The Top Conditions
Stroke Documentation & Coding

Commercial Risk Adjustment Operations

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- **The following is intended to be an informational resource only. Nothing expressed in this presentation should be construed as medical advice.**

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"Education is the most powerful weapon you can use to change the world."

- Nelson Mandela

By reviewing this presentation, you will learn:

- Objective and Intent
- Best Practices - Documentation
- ICD-10-CM Quick Tips
- Coding Example Review
- Continued Educational Resources

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Objectives and Intent

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The Top Condition Series| Objective and Intent

Enhance the accuracy and completeness of provider documentation, medical diagnosis coding, and promote proper reimbursement.

Instill providers with the knowledge, tools, and resources to accurately assess, treat, document, and code the current health status of Florida Blue members.

Accurate coding ensures the Center for Medicare and Medicaid Services (CMS) is fairly and accurately measuring the health of the Affordable Care Act (ACA) population as part of the ACA Risk Adjustment Program.

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Best Practices - Documentation

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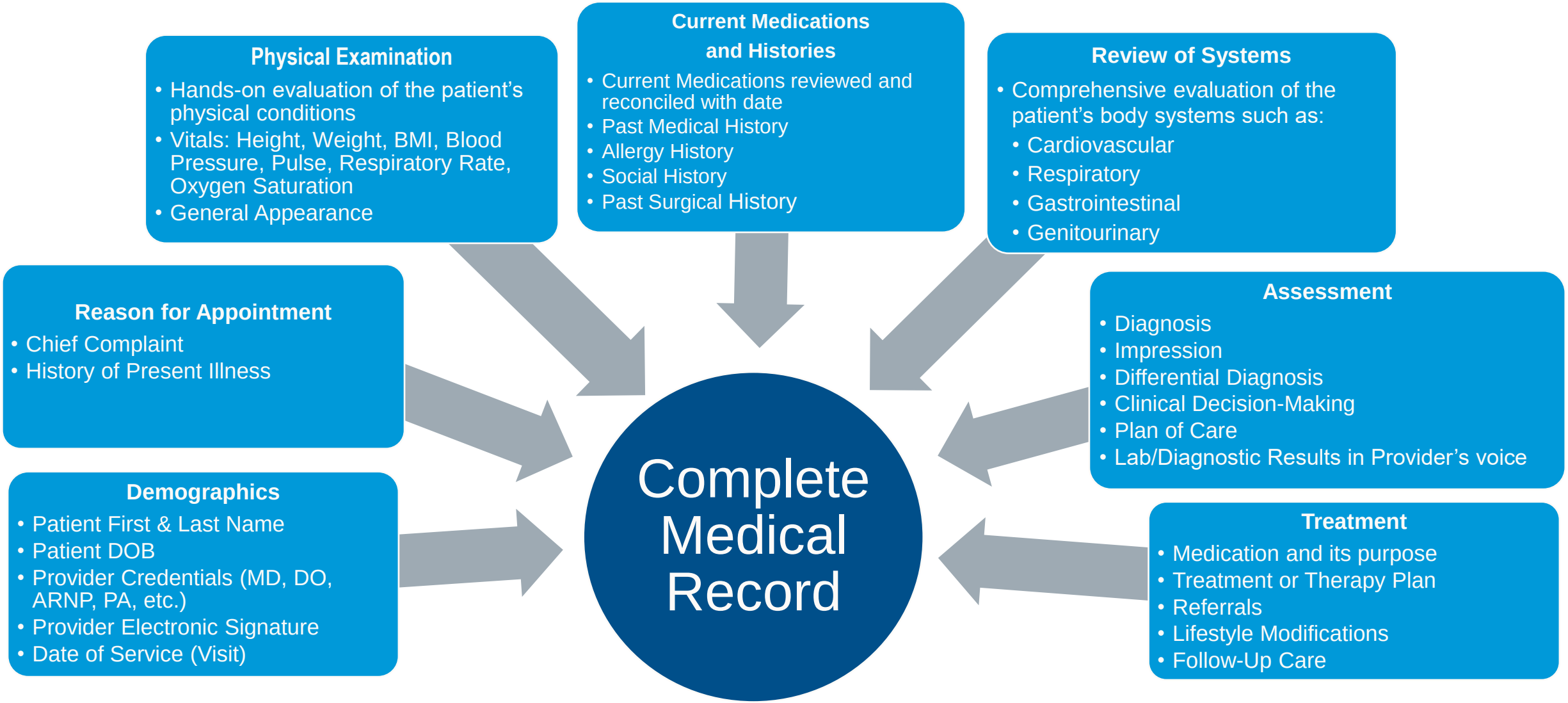
Critical Elements of Medical Record Documentation



Note: This is a partial list.

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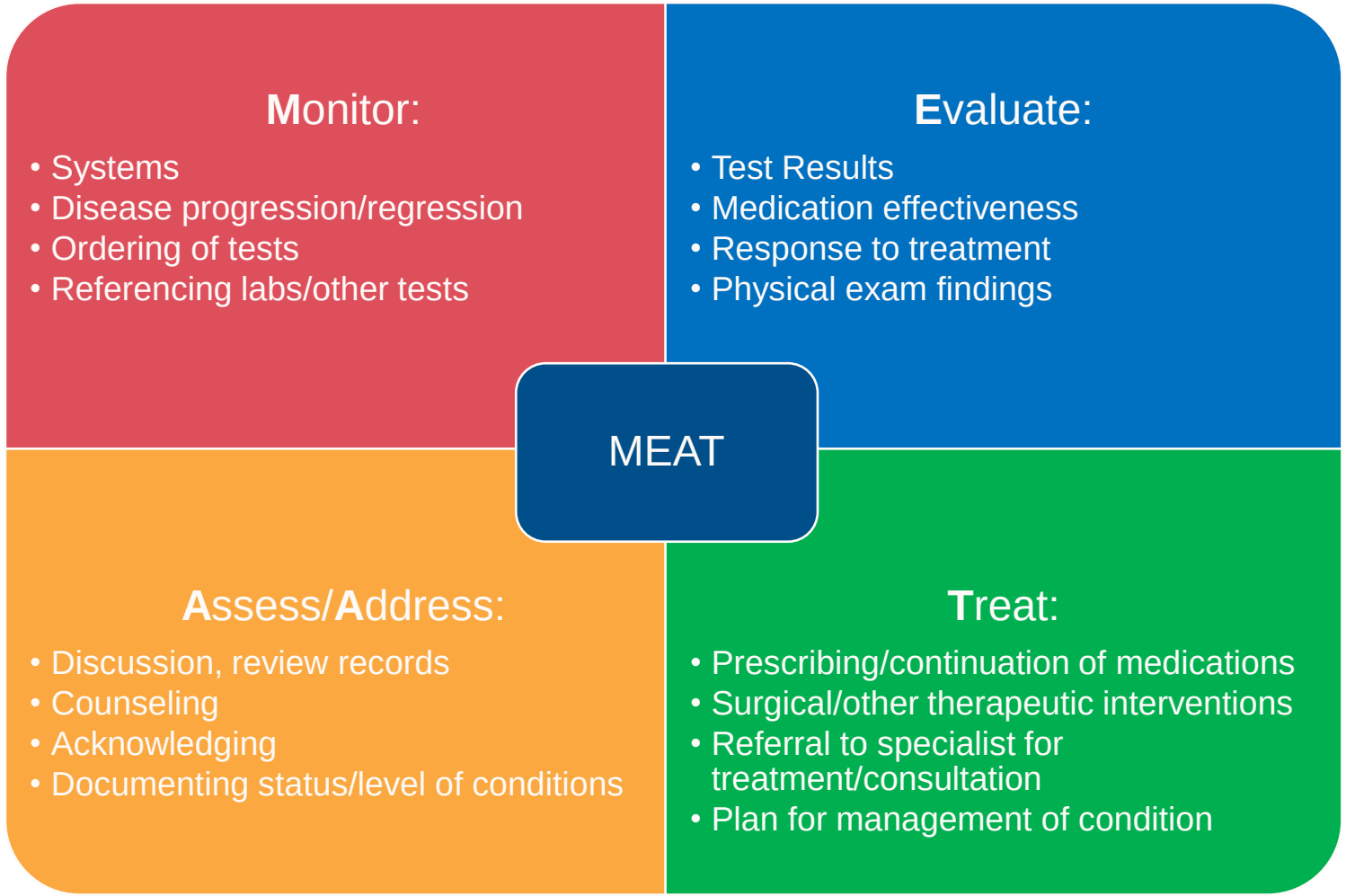
Best Practices - Documentation

- Accurate, complete **M.E.A.T.** documentation of chronic condition diagnoses by clinicians is an essential component of the risk adjustment and Hierarchical Condition Category (HCC) process. Most chronic conditions match to an HCC.
- To support an HCC, documentation must support the presence of the disease/condition. Additionally, it must include the clinical provider's assessment and/or plan for management of the disease/condition.
- Most organizations use the *M.E.A.T*. criteria as well as ICD-10-CM for their diagnosis coding and HCC assignments.

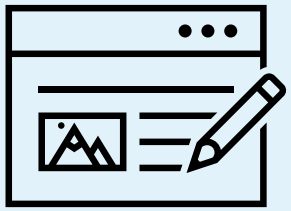


Helpful Tips

Best Practices - Documentation

Current Conditions

- Code chronic conditions at least on an annual basis.
- Code all existing conditions as many times as patient receives care and treatment.
- **Do not code** for conditions previously treated and no longer exist (history of).
- If condition is being treated by a specialist, code condition and status. E*xample*: *Patient on Coumadin for atrial fibrillation, followed by Dr. Hill.*



Specificity

- ICD-10 code selection should be at the highest level of specificity.
- Include chronic or acute, site, laterality, severity, status, etc., in the medical record.
- Be sure diagnosis codes billed are consistent with the medical record documentation. ICD-10 code should be followed by a written-out description.
  Example: I10, Essential Hypertension

Unconfirmed Diagnosis

- **Do not code** unconfirmed diagnoses such as probable, possible, suspected, working diagnosis.

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ICD-10-CM Guidelines

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Best Documentation Practices: Stroke

Subjective

In the **Subjective** section of the office note, document the presence or absence of any current patient-reported symptoms/sequelae of a prior stroke.

Objective

The **Objective** section should include any physical exam findings (e.g., dysphagia, hemiplegia/paresis, monoplegia/paresis, aphasia, etc.) and any related diagnostic testing results.

Assessment

In the **Assessment** section**:**

- Document the sequelae of the stroke to include laterality and dominant/non-dominant side (if applicable) or the history of the stroke with no residuals.
- There must be clear documentation of a cause-and-effect relationship between the stroke and related residuals.
- Include the status of the stroke sequelae (stable, worsening, improved).

Plan

In the **Plan** section:

- Document a clear and concise treatment plan for the history/sequelae of the stroke, linking related medications to the diagnosis.
- Include orders for diagnostic testing.
- Indicate in the office note to whom or where any referral or consultation requests are made.
- Document when the patient will be seen again, even if only on an as-needed basis.

Coding Basics: Stroke

Acute Stroke

- **Acute Stroke (ICD-10 code category I63)**
  - **Should not be coded from an outpatient setting** as confirmation of the diagnosis should be determined by diagnostics studies, such as a non-contrast brain CT or brain MRI, which would be ordered in an emergency room and/or inpatient setting.

  - Unconfirmed Stoke Diagnoses in the outpatient setting: 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.

- **Transient ischemic attack (TIA)**
  - When a TIA is diagnosed, a separate code is used (G45.9). This can be referred to as a “mini stroke” but should be considered separate from coding for a cerebral infarct.

History of Stroke and Sequelaes

- Sequelae of stroke codes are **History of Stroke (ICD-10 code Z86.73)**
  - The patient is **seen in the outpatient setting** after a confirmed diagnosis of a stroke, currently not experiencing a CVA, and shows no residual deficits.
  - A diagnosis of a transient ischemic attack (TIA) was made and has been resolved.

- **Sequelae (Late Effects) of Cerebrovascular Disease/Stroke (ICD-10 code category I69)**
  - used to indicate conditions classifiable to ICD-10 code categories I60 - I67.
  - Providers must link the deficit with the stroke to be able to comply with the sequela code.
  - Use codes from category I69 to specify the residual condition and the affected side of the patient (dominate or non-dominate).

Coding Reminders

- Unilateral weakness documented as related to past CVA is considered synonymous with hemiparesis and should be coded as such.

- Likewise, weakness of one extremity noted as related to past CVA is synonymous with monoplegia and should be coded as such.

- Residual weakness (without further description or specification of site) due to past CVA is coded I69.398, Other sequelae of cerebral infarction and R53.1, Weakness.

- Residual muscle weakness (without further description or site) related to a past CVA is coded as I69.398 and M62.81, Muscle weakness (generalized).

- Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows: For ambidextrous patients, the default should be dominant.
  - If the left side is affected, the default is non-dominant.
  - If the right side is affected, the default is dominant.

Knowledge Application – Case Review

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Case Review #1
Insufficient Documentation and Coding

Reason for Appointment:
Annual Exam

History of Present Illness: 50-year-old male presents to clinic for annual exam. PMH stroke, currently taking Warfarin daily, last INR within normal range. Blood pressure at home has been normal per patient.

Current Medications: Warfarin 10 mg daily, Losartan 100 mg, Hydrochlorothiazide 25 mg

Past Medical History: Stroke 2010, Hypertension

Surgical History: Cholecystectomy 2004

Review of Systems
General/Constitutional: denies fever, fatigue.
Ophthalmologic: denies visual change, redness, pain.
Cardiovascular: denies chest pain, shortness of breath (SOB), palpitations, vascular problems.
Respiratory: denies, cough, sputum, wheezing, SOB.
Genitourinary: denies pelvic pain, admit – burning with urination (Dysuria), frequent urination (urinary frequency), urgent urination (urinary urgency), blood in urine (hematuria, incomplete bladder emptying, urinary incontinence, and sexually transmitted disease exposure (STD exposure).
Gastrointestinal: denies N/V/D/C, heartburn, GERD. Endocrine: denies heat/cold intolerance, hormone problems.
Musculoskeletal: Denies joint stiffness, muscle aches, painful joints.
Neuro: denies motor/sensory problems, dizziness, HA, syncope.
Psych: denies.

Case Review #1 *continued*
Insufficient Documentation and Coding

Vital Signs
Ht 77 in, Wt 362 lbs, BMI 43.0 Index, BP 138/93 mmHg, HR 90/min, RR 20/min, Temp 97.2 F, Pain scale 0

Physical Examination
General: alert, pleasant, in no acute distress, morbidly obese.
Head: normocephalic, atraumatic.
Eyes: pupils equal, round, reactive to light and accommodation, extraocular movement intact (EOMI).
Nose: nares patent.
Oral Cavity: normal, good dentition, no lesions.
Neck/Thyroid: soft, supple, full range of motion, no lymphadenopathy, no thyromegaly.
Heart: regular rate and rhythm, S1, S2 normal, no murmurs, rubs, gallops.
Lungs: clear to auscultation bilaterally, no wheezes, rales, rhonchi.
Abdomen: bowel sounds present, no organomegaly, soft, nontender, nondistended.
Musculoskeletal: No tenderness, strength 5/5.
Extremities: full range of motion, no clubbing, cyanosis, or edema.
Psych: Normal mood and affect.

Assessments and Treatment

1. Stroke – **I63.9** **INCORRECT/DELETED**
   Continue Warfarin 10 mg daily – **Z79.01** **CORRECT/ADDED**
   Rationale: The correct code is Z86.73. Codes from category I63 should not be coded in an outpatient setting. Patient had a stroke in 2010 and is currently being treated prophylactically, this is now a ‘history of’ condition as the patient does not have any residual conditions from the prior stroke.

2. Hypertension – **I10** **CORRECT/ADDED**
   Continue Losartan 100 mg and Hydrochlorothiazide 25 mg

3. Morbid obesity – **E66.01** **CORRECT/ADDED**

Case Review #2
Insufficient Documentation and Coding

Reason for Appointment:
Follow up

History of Present Illness: A 63-year-old patient is seen in the clinic to follow up from a previous stroke. She suffered a cerebrovascular infarction 3 months ago that left her with aphasia and right-sided hemiparesis on her nondominant side. The patient will be referred to outpatient rehabilitation for speech, physical and occupational therapy.

Current Medications: Carvedilol 6.25 mg

Past Medical History: Cerebrovascular infarction, Congestive heart failure

Surgical History: Appendectomy

Review of Systems
General/Constitutional: denies fever, fatigue.
Ophthalmologic: denies visual change, redness, pain.
Cardiovascular: denies chest pain, SOB, palpitations, vascular problems.
Respiratory: denies, cough, sputum, wheezing, SOB.
Genitourinary: denies pelvic pain, admit – burning with urination (Dysuria), frequent urination (urinary frequency), urgent urination (urinary urgency), blood in urine (hematuria, incomplete bladder emptying, urinary incontinence, and sexually transmitted disease exposure (STD exposure).
Gastrointestinal: denies N/V/D/C, heartburn, GERD. Endocrine: denies heat/cold intolerance, hormone problems.
Musculoskeletal: admits to right-sided hemiparesis.
Neuro: admits to aphasia.
Psych: denies.

Case Review #2 *continued*
Insufficient Documentation and Coding

Vital Signs
Ht 5’2” Wt 221 lbs, BMI 40.4 Index, BP 126/70, Pulse 78, Temp 98.9 F

Physical Examination
Constitutional: Awake, alert, well developed, well nourished.
Cardiovascular: Heart rate and rhythm normal.
Lungs: Respiration rhythm and depth was normal.
Neurological: Right-sided hemiparesis, aphasia.
Psych: Normal, not depressed.

Assessments and Treatment

1. Cerebrovascular infarction with right-sided hemiparesis nondominant side and aphasia – **I63.9** **INCORRECT/DELETED**
   Rationale: The correct codes are I69.353 and I69.320. Codes from category I63 should not be coded in an outpatient setting. The patient has residual conditions of right-sided hemiparesis and aphasia from the cerebrovascular infarction. When there is documentation of a residual condition secondary to a stroke, assign a code from category I69.

2. Congestive heart failure – **I50.9** **CORRECT/ADDED**
   Continue Carvedilol 6.25 mg

Case Review #3
Sufficient Documentation and Coding

Reason for Appointment:
Follow up

History of Present Illness: 64-year-old male presents to clinic for evaluation after stroke. Patient reports that on 5/29/2025 he had symptoms of right-sided weakness and slurred speech. Stroke was confirmed with tests at the local hospital. Patient reports that since the stroke, he has right arm weakness. Patient is on Plavix and statin without side effects.

Current Medications: Atorvastatin 20 mg qhs, Clopidogrel 75 mg, Aspirin 162-325 mg po od, Janumet XR 50/1000 mg

Past Medical History: Stroke 5/2025, Diabetes type II

Surgical History: None

Review of Systems
General/Constitutional: denies fever, fatigue.
Ophthalmologic: denies visual change, redness, pain.
Cardiovascular: denies chest pain, SOB, palpitations, vascular problems.
Respiratory: denies, cough, sputum, wheezing, SOB.
Genitourinary: denies pelvic pain, admit – burning with urination (Dysuria), frequent urination (urinary frequency), urgent urination (urinary urgency), blood in urine (hematuria, incomplete bladder emptying, urinary incontinence, and sexually transmitted disease exposure (STD exposure).
Gastrointestinal: denies N/V/D/C, heartburn, GERD. Endocrine: denies heat/cold intolerance, hormone problems.
Musculoskeletal: admits to right-sided weakness.
Neuro: denies motor/sensory problems, dizziness, HA, syncope.
Psych: denies.

Case Review #3 *continued*
Sufficient Documentation and Coding

Vital Signs
Ht 72 in, Wt 271 lbs, BMI 36.8 Index, BP 118/74 mmHg, HR 74/min, RR 19/min, Temp 98.7 F, Pain scale 3/10

Physical Examination
Mental status: Awake, alert, oriented x3, 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

Assessments and Treatment

1. Right upper extremity weakness resulting from stroke – **I69.331** **CORRECT/ADDED**
   Continue Clopidogrel 75 mg and Aspirin 162-325 mg – **Z79.02, Z79.82** **CORRECT/ADDED**

2. Diabetes type II – **E11.9** **CORRECT/ADDED**
   Continue Janumet XR 50/1000 mg – **Z79.84** **CORRECT/ADDED**

Case Review #4
Sufficient Documentation and Coding

Chief Complaint:
Follow up from recent hospital stay

History of Present Illness: Patient being seen in follow up from hospital visit due to a cerebral infarction 3 weeks ago. She is not experiencing any residual effects.

Current Medications: Aspirin 80 mg, Rosuvastatin 20 mg

Past Medical History: CVA, Hyperlipidemia

Surgical History: None

Review of Systems
General/Constitutional: denies fever, fatigue.
Ophthalmologic: denies visual change, redness, pain.
Cardiovascular: denies chest pain, SOB, palpitations, vascular problems.
Respiratory: denies, cough, sputum, wheezing, SOB.
Gastrointestinal: denies N/V/D/C, heartburn, GERD. Endocrine: denies heat/cold intolerance, hormone problems.
Musculoskeletal: Denies joint stiffness, muscle aches, painful joints
Neuro: denies motor/sensory problems, dizziness, HA, syncope.

Case Review #4 *continued*
Sufficient Documentation and Coding

Vital Signs
BP 121/82 Pulse 99/min, Ht 64 in, Wt 170 lbs, BMI 29.2 Index, Temp 98.7 F

Physical Examination
Constitutional: Awake, alert, well developed, well nourished.
Cardiovascular: Heart rate and rhythm normal.
Lungs: Respiration rhythm and depth was normal.
Neurological: Normal.
Psych: Normal, not depressed.

Assessments and Treatment

1. History of CVA with no residuals – **Z86.73** **CORRECT/ADDED**
   Continue Aspirin 80 mg – **Z79.82** **CORRECT/ADDED**

2. Hyperlipidemia– **E78.5** **CORRECT/ADDED**
   Continue Rosuvastatin 20 mg
   Labs ordered.

Additional Education Available

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Help Us Help You!

You pick, we teach!

Our ACA Risk Adjustment Provider Education Team is here to support your learning!

Current Training Offered:

- Commercial Risk Adjustment 101
- Top Conditions Series
  - Autoimmune Disease
  - Cancer
  - Congestive Heart Failure
  - COPD/Asthma
  - Diabetes Mellitus
  - Heart Arrhythmia
  - HIV
  - Major Depression & Bipolar Disorders
  - Obesity and BMI
  - Seizure Disorders
  - Stroke
- Supplemental Claims Submission
- Provider Vista

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Florida Blue's Commercial Risk Adjustment Provider Educators are available for additional training, education, and support.

Email: CRAprovidereducationTeam@bcbsfl.com

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