FOCUS ON: STROKE & LATE EFFECTS

The Primary Care Physician (PCP) plays an important role in: (1) helping their patients reduce the risk of cerebrovascular disease and (2) assisting them in the longterm care and convalescence following a cerebrovascular event. Interventions are required in order mitigate the following risk factors for a first-time stroke: hypertension, diabetes, atrial fibrillation, coronary artery disease, hypercholesterolemia and other dyslipidemic syndromes, physically inactive lifestyle, heavy alcohol intake, current tobacco use, and chronic kidney disease.1

Cerebrovascular Accidents (CVA/Stroke)

In a CVA, there is a decreased supply of blood to the brain that can result in an area of infarction (necrotic cerebral tissue). CVA occurs because of thrombosis, embolism, occlusion or hemorrhage. Despite reduction in stroke mortality rates over the past decade, stroke incidence is unyielding. Stroke is still the leading cause of adult disability.

After the Initial Acute Care Episode of Stroke

After an initial stroke incident has occurred, generally one of two scenarios will exist. The patient will either make a recovery without any long-lasting effects. Clinically, residual deficits can be categorized generally as:

1. Physical disabilities following a stroke include hemiplegia, numbness, pressure sores, incontinence, apraxia, vision loss, seizures and pain.

2. Psychological and behavioral issues result from direct damage to centers in the brain or from difficulty adapting to new limitations. Difficulties include anxiety, panic attacks, flat affect, mania, apathy and psychosis.
   - Up to 50% of stroke survivors suffer post stroke depression, which can reduce motivation and worsen outcomes1
   - Emotional lability occurs in about 20% of stroke patients, causing the patient to switch quickly between emotional highs and lows.2

3. Cognitive deficits include perceptual disorders, speech problems including aphasia, dementia, and problems with attention and memory.


ALWAYS REMEMBER…3,4

- One of the most common coding errors seen in chart reviews is the assignment of a stroke code in the present tense when the provider is actually evaluating or treating residual conditions left behind by a prior stroke.
- Acute stroke is only coded during the initial episode of care, typically during the hospitalization.
  - Coding specifically for a CVA/Stroke (w/ cerebral infarction) requires documenting the type of stroke: Thrombotic (434.01), Embolic (434.11), Occlusive (434.91), Hemorrhagic (431).

DOCUMENTATION AND CODING TIPS3,4,5,6

Examples of Late Effects of CVA/Stroke:

- Physical disabilities, such as:
  - Hemiplegia/hemiparesis, affecting:
    - dominant side 438.21
    - nondominant side 438.22
    - unspecified side 438.20

- Apraxia 438.81

Psychological and behavioral issues:

- Specified type NEC 438.89 (Use additional code to identify the late effect)

Cognitive deficits 438.0

- Speech and language deficits such as: Speech and language deficit, unspecified (438.10), Aphasia (438.11), Dysphasia (438.12), Dysarthria (438.13), Fluency disorder (stuttering) (438.14), Other speech and language deficits (438.19)

In ICD-9-CM, correct codes for Late Effects of CVA/Stroke can be located under Late, effect(s) (of), cerebrovascular disease, with…3

In ICD-10-CM, correct codes for Late Effects of CVA/Stroke can be located under Sequelae (of), disease, cerebrovascular…6

If a provider documents personal history of: CVA (cerebrovascular accident), PRIND (Prolonged reversible ischemic neurologic deficit), RIND (Reversible ischemic neurological deficit) or TIA (transient ischemic attack), correct coding is V12.54, Personal history of transient ischemic attack [TIA], and cerebral infarction without residual deficits. If deficits are present, see category 438.

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