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Welcome! We will get started shortly.

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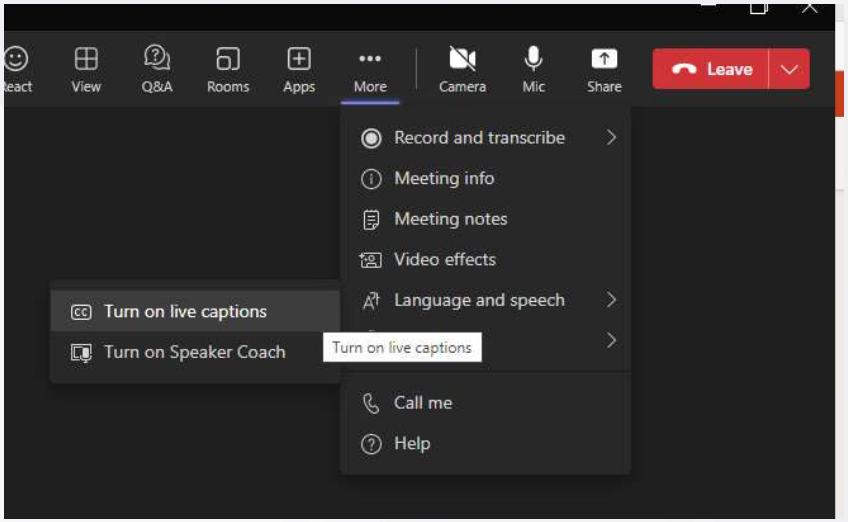

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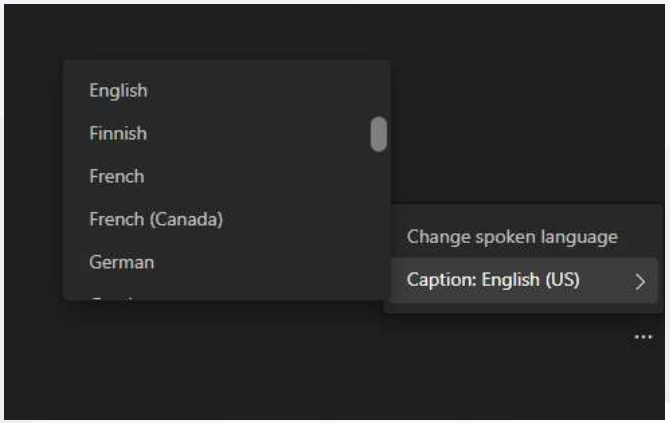

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CENTRAL HEALTH MEDICARE PLAN

CVA in Outpatient Settings

Presented by Bright HealthCare

Today's Agenda

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CVA in Outpatient Settings

Presented by Bright HealthCare

- Impact to Patient Risk Scores
- Documentation & Coding Best Practices
- CVA Documentation & Coding Resources

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Impact to Patient Risk Scores

Patient One: 74-year-old female

Impact to RAF Score

1

74-yo female had **a cerebral vascular accident (CVA)** and was transported to the hospital via ambulance.

74 yo female	0.395
I63.511 *Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery*	0.239

0.634

2

74-yo female stable on aspirin due to **history of CVA.**

*This is where most coding errors occur

74 yo female	0.395
Z86.73 *H/O CVA with no residual effects.*	0.000

0.395

Patient Two: 68-year-old male

Impact to RAF Score

1

68-yo male had **a cerebral vascular accident (CVA)** and was transported to the hospital via ambulance.

68 yo male	0.332
I63.113 *Cerebral infarction due to embolism of bilateral vertebral arteries*	0.239

0.571

2

68-yo male with **hx of CVA** now suffers from **right sided hemiplegia.** Uses a wheelchair for mobility.

68 yo male	0.332
I69.351 *Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side*	0.387

0.719

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Documentation & Coding Best Practices

Acute CVA vs. Residual Deficits

An acute CVA should never be coded in an office setting. All ICD-10 codes that map to a CVA should only be reported in an acute care setting.

What you, the clinician, can look out for after a patient has had a CVA are the residual deficits of the CVA, also known as late effects.

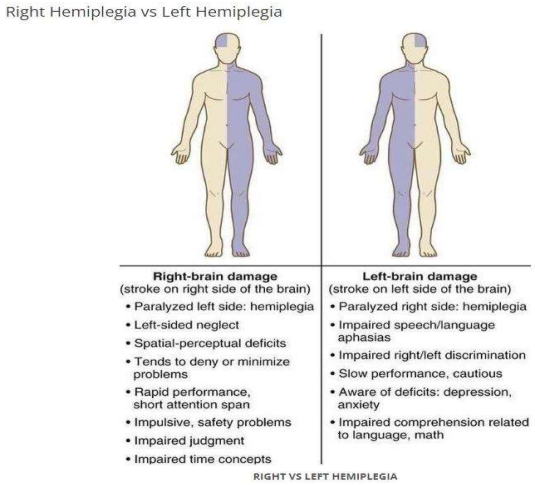
Anatomy of Hemiplegia/Hemiparesis Codes

- The ICD-10 code for late effects of CVA for hemiplegia/hemiparesis are I69.35x.
- The X represents an additional number to complete the ICD-10 code.
- These late effects of a CVA have a Risk Adjustable Value (RAF) of 0.387

Diagnosis Code	Description	V24 Model HCC	V28 Model HCC	RAF Score
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side	103	253	0.387
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side	103	253	0.387
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side	103	253	0.387
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side	103	253	0.387
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side	103	253	0.387

Hemiplegia/Hemiparesis Documentation Tips

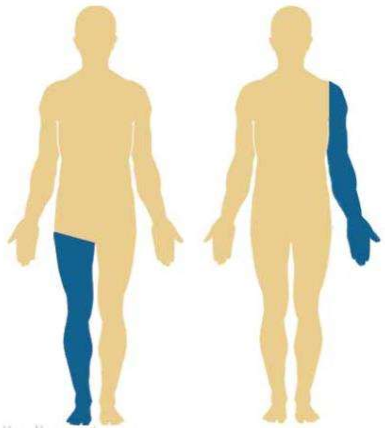
- **Examples of Documenting Hemiplegia/Hemiparesis:**
  - 74 y.o. female s/p CVA related dominant right side weakness.
    - Assessment: New onset right hemiparesis
      - Plan: Refer to neuro rehab now.
      - HCC ICD-10 code: **I69.351** (0.387 RAF Value)



- "Weakness" is ICD-10 code M62.81, which is NOT an HCC.
- "Weakness" is a symptom, whereas "paresis" including monoparesis, hemiparesis and even quadriparesis are diagnoses.
- Documenting solely to "weakness" does not influence severity or affect risk adjustment.
- Document whether the "paresis" impacts the dominant or nondominant side: ICD-10 presumes the right side to be dominant unless stated otherwise.
- Note: In ICD-10, hemiparesis and hemiplegia share the same code.
- Note: Weakness of a side can be interpreted to be hemiparesis if attributed to a stroke. Not for a single extremity

Anatomy of a Monoplegia Codes

- The ICD-10 code for late effects of CVA for monoplegia are I69.33x (upper limb) and I69.34x (lower limb).
- The X represents an additional number to complete the ICD-10 code.
- These late effects of a CVA have a Risk Adjustable Value (RAF) of 0.321



Anatomy of Monoplegia Codes

Diagnosis Code	Description	V24 Model HCC	V28 Model HCC	RAF Score
I69.331	Monoplegia of upper limb following cerebral infarction affecting right dominant side	104	254	0.321
I69.332	Monoplegia of upper limb following cerebral infarction affecting left dominant side	104	254	0.321
I69.333	Monoplegia of upper limb following cerebral infarction affecting right non-dominant side	104	254	0.321
I69.334	Monoplegia of upper limb following cerebral infarction affecting left non-dominant side	104	254	0.321
I69.339	Monoplegia of upper limb following cerebral infarction affecting unspecified side	104	254	0.321

Diagnosis Code	Description	V24 Model HCC	V28 Model HCC	RAF Score
I69.341	Monoplegia of lower limb following cerebral infarction affecting right dominant side	104	254	0.321
I69.342	Monoplegia of lower limb following cerebral infarction affecting left dominant side	104	254	0.321
I69.343	Monoplegia of lower limb following cerebral infarction affecting right non-dominant side	104	254	0.321
I69.344	Monoplegia of lower limb following cerebral infarction affecting left non-dominant side	104	254	0.321
I69.349	Monoplegia of lower limb following other cerebrovascular disease affecting unspecified side	104	254	0.321

Monoplegia Documentation Tips

Examples of Documenting Monoplegia:

- **A/P:** Established 72-year-old male with RUE weakness after CVA
  - **Assessment:** Right arm weakness d/t CVA. Stable
  - **Plan:** Continue PT
    - Non-HCC ICD-10 Code: **M62.81** (0 RAF Value)

- **A/P:** Established 72-year-old male with RUE weakness after CVA
  - **Assessment:** Right arm monoparesis d/t CVA. Stable
  - **Plan:** Continue PT
  - HCC ICD-10 Code: **I69.331** (0.321 RAF Value)

- Note: Weakness of a side can be interpreted to be hemiparesis if attributed to a stroke. Not for a single extremity

Specificity is Key!

Late effects of a CVA can vary depending on the type of stroke (Ischemic or Hemorrhagic), and the location of the brain that was affected.

Documenting these details can help with coding and improving the accuracy of the diagnosis.

Late effects of a CVA can affect different parts of the body, such as limbs, speech, and cognition.

Specify which body part is affected to ensure accurate coding.

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CVA Resources

Cancer Documentation & Coding Resources

Medicare HCC V24 Documentation & Coding Quick Guide

Provider Documentation Tip Sheet

Documentation & Coding Guide

Provider Education Biteable Video

All resources are available on the HCC Training Page: **Healthcare Provider Home | Brand New Day HMO (bndhmo.com)**

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HCC Documentation & Coding Reference Guide

If your patient has any of these problems, document the diagnosis, assessment, and plan (DSP), and report the corresponding code at least annually.

Includes documentation & coding tips for over twenty different condition categories!

Examples	ICD-10	CMS	RAF Value	Documentation and Coding Notes
Chronic Lung Disease				
Chronic respiratory failure	J96.10	84	0.282	• Smoker's cough = mild chronic bronchitis. • For patients who are dependent on supplemental oxygen (Sp02 < 87% on RA), consider chronic respiratory failure diagnosis.
Smoker's cough	J41.0	111	0.335	
COPD, unspecified	J44.9	111	0.335	
Chronic obstructive pulmonary disease (COPD), other	J44.X	111	0.335	
Emphysema	J43.X	111	0.335	
Pulmonary fibrosis	J84.10	112	0.219	
Neurologic Disease / Cerebrovascular Accident (CVA)				
Sequelae and late effects of stroke (hemiplegia, hemiparesis)	I69.XXX	103	0.437	• For sequelae and late effects of stroke, document cause-and-effect relationship of CVA and specific related deficits. • Acute CVA (ICD-10 I63.XXX) should only be documented during the initial episode of care. Post-discharge, document "history of CVA" with or without residual or late effects. History of CVA without residual effects (ICD-10 code Z86.73) has no RAF value. For patients with a history of CVA with residual effects, utilize the appropriate ICD-10 code(s) from codeset I69.XXX.
Parkinson's disease	G20	78	0.606	
Multiple sclerosis	G35	77	0.423	
Paralysis	G83.9	104	0.331	
Seizure disorder	G40.909	79	0.220	
Cardiac Disease				
CHF	I50.9	85	0.331	• Consider: a patient's CHF may be controlled and remain stable with medications or surgical interventions (ACEI's, ARB's, diuretics, BBs, digoxin, ICD's, valve replacements, etc.). • Consider: a patient's a-fibb may be controlled and remain in NSR with surgery, procedures, or medications (cardioversion, ablation, BBs, CCBs, antiarrythmics).
Atrial fibrillation	I48.91	96	0.268	
Coronary artery disease with angina	I25.119	88	0.135	
Angina	I20.9	88	0.135	
Unstable angina	I20.0	87	0.195	
Pulmonary hypertension	I27.20	85	0.331	
Cor pulmonale	I27.81	85	0.331	
Cardiomyopathy	I42.9	85	0.331	
Abdominal aortic aneurysm	I71.4	108	0.288	
Aortic atherosclerosis/calcifications	I70.0	108	0.288	• Often missed on radiologic reports. Must have CXR/US/CT scans verifying, document date of exam.

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Provider Documentation: CVA in Outpatient Settings

Documentation Tips & Best Practices

Tip: Acute CVA should only be documented during the initial episode of care. Post-discharge, document "history of CVA" with or without residual effect or late effects.

Documentation best practices:

- Be sure to explicitly document the cause-and-effect relationship of CVA and related deficits.
- Note the specific deficit(s), such as:
  - Hemiplegia/hemiparesis
  - Cognitive deficits
  - Speech and language deficits
  - Disturbance of vision
  - Facial weakness

Coding callouts:

- 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.
- Coding an acute CVA is not appropriate in an outpatient setting; therefore do not use ICD-10-CM codes from categories I60–I68 for outpatient settings.

Document the diagnosis, status, and plan (**DSP**) in your final assessment. For example:

Diagnosis:	**Status:**	**Plan:**
Mild hemiparesis on right side since CVA 2 weeks ago	Strength improving, now doing ADLs	Use 4-prong cane, continue physical therapy

Your note should include **MEAT** (**m**onitor, **e**valuate, **a**ssess, **t**reat) details that specifically address your patient's conditions, as well as a comprehensive plan of care.

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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 Symptoms Disease progression Disease regression	Test results Medication effectiveness Response to treatment Physical exam findings	Test ordered Counseling Record review Discussion	Medication Therapies Referral Other modalities
MEAT Examples: CVA Late Effects			
Left hemiparesis following old CVA – No improvement since last visit.	Right hemiparesis due to recent CVA – Right upper extremity without movement, baseline.	Residual left hemiparesis due to history of CVA – Discussed orthotic for night wear to counteract the progressive contracture.	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side – 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.

Reason for encounter is clearly documented.

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.

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.

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Questions?


Provider Education Series
Documentation & Coding for Risk Adjustment
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Thank you!

Visit our HCC Training page for more resources!

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