ICD-10 | Clinical Concepts for Cardiology

ICD-10 Clinical Concepts Series

- Common Codes
- Clinical Documentation Tips
- Clinical Scenarios

ICD-10 Clinical Concepts for Cardiology is a feature of Road to 10, a CMS online tool built with physician input.

With Road to 10, you can:

- Build an ICD-10 action plan customized for your practice
- Use interactive case studies to see how your coding selections compare with your peers' coding
- Access quick references from CMS and medical and trade associations
- View in-depth webcasts for and by medical professionals

To get on the Road to 10 and find out more about ICD-10, visit:

cms.gov/ICD10
roadto10.org

ICD-10 Compliance Date: **October 1, 2015**

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

Clinical Documentation Tips

ICD-10 Compliance Date: **October 1, 2015**

Specifying anatomical location and laterality required by ICD-10 is easier than you think. This detail reflects how physicians and clinicians communicate and to what they pay attention - it is a matter of ensuring the information is captured in your documentation.

In ICD-10-CM, there are three main categories of changes:

- **Definition Changes**
- **Terminology Differences**
- **Increased Specificity**

For cardiology, the focus is increased specificity and documenting the downstream effects of the patient's condition.

ACUTE MYOCARDIAL INFARCTION (AMI)

Definition Change

When documenting hypertension, include the following:

1. Timeframe	An AMI is now considered "acute" for 4 weeks from the time of the incident, a revised timeframe from the current ICD-9 period of 8 weeks.
2. Episode of care	ICD-10 does not capture episode of care (e.g. initial, subsequent, sequelae).
3. Subsequent AMI	ICD-10 allows coding of a new MI that occurs during the 4 week "acute period" of the original AMI.

ICD-10 Code Examples

I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall

HYPERTENSION

Definition Change

In ICD-10, hypertension is defined as essential (primary). The concept of "benign or malignant" as it relates to hypertension no longer exists.

When documenting hypertension, include the following:

1. Type	e.g. essential, secondary, etc.
2. Causal relationship	e.g. Renal, pulmonary, etc.

ICD-10 Code Examples

I10	Essential (primary) hypertension
I11.9	Hypertensive heart disease without heart failure
I15.0	Renovascular hypertension

CONGESTIVE HEART FAILURE

Terminology Differences & Increased Specificity

The terminology used in ICD-10 exactly matches the types of CHF. If you document "decompensation" or "exacerbation," the CHF type will be coded as "acute on chronic."

When documenting CHF, include the following:

1. Cause	e.g. Acute, chronic
2. Severity	e.g. Systolic, diastolic

ICD-10 Code Examples

I50.23	Acute on chronic systolic (congestive) heart failure
I50.33	Acute on chronic diastolic (congestive) heart failure
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure

UNDERDOSING

Terminology Difference

Underdosing is an important new concept and term in ICD-10. It allows you to identify when a patient is taking less of a medication than is prescribed.

When documenting underdosing, include the following:

1. Intentional, Unintentional, Non-compliance	Is the underdosing deliberate? (e.g., patient refusal)
2. Reason	Why is the patient not taking the medication? (e.g.financial hardship, age-related debility)

ICD-10 Code Examples

Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship
T36.4x6A	Underdosing of tetracyclines, initial encounter
T45.526D	Underdosing of antithrombotic drugs, subsequent encounter

ATHEROSCLEROTIC HEART DISEASE WITH ANGINA PECTORIS

Terminology Difference

When documenting atherosclerotic heart disease with angina pectoris, include the following:

1. Cause	Assumed to be atherosclerosis; notate if there is another cause
2. Stability	e.g. Stable angina pectoris, unstable angina pectoris
3. Vessel	Note which artery (if known) is involved and whether the artery is native or autologous
4. Graft involvement	If appropriate, whether a bypass graft was involved in the angina pectoris diagnosis; also note the original location of the graft and whether it is autologous or biologic

ICD-10 Code Examples

I25.110	Atherosclerotic heart disease of a native coronary artery with unstable angina pectoris
I25.710	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris

CARDIOMYOPATHY

Increased Specificity

When documenting cardiomyopathy, include the following, where appropriate:

1. Type	e.g. Dilated/congestive, obstructive or nonobstructive hypertrophic, etc.
2. Location	e.g. Endocarditis, right ventricle, etc.
3. Cause	e.g. Congenital, alcohol, etc.

List cardiomyopathy seen in other diseases such as gout, amyloidosis, etc.

ICD-10 Code Examples

I42.0	Dilated cardiomyopathy
I42.1	Obstructive hypertrophic cardiomyopathy
I42.3	Endomyocardial (eosinophilic) disease

HEART VALVE DISEASE

Increased Specificity

ICD-10 assumes heart valve diseases are rheumatic; if this is not the case, notate otherwise.

When documenting heart valve disease, include the following:

1. Cause	e.g. Rheumatic or non-rheumatic
2. Type	e.g. Prolapse, insufficiency, regurgitation, incompetence, stenosis, etc.
3. Location	e.g. Mitral valve, aortic valve, etc.

ICD-10 Code Examples

I06.2	Rheumatic aortic stenosis with insufficiency
I34.1	Nonrheumatic mitral (valve) prolapse

ARRYTHMIAS/DYSRHYTHMIA

Increased Specificity

When documenting arrhythmias, include the following:

1. Location	e.g. Atrial, ventricular, supraventricular, etc.
2. Rhythm name	e.g. Flutter, fibrillation, type 1 atrial flutter, long QT syndrome, sick sinus syndrome, etc.
3. Acuity	e.g. Acute, chronic, etc.
4. Cause	e.g., Hyperkalemia, hypertension, alcohol consumption, digoxin, amiodarone, verapamil HCl

ICD-10 Code Examples

I48.2	Chronic atrial fibrillation
I49.01	Ventricular fibrillation