HEART DISEASE

Physician Documentation

Heart health is critical to overall health, and treatments may include pharmacologic, nonpharmacologic, and surgical approaches. Details are important when documenting cardiac conditions, as treatment approaches vary, depending on the exact etiology, and because ICD-10-CM heart disease specificity has increased in recent years.

Documentation Tips

- **Identify chest pain as:** during respiration, precordal, intercostal, anterior chest wall, or pleurodynia.
- **Heart failure** is documented as arteriosclerotic, left ventricular, systolic, diastolic, or combined; right heart, high output, or end-stage heart failure. Note whether acute, chronic, or acute on chronic. Congestive heart failure is a nonspecific diagnosis.
- **ICD-10-CM assumes a causal link** between heart failure and hypertension. If the heart failure is not due to hypertension, document its cause.
- **Myocardial infarct** (MI) should be noted as having occurred within the past 28 days, or as being an old MI. A subsequent MI within 28 days of another MI should be so noted by date. Identify STEMI or NSTEMI and site as left main, left anterior descending, right coronary, left circumflex, or inferior/anterior wall.
- **Document any history of** coronary artery bypass surgery, cardiac pacemaker, or heart valve replacement. Document heart transplant status or if the patient is awaiting transplant.
- **In coronary artery disease (CAD),** document any lipid-rich plaque or chronic total occlusion. Note if the vessels involved are native vessels or grafts, and whether the CAD is accompanied by angina pectoris, with or without spasm, or instability.
- **Document the valve associated with any heart murmur,** if known.
- **In valve disease, specify insufficiency or stenosis,** and specify which valve(s) is involved.
- **Do not rely on electronic medication lists to capture long-term use** of medications. Actively document long-term use of anticoagulants, antithrombolitics, antiplatelets, NSAIDs, aspirin, or any other pertinent pharmaceuticals in the medical record for the current encounter.
- **Link cardiac arrest** to underlying conditions, as appropriate.
- **Document pertinent symptoms** (eg, nonexertional dyspnea, fatigue, edema, or weight gain).
- **Document any current use or history of use** of tobacco for patients with heart disease.

Atrial Fibrillation: Document Type	
I48.0	**Paroxysmal**—intermittent, stopping, starting by itself
I48.1	**Persistent**—can be stopped with treatment
I48.2	**Chronic**—cannot be stopped with treatment
I48.91	**Unspecified**—type is not documented or known

Common Tobacco Use and History Codes	
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.218	Nicotine dependence, cigarettes, with nicotine-induced disorders
Z72.0	Tobacco use
Z77.22	Contact with and (suspected) exposure to environmental tobacco smoke (acute)(chronic)
Z87.891	Personal history of tobacco dependence

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Coder Abstraction

Cardiology is a complex specialty with its own nomenclature. Often, more than one code is required to capture the nature of the patient's condition. Refer to anatomy references or search online to understand unfamiliar diagnoses.

Coding Tips

- **If the site of an MI or the type of heart failure is not noted in the physician documentation,** seek out supporting diagnostic documents from radiology or other departments. It is acceptable for diagnostic information from other sources to support a more detailed diagnosis for the physician, so long as it is generated and signed by an acceptable risk-adjustment provider and does not contradict the treating physician's diagnosis.

> **Evolving Myocardial Infarctions**
>
> If an NSTEMI evolves into a STEMI, report only the STEMI. If STEMI converts to NSTEMI due to thrombolytic therapy, code only the STEMI.

- **Any acute MI that is identified as subendocardial** or nontransmural is reported as an NSTEMI (I21.4), regardless of the documented site of the MI.

Common Heart-associated Symptom Codes

Code	Symptom
R01.0	Benign murmur
R01.1	Murmur, NOS
R06.01	Orthopnea
R06.02	Shortness of breath
R42	Dizziness
R60.0	Localized edema
R94.31	Abnormal ECG

Code	Symptom
R00.0	Tachycardia, NOS
R00.1	Bradycardia, NOS
R00.2	Palpitations
R07.2	Precordal pain
R07.9	Chest pain, NOS
R53.83	Fatigue NOS
R68.84	Jaw pain

- **An encounter for a patient who experiences a second acute MI within 28 days** of a previous MI requires two codes to capture the condition: a code from I21-, *ST-elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction,* for the initial MI, and a code from I22-, *Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction*, for the subsequent MI.
- **If a patient has a subsequent MI more than 28 days following a previous** MI, the new infarction is reported as an initial MI with a code from category I21.
- **Report any documented old MI (I25.2),** heart transplant status (Z94.1), heart valve replacement status, and any long-term use of blood-thinners, antithrombolitics, or aspirin.
- **Autogolous graft** is a graft using a vessel removed from the patient for a bypass. Nonautologous biological graft is usually composed of processed vessels from cadavers (allografts [same species]) or animals (xenografts [different species, ie, pigs or cows]).
- **In coronary artery disease,** assume the patient has native arteries if not otherwise documented. Use additional codes to report calcified coronary lesion (I25.84), lipid-rich plaque (I25.83), or chronic total occlusion (I25.82).
- **If a patient's heart arrhythmia is resolved** by placement of a pacemaker, report the pacemaker status rather than the arrhythmia. If a patient continues to take medication for the arrhythmia in addition to having a pacemaker, report the arrhythmia in addition to the pacemaker status.