Home Health Coding and OASIS Expert

ICD-10: Test Your ICD-10 Circulatory Condition Coding

Don't miss this MI update.

Are you feeling confident about your ICD-10 coding for hypertension, myocardial infarctions, and other circulatory conditions? Don't get caught off guard when you're faced with the new code set come Oct. 1.

Judy Adams, RN, BSN, HCS-D, HCS-O, with Adams Home Care Consulting in Asheville, N.C. presented these coding scenarios during her session at the **Coding Institute's 2014 CodingCon.** Try coding them in ICD-9 and then in ICD-10 before reading on to see the answers.

Scenario 1: Your patient has Stage 3 chronic kidney disease with chronic systolic and congestive heart failure (CHF) due to hypertension. How would you code for him in ICD-9? How will your coding differ in ICD-10?

Scenario 2: Mrs. H is being admitted to home health following an acute inferior wall myocardial infarction two weeks ago. She is still being monitored for her first MI and for a new NSTEMI myocardial infarct one week earlier and continues to have atrial fibrillation. Your agency will be providing observation and assessment of her unstable angina and CAD as well as teaching on her new cardiac medications. She is not a surgical candidate. How would you code for her in ICD-9? How will your coding differ in ICD-10?

Scenario 3: Your 62-year-old male patient was admitted to the hospital with progressive episodes of chest pain determined to be crescendo angina. The patient has no previous history of CABG. He had a myocardial infarction five years ago and was diagnosed with coronary artery disease and progressively has been having more frequent episodes of chest pain. How would you code for this patient's angina and MI in ICD-9? How will your coding differ in ICD-10?

Scenario 1 Answer: In ICD-9, you would code for this patient as follows:

- 404.91 — Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified;
- 428.22 — Chronic systolic heart failure;
- 428.0 — Congestive heart failure; and
- 585.3 — Chronic kidney disease, Stage III (moderate).

ICD-9 assumes a relationship between hypertension and chronic kidney disease, but you need physician documentation that links the patient's heart disease to the hypertension in order to report a 404.xx (Hypertensive heart and chronic kidney disease) code. In this scenario, the link is documented in the diagnosis statement which lists the two types of heart failure "due to" hypertension.

Remember to include additional codes that identify all the types of heart failure and the stage of the kidney disease. In this case the patient has chronic systolic failure and congestive heart failure.

In ICD-10, your coding for this patient would be:

- I13.0 — Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease;
- I50.22 — Chronic systolic (congestive) heart failure;and
- N18.3 — Chronic kidney disease, stage 3 (moderate).

Why: As in ICD-9, you'll use a combination code to report this patient's hypertensive heart and kidney disease, Adams said. Notice that the hypertension code no longer indicates benign, malignant, or unspecified.

Also note that when you look under I50.- for the heart failure code, congestive heart failure is not a part of all of the heart failure codes and no longer coded separately. The only time you would code for CHF specifically is if it was the only type of heart failure present, Adams tells **Eli.** In that situation, you would code for it with I50.9 (Heart failure, unspecified).

In your coding manual, under I13.0, you'll find a "use additional code" note to identify both the type of heart failure and the stage of chronic kidney disease.

Scenario 2 Answer: In ICD-9, you would code for this patient as follows:

- 414.01 – Coronary atherosclerosis of native coronary artery;
- 411.1 – Intermediate coronary artery syndrome;
- 410.42 – Acute myocardial infarction of other inferior wall; subsequent episode of care;
- 410.72 – Subendocardial infarction subsequent episode of care;
- 427.31 – Atrial fibrillation; and
- V58.69 – Long-term (current) use of other medications.

Your focus of care for this patient is her CAD and unstable angina, so these codes will lead your list of diagnoses.

This patient's two MIs fall within the eight-week range allowed for reporting in ICD-9, so you'll code for them next.

Report her atrial fibrillation as well as her medications later in your list.

In ICD-10, your coding for this patient would be:

- I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris;
- I21.19 – ST elevation (STEMI) myocardial infarction of inferior wall;
- I22.2 – Subsequent Non-ST elevation (NSTEMI) myocardial infarction;
- I48.91 –Atrial fibrillation, unspecified; and
- Z79.899 – Other long term (current) drug therapy.

Report your patient's CAD first. You'll notice that in ICD-10, these codes indicate both CAD and the presence or absence of angina. The Chapter 9-specific guidelines introduce a new assumption in ICD-10, Adams says. You can assume a causal relationship in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

Next, you'll list the patient's acute MIs. Remember the new four-week guidelines for reporting MIs as acute. ICD-10 coding guidelines for Chapter 9 advise you to base your sequencing of I22 and I21 "on the circumstances of the encounter." In this scenario, list the STEMI first since it is the more serious MI, Adams says.

Note that in ICD-9, "subsequent" refers to the subsequent health care setting caring for the patient in the eight-week acute period – home health and hospice are subsequent, points out Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O, consultant and principal of Selman-Holman & Associates and CoDR – Coding Done Right in Denton, Texas.

But in ICD-10, "subsequent" means the subsequent MI within the four-week definition of an acute myocardial infarction, Selman-Holman adds.

Scenario 3 Answer: In ICD-9, you would code for this patient as follows:

- 411.1 – Intermediate coronary syndrome;
- 414.01 – Coronary atherosclerosis of native coronary artery; and
- 414.8 – Other specified forms of chronic ischemic heart disease.

Report your patient's crescendo angina with 411.1 first.

Next, list 414.01 for his CAD.

Finally, report his MI with 414.8 because he still has symptoms after his MI.

In ICD-10, your coding for this patient would be:

- I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- I25.9 Chronic ischemic heart disease (with a stated duration of over 4 weeks

In ICD-10, crescendo angina is included in unstable angina, said Adams. To look it up in the alphabetic index, reference Angina, crescendo and you'll find "see Angina, unstable."