DRGs 132/133 — Atherosclerosis with or without Complication/Comorbidity

ICD-9-CM Coding Guidelines

The below listed atherosclerosis 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 the Principal Diagnosis
Generally, the principal diagnosis for DRG 132 is coronary artery disease, which is often the underlying cause for angina. Review the medical record to determine the type and cause of angina. If the medical record documentation does not indicate the underlying type and/or cause, query the attending physician.

Coding Guidelines

Angina/coronary artery disease (CAD)
A patient was admitted with unstable angina 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 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 underlying cause is known, it is sequenced as the principal diagnosis. If the cause of angina is unknown, then angina is sequenced as the principal diagnosis. (See Coding Clinic, third quarter 2001, page 15; Coding Clinic, second quarter 1997, page 13; Coding Clinic, second quarter 1995, pages 18-19; Coding Clinic, second quarter 1994, page 15; Coding Clinic, volume 10, number 5 1993, pages 17-20; and Coding Clinic, fourth quarter 1993, pages 43 and 44.)
Apical ballooning syndrome

Apical ballooning syndrome is an acute onset of transient extensive akinesia of the apical and mid portions of the left ventricle without significant stenosis on the coronary angiogram. It is accompanied by chest symptoms, ECG changes and a limited release of cardiac markers disproportionate to the extent of akinesia. Apical ballooning syndrome is assigned code 429.89, other ill-defined heart diseases, other. (See Coding Clinic, third quarter 2005 pages 14 and 15.)

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

If a patient has CAD, a CABG was performed in the past and 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 only information provided is a history of a CABG, assign code V45.81, CABG status, and do not code CAD. (See Coding Clinic, third quarter 1997, page 16.)

CAD/diastolic dysfunction

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

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.)

When an acute myocardial infarction (AMI) has occurred, no code from category 411 is assigned to indicate pre-infarction conditions such as unstable angina and acute myocardial ischemia. Codes for postmyocardial infarction syndrome, 411.0, and postinfarction unstable angina, 411.1, can be assigned when present. (See Coding Clinic, second quarter 1995, page 19, and Coding Clinic, third quarter 1991, page 24.)

Code 412, old MI

This code indicates a history of MI identifying a healed or old MI. An old MI is significant and affects the management of the patient. The note under code 412 which states, “currently presenting no symptoms ...” refers to symptoms related to previous MI, not cardiac symptoms in general. Code 412 cannot be sequenced as the principal diagnosis. (See Coding Clinic, second quarter 2003 page 10, Coding Clinic, second quarter 1991, page 22 and Coding Clinic, July-August 1984, pages 6 and 7.)

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. Effective October 1, 2003, code 414.06 was revised to coronary atherosclerosis of native coronary artery of transplanted heart and a new code 414.07 coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart was added. (See Coding Clinic, fourth quarter 2003, page 60, and Coding Clinic, fourth quarter 2002, pages 53 and 53.)

Impending myocardial infarction

A patient with a history of CAD is admitted for treatment of an impending myocardial infarction. The progression to an acute MI is averted with use of intravenous thrombolytic agents. The impending/aborted MI is assigned code 411.1, intermediate coronary syndrome. The principal diagnosis is CAD, 414.01, because the patient has an established diagnosis of CAD. (See Coding Clinic, second quarter 2002, page 35, and Coding Clinic, second quarter 2001, page 9.)
**Intracardiac echocardiography**

A new code, 37.28, was created October 1, 2001, for intracardiac echocardiography (ICE). This is a diagnostic procedure that provides direct, real-time, two-dimensional images and allows physiologic evaluation from inside the heart. Any synchronous Doppler flow mapping, 88.72, should also be assigned. (See *Coding Clinic*, fourth quarter 2001, page 62.)

**Ischemic cardiomyopathy**

Assign code 414.8, other specified forms of chronic ischemic heart disease, unless the documentation substantiates other ischemic heart disease (codes 410-414). (See *Coding Clinic*, second quarter 1990, page 19.)

**Ischemic cardiomyopathy/known CAD**

Assign codes 414.8, other specified forms of chronic ischemic heart disease, and 414.01, coronary atherosclerosis. (See *Coding Clinic*, third quarter 2001, page 16.)

**Mural thrombus**

Mural thrombus with no evidence of a cardiac condition 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.)

**Old MI**

See code 412, old MI.

**Postinfarction angina**

A code for postinfarction angina and a code for an AMI may be assigned during the same episode of care. Postinfarction angina is coded to the type of angina documented. Unstable angina is assigned code 411.1 and angina pectoris is assigned code 413.9. (See *Coding Clinic*, second quarter 1995, page 19, and *Coding Clinic*, fourth quarter 1994, page 55.)

**Therapeutic ultrasound/intravascular ultrasound of heart**

A new code for therapeutic ultrasound of heart, 00.02, was created effective October 1, 2002. Treatment is provided to prevent restenosis and to treat restenosis. This supercedes previous information to assign code 88.72, diagnostic ultrasound of heart. (See *Coding Clinic*, fourth quarter 2002, page 90-92, and *Coding Clinic*, first quarter 2000, page 21.)

**Unstable angina/acute MI**

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 an 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 and has a history of MI three years ago, 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 18-20 and 23.)