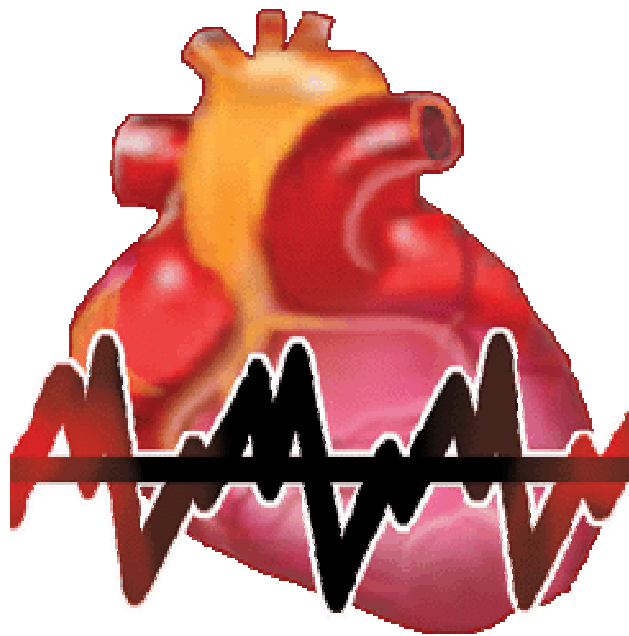# ICD-10 and Cardiology

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ICD-10 and Cardiology
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Note: ICD-9-CM and ICD-10 are owned and copyrighted by the World Health Organization. The codes in this guide were obtained from the US Department of Health and Human Services, NCHS website. This guide does not contain ANY legal advice. This guide shows what specific codes will change to when ICD-9-CM becomes ICD-10-CM

For the past thirty-one (31) years, we have learned and used ICD-9-CM when coding for our providers . 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, 2013. This can be found at https://www.cms.gov/ICD10/11b_2011_ICD10PCS.asp. As of May 5., 2011, you have 29 months to be ready for ICD-10-CM

There is an old saying in coding, "If it isn't documented, it doesn't exist or it didn't happen." When ICD-10 becomes effective, it's success is dependent on the provider's documentation.   If the documentation shows, "OM", many of us know this means Otitis Media. Under ICD-9-CM, you have the following codes for OM:

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 opens more with the anatomical area affected and allows for coding of chronic modalities.

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

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. ICD-9-CM was very forgiving to the documentationally challenged provider and coder. 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. One of my favorite doctor is a certified expert witness. He is called by lawyers for the doctor and malpractice insurance company. He reviews the documentation of the visit to make a recommend to proceed to trial or to settle out of court. Most of the depositions I've reviewed, this doctor's recommendation, most of the time, is to settle because the documentation is not sufficient to fight a lawsuit. His recommendation to doctors, medical school students, interns and residents is "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. Again, if it isn't documented, I don't code it because it doesn't exist. With 30 years of clinical medicine, I can say I know what should have been done during the visit, but I cant code based on that. Ive seen doctors in court that have said, "I did this procedure." The lawyers say, "Show Me!"

Lets say you take your car to a mechanic to have your oil changed. You pick up your car and you are charged $3,000 for a new engine. You want to know why a $25 oil change cost $3,000. You are told the engine was replaced. You are entitled to see the old parts that were replaced. This happened to me one time and I asked to see the old part. I was told it was thrown away. I looked at the engine and couldn't see the new part. All I saw was the old parts. I went to the dumpster and no part in the trash. The repair shop had no proof that they replaced the part. They dropped the charge for the replaced part.

The medical record is proof of the old part, unless the doctor, doctors the medical record and if so, then something more serious is taking place.

I just received a medical bill for care I received in 2007. There were charges I know didn't take place. I demanded the medical record copy. The doctor refused. I did obtain the record copy which was maintained by the hospital.   The doctor documented he saw me in my room on the ward. It was well documented to support a level 5 inpatient visit. The problem, I was in surgery having my heart operated on. It was impossible for the doctor to see me in my room while I was in surgery for 10 hours. The doctor is now being investigated for fraud because he trolled hospital wards, took medical records, documented extensive visits and waited for 4 years before sending a bill. It is very possible that this doctor will lose his medical license, not to mention patient lawsuits. I mention all of this to stress the importance of medical record documentation and to be 100% true, accurate, and correct with your documentation and coding.

Lets look at some of the most used codes in Public Medicine. 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 2013. They are current as of the day this guide was prepared.

NUMERICAL ORDER BY ICD-9-CM

ICD-9-CM
250.00 Diabetes mellitus; w/o mention of complication or manifestation; type II, controlled

ICD-10-CM
E11.9 - **Type 2 diabetes mellitus without complications**

Note there are approximately 150 ICD-10 codes for Diabetes.

ICD-9-CM
272.4 Other and unspecified hyperlipidemia, Alpha-lipoproteinemia, Combined hyperlipidemia, Hyperlipidemia NOS, Hyperlipoproteinemia NOS

ICD-10-CM
E78.5 - **Hyperlipidemia, unspecified**

ICD-9-CM
285.9 - **Anemia, unspecified, Anemia: NOS, essential, normocytic,**

not due to blood loss, profound, progressive, secondary, Oligocythemia

ICD-10-CM
D64.9 - **Anemia, unspecified**

ICD-9-CM

401.1 - **Essential hypertension; benign**

ICD-10-CM

I10 - Essential (primary) hypertension

ICD-9-CM

410.72 Acute myocardial infarction; subendocardial infarction; subsequent episode of care

ICD-10-CM

Needs more information

I25.2 Old myocardial infarction

I25.3 Aneurysm of heart

I25.4 Coronary artery aneurysm and dissection

I25.41 Coronary artery aneurysm

I25.42 Coronary artery dissection

I25.5 Ischemic cardiomyopathy

I25.6 Silent myocardial ischemia

ICD-9-CM
411.1 Intermediate coronary syndrome, Impending infarction, Preinfarction angina, Preinfarction syndrome, Unstable angina, Excludes: angina (pectoris)

ICD-10-CM
Needs more info

I20.0 Unstable angina

I20.1 Angina pectoris with documented spasm

I20.8 Other forms of angina pectoris

I20.9 Angina pectoris, unspecified

My Note: ICD-9 may exclude, ICD-10 may not exclude

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

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ICD-9-CM

414.9 Chronic ischemic heart disease, unspecified

ICD-10-CM

I25.9 Chronic ischemic heart disease, unspecified

ICD-9-CM

415.19 Pulmonary embolism and infarction; other

ICD-10-CM
Needs more Information

I74 Arterial embolism and thrombosis

I74.0 Embolism and thrombosis of abdominal aorta

I74.1 Embolism and thrombosis of other and unspecified parts of aorta

I74.10 Embolism and thrombosis of unspecified parts of aorta

I74.11 Embolism and thrombosis of thoracic aorta

I74.19 Embolism and thrombosis of other parts of aorta

I74.2 Embolism and thrombosis of arteries of the upper extremities

I74.3 Embolism and thrombosis of arteries of the lower extremities

I74.4 Embolism and thrombosis of arteries of extremities, unspecified

I74.5 Embolism and thrombosis of iliac artery

I74.8 Embolism and thrombosis of other arteries

I74.9 Embolism and thrombosis of unspecified artery

ICD-9-CM
427.2 Paroxysmal tachycardia, unspecified

ICD-10-CM
I47.9 Paroxysmal tachycardia, unspecified

ICD-9-CM

427.31 Atrial fibrillation

ICD-10-CM
I48.0 - Atrial fibrillation

ICD-9-CM
427.9 Cardiac dysrhythmia

ICD-10-CM–
I97.89 - **Other postprocedural complications and disorders of the circulatory system, not elsewhere classified or**

I49.9 - **Cardiac arrhythmia, unspecified**

ICD-9-CM
428.0 Congestive heart failure, unspecified

ICD-10-CM
Needs more information

I50.2 Systolic (congestive) heart failure

I50.20 Unspecified systolic (congestive) heart failure

I50.21 Acute systolic (congestive) heart failure

I50.22 Chronic systolic (congestive) heart failure

I50.23 Acute on chronic systolic (congestive) heart failure

I50.3 Diastolic (congestive) heart failure

I50.30 Unspecified diastolic (congestive) heart failure

I50.31 Acute diastolic (congestive) heart failure

I50.32 Chronic diastolic (congestive) heart failure

I50.33 Acute on chronic diastolic (congestive) heart failure

I50.4 Combined systolic (congestive) and diastolic (congestive) heart failure

I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure

I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure

I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure

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

ICD-9-CM

496 Chronic airway obstruction

ICD-10-CM

Needs more information

J43 Emphysema

J43.0 Unilateral pulmonary emphysema [MacLeod's syndrome]

J43.1 Panlobular emphysema

J43.2 Centrilobular emphysema

J43.8 Other emphysema

J43.9 Emphysema, unspecified

J44 Other chronic obstructive pulmonary disease

J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation

J44.9 Chronic obstructive pulmonary disease, unspecified

ICD-9-CM

746.6 Congenital mitral insufficiency

ICD-10-CM
Q23.3 - Congenital mitral insufficiency

ICD-9-CM
780.79 Other malaise and fatigue

ICD-10-CM
R53.8 Other malaise and fatigue

ICD-9-CM

786.05 Shortness of breath

ICD-10-CM

R06.02 - Shortness of breath

ICD-9-CM

786.50 Chest pain, unspecified, Not Elsewhere Classified

ICD-10-CM

R07.9 - Chest pain, unspecified

ICD-9-CM

794.30 Abnormal function study; cardiovascular function study, unspecified

ICD-10-CM

R94.30 - Abnormal result of cardiovascular function study, unspecified

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ICD-9-CM

794.31 Abnormal electrocardiogram [ECG] [EKG]

ICD-10-CM

R94.31 - Abnormal electrocardiogram [ECG] [EKG]

Alphabetical Index of Codes by Disease

Abnormal electrocardiogram [ECG] [EKG]

794.31 (ICD-9-CM)
R94.31 (ICD-10-CM)

Abnormal function study; cardiovascular function study, unspecified

794.30 (ICD-9-CM)
R21.0 (ICD-10-CM)

Acute myocardial infarction; subendocardial infarction; subsequent episode of care

410.72 (ICD-9-CM)
I22.2 (ICD-10-CM)

Anemia, unspecified, Anemia: NOS, essential, normocytic, not due to blood loss, profound, progressive, secondary, Oligocythemia,

285.9 (ICD-9-CM)
D64.9 (ICD-10-CM)

Atrial fibrillation

427.31 (ICD-9-CM)
I48.80 (ICD-10-CM)

Cardiac dysrhythmia

427.9 (ICD-9-CM)
I49.9 (ICD-10-CM)

Chest pain, unspecified

786.50 or 786.59 (ICD-9-CM)
R07.9 (ICD-10-CM)

Chronic airway obstruction

496 (ICD-9-CM)
(ICD-10-CM)
J43 Emphysema
J43.0 Unilateral pulmonary emphysema [MacLeod's syndrome]
J43.1 Panlobular emphysema
J43.2 Centrilobular emphysema

J43.8 Other emphysema
J43.9 Emphysema, unspecified
J44 Other chronic obstructive pulmonary disease
J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9 Chronic obstructive pulmonary disease, unspecified

Chronic ischemic heart disease, unspecified

414.9 (ICD-9-CM)
I25.9 (ICD-10-CM)

Congenital mitral insufficiency

746.6 (ICD-9-CM
Q23.3 (ICD-10-CM

Congestive heart failure, unspecified, Congestive heart disease, Right heart failure (secondary to left heart failure)

428.0 (ICD-9-CM)
(ICD-10-CM)
I50.20 Unspecified systolic (congestive) heart failure
I50.21 Acute systolic (congestive) heart failure
I50.22 Chronic systolic (congestive) heart failure
I50.23 Acute on chronic systolic (congestive) heart failure

Coronary atherosclerosis; of native coronary artery

414.01 (ICD-9-CM)
I25.75 Atherosclerosis of native coronary artery of **transplanted heart with angina pectoris**
I25.750 Atherosclerosis of native coronary artery of **transplanted heart with unstable angina**
I25.751 Atherosclerosis of native coronary artery of **transplanted heart with angina pectoris with documented spasm**
I25.758 Atherosclerosis of native coronary artery of **transplanted heart with other forms** of **angina pectoris**

I25.759 Atherosclerosis of native coronary artery of **transplanted heart with unspecified angina pectoris**

I25.76 Atherosclerosis of **bypass graft** of coronary artery of **transplanted heart with angina pectoris**

I25.760 Atherosclerosis of **bypass graft** of coronary artery of **transplanted heart with unstable angina**

I25.761 Atherosclerosis of **bypass graft** of coronary artery of **transplanted heart with angina pectoris with documented spasm**

I25.768 Atherosclerosis of **bypass graft** of coronary artery of **transplanted heart with other forms** of **angina pectoris**

I25.769 Atherosclerosis of **bypass graft** of coronary artery of **transplanted heart with unspecified angina pectoris**

I25.79 Atherosclerosis of **other** coronary artery **bypass graft(s) with angina pectoris**

I25.790 Atherosclerosis of **other** coronary artery **bypass graft(s) with unstable angina pectoris**

I25.791 Atherosclerosis of **other** coronary artery **bypass graft(s) with angina pectoris with documented spasm**

I25.798 Atherosclerosis of **other** coronary artery **bypass graft(s) with other forms** of **angina pectoris**

I25.799 Atherosclerosis of **other** coronary artery **bypass graft(s) with unspecified angina pectoris**

I25.8 Other forms of **chronic ischemic heart disease**

I25.81 Atherosclerosis of **other** coronary **vessels without angina pectoris**

I25.810 Atherosclerosis of coronary artery **bypass graft(s) without angina pectoris**

I25.811 Atherosclerosis of native coronary artery of **transplanted heart without angina pectoris**

I25.812 Atherosclerosis of **bypass graft** of coronary artery of **transplanted heart without angina pectoris**

Diabetes mellitus; w/o mention of complication or manifestation; type II, controlled

250.00 (ICD-9-CM)
E11.9 (ICD-10-CM)

Essential hypertension; benign

401.1 (ICD-9-CM)
I10 (ICD-10-CM)

Intermediate coronary syndrome, Impending infarction, Preinfarction angina, Preinfarction syndrome, Unstable angina, Excludes: angina (pectoris)

411.1 (ICD-9-CM)
I20.0 (ICD-10-CM)

Other and unspecified hyperlipidemia, Alpha-lipoproteinemia, Combined hyperlipidemia, Hyperlipidemia NOS, Hyperlipoproteinemia NOS

272.4 (ICD-9-CM)
E78.5 (ICD-10-CM)

Other malaise and fatigue
780.79 (ICD-9-CM)
R53.8 (ICD-10-CM)

Paroxysmal tachycardia, unspecified
427.2 (ICD-9-CM)
I47.9 (ICD-10-CM)

Pulmonary embolism and infarction; other
415.19 (ICD-9-CM)
(ICD-10-CM)
I74 Arterial embolism and thrombosis
I74.0 Embolism and thrombosis of abdominal aorta
I74.1 Embolism and thrombosis of other and unspecified parts of aorta
I74.10 Embolism and thrombosis of unspecified parts of aorta
I74.11 Embolism and thrombosis of thoracic aorta
I74.19 Embolism and thrombosis of other parts of aorta
I74.2 Embolism and thrombosis of arteries of the upper extremities
I74.3 Embolism and thrombosis of arteries of the lower extremities
I74.4 Embolism and thrombosis of arteries of extremities, unspecified
I74.5 Embolism and thrombosis of iliac artery

I74.8 Embolism and thrombosis of other arteries
I74.9 Embolism and thrombosis of unspecified artery

Shortness of breath

786.05 (ICD-9-CM)
R06.02 (ICD-10-CM)

Coding for ICD-10 appears to be 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.

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.

The proposed effective date for ICD-10 is October 1, 2013.

So, what do we have to do?

- **Retraining**

    Staff Coders with training and certification need to undergo ICD-10 familiarization training to show coding using ICD-10 codes is not going to be difficult. Untrained staff members in coding positions must undergo training and they should also undergo certification. While certification is not mandated by State or Federal law, Certification assures that the coder can code per established standards. AAPC Coders will need to undergo retesting for certification. PAHCS and POMAA certified coders do not.

Providers need training to be more detailed with health record documentation and the importance of how their documentation improves coding and improves practice revenue.

Billers will need to have knowledge of ICD-10 to ensure claims go out with the appropriate ICD-10 codes and to fight claim denials due to coding issues. Untrained billing staff members should undergo training and certification as a medical biller.

- **New Manuals**
  ICD-10 Manuals will need to be obtained and used.

- **Updated Software**
  Medical Billing software needs to be updated to include both ICD-9-CM and ICD-10. This is because with an October 1, 2013 proposed effective date, Claims for September 30th and before September 30th dates of service will still use ICD-9 Codes. You may have a patient who was seen under ICD-9-CM that did not provide insurance information and after 10/1/13, the patient reveals coverage, so the claim must go out using the ICD that was in effect. You also need to contact your clearinghouse, software company and insurance company regarding ANSI 5010 testing. Medicare requires ANSI 5010 testing to be completed by 12/31/2012.

- **Updated Carrier Policies and Procedures**
  Providers who are contracted and have agreed to carrier coding policies should be reviewing these policies and to make sure the contracted carrier is ready to accept the new codes. You should find out if there are going to be any claims payment delays due to the changeover to ICD-10 as this may affect contract payment timeframes.

- **Updated Compliance Plans**
  Practices and Billing Companies should update their compliance plans regarding ICD-10 coding. Extra attention should be directed to performing internal audits of charts and claims

- **Updated Coding Denial Appeals**
  If the billing company is using a cookie cutter appeal, then the appeals should be reviewed an updated to conform to ICD-10 standards.

- **Updated Superbills**
  If the practice is using a superbill that contains ICD-9 codes, these should be replaced with the appropriate ICD-10 code(s).

- Continue to fight fraud, abuse and any up/downcoding issues.

As with any changes there is always the fear that using something new is better resolved by downcoding a claim to remain under the "radar" Finding more codes available could lead to temptation to upcode or to submit a false claim to increase practice revenue.

If we use the time we have been given for preparation, the transition from ICD-9 to ICD-10 can be very seamless.

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). (PXSS Poor Documentation = Lawsuits and LOR.

I can always be reached at steve_verno@yahoo.com
That is steve_verno.

I wish all much success.

Steven M. Verno