

ICD-10-CM Specialty Code Set Training Cardiology

2014

Module 3



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Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual*, *redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

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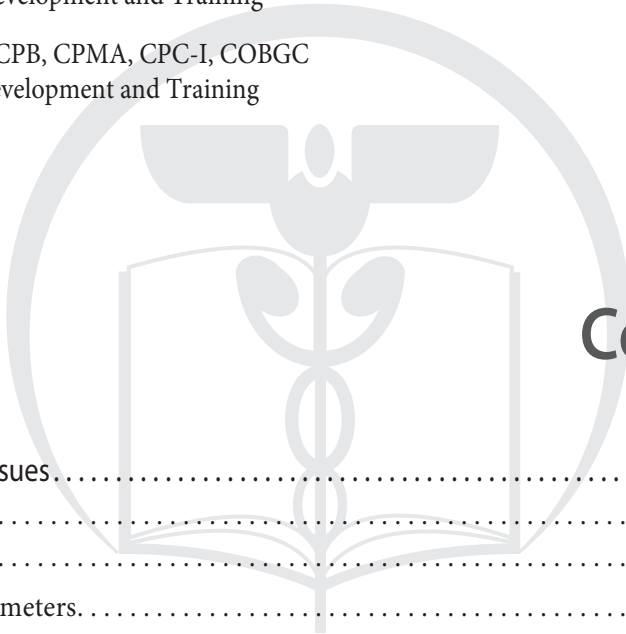
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Documentation Issues

One of the big hurdles in the transition to ICD-10-CM is ensuring that the documentation of the providers is supportive of the new coding criteria that will need to be met. You may consider that it is not only the codes that are transitioning, but also the documentation to meet it. Just as in ICD-9-CM, ICD-10-CM contains unspecified codes. But, with the greatly expanded granularity in ICD-10-CM, the unspecified codes will come under greater scrutiny.

Specificity

One of the reasons that we are transitioning to ICD-10-CM is the increased specificity to enable conditions to be clearly indicated. Care must be taken to ensure that providers and coders understand where the code set has expanded in order to be able to capture that information and denote it on a claim. Specificity issues include laterality, time parameters, site, and expansion of certain conditions under ICD-10-CM.

Laterality

The addition of laterality into the code set is one of the reasons for the increased number of codes in ICD-10-CM.

EXAMPLE

ICD-9-CM	451.81	Phlebitis and thrombophlebitis of iliac vein
ICD-10-CM	I80.211	Phlebitis and thrombophlebitis of right iliac vein
	I80.212	Phlebitis and thrombophlebitis of left iliac vein
	I80.213	Phlebitis and thrombophlebitis of iliac vein, bilateral
	I80.219	Phlebitis and thrombophlebitis of unspecified iliac vein

When you look at the codes above, there is no reason for the unspecified code to be used. Unspecified codes assigned due to missing laterality have a high probability of being denied. There is no defensible reason not to indicate laterality.

This issue may come up in an office using encounter forms or billing tickets. For instance, the proper documentation may be in the chart note, but a provider may write “iliac vein thrombophlebitis” on the form. If the person entering the charges and codes into the computer system does not have access to the medical record, the unspecified code would be the only code that could be assigned.

Consider providers that utilize an EMR and choose their own diagnosis codes. If they have “pick lists” that come up, or type in specific search words for diagnosis, there is a risk that the unspecified codes will populate first. If full descriptors do not show in the EMR fields, the unspecified codes may be chosen by mistake. A thorough check of the EMR and how it looks, how it populates fields, and how providers use it needs to be performed in order to ensure that the most specific code will be chosen and assigned.

EXAMPLE

- A. Patient presents with acute DVT of femoral vein. Patient to continue anticoagulation therapy.

I82.419 Acute embolism and thrombosis of unspecified femoral vein

- B. Patient presents with acute DVT of femoral vein in left leg. Patient to continue anticoagulation therapy.

I82.412 Acute embolism and thrombosis of left femoral vein

With the addition of the word “left” a specific code is able to be assigned and the unspecified code would not be reported.

Time parameters

The time parameters acute, chronic, acute on chronic, and recurrent are important documentation factors in ICD-10-CM. The difference between a specific and an unspecified code may be indication of the time parameter. Documentation should include this factor in order to assign a code to the highest level of specificity.

EXAMPLE

- A. Joy presents for recheck on her CHF. She states she is still short of breath and has lower extremity edema. Diuretic added.

I50.9 Heart failure, unspecified

- B. Joy presents for a recheck on her chronic systolic CHF. She states she is still short of breath and has lower extremity edema. Diuretic added.

I50.22 Chronic systolic (congestive) heart failure

With the addition of the words “chronic systolic” a more specific code is able to be assigned.

Site

There are additional codes in ICD-10-CM due to site specificity. Fracture coding is a good example of the expansion of site in the code set. Documentation must meet these new criteria to avoid unspecified code usage when possible.

EXAMPLE

- A. Jon presents for a recheck of his atherosclerosis of his native arteries. Patient scheduled for duplex scan.

I70.90 Unspecified atherosclerosis

- B. Jon presents for a recheck of his atherosclerosis of his native arteries of his right lower extremity with rest pain. Patient scheduled for duplex scan.

I70.221 Atherosclerosis of native coronary arteries of extremities with rest pain, right leg

Notice in example A, without specific site, the fact that the native arteries are affected is also lost in the code. That is one of the dangers of incomplete documentation. Other pieces of important information may be lost when an unspecified code is used.

Other and Multiple Issues

In some cases, multiple issues previously discussed will be present (time parameter, site, laterality). Cardiologists need full education on these areas to ensure that unspecified codes will not be used, or multiple provider queries to receive enough information to assign a code. Following are more examples of the expanded documentation necessary for ICD-10-CM.

EXAMPLE

- A. Michael presents with ASHD with angina. Patient has positive treadmill test and presently takes Procardia and Sorbitrate. Has nitroglycerin for PRN usage.

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

- B. Michael presents with ASHD of autologous artery graft with unstable angina. Patient had CABG 5 years ago. Patient has positive treadmill test and presently takes Procardia and Sorbitrate. Has nitroglycerin for PRN usage.

I25.720 Atherosclerotic heart disease of autologous artery coronary artery bypass graft(s) with unstable angina pectoris

In example A, with no documentation of prior CABG, the assumption in the index is that the disease is of the native coronary arteries. In example B, with the additional information documented, a much more specific code can be assigned. There is now specification that disease is present in the arterial bypass graft and that unstable angina is present.

EXAMPLE;

- A. Linda is in today for a follow-up of her atrial fibrillation. Meds: Cardizem. She states her heart rate is up just a little bit today. No chest pains. No shortness of breath. ECG: Afib with nonspecific ST-T changes.

I48.91 Unspecified atrial fibrillation

- B. Linda is in today for a follow-up of her persistent atrial fibrillation. Condition present for more than 2 years. Meds: Cardizem. She states her heart rate is up just a little bit today. She is experiencing more frequent symptomatic AFib recurrence with symptoms lasting for 5 days. No chest pains. No shortness of breath. ECG: Afib with nonspecific ST-T changes.

I48.1 Persistent atrial fibrillation

In example A, the type of atrial fibrillation is not stated. With the addition of the word “persistent” and the supporting documentation in example B, the case can be coded more appropriately.

EXAMPLE

- A. Patrick presents for check-up of his **valve disease. Status post valve replacement.** Patient feeling well and taking medications as prescribed. Upon exam, VSS. HEENT: Grossly normal. Neck: Normal. Thyroid, normal. Carotid, normal upstroke, no bruits. Lungs: Clear. Heart: PMI fifth intercostal space mid clavicular line. Normal S1 and prosthetic S2. No murmur, rub, gallop, or click. Abdomen: Soft and nontender. No palpable mass or hepatosplenomegaly.
- I38 Endocarditis, valve unspecified
Z95.2 Presence of prosthetic heart valve
- B. Patrick presents for check-up. He is status **post aortic valve replacement with porcine valve for aortic stenosis and regurgitation.** Patient feeling well and taking medications as prescribed. Upon exam, VSS. HEENT: Grossly normal. Neck: Normal. Thyroid, normal. Carotid, normal upstroke, no bruits. Lungs: Clear. Heart: PMI fifth intercostal space mid clavicular line. Normal S1 and prosthetic S2. No murmur, rub, gallop, or click. Abdomen: Soft and nontender. No palpable mass or hepatosplenomegaly.
- I35.2 Nonrheumatic aortic (valve) stenosis with insufficiency
Z95.3 Presence of xenogeneic heart valve

In example A, the default code must be reported as there is no information regarding the valve affected or the type of valvular disease. There is also no documentation of the type of replacement. The default code for the transplant is prosthetic valve replacement. With the more specific information in example B, the condition is indicated as aortic stenosis and regurgitation and the transplant type as xenogeneic. This allows for a more specific code choice.

Documentation Requirements for Common Conditions in Cardiology

To assist the providers with clinical documentation improvement, it is necessary that the coder/auditor/educator understand the documentation requirements of the most commonly coded conditions in their specialty. We will indicate the documentation requirements below for common conditions seen in Cardiology.

Hypertension

For correct coding for hypertension, documentation should include the following:

- Type
 - Essential (primary) hypertension
 - Secondary hypertension
 - Neonatal hypertension
- Associated complications
 - Heart failure
 - End stage renal disease
 - Chronic renal disease
 - Pregnancy

- Severity
 - Mild
 - Moderate
 - Severe
- Symptoms/Findings/Manifestations
 - With proteinuria
 - Ulcer related to chronic venous hypertension
- Temporal factors
 - Acute
 - Chronic
- Contributing factors
 - Smoking
 - » Exposure
 - » History of tobacco use
 - » Occupational exposure to environmental tobacco smoke
 - » Tobacco dependence
 - » Tobacco use

Not all factors listed above are associated with all hypertension codes, but this shows the comprehensive nature of the ICD-10-CM code structure.

Congestive Heart Failure

For correct coding for congestive heart failure, documentation should include the following:

- Type
 - Systolic
 - Diastolic
 - Combined systolic and diastolic
- Contributing factors
 - Rheumatic fever
- Temporal factors
 - Acute
 - Chronic
 - Acute on chronic
- Associated conditions
 - Heart (lung) transplant
 - Procedure
 - Hypertension
 - Renal failure

EXAMPLE

Subjective: 75-year-old female is seen for follow up for **chronic hypertensive heart disease**. She has been having ongoing **shortness of breath and orthopnea**. **Recent EKG demonstrates finding consistent with cardiomegaly**, but not recent change since a prior EKG. Currently, she is on Lasix, Lanoxin, and Atenolol.

Objective: BP = 175/95. HR = 100. Chest X-ray show mild pulmonary edema. There is 2+ pitting edema in both ankles.

Assessment: Hypertension – poorly controlled Chronic diastolic congestive heart failure

I11.0 Hypertensive heart disease with heart failure

I50.32 Chronic diastolic (congestive) heart failure

Myocardial Infarction

For correct coding for myocardial infarction, documentation should include the following:

- Time parameters
 - Initial
 - Subsequent
 - Old
 - Intraoperative
 - Postprocedural
- Type
 - ST elevation (STEMI)
 - Non-ST elevation (NSTEMI)
- Site
 - Left main coronary artery
 - Left anterior descending coronary artery
 - Other coronary artery of anterior wall
 - Right coronary artery
 - Other coronary artery of inferior wall
 - Left circumflex coronary artery
 - Other sites
- Contributing factors
 - Smoking
 - » Exposure
 - » History of tobacco use
 - » Occupational exposure to environmental tobacco smoke
 - » Tobacco dependence
 - » Tobacco use

EXAMPLE

Cardiology is called to see a 50-year-old male patient that presents with **9/10 constant anterior chest pressure/heaviness** that was **radiating into the left arm and jaw for the past two hours**. He had onset of pain at rest, dizziness, weakness, vomiting X 3, but no LOC. Risk factors indicate a **family history of MI**.

Vitals indicate BP of 118/64, O₂ Sat at 94 percent on room air. Patient's skin was pale, cool, and diaphoretic. **12 lead ECG confirms right coronary artery MI with ST elevation** in Lead2, Lead3, aVF with reciprocal changes.

I21.11 ST elevation (STEMI) myocardial infarction involving right coronary artery

Z82.49 Family history of ischemic heart disease and other diseases of the circulatory system

Atherosclerotic Heart Disease

For correct coding of atherosclerotic heart disease, documentation should include the following:

- Anatomical structure
 - Native heart
 - Transplanted heart
- Vessel affected
 - Native coronary artery
 - Autologous vein bypass graft
 - Autologous artery bypass graft
 - Nonautologous bypass graft
 - Other
- Associated with
 - Unstable angina
 - Angina pectoris with documented spasm
 - Other
- Due to
 - Calcified coronary lesion
 - Lipid rich plaque
- Contributing factors
 - Chronic total occlusion of coronary artery
 - Smoking
 - » Exposure to environmental tobacco smoke
 - » History of tobacco use
 - » Occupational exposure to environmental tobacco smoke
 - » Tobacco dependence
 - » Tobacco use

EXAMPLE

A 47-year-old non-obese female presents for treatment. She originally presented to the Emergency Department with typical exertional chest pain which radiated to her left arm. All laboratory data was normal. ETT and myocardial perfusion scan were positive and angiography was done **which revealed coronary artery disease**. She presents today with **unstable angina**. She states that the **chest pains are not regular, and occur while at rest at times**.

Her blood pressure is 110/80, pulse 75, afebrile. Lungs: clear. Heart: PMI displaced. S1 and S2 regular. Abdomen: Soft, nontender. Bowel sounds present.

Patient with CAD with unstable angina. Cardiac workup to be performed. Will schedule cardiac catheterization for patient.

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

Valve Disease/Disorder

For correct coding of valve disease/disorder, documentation should include the following:

- Valve affected
 - Aortic
 - Mitral
 - Pulmonary
 - Tricuspid
 - Mitral and aortic
 - Mitral and tricuspid
 - Aortic and tricuspid
 - Mitral, aortic, and tricuspid
 - Other multiple valves
- Time parameters
 - Congenital
 - Acquired
- Types of disorder
 - Stenosis
 - Prolapse
 - Insufficiency
 - Stenosis with insufficiency
- Caused by
 - Rheumatic fever
 - Endocarditis

EXAMPLE

An active 55-year-old woman, who had contracted **rheumatic fever as a child** resulting in **mitral stenosis** years ago, found her exercise tolerance gradually decreasing over the past year presents for evaluation. Echo indicates she has a modest abnormality of pulmonary artery pressure with complex valve anatomy unsuitable for a catheterization-based balloon valvuloplasty. Patient to be scheduled for open mitral valve repair to widen the opening and allow better blood flow from the atrium to the ventricle.

I05 Rheumatic mitral stenosis

Cardiomyopathy

For correct coding for cardiomyopathy, documentation should include the following:

- Type
 - Dilated
 - Obstructive hypertrophic
 - Other hypertrophic
 - Endomyocardial
 - Endocardial fibroelastosis
 - Other constrictive
 - Other
- Caused by
 - Alcohol
 - Drugs and external agents

EXAMPLE

Jack comes in today complaining of **chest distress, shortness of breath and abdominal distention. I implanted a pacemaker in him 7 years ago.** His blood pressure, temperature, and pulse measurements were within normal limits. No precardiac prominence was detected and apical pulsation was normal. **Cardiac silhouette was enlarged to the left.** Cardiac rhythm was regular, the first heart sound was normal, and a murmur was heard from the mitral valve and tricuspid valve. **Cardiac ultrasound** was performed and a diagnosis of **dilated cardiomyopathy is confirmed.**

I42.0 Dilated cardiomyopathy

Z95.0 Presence of cardiac pacemaker

Assisting Providers with Transition to ICD-10-CM

A real emphasis needs to be made with the family practitioners to move away from usage of unspecified codes. As seen in the many examples given previously, a few more precise words and sentences can allow for more specific code assignment. There is a high risk for denial by payers under ICD-10-CM for certain unspecified code usage.

Multiple assessments may need to be made in a practice to ensure that documentation meets the standards of ICD-10-CM. If a practice utilizes diagnosis-driven templates, whether electronic or paper, an assessment will need to be performed to ascertain if changes need to be made to the templates to meet ICD-10-CM specificity. For example, a non-pressure chronic ulcer template will need to include site, laterality, severity, and causation in the template for complete documentation for the best code selection. If updates are necessary, the providers need to be made aware of all the changes with time enough to get used to them.

The best way to help providers transition their documentation to be ICD-10 ready is to perform documentation readiness assessments. If the providers don't know how the coding parameters have changed for ICD-10-CM, they cannot be expected to meet them. A documentation assessment will compare the documentation of the provider today against ICD-10-CM to show the providers the differences. This will allow time to prepare and make any documentation adjustments necessary.

The first step to performing an ICD-10-CM documentation readiness assessment is to run a frequency report by diagnosis code. It can be run for the entire practice to see what the top overall codes are that are seen. It can be run by clinic to compare top codes by facility. Finally, it must be run by provider. With the entire practice report, you can see a number of things: what kind of codes are most used? Are they unspecified codes? Compare them to their ICD-10-CM counterparts to assess how much, if any, they will change. This will give you a “big picture” of what the practice will need to do in order to become ICD-10 documentation ready. If you have multiple clinics, the report will give you an idea of which clinic will need the most help, education, and time to make the documentation upgrade for ICD-10-CM. The report you run by provider will be your working list for education. Take the number one code for the provider. Run another report looking for patients with that diagnosis in the past 1-2 months. From that report, pull 10-15 patients. From the documentation present, can you assign an ICD-10-CM code? If so, are they codes that are comprehensive, or are they unspecified codes? Next, create a report by patient that shows what, if any ICD-10-CM code could be assigned and what deficiencies, if any, were present that made the record unable to support a more specific code. If there were no deficiencies, point that out also.

After the report is put together, take a copy of the chart notes and the report and meet with the provider. Show the provider where the deficiencies are in their documentation as it relates to ICD-10-CM. Show them what needs to be present in order to assign an ICD-10-CM code to the highest level of specificity. There should be a QA percentage that your providers are expected to meet from a compliance standpoint. If they did not meet QA, then the same condition will be assessed at their next session. The same condition will continue to be assessed with education provided until QA is met for that condition. Once met, the next diagnosis on the list is assessed and the process is repeated. This tool is very important as it relates to the most used diagnoses for each provider, using their own recent notes, showing them how their documentation directly relates to a code.

EXAMPLE

Physician Name: Robert Smith, M.D.			Date of Assessment: mm/dd/yyyy
Reviewer/Auditor: Mary Clark, CPC, CPMA			
Chart	Patient ID	ICD-10-CM code(s)	ICD-10-CM code description
1	A244893	I48.91	Unspecified atrial fibrillation

In ICD-10-CM, in order to assign a code for atrial fibrillation to the highest level of specificity, documentation needs to include type.

Chart	Patient ID	ICD-10-CM code(s)	ICD-10-CM code description
2	J990356	I48.0	Paroxysmal atrial fibrillation

Code appears to make transition to ICD-10-CM.

It is important to understand the impact of overutilization of unspecified codes in ICD-10-CM. There is a real, increased risk of denials, pended claims, and medical necessity issues due to unspecified code assignment with the new code set. A longer adjudication process due to increased denials, increased A/R due to an increase in pended claims, decrease in productivity as staff spend more time working problem claims. These factors may have a heavy impact on the practice's finances. Working early and often with providers to help improve documentation practices will be a definite benefit.

