START SMART CODING TIP

CVAs

Cerebrovascular accidents & residual conditions

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Empowering Better Health

RELEVANT CODING CLINICS

1Q 2015 | 1Q 2017 | 2Q 2025

OVERVIEW

Strokes & Residual Conditions

Residuals of a prior stroke are common in the outpatient record – and commonly miscoded

- Acute strokes are rarely seen in the outpatient office – yet this is a **very common coding error.**
- For residuals of a previous CVA, documentation should name the **specific deficit / residual condition.**
- Left- or right-sided weakness = **hemiplegia** in the coding world – and is an **HCC.**
- **Monoplegia** is also an **HCC.**

REMEMBER

When unilateral weakness is clearly documented as **associated with a stroke**, it is considered synonymous with hemiparesis / hemiplegia.

MOST COMMON DIAGNOSIS CODES

I69.954
Hemiplegia – left side (dominant not specified)

I69.951
Hemiplegia – right side (dominant not specified)

I69.344
Monoplegia – lower limb, left non-dominant side

I69.341
Monoplegia – lower limb, right dominant side

I69.332
Monoplegia – upper limb, left non-dominant side

I69.331
Monoplegia – upper limb, right dominant side

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CODING CLINIC · 1Q 2015

Residual Right Sided Weakness

ICD-10-CM/PCS Coding Clinic, First Quarter 2015 · Page 25 · Effective with discharges March 16, 2015

QUESTION

A 72-year-old male is admitted for gastrointestinal bleeding. The provider documents a history of acute cerebral infarction with residual right-sided weakness (dominant side) and orders a physical and occupational therapy evaluation. What is the appropriate code assignment for residual right-sided weakness resulting from an old CVA, without mention of hemiplegia / hemiparesis?

ANSWER

I69.351

Assign **I69.351**, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, for the residual right-sided weakness. **When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis / hemiplegia.** Unilateral weakness outside of this clear association cannot be assumed as hemiparesis / hemiplegia unless it is associated with some other brain disorder or injury.

CODING CLINIC · 1Q 2017

Monoplegia

ICD-10-CM/PCS Coding Clinic, First Quarter 2017 · Pages 47–48 · Effective with discharges March 13, 2017

QUESTION

A patient presents with weakness of the right arm due to an old cerebrovascular accident (CVA). The provider documents, "h/o CVA with mild residual right arm weakness." How would weakness of one extremity (upper or lower) be coded in a patient who is post-CVA?

ANSWER

I69.33- **I69.34-**

Assign the appropriate code from subcategory **I69.33-** (Monoplegia of upper limb following cerebral infarction) or **I69.34-** (Monoplegia of lower limb following cerebral infarction) for upper or lower limb weakness that is clearly associated with a CVA. **The same logic from Coding Clinic 1Q 2015 applies: unilateral weakness clearly documented as associated with a stroke is synonymous with hemiparesis / hemiplegia** – and it extends to single-limb (upper or lower) weakness linked to the stroke.

CODING CLINIC · 2Q 2025

Monoplegia

ICD-10-CM/PCS Coding Clinic, Second Quarter 2025 · Pages 18–19 · Effective with discharges June 13, 2025

QUESTION

A patient with left-side facial weakness and numbness, left arm and leg weakness, right tongue deviation, left-eye photophobia, and left-face twitching is admitted for stroke evaluation. Imaging shows no acute intracranial pathology; the patient is diagnosed with left-sided facial droop / weakness secondary to complex migraine (CM). Is it appropriate to assign a hemiplegia code when the left-sided weakness is secondary to CM, and what is the correct assignment?

ANSWER

G43.409

Assign **G43.409**, Hemiplegic migraine, not intractable, without status migrainosus, since the provider linked the left-sided weakness to the CM. **Coding Clinic 1Q 2015 clarifies that unilateral weakness associated with a brain disorder is coded as hemiparesis / hemiplegia – and a migraine is a type of brain disorder.** Index path: Migraine → hemiplegic → not intractable → without status migrainosus → G43.409.

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CLINICAL SCENARIO

Brain Disorder

Applying the guidance to real provider documentation

DOCUMENTATION STATES

"Presenting with 2 to 3 days of **right lower extremity & right upper extremity weakness & paresthesias**, found to have **right occipital-parietal and left frontal metastases** with vasogenic edema."

GUIDANCE

Supported by advice in **Coding Clinic 1Q 2015 – Acute CVA with Left-Sided Weakness.** Unilateral weakness that is clearly associated with **another brain disorder or injury** – here, the brain metastases – is coded as **hemiparesis / hemiplegia.**

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CODING CLINIC · 1Q 2015

Acute CVA w/ Left Sided Weakness

ICD-10-CM/PCS Coding Clinic, First Quarter 2015 · Pages 25–26 · Effective with discharges March 16, 2015

QUESTION

An 88-year-old male is admitted secondary to a cerebral infarction. In the final diagnostic statement the provider documents "acute cerebral infarction involving the right hemisphere with left-sided (nondominant) weakness." How should left-sided weakness due to an acute cerebral infarction be coded when there is no specific mention of hemiplegia / hemiparesis?

ANSWER

I63.9 **G81.94**

Assign **I63.9**, Cerebral infarction unspecified, as the principal diagnosis, and **G81.94**, Hemiplegia unspecified affecting left nondominant side, as an additional diagnosis. **When unilateral weakness is clearly documented as associated with a stroke, it is synonymous with hemiparesis / hemiplegia.**

NOTE *Effective 10/1/2016, subcategory R29.7- was created to report NIH Stroke Scale (NIHSS) scores – see Coding Clinic 4Q 2016, pages 61–62.*