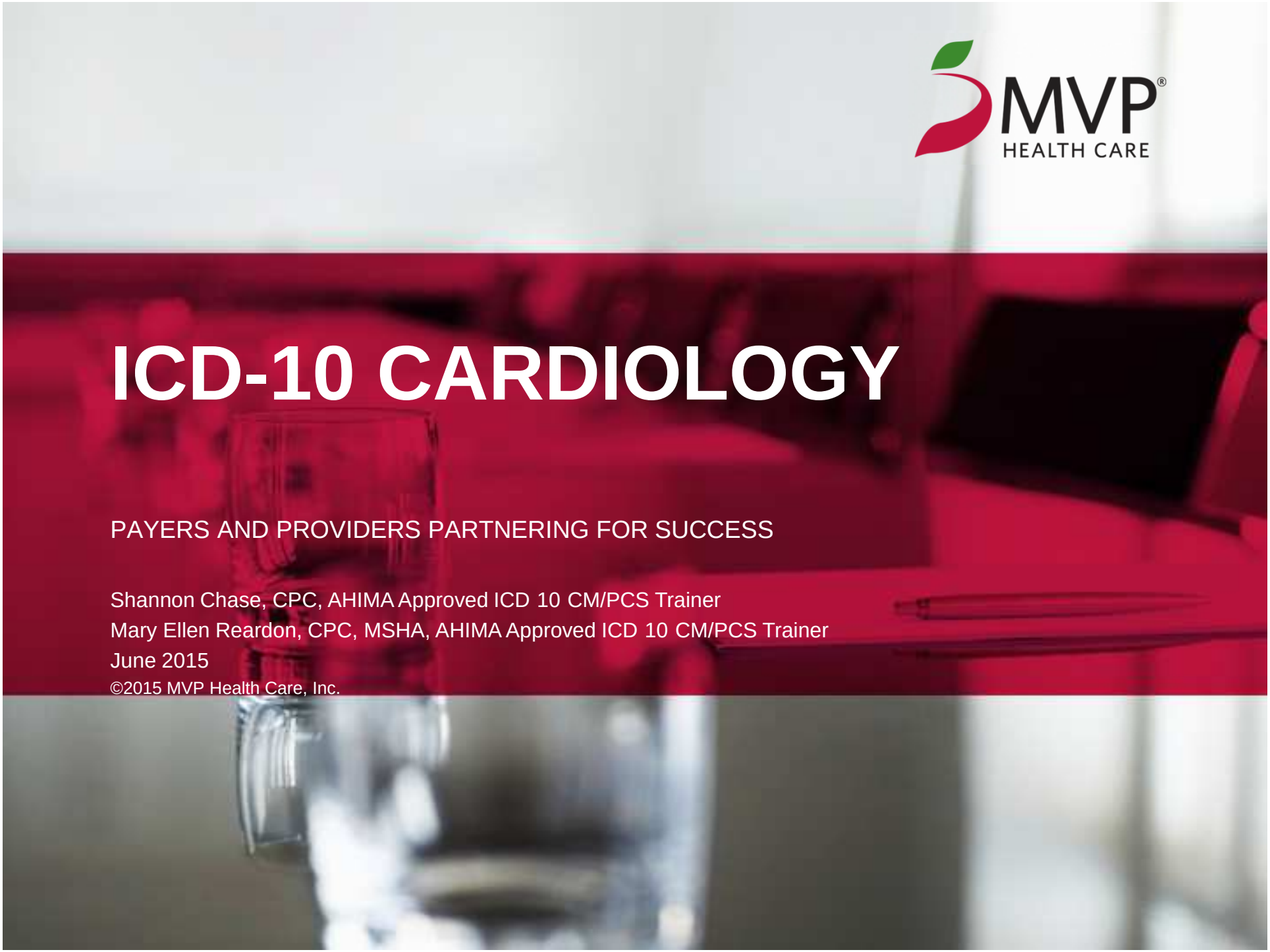

ICD-10 CARDIOLOGY

PAYERS AND PROVIDERS PARTNERING FOR SUCCESS

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IMPORTANCE OF DOCUMENTATION

- A significant portion of practice revenues, however, can be attributed to E&M services.
- Neglecting the proper documentation and coding of encounters is a common and costly mistake.
- If the coding for a service is incorrect at the outset, payment may be delayed, reduced, or not forthcoming at all.
- You also stand to increase revenues by learning to code correctly because as often as not, coding errors are "under coded" versus "over coded.“

CHANGES FROM ICD-9 TO ICD-10

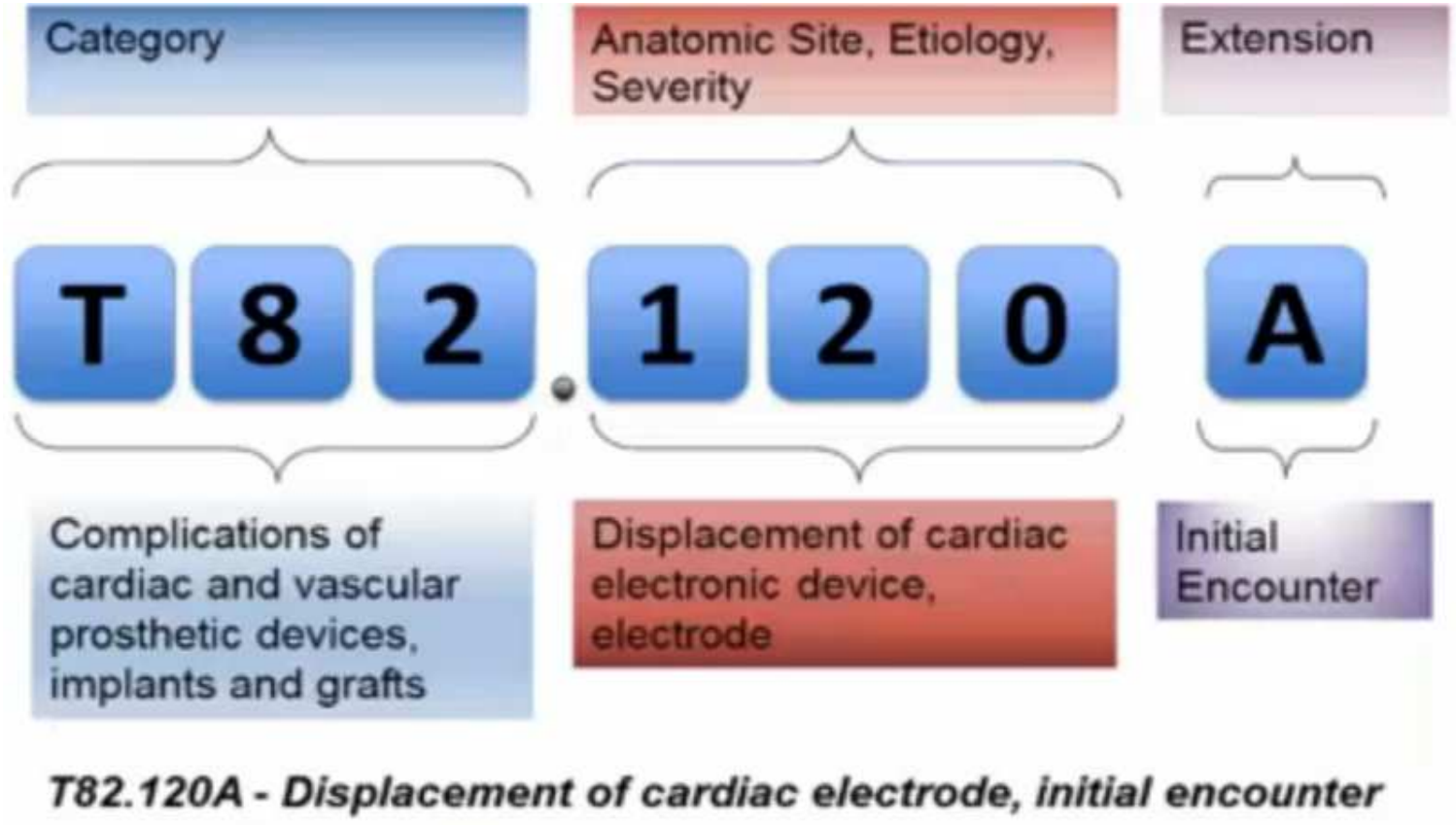
- ICD-10-CM codes specify laterality.
- In ICD-9-CM, coders use V codes and E codes and these will change to Z and S-Y codes.
- MI in ICD-9 is acute for 8 weeks and only 4 weeks in ICD-10.
- ICD-10 contains more than eight times the number of codes used in ICD-9.
- ICD-10 provides a category to identify current complications following STEMI and NSTEMI.
- ICD-10 does not differentiate between benign and malignant hypertension.

ICD-10-CM

ICD-10 STRUCTURE & CONTENT

- ICD-10 diagnosis codes have between 3 and 7 characters
- Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of any or all of the 4th, 5th and 6th characters
- Digits 4-6 provide greater detail of etiology, anatomical site and severity
- A code using only the first three digits is to be used only if it is not further subdivided.

ICD-10 STRUCTURE & CONTENT (CONT.)



VARYING CHANGES BY CLINICAL AREAS

Clinical Area	ICD-9 Code	ICD-10 Codes
Fracture's	747	17099
Poisoning and Toxic effects	244	4662
Pregnancy related conditions	1104	2155
Brain Injury	292	574
Diabetes	69	239
Migraine	40	44
Bleeding disorders	26	29
Mood related disorders	78	71
Hypertensive Disease	**33**	**14**
End stage renal disease	11	5
Chronic respiratory failure	7	4

ICD-10 BILLING AND CODING

- If you are a provider, then you will need to understand how ICD-10 requires specific documentation that differs from what was sufficient for ICD-9.

- If you are a coder, you must know how to translate the clinical information from the operative report into the ICD-10 system. One incorrect character and your entire claim will be undermined.

- When ICD-9 becomes ICD-10, your fracture codes explode with ultra specific options, meaning providers have to document extensive details to ensure the right diagnosis.

ICD-10-CM EXAMPLE OF REVISED CLASSIFICATION

- Hypertension is no longer classified by type- benign, malignant or unspecified
- ICD-10 classifies hypertension as Essential (primary).
- The following are the available categories for hypertensive conditions in ICD-10-CM. In some cases you may need to note if heart failure is present (e.g., I11) and the type of heart failure.
  - I10, Essential (primary) hypertension
  - I11, Hypertensive heart disease
  - I12, Hypertensive chronic kidney disease
  - I13, Hypertensive heart and chronic kidney disease
  - I15, Secondary hypertension
- I10 is used when hypertension is not further specified/associated with/caused by another disease process such as chronic kidney disease.
- Gestational hypertension is assigned OB chapter codes O13.- or O14.-

CLINICAL IMPACTS

CLINICAL DOCUMENTATION IMPACTS

- Quality clinical documentation is essential for communicating the intent of an encounter, confirming medical necessity, and providing detail to support ICD-10 code selection.
- ICD-10-CM contains multiple combination codes so the documentation must reflect the association between conditions.
- Children's conditions differ from those of adults, therefore; accurate documentation of pediatric conditions is important for proper coding.
    - The accuracy of pediatric clinical documentation can have a great impact on many factors of children's healthcare.

CLINICAL DOCUMENTATION IMPACTS (Cont.)

- Poor physician documentation will have long-term implications including inaccurate coding and billing and the loss of critical historic data.

- With ICD-10 dramatically altering the way in which procedures are codes, the impact and trickle down effect of the transition will touch nearly every department within the organization from clinical documentation and coding to claims and processing and reimbursement, as well as audit, compliance and risk management programs, therefore accurate documentation is necessary.

- ICD-10 makes documentation and coding for cardiology easier and more efficient with the new updated codes that contain useful combinations of conditions and use current clinical definitions:
  - I25.110-Atherosclerotic heart disease of native coronary artery with unstable angina pectoris replaces 414.01 (Coronary atherosclerosis of native coronary artery) and 411.1 (Intermediate coronary syndrome)
  - I21.02 ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery replaces 410.11 (First visit- Acute myocardial infarction of other anterior wall, initial episode of care) and 410.12 (All other visits- Acute myocardial infarction of other anterior wall, subsequent episode of care)

WITH ICD-10, APPROPRIATE CLINICAL DOCUMENTATION CAN:

- Enhance communication and collaboration among providers and between physician and patient by filling in the gaps in treatment and care.
- Provide an accurate representation of the severity and complexity of a patients illness.
- Improve the quality of patient care, the patient care experience and strengthen the doctor-patient relationship.
- Connect the pieces of the medical record together for problems, assessments, procedures and treatments.
- Improves the reporting of clinical data for numerous diseases and conditions, including cardiac arrest.
- Support and supplement provider documentation.
- Help substantiate the level of specificity required within ICD-10.

ICD-10 CLINICAL DOCUMENTATION IMPACTS

- Onset of care
- Etiology and Manifestation
- Anatomical site specificity
- Complications
- Laterality
- Combination Codes
- Disease severity
- Non-specific/unspecified

DOCUMENTATION REQUIREMENTS

ACUTE MYOCARDIAL INFARCTION

- Classifications of acute myocardial infarctions should be documented as:
  - ST elevation (STEMI)
  - Non-ST elevation (NSTEMI)

- Identify the site of the STEMI, for example:
  - 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

- Document any old myocardial infarction or post-myocardial infarction syndrome

ACUTE MYOCARDIAL INFARCTION (cont.)

- Identify any subsequent myocardial infarctions
  - Subsequent myocardial infarctions are categorized as those which occur within 28 days of a previous MI regardless of site

- Document site of subsequent STEMI, for example:
  - Anterior, posterior, inferior wall, lateral wall

- Indicate any history of or current tobacco use or dependence or environmental exposure to tobacco smoke

- Document any prior administration of thrombolytics that occurred within 24 hours of admission to facility

ACUTE MYOCARDIAL INFARCTION (cont.)

- Document any complications which occur within 28 days of a STEMI or NSTEMI, such as:
  - Hemopericardium
  - Ventricular septal defect
  - Rupture of cardiac wall
  - Rupture of chordae tendinae
  - Rupture of papillary muscle
  - Thrombosis of atrium, auricular appendage and ventricle
  - Post infection angina

ANGINA

- Terminology change: Intermediate Coronary Syndrome is now classified as Unstable Angina
- Identify any signs or symptoms associated with angina equivalent presentation
- Document presence of hypertension or hypertensive heart and/or chronic kidney disease
- Indicate any history of or current tobacco use or dependence or environmental exposure to tobacco smoke

CORONARY ARTERY DISEASE

- Include the type of angina pectoris present such as:
  - Unstable
  - Chronic stable
  - With documented spasm
  - None
  - Other

- Atherosclerotic heart disease is further classified, for example:
  - Native coronary artery
  - Coronary artery bypass grafts
  - Autologous vein coronary artery bypass grafts
  - Autologous artery coronary artery bypass grafts
  - Nonautologous biological coronary artery bypass grafts
  - Native coronary artery of transplanted heart
  - Bypass graft of coronary artery of transplanted heart

CORONARY ARTERY DISEASE (cont.)

- Atherosclerotic heart disease without angina pectoris is classified to:
  - Native coronary artery
  - Coronary artery bypass grafts
  - Native coronary artery of transplanted heart
  - Bypass graft of coronary artery of transplanted heart

- Document the presence of a healed/old myocardial infarction (one that does not require treatment)

- Identify causal agents such as lipid plaque or calcified coronary lesion

- Indicate if a total occlusion of the artery is present and if it is chronic

HEART FAILURE

- Document the type of failure such as:
  - Left Ventricular
  - Right Ventricular
  - Congestive

- For congestive failure specify if it is:
  - Systolic
  - Diastolic
  - Combined systolic and diastolic

- Further specify acuity of congestive heart failure as:
  - Acute
  - Chronic
  - Acute on Chronic

HEART FAILURE

- Ejection fraction, if measured

- Identify any causal conditions, such as:
  - Hypertension or hypertension with chronic kidney disease
  - Cardiomyopathy, rheumatic, valvular
  - Postpartum
  - Alcohol induced

- Indicate if heart failure is rheumatic, if present

- Document the underlying cause, such as in the case of cardiac arrest

DOCUMENTING ADVERSE EFFECTS, POISONINGS OR TOXIC EFFECTS

- Document nature of adverse effect such as:
  - Aspirin gastritis
  - Nephropathy
  - Blood disorders
  - Contact dermatitis

- Identify complications or manifestations caused by a substance such as cardiac arrest, convulsions or an anaphylactic reaction

- Document the name of the substance causing the complications or manifestations (e.g., Prednisone, shellfish, digoxin, latex, tide detergent, etc…)

- Specify any external causes including indicating any abuse or dependence associated with the substance

- Provide information regarding the circumstances surrounding the event or the mindset of to help identify if the event was accidental, intentional or the result of an assault

DOCUMENTING COMPLICATIONS OF CARE

- Complications of care are based solely on the providers documentation of the relationship between the condition and the care or procedure.
- The provider must state the condition as a complication.
- Inquire if there appears to be a cause-and-effect relationship between the care provided and the condition.

DOCUMENTATION CHANGES & NEW CONCEPTS

ACUTE MYOCARDIAL INFARCTION (AMI)

- When documenting an AMI, keep the following in mind:
  - Timeframe an AMI is now considered “acute” for four weeks from the time of the incident, a revised timeframe from the current ICD-9 period of eight weeks.
  - Episode of care ICD-10 does not capture episode of care (e.g. initial, subsequent, sequelae).
  - Subsequent AMI ICD-10 allows coding of a new MI that occurs during the four 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 (CHF)

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. Acuity e.g. Acute, chronic
  2. Type 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

ATHEROCLEROTIC 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

CARDIAC ARREST

- In the current ICD-9-CM alphabetic index, the main term “arrest,” subterm “cardiac” lists code 427.5 (cardiac arrest).

- ICD-10-CM, on the other hand, contains seven cardiac arrest codes. The new coding system also provides the following specific surgical complication codes:
  - I46.2 (cardiac arrest due to underlying cardiac condition)
  - I46.8 (cardiac arrest due to other underlying condition)
  - I46.9 (cardiac arrest, cause unspecified)
  - I97.120 (postprocedural cardiac arrest following cardiac surgery)
  - I97.121 (postprocedural cardiac arrest following other surgery)
  - I97.710 (intraoperative cardiac arrest during cardiac surgery)
  - I97.711 (intraoperative cardiac arrest during other surgery)

CONTACT

If you have any questions or concerns about the information presented here, please contact Shannon Bujak-Chase or Mary Ellen Reardon and we will be glad to assist you.

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THANK YOU!