DRGs 124/125 — Circulatory Disorders Except AMI with Cardiac Catheterization with and without Complication/Comorbidity

ICD-9-CM Coding Guidelines

The below listed circulatory disorders and heart catheterization guidelines are not inclusive. The coder should refer to the applicable Coding Clinic guidelines for additional information. The Centers for Medicare & Medicaid Services considers Coding Clinic, published by the American Hospital Association, to be the official source for coding guidelines. Hospitals should follow the Coding Clinic guidelines to assure accuracy in ICD-9-CM coding and DRG assignment.

Definition of Principal Diagnosis

The principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Two or more diagnoses may equally meet the definition for principal diagnosis as determined by the circumstances of admission, diagnostic work-up and/or therapy provided. Be aware that there is a difference between admitting a patient to treat two conditions and two conditions being present at the time of admission. The principal diagnosis is always the reason for admission.

Documentation to Support Circulatory Disorders and Heart Catheterizations

When reviewing a record with circulatory disorders, determine whether or not the documentation supports sequencing as the principal diagnosis. For example, did the cardiac catheterization substantiate the presence of coronary artery disease? Was chest pain, unstable angina or angina pectoris due to a noncardiac condition or chest pain, unspecified? Refer any questions to the attending physician.

Was a diagnostic cardiac catheterization performed, or was cardiac catheterization an approach for another procedure? Was angiocardiography and/or coronary arteriography performed? If the documentation is not clear whether or not a procedure was performed, refer the question to the attending physician.

Coding Guidelines

Diagnoses

Abnormal stress test/normal heart catheterization

A patient without signs or symptoms is admitted due to an abnormal stress test. A cardiac catheterization is performed and the findings are within normal limits. Assign a code for observation for suspected cardiovascular disease, V71.7, and sequence as the primary diagnosis. (See Coding Clinic, volume 10, number 5, 1993, page 23.)

Accelerated angina

Accelerated angina should be assigned code 411.1, intermediate coronary syndrome. (See Coding Clinic, first quarter 2003, pages 12 and 13.)

Acute myocardial infarction (AMI)

Effective October 1, 2005, inclusion terms have been added to category 410, AMI, to indicate these codes apply to ST-segment elevation myocardial infarction (STEMI) and non-ST segment elevation myocardial infarction (NSTEMI).
STEMI show an ST segment change on electrocardiogram (ECG) and generally involve the whole thickness of myocardium from epicardium to endocardium. Codes 410.0-410.6 and 410.8 specify sites that equate to STEMI.

NSTEMI do not show an ST segment change on ECG and do not involve thickness of the myocardium. Code 410.7, subendocardial infarction, should be assigned for NSTEMI.

Code 410.9, AMI, unspecified site, does not indicate a site or whether there is an ST elevation. If only STEMI without site is documented, assign a code from subcategory 410.9.

If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

These codes only apply to abnormal ST-segment elevation involving AMIs. Other conditions such as acute pericarditis, acute myocarditis, hyperkalemia, Brugada syndrome, pulmonary embolism, left bundle branch block and Prinzmetal’s angina may cause ST-segment elevation.

An ST-elevation may be a normal variant.

Nontransmural AMI is assigned code 410.7x regardless of the site. (See Coding Clinic, fourth quarter 2005, pages 69-72.)

Effective October 1, 1989, fifth digit subclassifications were added to category 410, AMI, to indicate whether the episode of care was unspecified, initial or subsequent. (See Coding Clinic, third quarter 1989, pages 3 and 4.)

**Acute myocardial ischemia/AMI**

If an AMI has occurred, assign a code from the 410.xx series.

If an acute myocardial ischemia has occurred without an infarction, assign code 411.8x. Assign code 411.81 if an occlusion or thrombosis is present, otherwise assign code 411.89. (See Coding Clinic, third quarter 1991, page 18.)

**Angina/coronary artery disease (CAD)**

A patient was admitted with unstable angina, which was secondary to CAD of the native vessels. CAD was due in part to secondhand tobacco smoke exposure. The principal diagnosis is CAD of native vessel, 414.01, with the secondary diagnoses of unstable angina, 411.1, and secondhand tobacco smoke, E869.4. (See Coding Clinic, second quarter 1996, page 10.)

Code 414.0, coronary atherosclerosis, had fifth digits added effective October 1, 1994. (See Coding Clinic, second quarter 1995, pages 17-19.)

Coding and sequencing guidelines for angina and CAD in Coding Clinic, volume 10, number 5, 1993, pages 17-24, supersedes advice published in Coding Clinic, third quarter 1990, pages 6-10.

Angina is a symptom. Therefore, when the cause is known, the cause is sequenced as the principal diagnosis. If the cause of angina is unknown, then angina is sequenced as principal diagnosis. (See Coding Clinic, second quarter 1997, page 13; Coding Clinic, second quarter 1994, page 15; Coding Clinic, volume 10, number 5 1993, page 19; and Coding Clinic, fourth quarter 1993, pages 43 and 44.)

**Coronary artery disease (CAD)/coronary artery bypass graft (CABG)**

If a patient has CAD and a CABG was performed in the past, however the chart does not document the location of the CAD (i.e., - native vessel vs. graft), assign codes 414.00, CAD unspecified type of vessel, and V45.81, CABG status. (See Coding Clinic, first quarter 2004, page 24, and Coding Clinic, third quarter 1997, pages 15 and 16.)
If a patient has a history of CAD and no mention of having had a CABG, assign code 414.01, CAD of native coronary artery. (See Coding Clinic, third quarter 1997, page 5, and Coding Clinic, second quarter 1995, page 17.)

If the documentation states the patient has a history of a CABG, assign code V45.81, CABG status, and do not assign a code for CAD. (See Coding Clinic, third quarter 1997, page 16.)

**Coronary artery disease (CAD)/diastolic dysfunction**

Assign a code for CAD, 414.01, and diastolic dysfunction, 429.9. (See Coding Clinic, first quarter 1993, page 20.)

**Coronary atherosclerosis of transplanted heart**

Code 414.06, coronary atherosclerosis of coronary artery of transplanted heart, is a new code that was created effective October 1, 2002. (See Coding Clinic, fourth quarter 2002, pages 53 and 54.)

**Codes 411.1/411.81**

Code 411.1, intermediate coronary syndrome, is not assigned with code 411.81, coronary occlusion without myocardial infarction (MI). (See Coding Clinic, first quarter 1991, page 14.)

No code from category 411, except code 411.0, postmyocardial infarction syndrome, should be assigned when the infarction has occurred. Postmyocardial infarction syndrome does sometimes occur on the same admission in which the infarction is treated. (See Coding Clinic, second quarter 1995, page 19, and Coding Clinic, third quarter 1991, page 24.)

**History of angina pectoris**

Angina pectoris, 413.9, can be sequenced as a secondary diagnosis if there is a history of angina and the patient receives medication for angina during the hospital stay. (See Coding Clinic, third quarter 1991, page 16.)

**Hypertension/heart disease**

Hypertension and heart disease are not assigned hypertensive heart disease code, 402.xx, unless the physician has established that heart disease is due to hypertension. If heart disease is not due to hypertension, assign a separate code for heart disease and hypertension. (See Coding Clinic, second quarter 2002, page 43, C.7, #2 and Coding Clinic, third quarter 1990, page 3.)

**Hypertensive cardiomyopathy**

Hypertensive cardiomyopathy is assigned codes 402.9x, hypertensive heart disease, unspecified, and 425.8, cardiomyopathy in other diseases classified elsewhere. (See Coding Clinic, second quarter 1993, page 9.)

**Mural thrombus**

Mural thrombus with no evidence of a cardiac condition or CAD is assigned code 429.89. If the underlying cardiac condition is known, sequence the underlying condition first with an additional code for mural thrombus, 429.89. Assign code 429.79 for mural thrombus if it occurs following an earlier MI. (See Coding Clinic, first quarter 1992, page 10.)

**Rheumatic heart failure**

Effective October 1, 2002, rheumatic heart failure has been added as a complex diagnosis to DRG 124. (See Federal Register, August 1, 2002, pages 49991-49992.)

**Unstable angina/angina pectoris**

Unstable angina is a complication/comorbidity (CC) for DRG 124. Angina pectoris is not a CC for DRG 124. Documentation to substantiate the type of angina must be present. (See Coding Clinic, volume 10, number 5 1993, pages 18 and 19.)
**Unstable angina/AMI**

If a patient is admitted with unstable angina and it is determined after study the patient had an AMI, only AMI is assigned a code. Unstable angina is considered integral to AMI. (See *Coding Clinic*, fourth quarter 1993, pages 39 and 40 and *Coding Clinic*, second quarter 1990, page 15, ODX #3.)

**Unstable angina/history of MI**

If a patient is admitted for unstable angina, has a history of MI three years ago and angina is treated during the admission, unstable angina, 411.1, is sequenced as the principal diagnosis and history of MI, 412, is sequenced as a secondary diagnosis. If MI occurred within eight weeks of the admission, a code from the 410.x2 series should be assigned. (See *Coding Clinic*, volume 10, number 5, 1993, pages 18, 19, 20 and 23.)

**Procedures**

**Attempted angioplasty left anterior descending artery**

Integrilin bolus and drip were started. Attempts for the guidewire and balloon backup to cross the occlusion in the left anterior descending artery (LAD) were unsuccessful. Catheter and guidewire were removed and Integrilin was stopped. Integrilin is a platelet inhibitor. Assign codes 99.20, injection or infusion of platelet inhibitor, for Integrilin and 88.55, coronary arteriography using a single catheter, for catheterization of the LAD. (See *Coding Clinic*, fourth quarter 2002, page 114 correction and *Coding Clinic*, third quarter 2002, page 20.)

**Cutdown of artery**

If a cutdown of an artery is done as part of a heart catheterization, a code is not assigned. Cutdown of an artery is integral to the heart catheterization procedure. (See *Coding Clinic*, second quarter 1990, page 23.)

**Diagnostic cardiac catheterization**

Diagnostic cardiac catheterizations, 37.21-37.23, include a report indicating measurements and calculations. Additional codes for pressure measurements, cardiac output measurements and blood gas determinations are considered integral to the cardiac catheterization code. (See *Coding Clinic*, May-June 1987, page 11. For further information regarding cardiac catheterization see *Journal of AHIMA*, March 1992, volume 63, number 3, pages 25 and 26.)

A code for diagnostic cardiac catheterization should not be assigned if a catheter is passed into or through the chambers of the heart as part of the approach when performing another procedure, i.e., percutaneous transluminal coronary angioplasty (PTCA). An additional code for diagnostic cardiac catheterization would be assigned only if a diagnostic cardiac catheterization is actually performed. This would require a diagnostic cardiac catheterization report of the studies and evaluations. (See *Coding Clinic*, May-June 1987, pages 11 and 12.)

Testing for internal pressure measurements and ventricular function is not the sole definition of cardiac catheterization. (See *Coding Clinic*, second quarter 2005, pages 10 and 11.)

When coding diagnostic cardiac catheterizations, the catheterization is assigned codes 37.21-37.23. Ventriculogram and coronary angiogram is assigned codes under 88.5, angiocardiography using contrast material. (See *Coding Clinic*, May-June 1987, page 11, and *Coding Clinic*, fourth quarter 1988, page 4.)