Acute Conditions at Ambulatory Visits

Overview
Acute conditions typically develop suddenly and then last for a short time, often only days or weeks. Because of their sudden, severe, and transient nature, many acute conditions are rarely diagnosed and billed at ambulatory visits unless the patient is being sent to an emergency department. In all cases, these diagnosis codes should not be carried forward after the acute condition has resolved. The underlying cause or sequelae of these acute conditions may be chronic or even permanent.

The below information is intended to provide documentation and coding guidance for providers at ambulatory visits around four acute diagnoses that have been noted on national audits to be at high risk for being miscoded.

Acute Ischemic Stroke (i63.-)
- An acute stroke code (i63.-) should only be used for the episode of care when the stroke is first diagnosed, typically be an emergency room evaluation and/or an inpatient admission.
- After the initial episode of care for an acute ischemic stroke:
  - Sequelae of the acute ischemic stroke (i69.3-) should be coded if they are present.
  - **Pearl:** examples of sequelae include cognitive deficits (i69.31-), speech and language deficits (i69.32-), monoplegia of the upper (i69.33-) and lower (i69.34-) limbs, and hemiplegia/hemiparesis (i69.35-).
  - If no sequelae are present, personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits (z86.73) can be used as a billing diagnosis.

Acute Myocardial Infarction (i21.-)
- An acute myocardial infarction code (i21.-) should be used at the time of the acute event and for related care within 28 days of the event.
  - **Pearl:** including the date of acute infarction in a note helps to clarify the 28-day window.
  - **Pearl:** unstable angina (i20.0) is considered an acute coronary syndrome and should only be coded when symptoms are present in a given encounter.
- Once 28 days have passed since the initial acute myocardial infarction, chronic ischemic heart disease (i25.), such as coronary artery disease (i25.1-) or old myocardial infarction (i25.2) should be used.

Acute Deep Venous Thrombosis and Acute Pulmonary Embolism
- There is a lack of consensus in clinical and coding guidelines on when to classify deep venous thromboses (DVT) and pulmonary emboli (PE) as acute or chronic. Coders must rely on the clinician’s judgement and documentation for proper diagnosis code assignment.
- An acute or chronic DVT and/or PE should be coded when it is felt that a blood clot or fibrosis of a clot is present. If it is felt that no clot or fibrosis is present, history of DVT (z86.718) or history of PE (z86.711) should be coded.
- A general timeline that can be considered is:
  - **Pearl:** the use of and duration of anticoagulation does not help distinguish between acute DVT/PE, chronic DVT/PE, and history of DVT/PE. A patient with an acute or chronic blood clot may have a contraindication to or decline anticoagulant therapy. Likewise, a patient may be on lifelong anticoagulant therapy due to a history of DVT/PE to prevent recurrence of an acute blood clot.

Resources: (1) Medicare Advantage Compliance Audit of Specific Diagnosis Codes That MCS Advantage, Inc. (Contract H5577) Submitted to CMS, A-02-20-01008 [hhs.gov] (2) ACDIS Outpatient Pocket Guide 2023

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