ICD-9-CM

for Home Health Services and Hospices–Volumes 1, 2 & 3

2015 Expert

International Classification of Diseases
9th Revision
Clinical Modification
Sixth Edition

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Codes Valid October 1, 2014, through September 30, 2015

Chapter 7: Diseases of the Circulatory System (390–459)

Coding Guidance

Very specific guidelines and instructions affect assignment of codes within this category. Pay careful attention to instruction notes in both the alphabetic index and the tabular list. Many of the conditions within this chapter are complex and interrelated. Physicians may use a variety of terms and phrases to describe a diagnosis.

Acute Rheumatic Fever (390–392)

Rheumatic fever is a febrile disease occurring mainly in children or young adults following throat infection by Group A Streptococci. Symptoms include sudden occurrence of fever and joint pain; followed by lesions of the heart, blood vessels, and joint connective tissue, abdominal pain, skin changes, and chorea.

The instructional notes below each of the subcategories further define and clarify the subcategory. These instructional notes assist the user to assign codes accurately even though a variety of terms and phrases may be used to describe diagnosis. For example, the Includes" notes below category 390 indicate that the conditions rheumatic arthritis (acute or subacute), rheumatic fever (active or acute), and articular rheumatism (acute or subacute) are included in this category. “Excludes” notes under category 392 indicate that if the medical documentation states the condition to be chorea, NOS, or Huntington’s chorea, a code from category 392 is not an appropriate assignment.

Chronic Rheumatic Heart Disease (393–398)

Heart disease as a consequence of acute rheumatic fever commonly involves damage to the heart valves during the acute phase of the streptococcal infection. ICD-9-CM makes the presumption that certain conditions of the mitral valve such as stenosis, stenosis with insufficiency, and failure of unknown etiology are of rheumatic fever origin. None of the disorders of the aortic valve are presumed to be of rheumatic origin, however, and must be specified by documentation as “rheumatic” to be classified to these categories. However, when disorders to both mitral and aortic valves are described with the terms stenosis, stenosis with insufficiency, and failure, then ICD-9-CM presumes rheumatic origin.

Hypertensive Disease (401–405)

Hypertension is the condition of abnormally elevated arterial blood pressure. The blood pressure range considered to be hypertensive varies, but most commonly a 140/ 90 mm. Hg. is considered hypertensive.

Hypertension is classified using three axes: First, by type (i.e., primary or secondary); second is by nature of hypertension (i.e., benign, malignant, or unspecified); and third indicates associated heart disease, renal disease, or both heart and renal disease. Refer to instructional notes in coding hypertension. There are many diagnostic terms used to describe the types of hypertension.

The hypertension table, a complete list of diagnoses associated with or due to hypertension, is located in the alphabetic index under the main term “Hypertension.”

Three terms “malignant,” “benign,” and “unspecified,” serve as headings in the table to assist the user to select the most specific code to describe the diagnosis. They are defined as follows:

- Malignant: This type of hypertension is considered the most severe and difficult to treat. A malignant diagnosis is made when the patient’s diastolic blood pressure is consistently greater than 140 and if other clinical features are present, such as cardiac and renal involvement, and neuroretinopathy.
- Benign: This type of hypertension is considered relatively mild and usually is chronic or occurs over a prolonged period of time.
- Unspecified: This term is selected when the physician does not specify the type of hypertension as benign or malignant. If the physician has not specified the type, request clarification of the diagnosis.

Essential hypertension (401) is also referred to as primary, idiopathic, or systolic hypertension, and is defined as hypertension without apparent cause. The physician must document in the medical record whether the hypertension is malignant or benign to assign a fourth digit of 0 or 1 respectively. When no entry in the medical record supports either designation, assign a fifth digit of 9, unspecified.

Hypertensive heart disease is assigned to category 402. Chronic elevated blood pressure often produces changes in the heart myocardium as a result of the increased workload against the elevated blood pressure in the vessels. Hypertensive heart disease includes cardiomegaly, cardiopathy, cardiovascular disease, and heart failure. The first axis of coding is the kind of hypertension (i.e., malignant, benign, or unspecified). The second axis indicates hypertension, with or without heart failure.

In order to assign a code from the 402 category, the diagnostic statement must indicate a causal relationship between the hypertension and the heart disease. Phrases such as “due to hypertension” and “hypertensive” indicate a causal relationship. For example, hypertensive heart disease without heart failure, unspecified, is coded 402.90.

A diagnostic statement “with hypertension” does not indicate a casual relationship between the heart disease and the hypertension and the combination code 402 is inappropriate. In this case, code the heart disease and the hypertension separately. For example, congestive heart failure with hypertension, unspecified, is coded 428.0, 401.9.

Heart disease in combination with an associated hypertensive heart condition classifiable to 428, 429.0–429.3, 429.8, 429.9 is presumed by ICD-9-CM to be hypertensive. For example, congestive heart failure with unspecified hypertensive cardiovascular disease is coded 402.91.

A causal relationship between hypertension and kidney disease is assumed when the diagnostic statement indicates both conditions, even though the statement does not specify hypertensive kidney disease. Hypertensive chronic kidney disease is assigned to the category 403. Fourth-digit assignment, as with other hypertension subcategories, indicates malignant (0), benign (1), or unspecified (9). Fifth-digit assignment indicates without mention of chronic kidney disease (0) or with chronic kidney disease (1). To report chronic renal insufficiency (CRI) with hypertension, assign 403.90 Hypertensive chronic kidney disease stage I through stage IV, or unspecified and code 585.9 Chronic kidney disease, unspecified.

Category 404 includes conditions of hypertensive heart and kidney disease. This category is reviewed when the diagnostic statement indicates both hypertensive heart disease (402) and hypertensive kidney disease (403). Fifth-digit assignment in this category indicates the presence of congestive heart failure, chronic kidney disease, both conditions, or neither. Assign codes from combination category 404 Hypertensive heart and kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the kidney disease, whether or not the condition is so designated.

A patient may have an elevated blood pressure reading during an outpatient visit without having a known diagnosis of hypertension. In this situation, code 796.2, which describes an elevated blood pressure reading that may be the result of emotional problems or stress. This diagnosis code can be found in the alphabetic index under the main term “Elevation” and subterms “blood pressure,” “reading,” and “no diagnosis of hypertension.”

For hypertensive cerebrovascular disease, first assign codes from 430–438 Cerebrovascular disease, then the appropriate hypertension code from categories 401–405.

Hypertensive retinopathy requires two codes to identify the condition. First assign the code from subcategory 362.11 Hypertensive retinopathy, then the appropriate code from categories 401–405 to indicate the type of hypertension.

Secondary hypertension defined as high blood pressure due to or with a variety of primary diseases requires two codes: one to identify the underlying etiology and one from category 405 to identify the hypertension.

The terms “controlled” or “uncontrolled” hypertension refer to whether the hypertension is responding to current therapeutic regimen or not. In either case, code to the type of hypertension, and assign an appropriate code from categories 401–405.

428.43 **Acute on chronic**
AHA: 3Q, '06, 7; 4Q, '02, 52

428.9 **Heart failure, unspecified**
Cardiac failure NOS
Heart failure NOS
Myocardial failure NOS
Weak heart
AHA: 2Q, '89, 10; N-D, '85, 14

✓4th **429 Ill-defined descriptions and complications of heart disease**

429.0 **Myocarditis, unspecified**
Myocarditis
  NOS
  chronic (interstitial
  fibroid
  senile
} (with mention of arteriosclerosis)
Use additional code to identify presence of arteriosclerosis
EXCLUDES *acute or subacute (422.0-422.9)*
rheumatic (398.0)
acute (391.2)
that due to hypertension (402.0-402.9)

429.1 **Myocardial degeneration**
Degeneration of heart or myocardium:
  fatty
  mural
  muscular
Myocardial:
  degeneration
  disease
} (with mention of arteriosclerosis)
Use additional code to identify presence of arteriosclerosis
EXCLUDES *that due to hypertension (402.0-402.9)*

429.2 **Cardiovascular disease, unspecified**
Arteriosclerotic cardiovascular disease [ASCVD]
Cardiovascular arteriosclerosis
Cardiovascular:
  degeneration
  disease
  sclerosis
} (with mention of arteriosclerosis)
Use additional code to identify presence of arteriosclerosis
EXCLUDES *that due to hypertension (402.0-402.9)*

429.3 **Cardiomegaly**
Cardiac:
  dilatation
  hypertrophy
Ventricular dilatation
EXCLUDES *that due to hypertension (402.0-402.9)*
I51.7 Cardiomegaly I-10

429.4 **Functional disturbances following cardiac surgery**
Cardiac insufficiency
Heart failure
} following cardiac surgery or due to prosthesis
Postcardiotomy syndrome
Postvalvulotomy syndrome
EXCLUDES *cardiac failure in the immediate postoperative period (997.1)*
AHA: 2Q, '02, 12; N-D, '85, 6

429.5 **Rupture of chordae tendineae**
DEF: Torn tissue, between heart valves and papillary muscles.

429.6 **Rupture of papillary muscle**
DEF: Torn muscle, between chordae tendineae and heart wall.

✓5th 429.7 **Certain sequelae of myocardial infarction, not elsewhere classified**
Use additional code to identify the associated myocardial infarction:
  with onset of 8 weeks or less (410.00-410.92)
  with onset of more than 8 weeks (414.8)
EXCLUDES *congenital defects of heart (745, 746)*
coronary aneurysm (414.11)
disorders of papillary muscle (429.6, 429.81)
postmyocardial infarction syndrome (411.0)
rupture of chordae tendineae (429.5)
AHA: 3Q, '89, 5

429.71 **Acquired cardiac septal defect** A
EXCLUDES *acute septal infarction (410.00-410.92)*
DEF: Abnormal communication, between opposite heart chambers; due to defect of septum; not present at birth.

429.79 **Other** A
Mural thrombus (atrial) (ventricular), acquired, following myocardial infarction
AHA: 1Q, '92, 10

✓5th 429.8 **Other ill-defined heart diseases**

429.81 **Other disorders of papillary muscle**
Papillary muscle:
  atrophy
  degeneration
  dysfunction
  incompetence
  incoordination
  scarring

429.82 **Hyperkinetic heart disease**
DEF: Condition of unknown origin in young adults; marked by increased cardiac output at rest, increased rate of ventricular ejection; may lead to heart failure.

429.83 **Takotsubo syndrome**
Broken heart syndrome
Reversible left ventricular dysfunction following sudden emotional stress
Stress induced cardiomyopathy
Transient left ventricular apical ballooning syndrome
AHA: 4Q, '06, 87

429.89 **Other**
Carditis
EXCLUDES *that due to hypertension (402.0-402.9)*
AHA: 2Q, '06, 18; 3Q, '05, 14; 1Q, '92, 10

429.9 **Heart disease, unspecified**
Heart disease (organic) NOS
Morbus cordis NOS
EXCLUDES *that due to hypertension (402.0-402.9)*
AHA: 1Q, '09, 7; 1Q, '93, 19
I51.9 Heart disease unspecified I-10

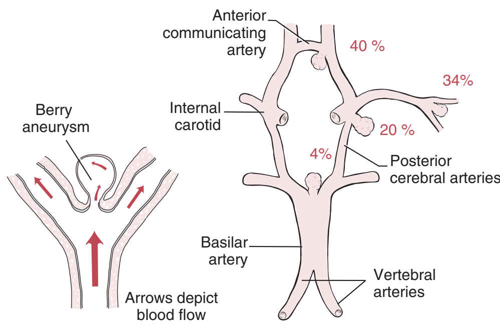
Cerebrovascular Disease (430-438)

INCLUDES with mention of hypertension (conditions classifiable to 401-405)
Use additional code to identify presence of hypertension
EXCLUDES *any condition classifiable to 430-434, 436, 437 occurring during pregnancy, childbirth, or the puerperium, or specified as puerperal (674.0)*
iatrogenic cerebrovascular infarction or hemorrhage (997.02)
AHA: 1Q, '93, 27; 3Q, '90, 3; 2Q, '89, 8; M-A, '85, 6

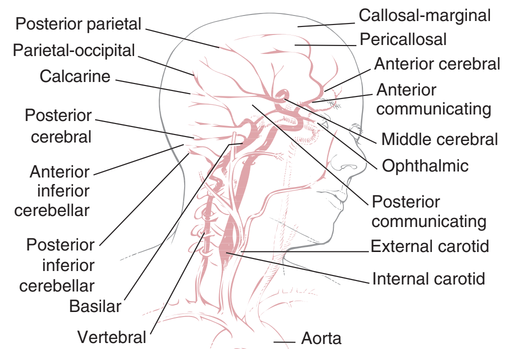
430 Subarachnoid hemorrhage
Meningeal hemorrhage
Ruptured:
  berry aneurysm
  (congenital) cerebral aneurysm NOS
EXCLUDES *berry aneurysm, nonruptured (437.3)*
syphilitic ruptured cerebral aneurysm (094.87)
DEF: Bleeding in space between brain and lining.
AHA: 4Q, '04, 77

431 Intracerebral hemorrhage
Hemorrhage (of):
  basilar
  bulbar
  cerebellar
  cerebral
  cerebromeningeal
  cortical
Hemorrhage (of):
  internal capsule
  intrapontine
  pontine
  subcortical
  ventricular
Rupture of blood vessel in brain
DEF: Bleeding within the brain.
AHA: ►1Q, '12, 14;◄ 3Q, '10, 5-6; 1Q, '10, 8; 3Q, '07, 4; 4Q, '04, 77
I61.9 Nontraumatic intracerebral hemorrhage unspec I-10

Berry Aneurysms



Cerebrovascular Arteries



✓4th 432 Other and unspecified intracranial hemorrhage
AHA: 4Q, '04, 7

432.0 Nontraumatic extradural hemorrhage
Nontraumatic epidural hemorrhage
DEF: Bleeding, nontraumatic, between skull and brain lining.

432.1 Subdural hemorrhage
Subdural hematoma, nontraumatic
DEF: Bleeding, between outermost and other layers of brain lining.

432.9 Unspecified intracranial hemorrhage
Intracranial hemorrhage NOS

✓4th 433 Occlusion and stenosis of precerebral arteries

INCLUDES embolism, narrowing, obstruction, thrombosis } of basilar, carotid, and vertebral arteries

Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility (V45.88)

EXCLUDES *insufficiency NOS of precerebral arteries (435.0-435.9)*

The following fifth-digit subclassification is for use with category 433:
0 without mention of cerebral infarction
1 with cerebral infarction

DEF: Blockage, stricture, arteries branching into brain.
AHA: 2Q, '95, 14; 3Q, '90, 16

§ 6 ✓5th **433.0 Basilar artery**
[0-1]

§ 6 ✓5th **433.1 Carotid artery**
[0-1]
AHA: 1Q, '00, 16; **For code 433.10:** 1Q, '06, 17; 1Q, '02, 7, 10
I65.29 Occlusion and stenosis of unspec carotid artery I-10
I63.239 Cerebrl infarct d/t uns occl/stenosis of uns carotid artery I-10

§ 6 ✓5th **433.2 Vertebral artery**
[0-1]

§ 6 ✓5th **433.3 Multiple and bilateral**
[0-1]
AHA: 2Q, '02, 19

§ 6 ✓5th **433.8 Other specified precerebral artery**
[0-1]

§ 6 ✓5th **433.9 Unspecified precerebral artery**
[0-1]
Precerebral artery NOS

✓4th 434 Occlusion of cerebral arteries

The following fifth-digit subclassification is for use with category 434:
0 without mention of cerebral infarction
1 with cerebral infarction

Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility (V45.88)

AHA: 2Q, '95, 14

§ 6 ✓5th **434.0 Cerebral thrombosis**
[0-1]
Thrombosis of cerebral arteries
AHA: For code 434.01: 4Q, '04, 77

§ 6 ✓5th **434.1 Cerebral embolism**
[0-1]
AHA: For code 434.11: 3Q, '97, 11; 4Q, '04, 77
I63.449 Cerbral infarct d/t embo of uns cerebellar art I-10

§ 6 ✓5th **434.9 Cerebral artery occlusion, unspecified**
[0-1]
AHA: For code 434.91: 3Q, '10, 5-6; 4Q, '08, 108; 3Q, '07, 9; 1Q, '07, 23; 4Q, '04, 77-78; 4Q, '98, 87

✓4th 435 Transient cerebral ischemia

INCLUDES cerebrovascular insufficiency (acute) with transient focal neurological signs and symptoms
insufficiency of basilar, carotid, and vertebral arteries
spasm of cerebral arteries

EXCLUDES *acute cerebrovascular insufficiency NOS (437.1)*
that due to any condition classifiable to 433 (433.0-433.9)

435.0 Basilar artery syndrome

435.1 Vertebral artery syndrome

435.2 Subclavian steal syndrome
DEF: Cerebrovascular insufficiency, due to occluded subclavian artery; symptoms include pain in mastoid and posterior head regions, flaccid paralysis of arm and diminished or absent radial pulse on affected side.

435.3 Vertebrobasilar artery syndrome
DEF: Transient ischemic attack; due to brainstem dysfunction; symptoms include confusion, vertigo, binocular blindness, diplopia, unilateral or bilateral weakness and paresthesis of extremities.
AHA: 4Q, '95, 60

435.8 Other specified transient cerebral

435.9 Unspecified transient cerebral ischemia
Impending cerebrovascular accident
Intermittent cerebral ischemia
Transient ischemic attack [TIA]
DEF: Temporary restriction of blood flow to arteries branching into brain.
AHA: N-D, '85, 12
G45.9 Transient cerebral ischemic attack unspecified I-10

436 Acute, but ill-defined, cerebrovascular disease

Apoplexy, apoplectic:
- NOS
- attack
- cerebral
- seizure

Cerebral seizure

EXCLUDES *any condition classifiable to categories 430-435*
cerebrovascular accident (434.91)
CVA (ischemic) (434.91)
embolic (434.11)
hemorrhagic (430, 431, 432.0-432.9)
thrombotic (434.01)
postoperative cerebrovascular accident (997.02)
stroke (ischemic) (434.91)
embolic (434.11)
hemorrhagic (430, 431, 432.0-432.9)
thrombotic (434.01)

AHA: 4Q, '04, 77; 4Q, '99, 3
TIP: Do not assign when documentation indicates "CVA, stroke, or cerebral infarction." See instead default code 434.91.

✓4th 437 Other and ill-defined cerebrovascular disease

437.0 Cerebral atherosclerosis A
Atheroma of cerebral arteries
Cerebral arteriosclerosis
AHA: 3Q, '10, 15
I67.2 Cerebral atherosclerosis I-10

§ Requires fifth digit. Valid digits are in [brackets] under each code. See appropriate category for codes and definitions.
6 Hospice noncancer Dx with fifth digit 1

✓4th ✓5th Additional Digit Required | Clinical Dimension Dx | Unspecified Code | Other Specified Code | Manifestation Code | Hospice Non-cancer Dx

ICD-10-CM Coding and Documentation Proficiency Self-Assessment

Introduction

This self-assessment covers ICD-10-CM coding guidance and the required level of detail for clinical documentation of heart disease, diabetes, and pneumonia. These high-volume diagnoses have numerous coding guidelines and documentation requirements. The assessment also covers ICD-10-CM conventions that are new or problematic. Use this self-assessment to identify the areas that may require additional coding training or documentation improvement before ICD-10-CM is implemented on October 1, 2014.

Instructions

Code assignments are based upon the 2012 ICD-10-CM diagnosis code set for all reportable diagnoses, including external causes of morbidity (V00–Y99), as appropriate, according to the instructions in ICD-10-CM conventions and the 2012 *ICD-10-CM Draft Official Guidelines for Coding and Reporting*. Answer each question based on the information provided. Note that for some questions, the codes in the answer are not based upon the information provided, requiring that the provider be queried for specific information because the documentation is insufficient to assign codes correctly.

Self-Assessment Questions

1. **In ICD-1Ø-CM what are the two anatomical classifications of pneumonia and the sites of the lung affected by each?**

2. **The attending physician's final diagnosis on the progress note on the day of discharge: atypical pneumonia. Sputum results: normal flora. Chest x-ray: bilateral lower lobe consolidation.**

   A Assign J18.9 Pneumonia, unspecified organism.

   B Documentation does not follow guidelines and/or the physician must be queried to determine the following:

   - Clinical significance of the sputum results
   - Clinical significance of the chest x-ray

3. **What is the appropriate diagnosis code assignment(s) for ESRD due to type I diabetes on chronic dialysis via right arm AV shunt and hypertension as documented by the provider?**

   Code assignment:______________________________

4. **Attending admission note: Patient is a 42-year-old female who presents with diabetes with hypoglycemia.**

   A Assign E11.649 Type II diabetes mellitus with hypoglycemia without coma.

   B Documentation does not follow guidelines and/or the physician must be queried to determine the following:

   - Type of diabetes mellitus
   - Cause of the hypoglycemia

5. **Assign the appropriate code(s) for a diagnosis by the provider of ischemic heart disease and coronary artery disease without history of coronary bypass and current smoker.**

   Code assignment:______________________________

6. **Assign the appropriate code(s) for a patient diagnosed by the provider with community-acquired pneumonia who presented with hemoptysis, productive cough, fever, and an increased respiratory rate with sputum culture stain showing gram-negative bacilli.**

   Code assignment:______________________________

7. **Discharge summary: 1. VAP, with sputum stain identifying *Klebsiella pneumoniae*, sensitivity performed and Keflex administered. 2. Vent-dependent patient.**

   A Assign J95.851 Ventilator associated pneumonia, B96.1 Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified elsewhere, and Z99.11 Dependence on respirator [ventilator] status.

   B Documentation does not follow guidelines and/or the physician must be queried to determine the following:

   - Clinical significance of the sputum results
   - Pneumonia: present on admission or post admission

8. **Assign the appropriate diagnosis code(s) for diabetes II with Charcôt joint, left hallux with ulcer, with dry gangrene and with chronic osteomyelitis. The patient is admitted for amputation due to osteomyelitis documented in the surgeon's admission note.**

   Code assignment:______________________________

9. **What is the appropriate code assignment for a diagnosis of ischemic cardiomyopathy and coronary artery disease, as documented by the provider?**

   Code assignment:______________________________

1Ø. **Discharge summary: Patient was admitted from the ED for work-up of precordial chest pain, elevated troponin; history of CABG, congestive heart failure, hypertension. Final diagnosis: ASCAD with USA, s/p CABG, CHF. Most recent diagnostic left heart catheterization showed clean vein and mammary grafts with 9Ø% atherosclerotic stenosis of the native LAD portion. Plans are for future coronary angioplasty as an outpatient. Continue Lasix, Norvasc, and Nitrolingual.**

   A Assign I25.11Ø Atherosclerotic heart disease of native coronary artery with unstable angina, I11.9 Hypertensive heart disease without heart failure, I5Ø.9 Heart failure, unspecified, Z95.1 Presence of aortocoronary bypass graft.

   B Documentation does not follow guidelines and/or the physician must be queried to determine the following:

   - Description of relationship between the hypertension and congestive heart failure
   - Type of congestive heart failure

11. **What is the appropriate diagnosis code assignment for the postobstructive pneumonia, right middle lobe, due to hilar lung cancer right lobe when the treatment is directed only toward the pneumonia as documented in the admission note by the resident?**

   Code assignment:______________________________

Chart C—Home Health Correct Coding Protocol:

Selection and Assignment of Secondary Diagnoses

This flow chart is used to select the proper secondary diagnosis code, i.e., a V code or an ICD-9-CM numeric code. It is a series of questions with "Yes" and "No" responses along with actions associated with each response.

General Directions for Chart C

1. Selection of the secondary diagnosis is to be based on the patient's clinical condition and NOT on the case mix status of the diagnosis.
2. Each secondary diagnosis should be assigned according to the seriousness of the patient's condition.

Start C

Question 1: Is the selected secondary diagnosis a V code?

If no, answer follow-up question: Is the selected secondary diagnosis part of an etiology/manifestation pair?

If no, report the numeric diagnosis in M0240(b) and return to Start A.

If yes, report the etiology code in M0240(b), report the manifestation code in M0240(c), and return to Start A.

If the answer to Question 1 "Is the selected secondary diagnosis a V code?" was "Yes," then go to Question 2.

Question 2: Is the V code eligible for assignment as a secondary diagnosis under ICD-9-CM guidelines? (Refer to the V code Table in the *ICD-9-CM Official Guidelines for Coding and Reporting* at the following link): http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf

If no, do not report the V code and return to Start A.

If yes, go to Question 3.

Question 3: Is the V code replacing a case mix diagnosis?

If no, report the V code in M0240(b), report the numeric non-case mix diagnosis (if applicable) in M0240(c), and return to Start A.

If yes, go to Question 4.

Question 4: Is the V code replacing an etiology/manifestation pair?

If no, report the V code in M0240(b) and numeric case mix diagnosis in M0240(c) and return to Start A.

If yes, report the V code in M0240(b), report the etiology code in M0240(c), and report the manifestation code in M0240(d). Return to Start A.