CareSource PARTNER with Purpose

Risk Adjustment Coding Guidance
Stroke

Context
CareSource reviews provider documentation to ensure the accuracy of diagnoses codes reported. Recent reviews have demonstrated an opportunity to improve the accuracy of ICD-10 codes reported for services rendered in the office setting, specific to stroke.

Scenario
Patient is admitted into hospital and diagnosed with cerebral infarction, unspecified (ICD-10 code I63.9). At the 3-week post-discharge follow-up appointment for the cerebral infarction, the office visit note states the patient had a stroke and has a residual deficit of hemiplegia, affecting the right dominant side.

Coding Guidance
In the scenario described above, assigning ICD-10 code I69.351, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, accurately reflects the documentation in the medical record.

- Documentation does not support coding for cerebral infarction I63.9.
- Once the patient is discharged, it is not appropriate to code for the cerebral infarction. Instead, you would code any and all residual deficits the patient has.
- If the patient does not have any cerebral infarction deficits, you can apply the ICD-10 code Z86.73, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits, if supported by the documentation in the chart.

Importance
Complete, specific and accurate coding helps to ensure CareSource is able to connect our members, your patients, to appropriate disease management and case management resources.

Questions
For questions about risk adjustment coding, please send your inquiries to:
raprovidereducation@caresource.com

Source
ICD-10-CM Official Guidelines for Coding and Reporting 2020

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