The Residual Effects of Stroke: Documentation and Coding

Example: Progress note:  History of embolic stroke with no residual effects
Diagnosis code: V12.59

The diagnosis of stroke of any kind (thrombotic, ischemic, hemorrhagic, or non-specific) is an acute diagnosis that should only be used if the patient is being treated in the hospital for a stroke or if the patient is having a stroke at the time of the visit. Depending on the specific diagnosis, the ICD-9 code range is between 430 and 434.

Examples: 430 Subarachnoid hemorrhage
           433.11 Occlusion and stenosis of carotid artery with cerebral infarct

Note: The ICD-9 diagnosis code 436 is no longer the correct code for an unspecified acute stroke or CVA and has been replaced by code 434.91.

If the patient has had a stroke but has no residual effects, the correct diagnosis is “history of stroke” or “S/P stroke” or similar documentation. However, if the patient has had a stroke and has residual effects from the stroke, then the residual effects should be documented and coded.

Documentation and ICD-9 coding for stroke and its late or residual effects include:

ICD-9  Physician Documentation
V12.59 Previous history of stroke or CVA with no residual effects
(or personal history of other diseases of the circulatory system)

438.11 aphasia due to cerebrovascular disease
438.20 hemiplegia affecting unspecified side due to cerebrovascular disease
438.30 monoplegia of upper limb affecting unspec side due to cerebrovasc disease
438.40 monoplegia of lower limb affecting unspec side due to cerebrovasc disease

Example: The correct documentation and coding for a residual effect of stroke might be:
- Progress note:  S/P CVA resulting in right arm paralysis
- Diagnosis codes: 438.30

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record, which is dated and signed by a physician. A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.

The information provided here is for general advice for appropriate documentation and coding. Final decisions should be based on review of standard reference materials.

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