ICD-10-CM Documentation and Coding Best Practices
Coding for CVA, MI and other Acute Conditions

Active Condition or Personal History?

Active – While some conditions develop slowly and exist over extended periods, others develop suddenly and last a short time, often only a few days or weeks. It is appropriate to report an acute condition when it is present and actively being treated.

Historical – Once an acute illness has resolved, it should no longer be reported as active. ICD-10-CM recognizes the need to report the occurrence of past conditions that no longer exist, and has provided personal history codes for this purpose.

Coding for Myocardial Infarction

Acute MI – A new myocardial infarction is considered acute from onset up to 4 weeks old. Acute myocardial infarction (AMI) may be reported in the acute care setting, following transfer to another acute setting, and in the post-acute setting. To report AMI, refer to the following code categories:

- *I21.0x-I21.2x STEMI of x site* **5th digit identifies site*
- *I21.3 Myocardial infarction, NOS/STEMI, NOS*
- *I21.4 NSTEMI/Nontransmural MI*

Subsequent Acute MI – When a patient who has suffered an AMI has a second MI within the four-week time frame of the initial infarction, the second MI is reported as a subsequent AMI:

- *I22.x Subsequent Myocardial Infarction* **4th digit identifies location and type*

Old MI – After the passage of four weeks, a myocardial infarction is reported as an old MI. This code is also used to report a healed MI that is observed via testing such as ECG.

- *I25.2 Old myocardial infarction*

Coding for CVA

Initial Care

A CVA is an emergent event that requires treatment in an acute care setting. To report CVA, refer to code category:

- *I63.xx Cerebral infarction* **4th and 5th digits identify location and cause*

Subsequent Care

Following discharge from the acute care setting, report any sequelae (late effects) related to the CVA:

- *I69.3xx Sequelae of cerebral infarction* **5th and 6th digits identify nature of late effect*

In the absence of sequelae, report:

- *Z86.73 Personal history of TIA and CVA without residual deficits*

Coding for TIA

Initial Diagnosis – A TIA is a temporary interruption of blood flow to the brain, causing symptoms similar to those of a stroke. These can resolve within minutes, or can last up to 24 hours. To report a TIA at the time of initial workup/diagnosis, refer to code:

- *G45.9 Transient cerebral ischemic attack, unspecified*

Subsequent Care – As TIA is a fleeting event, it should only be reported at the time of initial diagnosis. For subsequent encounters refer to code:

- *Z86.73 Personal history of TIA and CVA without residual deficits*

Coding for Nontraumatic Intracranial Hemorrhage

Nontraumatic intracranial hemorrhage (hemorrhagic stroke) is a spontaneous discharge of blood within the cranium. Causes include ruptured cerebral aneurysm and arteriovenous malformation, among others.

Initial Care

Intracranial hemorrhage requires immediate treatment in an acute care setting. To report, refer to code category:

- *I60.xx* *Nontraumatic subarachnoid hemorrhage*
  **4th and 5th digits identify location (artery) and laterality*
- *I61.x* *Nontraumatic intracerebral hemorrhage*
  **4th digit identifies location*
- *I62.xx* *Other nontraumatic intracranial hemorrhage*
  **4th and 5th digits identify location and acuity*

Subsequent Care

Once a patient has completed initial treatment and is discharged from the acute care setting, report any sequelae:

- *I69.0xx* *Sequelae of nontraumatic subarachnoid hemorrhage*
- *I69.1xx* *Sequelae of nontraumatic intracerebral hemorrhage*
- *I69.2xx* *Sequelae of other nontraumatic intracranial hemorrhage*
  **5th and 6th digits identify nature of late effect*

In the absence of sequelae, report:

- *Z86.73* *Personal history of TIA and CVA*

Coding for DVT and PE

Acute DVT/PE

An acute DVT/PE is a new thrombosis or embolism that requires the initiation of anticoagulant therapy.

- *I26.99* *Acute pulmonary embolism, NOS*
- *I82.4xx* *Acute embolism and thrombosis of deep veins of lower extremity*
  **5th and 6th digits identify vessel and laterality*
- *I82.62x* *Acute embolism and thrombosis of deep veins of upper extremity*
  **6th digit identifies laterality*

Chronic DVT/PE

A chronic DVT/PE is an old or previously diagnosed thrombus or embolism that requires continuation of anticoagulation therapy. There are no specific coding guidelines for when a DVT or PE is considered chronic. The code assignment is based solely on physician documentation.

- *I27.82* *Chronic pulmonary embolism*
- *I82.5xx* *Chronic embolism and thrombosis of deep veins of lower extremity*
  **5th and 6th digits identify vessel and laterality*
- *I82.72x* *Chronic embolism and thrombosis of deep veins of upper extremity*
  **6th digit identifies laterality*

History of DVT/PE

A history code can be used to explain follow-up visits for patients with a history of thrombosis or embolism who are maintained on anticoagulation drugs for many years.

- *Z86.711* *Personal history of pulmonary embolism*
- *Z86.718* *Personal history of other venous thrombosis and embolism*