation of a cause-and-effect relationship between the CVA and related deficits to assign a code from category I69.

Example A: Patient is seen for history of stroke 5 years ago. Patient has residual right-sided hemiplegia due to the stroke. Below is the correct code assignment for this patient’s condition:

|         |  |
|---------|--|
| I69.351 | Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side |
|---------|--|

Example B: Patient is seen for routine follow-up. She has a history of stroke. Patient’s only complaint is weakness of the right hand. Below is the correct code assignment for this patient’s condition:

|        |                                |
|--------|--------------------------------|
| Z86.73 | Personal history of stroke NOS |
| R53.1  | Generalized weakness           |

**Note:** Because the patient’s right-hand weakness was not directly linked to her history of stroke, it cannot be coded as a sequelae or late effect.