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Common Conditions in Primary Care

Identification, documentation, and coding

Context & Objectives

Context

- There are several common conditions that are important to consistently and accurately diagnose, code, and document
- Capturing these diagnoses supports
  - Accurate reflection of medical complexity (e.g., BOI) for estimating expected resources needed to care for the patient
  - Engagement of programs targeted to specific populations (e.g., heart failure, advanced illness)
- Accurate condition capture depends on knowledge of diagnostic criteria, coding rules, and documentation requirements

Learning Objectives

Review the diagnostic criteria and understand accurate coding and documentation of specific common conditions including:

- Morbid Obesity
- Type 2 Diabetes
- Chronic Kidney Disease
- Heart Failure
- Pulmonary Hypertension
- Atherosclerosis of the Extremity with Rest Pain
- Chronic Obstructive Pulmonary Disease
- Major Depressive Disorder
- Substance Use Disorders
- Alcoholic Hepatitis
- Malignancy
- Dementia
- Residual impairments after CVA

Morbid Obesity

- Clinical criteria for the diagnosis of morbid obesity:
  - Body Mass Index (BMI) ≥ 40
  - BMI 35- 39.9 with at least one serious comorbid condition that is due to or significantly worsened by obesity.
    - ***Common comorbid conditions:*** poorly controlled hypertension, coronary heart disease, asthma, sleep apnea, type 2 diabetes, hyperlipidemia, metabolic syndrome, obesity hypoventilation syndrome, insomnia, uncontrolled GERD, debilitating osteoarthritis
    - ***Additional potentially qualifying conditions:*** obesity causing considerably impaired quality of life, impaired mobility, or disqualification from other surgeries (such as surgeries for osteoarthritis, ventral hernias, or stress incontinence)
- Morbid obesity is synonymous with severe obesity, and coding rules require coding both the diagnosis (e.g., “severe obesity”) and the BMI
- New codes exist for each class of obesity
  - ICD-10 code for class II obesity with BMI 35-39.9 does not have an option to specify if patient has a serious comorbid condition
  - Clinicians may opt to continue using the diagnosis of severe or morbid obesity if more clinically accurate
- Patients with obesity and severe OSA are at risk for obesity hypoventilation syndrome
  - Signs of obesity hypoventilation syndrome include elevated serum bicarbonate (e.g., >27 mEq/L) and polycythemia
  - Hypoxic respiratory failure due to obesity hypoventilation syndrome can be treated with oxygen added to positive airway pressure (e.g., CPAP, BiPAP)

Related diagnoses:

- Weighted to risk adjust:
  - Morbid or severe obesity
  - Obesity class 3
  - Hypoxic respiratory failure related to obesity hypoventilation syndrome
  - Pulmonary hypertension
- Not weighted to risk adjust:
  - Obesity class 1 or 2
  - Non-alcoholic steatohepatitis

Example documentation:

- **Morbid Obesity**: BMI 38. Adjust diabetes medications to include GLP-1 for better glucose control as well as weight loss benefit. RTC in 3 months with labs and for weight check.
- **Morbid Obesity:** BMI 42. Discussed health risk with weight. Refer to nutritionist and encouraged exercise. Follow up in 1 month. Consider discussion of medications or bariatric procedures.

Type 2 Diabetes

- Type 2 diabetes is diagnosed based on elevated blood sugars:
  - Two tests showing hyperglycemia (e.g., A1c ≥ 6.5% or fasting glucose ≥ 126)
  - Symptomatic hyperglycemia with a random plasma glucose ≥ 200
- Diabetic retinopathy outcomes can be improved with screening and treatment
  - Retinal exams are recommended at least yearly for patient with diabetic eye disease
  - Diabetic retinopathy with macular edema and proliferative diabetic retinopathy confer greater risk of vision loss and have specific treatments aimed at preserving visual acuity (e.g., anti-VEGF injections, photocoagulation)
- Diabetic patients are at risk for skin ulcers which can become limb threatening
  - Regular skin exams, particularly of the feet, can identify skin breakdown early
  - Diabetic ulcers require evaluation for infection and ischemia, as well as regular care to support healing and prevent recurrence
- Gangrene can occur gradually with progressive peripheral artery disease or more rapidly when due to embolic occlusion with atheroembolic material

Related diagnoses:

- Weighted to risk adjust:
  - Diabetes (e.g., type I, type II)
- Additional risk adjustment weight:
  - Diabetic retinopathy with macular edema
  - Proliferative diabetic retinopathy
  - Diabetic peripheral angiopathy with gangrene
  - Diabetes with skin ulcer
- No change in risk adjustment weight:
  - Diabetic retinopathy *without* macular edema or proliferation
  - Diabetes with neuropathy, hyperglycemia, arthropathy

Example documentation:

- **Type II diabetes with proliferative diabetic retinopathy.** Reviewed ophthalmology's treatment recommendation and explained importance for preserving vision. Patient will schedule with ophthalmology.

Chronic Kidney Disease

- CKD is defined by kidney damage or decreased kidney function for ≥ 3 months, as defined by
  - eGFR < 60 mL/min/1.73m^2
  - Urinary sediment abnormalities (e.g., casts) or increased urine albumin
  - Pathologic abnormalities on kidney biopsy or imaging (e.g., small and echogenic kidneys)
- CKD is staged based on estimated GFR (mL/min/1.73m^2):
  - Stage 3A: 45 - 59
  - Stage 3B: 30 - 44
  - Stage 4: 15 - 29
  - Stage 5 / ESRD: <15
- SGLT2 inhibitors can affect eGFR
  - Initial reductions in eGFR are unlikely to be reflective worsened CKD stage, particularly if reversed with continued therapy
  - Though SGLT2is are known to slow progression, CKD generally does not improve. Improvements in eGFR on SGLT2i may reflect the medication's affect on the lab values used to calculate eGFR and may not be reflective of improvement in kidney function
  - If a provider's clinical judgement is that improvement in eGFR is related to the effects of SGLT2i therapy and not reflective of improvement in CKD, then CKD remains the appropriate diagnosis, and the provider must document the clinical rationale

Related diagnoses:

- Weighted to risk adjust:
  - CKD stage 3A, 3B
- Additional risk adjustment weight
  - CKD Stage 4
  - CKD Stage 5 / ESRD

Example documentation:

- **CKD stage 3A.** Prior to starting SGLT2, eGFR was consistently in the 50s, indicating CKD stage 3A. Now on SGLT2, eGFR >60 is related to the effect of SLGT2 on lab values, and underlying CKD stage 3A remains. Continue SGLT2, discussed avoidance of NSAIDs.

Source: Soungas et al. SGLT2 Inhibitors in Diabetic Kidney Disease – PMC. Clin J Am Soc Nephrol, 2021.
Mende. Chronic Kidney Disease and SGLT2 Inhibitors: A Review of the Evolving Treatment Landscape – PMC. Adv Ther 2021.
National Kidney Foundation Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification | Annals of Internal Medicine. 2003.

Congestive Heart Failure (CHF)

The diagnosis of heart failure is based on the ACC/AHA Heart Failure Stages

- **Stage A:** At risk for heart failure, including patients with hypertension, CVD, DM, obesity, exposure to cardiotoxic agents, and genetic variant / family history of cardiomyopathy
- **Stage B:** People *without current or previous symptoms of heart failure* but with one of the following three criteria:
  - Structural heart disease
    - Reduced left or right ventricular systolic function
    - Reduced EF, low global longitudinal strain (GLS)
    - Ventricular hypertrophy
    - Chamber enlargement
    - Wall motion abnormalities
    - Valvular heart disease
  - Increased filling pressures
    - By echocardiogram
    - By invasive hemodynamic measurements

    (Non-invasive LVEDP can be obtained with Ventric Vivio)
  - Risk factors (e.g., Stage A) and positive labs (e.g., BNP ≥ 35, proBNP ≥ 125 or positive troponin, in the absence of alternative cause)
- **Stage C** (Symptomatic heart failure): People *with current or previous symptoms of heart failure*.
- **Stage D** (Advanced heart failure): Marked HF symptoms with interfere with daily life and with recurrent hospitalizations despite attempts to optimize therapy. While specific definitions vary, patients with any of the following three criteria likely meet common definitions of Stage D:
  - Marked symptoms despite maximally tolerated GDMT (e.g., symptoms during minimal activity, functionally limiting fatigue) not due to other cause
  - 2 or more hospitalizations within 12 months while on maximally tolerated GDMT
  - Decreasing or withdrawing GDMT due to low blood pressure or end-organ dysfunction (e.g., Cr or LFT increase)

Coding tips for heart failure:

- Heart failure is assigned codes based on EF (e.g., **I50.2X for HFrEF**; **I50.3X for HFpEF**), based on the side of the heart affected (e.g., **I50.1 for left sided heart failure**), or **I50.9 for heart failure unspecified**
- **Stage B heart failure can be coded as I50.9** or with a more specific code if documentation matches. It is important to ensure the documentation is accurate, as some EMRs will auto-populate the words “Stage B” only with I50.9.
- **Stage D Heart Failure** is assigned code **I50.84**. Synonyms include Advanced Heart Failure and End Stage Heart Failure.
- Documentation must reflect the stage of heart failure, for example:
  - Stage B Heart Failure with Preserved Ejection Fraction
  - Stage B Left Sided Heart Failure
  - Stage C Heart Failure with Reduced Ejection Fraction
  - Advanced Heart Failure

Related diagnoses

- Weighted to risk adjust:
  - Stage B Heart Failure
  - Stage C Heart Failure
  - Stage D Heart Failure (higher weight)
  - Diabetes Mellitus
  - Chronic Kidney Disease
  - Obesity
  - Atrial Fibrillation
- Not weighted to risk adjust:
  - Hypertension

Example documentation:

Stage B Heart Failure: Chamber enlargement on recent echo, EF 55%. Asymptomatic. Will continue losartan

Advanced Heart Failure. Activities remain limited by fatigue. SBP 92 today, decrease metoprolol given likely contributing to fatigue. Discussed the signs of progression to Stage D with patient and implications for future risk. Referral to cardiology and follow up in 1mo.

Pulmonary Hypertension (PH)

- **ECHO Diagnostic Criteria**
  - ePASP >40mmHG (or >35 in younger adults)
  - TRV>2.8 m/s
  - These findings should be interpreted in the context of signs of RV dysfunction (e.g., abnormal RV size, wall thickness) and clinical suspicion
- Once identified, further testing and treatment is guided by the underlying cause
- **Common causes of elevated systolic pulmonary artery pressure**:
  - Left heart disease, including heart failure with preserved or reduced ejection fraction
  - Chronic lung disease and sleep disorders including COPD and OSA
  - High cardiac output states (anemia, hyperthyroidism)
  - Obesity
  - Volume overload, particularly in heart failure or in the setting of dialysis and chronic kidney disease
  - Thromboembolic lung disease

Related diagnoses:

- Weighted to risk adjust:
  - Pulmonary hypertension
  - Heart Failure
  - CKD/ESRD
  - Morbid Obesity
  - COPD
- Not weighted to risk adjust:
  - Anemia
  - Hyperthyroidism

Example documentation:

- **Secondary pulmonary hypertension.** Patient has a history of pulmonary emboli and progressive dyspnea, stable, as noted with TTE. Continue current meds, follow-up appointment with pulmonologist for active management.

Atherosclerosis of the Extremity with Rest Pain

- Peripheral vascular disease can be diagnosed in patients with risk factors based on:
  - Physical examination (e.g., thin skin, brittle hypertrophic nails, pallor with elevation, decreased pulses) and symptoms (e.g., claudication, rest pain)
  - ABI ≤0.9
- Ischemic rest pain can occur with severe decreases in limb perfusion
  - Ischemic rest pain is typically made worse with elevation, and affected patients often hang their feet over the edge of the bed to relieve the pain
  - Pain is often localized in the forefoot and toes but can be felt more proximally
  - Reduced blood flow can cause ischemic neuropathic pain, which is difficult to distinguish from diabetic neuropathy
- Ischemic ulcers often begin as minor traumatic wounds which then fail to heal, making evaluation and treatment of vascular disease critical to ulcer treatment
- Gangrene can start as focal areas of skin discoloration that progress to ischemia
- Treatments approaches vary according to the degree of pain, tissue loss, ulceration, and infection
  - Depending on patient factors, minimal ischemia with mild pain and without tissue loss or infection may be managed conservatively with pain control and cardiovascular risk reduction
  - Ischemia with severe pain, tissue loss or ulceration likely require additional treatments such as aggressive wound care, antibiotics, revascularization, or antithrombic therapy

Related diagnoses:

- Weighted to risk adjust:
  - Atherosclerosis of native arteries of extremities with rest pain
  - Atherosclerosis of native arteries of extremities with ulceration
  - Atherosclerosis of native arteries of extremities with gangrene
- Not weighted to risk adjust:
  - Peripheral vascular disease with claudication
  - Peripheral vascular disease without symptoms

Example documentation:

- **Atherosclerosis of right leg with rest pain.** History and physical exam consistent with PVD and has mild rest pain at night. Discussed smoking session, referral for ABIs.

Chronic Obstructive Pulmonary Disease

- The diagnosis of COPD requires
  - Pulmonary symptoms (e.g., chronic cough, dyspnea, sputum production)
  - Appropriate clinical context (e.g., smoking history, environmental exposure, asthma, childhood infections, prematurity)
  - Evidence of airflow limitation that is not fully reversible, including spirometry showing FEV1 to FVC ratio <0.7
- Chronic Bronchitis is a clinical diagnosis defined by chronic productive cough for at least three months in each of two successive years, when other causes of chronic cough (e.g., bronchiectasis) have been excluded
- Emphysema is a pathologic finding often identified on imaging studies
- COPD, chronic bronchitis, and emphysema often co-occur, and patients with chronic bronchitis or emphysema who do not have airflow obstruction are at high risk of developing COPD

Related diagnoses:

- Weighted to risk adjust:
  - Chronic obstructive pulmonary disease
  - Emphysema
  - Chronic bronchitis
  - Bronchiectasis
  - Hypersensitivity pneumonitis
- Not weighted to risk adjust:
  - Chronic cough
  - Shortness of breath

Example documentation:

- **Emphysema.** CT findings indicate emphysema, discussed implications with patient. Exertional dyspnea but spirometry does not show airflow limitation. Discussed smoking session, continue to monitor.

Source: Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease: 2025 Report. www.goldcopd.org

Major Depressive Disorder

- Diagnosis is based on the DSM-5 criteria, with PHQ-9 translating criteria into a questionnaire
  - Symptoms must last at least two weeks and include at least one of the following:
    - Depressed mood most of the day, nearly every day
    - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
  - At least five symptom criteria must be present (e.g., positive answers on PHQ-9)
- Severity can be determined by number of symptoms or functional impairment
  - PHQ-9 Score helps determine severity: 5 to 9 is mild; 10 to 14 is moderate; 15+ is severe
  - Seriously distressing symptoms with significant social and occupational functional impairment also confer moderate or severe severity (separate from PHQ9)
- Remission is defined by:
  - Full remission is the absence of symptoms for two months
  - Partial remission is absence of symptoms for less than two months or presence of symptoms without meeting full criteria
  - “In remission” should be used even when the lack of symptoms is due to being on medication or actively in counseling

Related diagnoses:

- Weighted to risk adjust:
  - Major depression, moderate
  - Major depression, severe
- Not weighted to risk adjust:
  - Major depression, mild
  - Major depression, in remission (partial or full)
  - Persistent depressive disorder
  - Adjustment disorder with depressed mood
  - Other specified depressive disorder

Example documentation:

- **Major depressive disorder, moderate, recurrent.** Significant distress and functional impairment. Discussed going to senior center once a week.

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Substance Use Disorders (SUD)

- Diagnosis of SUD is based on having at least two DSM V criteria:
  - Recurrent use in situations in which it physically hazardous
  - Continued use despite known health issue likely to be caused or exacerbated by the substance
  - Continued use despite recurrent social or interpersonal issues
  - Tolerance
  - Withdrawal
  - Persistent desire or unsuccessful efforts to cut down or control use
  - Taken in larger amounts or over a longer period than intended
  - Craving or strong desire or urge to use the substance
  - Giving up or reducing important social, occupational or recreational activities because of use
  - Recurrent use resulting in failure to fulfill major role obligations at work, school, or home
- Number of criteria determines severity : 2-3 is mild, 4-5 is moderate, 6+ is severe
  - Historically, severity was classified as “abuse” and “dependence”, which are now mild and moderate/severe respectively
  - Many older adults with significant alcohol use have **tolerance**, are at **risk of falls** (e.g., physically hazardous), have **diagnoses or medication interactions** that make drinking dangerous (e.g., use despite known health issue), and/or **tension with a spouse or family member** around their use (e.g., recurrent interpersonal issues). Presence of all four fills criteria for moderate use disorder.
- Remission has two phases:
  - Early remission: No symptoms of abuse or dependence for >3 months but <12 months
  - Sustained remission: No symptoms except cravings for >12 months
- Common substance-induced disorders include:
  - Mood disorder (e.g., depression)
  - Anxiety
  - Sleep disorder (e.g., insomnia)
  - Withdrawal
  - Dementia
  - Sexual dysfunction
- Patients can experience tolerance and withdrawal in the context of taking prescription drugs to treat a medical or mental health condition, which is not considered a substance use disorder.

Related diagnoses:

- Weighted to risk adjust:
  - Substance use or mild use disorder *with* substance-induced disorder (e.g., mood disorder, anxiety, insomnia, dementia, withdrawal)
  - Mild opiate, sedative, stimulant use disorders
  - Moderate or severe substance use disorder, including in remission
  - Alcohol-induced chronic pancreatitis, dementia, cardiomyopathy, hepatitis
- Not weighted to risk adjust:
  - Substance use *without* substance-induced disorder
  - Mild alcohol/cannabis use disorder
  - Long-term use of prescribed opioid medication used to treat a medical condition

Example documentation:

- **Moderate alcohol use disorder, in remission**: Patient continues to remain sober for the past 6 years. Continue with AA meetings.

Acute Alcoholic Hepatitis & Alcoholic Steatohepatitis

- Both acute alcoholic hepatitis and alcoholic steatohepatitis are coded as alcoholic hepatitis
- Acute alcoholic hepatitis
  - Diagnosis is defined by jaundice and markedly abnormal LFTs: AST/ALT elevations typically <300 and rarely >500 with AST:ALT ratio ≥2; bilirubin > 5, elevated INR
  - Treatment often requires hospitalization for alcohol withdrawal, renal failure, infection, and severe coagulopathy and/or liver failure
- Alcoholic steatohepatitis
  - Diagnosis is based on a history of harmful alcohol use plus LFT elevations (usually <400 with AST>ALT) and imaging showing steatosis (e.g., ultrasound, incidental CT finding)
    - Harmful alcohol use definition in this context: for men, >3 drinks/day or >21/wk; for women drinks >2/day or >14/wk)
    - Higher risk in patients with tobacco use, higher BMI, or diabetes
    - Symptoms are often absent or mild (e.g., fatigue)
  - Often coexists with other alcohol-related organ damage (e.g., cardiomyopathy, pancreatitis)

Related diagnoses:

- Weighted to risk adjust:
  - Alcoholic hepatitis
  - Cirrhosis
  - Alcohol use disorder, moderate/severe
  - Alcoholic cardiomyopathy
  - Alcoholic pancreatitis
- Not weighted to risk adjust:
  - Alcoholic steatosis
  - Non-alcoholic steatohepatitis
  - Malnutrition
  - Alcoholic steatosis
  - Alcoholic polyneuropathy

Example documentation:

- **Alcoholic steatohepatitis**. Patient unwilling to abstain from alcohol. Discussed cutting back. Repeat LFTs and platelet count in 3 months.

Malignancy: defining active vs historical cancer

- Cancers are coded differently when “active” vs “historical”
- Active cancers include:
  - Currently on treatment (e.g., chemotherapy, radiation, drug therapy, adjuvant therapy)
  - Known cancer cells within the body (e.g., waiting to start treatment, active known cancer with plan of watchful waiting)
  - Palliative treatment (e.g., cancer not responding to treatment, declining curative treatment)
- Treatment plan components that are *not* considered active treatment include surveillance for recurrence and prophylactic treatment
- Patients who have no evidence of disease and decline adjuvant therapy are considered to have a history of malignancy
- The note must consistently reflect a diagnosis to ensure accurate coding
  Common examples of conflicting documentation include:
  - The Problem List states “history of” a cancer while the Assessment/Plan shows the same cancer as active
  - The provider choses a code for active cancer but documents that the cancer has been removed and treatment completed

Related diagnoses:

- Weighted to risk adjust:
  - Active cancer (e.g., breast, prostate, colon, lung)
  - Benign neoplasm of meninges
- Not weighted to risk adjust:
  - History of cancer
  - Breast, prostate, colon, lung cancer in remission

Example documentation:

- **Breast cancer, Stage IIA, ER+.** Primary tumor removed and radiation complete. Continue aromatase inhibitor as adjuvant therapy, follows with oncology.
- **History of breast cancer, Stage IIA, ER+.** Primary tumor removed and radiation complete. Declined adjuvant therapy with aromatase inhibitor. Continue surveillance.

Malignancy: coding metastases

- Cancer metastases, including positive lymph nodes, are coded as “secondary malignancy of [metastases location]” and are coded in addition to the most appropriate code for the primary cancer
  - Metastases are coded as “secondary malignancy of” when still present in the body or under active treatment (e.g., radiation, chemotherapy) similar to the coding for primary tumor site
  - If the primary cancer has been removed and is no longer under active treatment or adjuvant therapy, then the primary cancer is coded as “history of”
- Specifying the location of the metastases ensures accurate coding and can affect the level of associated risk
  - For example, metastases to the lung, liver, brain, and intrathoracic lymph notes are expected to incur higher future healthcare expenditures and have higher risk adjustment weight compared to metastases to the bone, skin, and intrabdominal lymph nodes

Related diagnoses:

- Weighted to risk adjust:
  - Secondary malignant neoplasm of lung, bone, brain, lymph node, and a wide range of other sites
  - Malignant pleural effusion
- Not weighted to risk adjust:
  - History of cancer or metastasis

Example documentation:

- **History of breast cancer.** Primary tumor and positive lymph node removed in 2017, and treatment fully completed in 2022.

  Secondary malignancy of the lung. Biopsy of lung mass indicative of breast cancer recurrence. Has follow up scheduled with oncology.

Malignancy: leukemia & lymphoma

- Leukemia and lymphoma comprise a diverse group of diseases with variable risks and prognoses, many with significant risk of recurrence after achieving remission
  - For example, 60-80% of adult patient with acute myeloid leukemia will attain remission with induction chemotherapy but most will relapse within 4-8 months without post-remission therapy
- Many patients in remission will be under treatment (e.g., stem cell transplant, chemotherapy, drug therapy) and monitoring for relapse for months or years, during which time it is appropriate to code the disease as “in remission”
- Once there are no traces of cancer and it is unlikely to return, the cancer is considered cured, and the appropriate code is “history of”
  - In general, recurrence after five years of being in complete remission is low, so it may be appropriate to use a “history of” code after 5 years
  - However, providers must use clinical judgement as the amount of time may vary depending on patient factors, cancer type, treatment regimen, and response to treatment
  - When “in remission” is the most clinically accurate diagnosis, document the clinical rational (e.g., continued high risk of recurrence), particularly if the patient has been in remission for over five years

Related diagnoses:

- Weighted to risk adjust:
  - Leukemias and lymphomas in remission (e.g., follicular lymphoma, acute leukemia)
- Not weighted to risk adjust:
  - History of leukemia and lymphoma

Example documentation:

- **Diffuse large B cell lymphoma in remission.** Achieved remission with R-CHOP in 2023. Per last oncology note, continues to be at significant risk of recurrence. Continue to follow with oncology every 6 months.

Dementia

- Diagnosis is based on the DSM-5 criteria:
  - Evidence that indicates significant **cognitive impairment in ≥ 1 domain**:
    - Learning and memory
    - Executive function
    - Perceptual-motor function
    - Language
    - Complex attention
    - Social cognition
  - The impairment represents a **significant decline in function** and interferes with independence in everyday activities
  - The impairment is acquired and not better accounted for by another disorder (e.g., delirium, MDD, hypothyroidism)
- Several tools can aid in detecting cognitive impairment:
  - MOCA: ≤22 indicative of cognitive impairment, though varies with education level
  - SLUMS: <25 if <12 years education OR <27 if ≥12 years education indicates cognitive impairment
  - Creyos: tablet-based test; scored automatically based on patient's ability to complete game-like tasks; reliability unaffected by education level
- If there is no decline in function, then the diagnosis is mild cognitive impairment

Related diagnoses:

- Weighted to risk adjust:
  - Dementia, unspecified
  - Vascular dementia
- Not weighted to risk adjust:
  - Mild cognitive impairment
- Risk adjustment weight is same regardless of severity or complications (e.g., agitation, psychosis)

Example documentation:

- **Dementia.** Likely vascular dementia given risk factors. Continue statin, BP control. Discussed exercise and social connections

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Residual Impairments of Cerebrovascular Accident (CVA)

- In the outpatient setting, stroke patients are often seen for seen for the **residual deficits** from the acute episode
  - Literature suggests as many as 76% of stroke patients have ongoing impairment
  - ***Acute CVA should only be documented during the initial episode of care.*** *Acute strokes are inpatient-only diagnosis and are not coded on outpatient encounters without overwhelming evidence that they are truly active at the encounter.*
  - Post-discharge, providers should document "history of CVA" with or without residual or late effects.
- Common sequelae weighted to risk adjust include:
  - **Hemiparesis -** It is important to note that documented unilateral weakness of the right or left side is coded as hemiparesis and risk adjusts. If the weakness is isolated to a single limb (e.g., monoparesis), it does not risk adjust.
  - **Monoplegia & Hemiplegia –** Complete or near complete paralysis of one limb or unilateral paralysis risk adjusts
  - **Other paralytic syndrome**
  - **Vascular dementia**

ICD-10 Code Category	Category Description
I69.33x	Monoplegia of upper limb following cerebral infarction
I69.34x	Monoplegia of lower limb following cerebral infarction
I69.35x	Hemiplegia and hemiparesis following cerebral infarction
I69.36x	Other paralytic syndrome following cerebral infarction
F01.XX	Vascular dementia

Related diagnoses:

- Weighted to risk adjust:
  - Hemiparesis
  - Monoplegia, hemiplegia
  - Vascular dementia
- Residual Impairments not weighted to risk adjust:
  - Monoparesis
  - Cognitive deficits
  - Speech and language deficits
  - Apraxia, dysphagia, facial weakness, ataxia

Example documentation:

- **Hemiparesis**: Weakness in L arm and leg residual from stroke 2 years ago. Continues with walker for ambulation. No recent falls.
- **History of stroke**: Hospital follow-up. Reviewed medications, discussed how to take them, answered questions. Continue as planned with neurology.