Codify
BY AAPC

MDS Alert

Coding Quiz: Test Your Diagnosis Code Knowledge

Hint: None of the answers are in the 'Return to Provider' category.

Understanding which ICD-10-CM code to pair with which diagnosis can be difficult, especially because so many diagnosis codes are unique due to rather small differences. Many people who are residents of nursing facilities across the country have heart conditions or circulatory system diseases, so having a grasp on cardiology-related diagnoses can be especially helpful.

Try your hand at coding these four scenarios and then check your answers to see where you may need to focus your learning.

Question 1: The resident's health record shows that she has atherosclerotic heart disease of the native coronary artery, along with stable angina (controlled with medication). Which ICD-10 code best describes this condition?

Question 2: The resident's medical record shows that he has hypertensive heart and chronic kidney disease with acute systolic (congestive) heart failure and with stage 5 CKD. Which ICD-10 code(s) best reflect this diagnosis?

Question 3: According to the documentation, the resident has left ventricular failure caused by hypertension. Per a note in ICD-10 manual, you must also include the code showing the type of heart failure the resident suffers from. Does the sequencing of these codes matter?

Question 4: Which ICD-10 code would you select for myocardial infarction (MI) type 5?

Utilize this Code for Atherosclerotic Heart Disease Dx

Answer 1: You should choose code I25.118 (Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris) for this condition.

"The Official ICD-10 Guidelines for coding atherosclerosis or coronary artery disease (CAD) with angina include a combination code for both," explains **Mari Robinson, CPC, CPMA, CRC, CCC**, compliance analyst of chronic conditions at **Riverside Medical Group** in Newport News, Virginia. "The angina is not coded separately when both are documented as the [resident's] diagnosis or condition. The specific type of angina should be documented and is coded within the combination code for CAD with angina."

When you report a combo code for CAD with angina, you should first query the provider to confirm that is the final diagnosis, Robinson says. Additionally, if the physician documents the medicine that stabilized the resident's angina, then you should code the angina with the CAD by using the appropriate combination code I25.1XX that represents the CAD with the type of angina.

Note Code Order for This Condition Combo

Answer 2: For hypertensive heart and chronic kidney disease with acute systolic (congestive) heart failure and with stage 5 CKD, you would report these codes in the following order:

- I13.2 (Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease)
- I50.21 (Acute systolic (congestive) heart failure)
- N18.5 (Chronic kidney disease, stage 5)

Don't miss: You should also pay close attention to "code first" notes in ICD-10. For example, a "code first" note under category I50- (Heart failure) tells you to sequence heart failure due to hypertensive heart and CKD - II13.-.

A common error is not using the combination codes or the hypertensive with heart disease codes, says **Carol Hodge, CPC, CDEo, CCC, CEMC**, certified medical coder of **St. Joseph's Cardiology** in Savannah, Georgia.

"These codes should be used to indicate hypertensive heart disease followed by the code for the type of heart failure," Hodge adds. "Kidney disease very often occurs with hypertension and congestive heart failure, and those guidelines should be followed to correctly sequence those codes."

Notice Code Sequencing for Accuracy

Answer 3: Absolutely. The code sequencing is key here. Since the resident's hypertension is the cause of his heart failure, you would first report I11.0 (Hypertensive heart disease with heart failure). Then, you would report an additional code from the I50- (Heart failure) series to identify the specific type of heart failure. In this case, the resident's heart failure is I50.1 (Left ventricular failure, unspecified).

In the ICD-10 code book, you will see that all the I50- codes come with a code first note that states I50.1 must always be reported after I11.0, when appropriate.

Remember: Code first notes indicate the primary reason for the diagnosis. They indicate the main cause for this other diagnosis. The code first note, then, says that this disease or illness has caused this other disease or illness. So, you would report I11.0 before I50.1 if hypertension was the cause of the heart failure.

Go for This Code for MI Type 5

Answer 4: You should report I21.A9 (Other myocardial infarction type) for MI type 5. If you look under this code in the ICD-10 code book, you will see that MI type 5 is an included condition for I21.A9. Other included diagnoses with this code are as follows:

- Myocardial infarction associated with revascularization procedure
- Myocardial infarction type 3
- Myocardial infarction type 4a
- Myocardial infarction type 4b
- Myocardial infarction type 4c

Don't miss: Category I21.A9 has a few specific instructions for you to follow.