ICD-10-CM and Cardiology

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For the past thirty-one (31) years, we have learned and used ICD-9-CM when diagnosis coding for our providers. ICD stands for International Classification of Diseases. We’ve been using the 9th Revision to code a documented medical condition. We will be replacing the 9th Revision with the 10th revision. As someone once said, just when we learned the answers, they changed the questions. Also, for years, there has been rumor that ICD-10 would be replacing ICD-9, and now this will soon be a reality.

**ICD-10 will replace ICD-9-CM as of October 1, 2014.**
There is a new rumor that ICD-10 will be bypassed with ICD-11. The problem with this new rumor is that there is nothing, in writing, about this rumor. The fact that ICD-10 will be effective as of October 1, 2014 is published by the Centers for Medicare and Medicaid Services and the World Health Organization. Anytime someone tells you something, GET IT IN WRITING! Rumors can ruin a practice and can cost a practice a lot of money because you trust the person who told you the rumor and you want to believe it, so you or you have your staff search the internet for anything that provides provenance to the rumor. In coding, there is a rule, If it isn’t documented, it doesn’t exist. If an employee or a doctor told you something, make sure that they provide you with documentation to back it up. How do I know this? My boss went to a conference and during a break, heard people talking about something. One of the speakers even said the same thing. When my boss came back, he had me stop my work and find out if what he heard was true. After a week of searching, I went back to my boss and told him that what he heard didn’t exist. His reply was, I don’t believe you. I am a speaker at conferences. Anything I present has laws, rules, or policies provided to show that what I’m saying is true, accurate, and correct. I personally attended a conference where I heard a speaker say something that didn’t sound right. I wasn’t the only one because many hands went up. The speaker had many respected certifications, yet the speaker failed to provide any proof to his statement. When I asked for his documentation, he smiled and said I’ll send it to you. Its been 10 years and nothing has come forth. All this did was lower my respect for this person and I now question everything this person provides. I refuse to attend any conference where he still speaks. My boss was correct with saying he didn’t believe me, but he learned a hard lesson. He spent about $1,000 in payroll to have me find anything that backed up what he heard at a conference. In the end, he dismissed what he heard and from that point on, when we brought anything to him, we had to
provide documented proof. That made me a better researcher. To provide proof to ICD-10 being effective on October 1, 2014, can be found here: http://www.cms.gov/Medicare/Coding/ICD10/Index.html

October 1, 2014 is on a Wednesday. What this means is, on Tuesday, September 30, 2014, you will use ICD-9-CM. At the end of the day, put your ICD-9 manuals in a safe place because you may need them later on and I will explain this. When you come in the next morning, you will open the brand new ICD-10-CM manuals and code the visit using them.

One huge change with ICD-10-CM is that there will be more codes to select from. ICD-9 has about 14,000 codes. ICD-10 starts with 68,000 codes and can go higher. ICD-9 did not have a code for a cranialrectal blockage, so you couldn’t code that diagnosis or you had to select an unspecified code, but now you can have a code for a cranialrectal blockage (YOU do know that cranialrectal blockage is not a real disease or injury). ICD-10 is going to change the way YOU do business. Why? It is 100% dependent on medical record documentation. ICD-9 was forgiving to a doctor who is lax on their documentation. Steve could visit Dr Smith with pain in his right ear. All Dr Smith had to document was that Steve has OM which is short for otitis media and the coder could select a code for simple OM.

That code is **382.9** - Unspecified otitis media, Otitis media: NOS, acute NOS, chronic NOS

**ICD-10 will require more work on the provider to document the exact type of diagnosis found with the patient. ICD-10 demands documentation of the anatomical area affected and allows for coding of chronic modalities.**

**Under ICD-10-CM, you have the following codes for Otitis Media:**

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H66.9 **Otitis media**, unspecified

H66.90 **Otitis media**, unspecified, unspecified ear

H66.91 **Otitis media**, unspecified, right ear

H66.92 **Otitis media**, unspecified, left ear

H66.93 **Otitis media**, unspecified, bilateral

As you can see, under ICD-9-CM, you have one code you can select if the documentation is not specific. The patient may have been a child with ear pain in both ears, but all the doctor wrote is “OM” and nothing more. Under ICD-10-CM, you have a possibility of five (5) codes and you do need more anatomical information to select the best possible code. Using a pure unspecified code such as H66.9 could cause your claim to be pended or placed under review, which could cause a significant revenue loss for the practice. A favorite doctor I've known for many years is an expert witness where he is called to determine if a malpractice lawsuit should proceed to court or if the malpractice insurance company should issue a check. Most of the time, after looking at the medical record, he recommends writing a check. He provides instruction to medical interns and residents and he tells them: “Document the visit as if you had to appear in court to defend your actions.” I usually add, “Document the visit as if your paycheck and career is on the line.” I spend a lot of my time returning medical records for additional information because the documentation is insufficient to code the visit with 100% truth, accuracy and correctness. I code to protect the doctor, the patient, and MY paycheck. I only code what is documented. I never code a visit just to get paid. There will be an unofficial rule with coding and that rule will be: If it isn’t documented, we don’t code it. We do NOT code something just to get it paid. With 30 years of clinical medicine in my personal background, I can say I
know what should have been done during the visit, but I cant code based on that. Ive seen doctors tell me, “I did this procedure.” I say show me where it says you did this. There is no documentation to prove that the doctor said they did what they say and the doctor loses. I also NEVER code based on what I am told on the internet. I don’t know if what Im told is 100% true, accurate and complete. I don’t know if the person asking the question works for a doctor or if they are a coding student and I NEVER help students. If I provide them with answers, they submit my work as their own and I NEVER support fraud, including academic fraud, in any form. If I do a coders work for them, they will never learn to become self-sufficient. Lets say you have an untrained coder who needs to code a cranialrectalectomy. They will go to the internet and ask, I forgot what the code is for a cranialrectalectomy, can someone help me? When they don’t get a response, they become angry and then they will post, Cant anyone here help me out? They do this hoping someone will feel guilty and give them what they want. Someone may come along with a name of ToddCPC and say we use code 99999. ToddCPC is NOT a coder. ToddCPC is a schoolkid in Omaha, Nebraska having fun punking the poster. So, now the coder enters 99999 as the code and sends the claim to the insurance company. The claim is denied payment. Claim after claim is denied payment because this coder is sending claims with bad codes. The doctor begins to notice the volume of denials and notices a huge drop in his practice revenue, so he contacts a consultant. In addition, the insurance company put a halt on all claims sent by the doctor. They send a letter demanding medical records and they’re now going back 20 years. The information on the claim is wrong and it is not documented in the medical record. The next letter the doctor receives is a demand for the return of claim payments and they are demanding a 6 figure refund. The doctor cant fight this
because the claim was sent with wrong codes, codes that are not supported by the medical record documentation. I recently went to a doctor who received a letter demanding the return of $64,000. That would cause him to go out of business. I showed how his coder was sending claim with wrong codes and that the medical record documentation was so poor, that they didn’t support any correct code that was submitted. Again, DOCUMENT THE MEDICAL RECORD AS IF YOU HAD TO GO TO COURT!

**Coding Guidelines**

Many of the guidelines under ICD-9-CM won’t change under ICD-10-CM. You will see new guidelines because ICD-10 will offer new codes never seen before. As an example:

**ICD-9 Guideline for Symptoms:**

*Signs and symptoms*

*Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 -799.9) contain many, but not all codes for symptoms.*

7. **Conditions that are an integral part of a disease process**

*Signs and symptoms that are integral to the disease process should not be assigned as additional codes.*

8. **Conditions that are not an integral part of a disease process**

*Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.*
ICD-10 Guideline for Symptoms:

**Signs and symptoms**

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

5. **Conditions that are an integral part of a disease process**

   Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. **Conditions that are not an integral part of a disease process**

   Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

As you can see, both guidelines are virtually identical, so the change to ICD-10 won't be a shock to a trained coder.

The ICD-10 coding guidelines related to cardiology are as follows:

**Hypertensive Heart and Chronic Kidney Disease**

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.
Hypertensive Cerebrovascular Disease
For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.

Hypertensive Retinopathy
Code H35.0, Hypertensive retinopathy, should be used with code I10, Essential (primary) hypertension, to include the systemic hypertension. The sequencing is based on the reason for the encounter.

Hypertension, Secondary
Secondary hypertension is due to an underlying condition. Two codes are required: one to identify the underlying etiology and one from category I15 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

Hypertension, Transient
Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code O13.-, Gestational [pregnancy-induced] hypertension without significant proteinuria, or O14.-, Gestational [pregnancy-induced] hypertension with significant proteinuria, for transient hypertension of pregnancy

Hypertension, Controlled
This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign code I10.

Hypertension, Uncontrolled
Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign code I10.

Atherosclerotic coronary artery disease and angina
ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris
and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris. When using one of these combination codes it is not necessary to use an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease.

See Section I.C.9. Acute myocardial infarction (AMI)

**Sequelae of Cerebrovascular Disease**

**Category I69, Sequelae of Cerebrovascular disease**
Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67.

**Codes from category I69 with codes from I60-I67**
Codes from category I69 may be assigned on a health care record with codes from I60-I67, if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

**Code Z86.73**
Assign code Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits (and not a code from category I69) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.
Acute myocardial infarction (AMI)  ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)
The ICD-10-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories I21.0-I21.2 and code I21.4 are used for ST elevation myocardial infarction (STEMI). Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

Acute myocardial infarction, unspecified
Code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site, is the default for the unspecified term acute myocardial infarction. If only STEMI or transmural MI without the site is documented, query the provider as to the site, or assign code I21.3.

AMI documented as nontransmural or subendocardial but site provided
If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI. If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.
See Section I.C.21.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

Subsequent acute myocardial infarction
A code from category I22, Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21.

The sequencing of the I22 and I21 codes depends on the circumstances of the encounter. Should a patient who is in the hospital due to an AMI have a subsequent AMI while still in the hospital code I21 would be sequenced
first as the reason for admission, with code I22 sequenced as a secondary code. Should a patient have a subsequent AMI after discharge for care of an initial AMI, and the reason for admission is the subsequent AMI, the I22 code should be sequenced first followed by the I21. An I21 code must accompany an I22 code to identify the site of the initial AMI, and to indicate that the patient is still within the 4 week time frame of healing from the initial AMI. The guidelines for assigning the correct I22 code are the same as for the initial AMI.

Anytime you have a question regarding coding, you must OPEN the manual and READ the guidelines. The problem most people have when they ask questions about coding can be found in the manual.

I've been to practices where the coding manuals, usually 5 years old, are still in their unopened packages. A good coder has the worst looking coding manual where the pages are worn, dog-eared, ink filled with personal notes, has pages containing yellow post it notes, and almost falling apart. Most important, NEVER listen to the office wannabe! **RTFM!**

**Cardiology Codes**

**Lets look at some of the most used codes in some Cardiology practices. Please understand that this guide does NOT contain all codes used. This guide does not take the place of coding or published coding manuals. These codes may change in October 2014. They are current as of the day this guide was prepared. If additional information is needed to obtain a more accurate code, it will be noted. Some ICD-9-CM codes do NOT convert easily to ICD-10-CM. The medical record documentation will need to be more specific.**
ICD-9 codes are 3, 4, or 5 numbers with E or V codes being a letter and a set of numbers, up to 5 digits. ICD-10 is a letter and numbers. It can go up to 7 digits. Code I06.8 is not one zero six point eight. It is letter eye zero six point eight. V70.0 is an ICD-9 code, not an ICD-10 code.

**NUMERICAL ORDER BY ICD-9-CM**

**ICD-9-CM**
395.9 - Other and unspecified rheumatic aortic diseases

**ICD-10-CM**
I06.8 - Other rheumatic aortic valve diseases

**ICD-9-CM**
396.9 - Mitral and aortic valve diseases, unspecified

**ICD-10-CM**
Too many codes to list, requires more specific documentation and information

**ICD-9-CM**
401.1 - Benign essential hypertension

**ICD-10-CM**
I10 - Essential (primary) hypertension

**ICD-9-CM**
414.01  Coronary atherosclerosis of native coronary artery
**ICD-10-CM**

I25.110 - Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

I25.111 - Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm

I25.118 - Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris

I25.119 - Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris

**ICD-9-CM**

427.31 - Atrial fibrillation

**ICD-10-CM**

Too many codes to list, requires additional information to obtain a specific and accurate code.

**ICD-9-CM**

428.0 - Congestive heart failure, unspecified

**ICD-10-CM**

I50.20 - Unspecified systolic (congestive) heart failure

I50.30 - Unspecified diastolic (congestive) heart failure
ICD-9-CM

444.09 - Other arterial embolism and thrombosis of abdominal aorta

ICD-10-CM

I74.09 - Other arterial embolism and thrombosis of abdominal aorta

ICD-9-CM

440.21 - Atherosclerosis of native arteries of the extremities with intermittent claudication

ICD-10-CM

I70.25 - Atherosclerosis of native arteries of other extremities with ulceration

ICD-9-CM

451.83 - Phlebitis and thrombophlebitis of deep veins of upper extremities

ICD-10-CM

I82.721 - Chronic embolism and thrombosis of deep veins of right upper extremity

More anatomical reference to specific blood vessels are needed to obtain a more better code.
ICD-9-CM
414.01 Coronary atherosclerosis; of native coronary artery

ICD-10-CM
Needs more information
I25.1 Atherosclerotic heart disease of native coronary artery
I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.11 Atherosclerotic heart disease of native coronary artery with angina pectoris
I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris

ICD-9-CM
414.9 Chronic ischemic heart disease, unspecified

ICD-10-CM
I25.9 Chronic ischemic heart disease, unspecified

ICD-9-CM
996.0 (ICD-9-CM Code does not exist) *(This was a code provided to me by a cardiology practice as one of their top 10 codes they use with patient visits.)*
The process for coding ICD-10 is no different than that of ICD-9, but documentation will be the success or failure of ICD-10. Improper or lack of documentation will only delay claims processing and will decrease practice revenue. The coder reads the medical record. The coder reads that the doctor documented “Chest pain”. The coder opens the ICD-10 manual, goes to the Index (words) and looks up the condition, which in this case is Pain.

**Pain(s)** (see also Painful) R52
- chest (central) R07.4
- anterior wall R07.89
- atypical R07.89
- ischemic I20.9
- musculoskeletal R07.89
- non-cardiac R07.89
- on breathing R07.1
- pleurodynia R07.81
- precordial R07.2
- wall (anterior) R07.89

As you can see from the above ICD-10 index, you have chest pain listed as R07.4. Next you want to go to the tabular section to make sure that R07.4 is the correct code and to see if there are any coding conventions. Coding conventions provide us with additional information we need to ensure we have the correct code. The tabular for R07 is on the next page.
• **R07** Pain in throat and chest
  • Excludes.: dysphagia (R13) epidemic myalgia (B33.0) pain in: breast (N64.4)
  • neck (M54.2)
  • sore throat (acute) NOS (J02.9)
• **R07.0** Pain in throat
• **R07.1** Chest pain on breathing
  • Incl.: Painful respiration
• **R07.2** Precordial pain
• **R07.3** Other chest pain
  • Incl.: Anterior chest-wall pain NOS
• **R07.4** Chest pain, unspecified

If you look at the above tabular section, you can see coding conventions identical to those from ICD-9-CM. You can see NOS which means Not Otherwise Specified, Incl which means Includes and excludes which means these medical conditions are not included in this code. Code R07.4 has no coding conventions or additional information, so, based on the medical record documentation of chest pain, we can select R07.4. Again, if you can code ICD-9, you can code ICD-10. If you don't have the training in the process of coding, you won't be able to code under ICD-10.

**CODING CHAPTERS**

Under ICD-9-CM, you have the following:

- Chapter 1: Infectious and Parasitic Diseases (001-139)
- Chapter 2: Neoplasms (140-239)
- Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
- Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)
- Chapter 5: Mental Disorders (290-319)
- Chapter 6: Diseases of Nervous System and Sense Organs (320-389)
- Chapter 7: Diseases of Circulatory System (390-459)
- Chapter 8: Diseases of Respiratory System (460-519)
- Chapter 9: Diseases of Digestive System (520-57)
Chapter 10: Diseases of Genitourinary System (580-629)
Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)
Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)
Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)
Chapter 14: Congenital Anomalies (740-759)
Chapter 15: Newborn (Perinatal) Guidelines (760-779)
Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)
Chapter 17: Injury and Poisoning (800-999)
Chapter 18: Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V84) and Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Under ICD-10, you have the following:

Chapter 1: Certain infectious and parasitic diseases (A00-B99)
Chapter 2: Neoplasms (C00-D48)
Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E90)
Chapter 5: Mental and behavioral disorders (F01-F99)
Chapter 6: Diseases of the nervous system (G00-G99)
Chapter 7: Diseases of the eye and adnexa (H00-H59)
Chapter 8: Diseases of the ear and mastoid process (H60-H95)
Chapter 9: Diseases of the circulatory system (I00-I99)
Chapter 10: Acute upper respiratory infections (J00-J06)
Chapter 11: Diseases of oral cavity and salivary glands (K00-K14)
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)
Chapter 14: Diseases of the genitourinary system (N00-N99)
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)
Chapter 16: Certain conditions originating in the perinatal period (P00-P96)
Chapter 17  Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
Chapter 18: Symptoms and signs involving the circulatory and respiratory systems (R00-R09)
Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T98)
Chapter 20: External causes of morbidity (V01-Y98)
Factors influencing health status and contact with health services (Z00-Z99)

E Codes will become V-Y Codes
V Codes will become Z Codes.

The Table of Drugs and Biologicals that were 900 series codes and E Codes are now T Codes.

There were 18 Chapters in ICD-9-CM and we have 20 chapters under ICD-10-CM.

The proposed effective date for ICD-10 is October 1, 2014.

The key to the successful use and transition to ICD-10 is going to ensure our Providers are aware of their responsibility towards better documentation of the patient’s medical condition(s).

Use the following formula: PPD = Lawsuits and LOR (Loss of Revenue).
(PPD stands for PISS Poor Documentation = Lawsuits and LOR.

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I wish all much success!

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