OASIS Alert

Diagnosis Coding: DIFFERENT STROKES FOR THE SAME FOLKS

If youre flip-flopping between the code for acute CVA and late-effect CVA, youre having a CVA of your own a "coding validity accident."

Coding for a cerebrovascular accident continues to be a sore spot for many home health agencies, notes regional home health intermediary **Palmetto GBA** in a recent guidance titled "Udderly Confused About M00?" Specifically, agencies trip up on when to switch from the acute CVA code (436) to the late-effect code (438), Palmetto says.

"While the patient continues to improve under rehabilitation therapy, it would be appropriate to report stroke," (i.e., code 436), Palmetto instructs. Focus on "basic medical practices and the physiology of the stroke itself," counsels consultant **Rose Kimball** with **Med-Care Administrative Services** in Dallas. The acute CVA code usually is appropriate for a window of six to nine months after the stroke, she offers. Once the patient "gets as good as shes going to get" and youve ceased restorative therapy, its time to stop using 436.

"Once the patients recovery has reached a plateau," HHAs should use the late-effect CVA code to designate any further problems related to the stroke, Palmetto advises. For example, if an extremity suddenly goes weak or the patient is having memory lapses, shes "showing signs of late-effect CVA," Kimball notes.

When coding for late-effect CVA, agencies should keep in mind that three new codes took effect Oct. 1, reminds consultant **Prinny Rose Abraham** with **HIQM Consulting** in Minneapolis. These codes are 438.83 (facial weakness), 438.84 (ataxia) and 438.85 (vertigo). "Agencies should use the original date of the CVA on the 485," Abraham says. And they should list the current condition first (i.e., the late-effect manifestation), followed by the code for the original problem.

Of course, a patient sometimes will have symptoms that are unrelated to the stroke, Abraham reminds agencies. In those instances, use signs and symptoms codes for example, 780.4 (dizziness), 781.3 (lack of coordination), 782.0 (disturbances of skin sensation) and 368.9 (unspecified visual disturbances). "You have to use pure clinical logic," adds Kimball.

The only time a clinician should switch from the late-effect CVA code back to the acute code is if the patient suffers another stroke, warns Kimball. If that occurs, youre dealing with an entirely new event and the process begins afresh, she concludes.