STROKE AND INFARCTION

Physician Documentation

Do not document cardiovascular accident (CVA). Classification of stroke in ICD-10-CM requires more information than many physicians have traditionally documented, and coding of sequelae of stroke and infarction also demands a level of detail often missing in medical records. Etiology and site of stroke or infarction impact outcomes, so document as thoroughly as possible during emergent and ongoing care.

Documentation Tips

- **Identify the etiology of an acute stroke, infarction, or transient ischemic attack (TIA)** by category as shown below:

Codes	Stroke Type
I60.-	Spontaneous subarachnoid hemorrhage
I61.-	Spontaneous intracerebral hemorrhage
I62.-	Spontaneous subdural hemorrhage
I63.0-I63.2	Thrombosis/embolus precerebral arteries
I63.3-I63.5	Thrombosis/embolus cerebral arteries
I63.6	Venous thrombosis
I63.8	Other specified cerebral infarction
I63.9	Unspecified cerebral infarction
G45.9	Transient cerebral ischemic attack, unspecified (TIA)

- **In addition to the stroke or infarction type,** the vessel and laterality should be documented.
- **Once a patient has been released from the acute-care facility** following the initial stroke or infarction, the stroke or infarction is classified by its late effects. Therefore, document an encounter as an acute event or sequelae. The site and type of stroke impact long-term care coding, so identify whether the initial event was hemorrhagic or ischemic, and document affected site.
- **Document specific symptoms** of cognitive deficit following stroke (eg, attention, memory, executive function, psychomotor, visuospatial, social, emotional). Document other symptoms, including aphasia, dysphasia, dysarthria, apraxia, dysphagia, facial weakness, ataxia, or fluency disorder, or paralyses, including monoplegia or paraplegia.
- **For patients experiencing hemiplegia from stroke or infarction,** document which side is dominant, and which is affected. Document a link between the hemiplegia and the CVA as appropriate.

Etiology of Sequelae

Document in each encounter for sequelae of stroke, if the original stroke was due to subarachnoid hemorrhage, intracerebral hemorrhage, intracranial hemorrhage, or cerebral infarction.

- **Clearly identify the cause-and-effect relationship** of any cerebrovascular accident that occurs due to a surgical intervention. Specify whether the event occurred intraoperatively or postprocedurally, and whether infarction or hemorrhage. For cerebral hemorrhage, the type of surgery that was being performed must also be documented.
- **Document any tissue plasminogen activator (tPa) administration** and time started. If the stroke was aborted, document that fact.
- **Identify tobacco use** history, as appropriate. Document any coexisting hypertension, atrial fibrillation, coronary artery disease (CAD), or hypertension.

STROKE AND INFARCTION

Coder Abstraction

Seek answers to these questions when coding a stroke, infarction, or hemorrhage. First, ask if the cerebral event is acute and emergent or a previous event. Second, look for documentation of the site, laterality, and type of stroke or infarction.

Coding Tips

- **Documentation of unilateral weakness due to a stroke** is considered by ICD-10-CM to be hemiparesis/hemiplegia due to the stroke, and should be reported separately. Hemiparesis is not considered a normal sign or symptom of stroke and is always reported separately.
- **If the patient's dominant side is not documented,** assume the right side is dominant, except for ambidextrous patients. In ambidextrous patients, assume the affected side is dominant.
- **Report any and all neurological deficits** of a cerebrovascular accident that are exhibited anytime during a hospitalization, even if the deficits resolve before the patient is released from the hospital.
- **Once the patient has completed the initial treatment** for stroke and is released from acute care, report deficits with codes from category I69, *Sequelae of cerebral infarction*. Neurologic deficits may be present at the time of the acute event, or may arise at any time after the condition, reported with codes from categories I60-I67.
- **If the physician is not specific in recording the site of a stroke or infarction,** it is permissible for coders to use the accompanying CT scans or other radiological reports to report the specific anatomic site, so long as the diagnoses are documented and authenticated by a radiologist.
- **Codes from categories I60-I69 should never be used** to report traumatic intracranial injuries.

ICD-10-CM Guideline Section I(C.9.c)

Medical record documentation should clearly specify the cause-and-effect relationship between the medical intervention and the cerebrovascular accident, in order to assign a code for an intraoperative or postprocedural cerebrovascular accident.

- **Normally, do not report codes from categories I60-I67 with codes from category I69.** However, if the patient has deficits from an old cerebrovascular event and is currently having a new cerebrovascular event, both categories may be reported.
- **If a patient has a history of a past cerebrovascular event** and has no residual sequelae, report code Z86.73, *Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits.*
- **If a patient is diagnosed with bilateral nontraumatic intracerebral hemorrhages,** report code I61.6, *Nontraumatic intracerebral hemorrhage, multiple localized.* For bilateral subarachnoid hemorrhage, assign a code for each site. Categories I65 and I66 classify bilateral conditions with unique codes.
- **Also code any documented atrial fibrillation,** coronary artery disease, diabetes mellitus, or hypertension, as these comorbidities are stroke risk factors.

Term	Definition
Stenosis	Narrowing of lumen
Thrombus	Stationary blood clot lodged in vessel
Occlusion	Complete/partial obstruction of lumen
Embolism	Blood clot or other clot carried through vessel to new location, usually lodging in a smaller vessel