TEST YOUR KNOWLEDGE

Q8: A patient is seen for bilateral acute otitis media. Which ICD-10-CM code should you assign?

TIP: Always remember to check both the Alphabetic Index and the Tabular List when assigning codes. Never assign codes directly out of the Alphabetic Index.

ICD-10-CM Chapter 9: Diseases of the Circulatory System (I00–I99)

Cerebrovascular accidents and transient ischemic attacks

In ICD-9-CM, several codes pertain to cerebrovascular accidents (CVA) and transient ischemic attacks (TIA). CVAs appear in code category 430–434. These codes distinguish between hemorrhagic (e.g., due to a hemorrhage in the brain, not due to trauma) and occlusive (e.g., due to a blockage in the vessel) CVAs. With occlusive codes, the fifth digit denotes whether an infarction is mentioned. TIAs appear in code category 435.x. Late effects of CVAs appear in category 438.xx. The fourth and fifth digits in this category denote the type of late effect (e.g., hemiplegia, dysphagia). Note that code V12.54 denotes a personal history of CVA/TIA without residual deficits.

In ICD-10-CM, CVAs appear in code category I60–I63.

More specifically, nontraumatic hemorrhagic CVAs appear in category I60–I62 and specify the following:

- Location or source of the hemorrhage

- Right or left artery (if applicable)

Documentation should clearly reflect the location/source and laterality to ensure correct code assignment in ICD-10-CM. If the documentation states bilateral hemorrhage sites, codes should be assigned for each side, since there is no bilateral option for this series. For example, if a patient has a nontraumatic subarachnoid hemorrhage of bilateral vertebral arteries, code assignment would be I60.51 (nontraumatic subarachnoid hemorrhage from right vertebral artery) and I60.52 (nontraumatic subarachnoid hemorrhage from left vertebral artery).
Occlusive CVAs appear in category I63–I68. These codes specify the following:

- Thrombosis, embolism, or unspecified
- Infarction or not resulting in infarction
- Location of occlusion

As with hemorrhagic CVAs, documentation of occlusive CVAs should reflect the specific details described previously to ensure correct code assignment. For example, code I63.031 denotes cerebral infarction due to thrombosis of right carotid artery. Code I63.032 denotes cerebral infarction due to thrombosis of left carotid artery; therefore, if the patient has an infarction due to bilateral thromboses in the right and left carotid arteries, both codes would need to be assigned. Note that, like ICD-9-CM, ICD-10-CM also includes an option for unspecified. Code I63.039 denotes cerebral infarction due to thrombosis of unspecified carotid artery. Although an unspecified option exists, coders should take advantage of more specified options when possible.

In some instances, occlusion and stenosis can occur in the precerebral and cerebral arteries without an infarction occurring. In ICD-9-CM, this was identified by the fifth digit; however, coders will notice in ICD-10-CM that separate code categories are designated (I65 and I66) depending on location. A key point is that for this particular series there is a bilateral option (unlike the infarction code category I63); therefore, if a patient has bilateral stenosis of the carotid arteries, only code I65.23 would be assigned. It would be inappropriate to assign codes I65.21 (right carotid) and I65.22 (left carotid) separately.

Sequelea of cerebrovascular disease (i.e., synonymous with late effect) appears in ICD-10-CM code I69.-. This code specifies whether the sequelae are a result of a hemorrhagic or occlusive CVA, as well as the residual condition. The combination codes make it easier to identify all specific information in one code. This description is more specific than in ICD-9-CM, where category 438 doesn’t distinguish the type of CVA that caused the sequelae.

In ICD-10-CM, TIAs appear in category G45.-, located in ICD-10-CM Chapter 6 (Diseases of the Nervous System). Report code Z86.73 (personal history of CVA/TIA without residual deficits) when applicable.
**Coronary artery disease and angina**

In ICD-9-CM, coronary artery disease or, more specifically, coronary arteriosclerotic disease (CAD), appears in code category 414.xx. Codes assignment is based on the vessel involved (i.e., native, bypass graft). Angina pectoris appears in code 411.1 (unstable angina) or category 413.x (stable angina). Code 411.1 also denotes intermediate coronary syndrome.

**Test Your Knowledge**

Q9: A patient suffered a nontraumatic intracerebral hemorrhage seven months ago and is being seen for longstanding dysphagia as a result of the stroke. Which ICD-10-CM code(s) should you assign?

**TIP:** Note that the ICD-10-CM codes that denote CVAs start with the letter I—not the digit 1. All ICD-10-CM codes begin with a letter.
In ICD-9-CM, if a patient has both CAD and angina, code both independently. However, this has always presented a question about sequencing and which should be sequenced as the principal diagnosis. The principal diagnosis should always be the reason—after study—why a patient was admitted to the hospital. However, when a patient has both CAD and angina (i.e., both are present on admission and treated equally), it is sometimes difficult to make this determination.

ICD-10-CM separates CAD into codes for CAD of the native artery and CAD of a bypass graft, just like in ICD-9-CM. CAD of a native artery appears in category I25.1-. Note that the additional characters in this code denote the presence or absence of angina pectoris, making it a combination code. The default code is I25.10 for a native artery without angina pectoris. By creating a combination code, this eliminates the debate of which diagnosis should be considered the principal diagnosis.

CAD of a bypass graft appears in category I25.7-. This category also includes CAD of a transplanted heart. Additional characters denote type of bypass graft and presence of angina pectoris, also
making it a combination code. Note that this code has an “Excludes1” note which states coders must not report a code from category I20- for angina without atherosclerotic heart disease when CAD is present. Category I20 is reserved for patient with angina not related to CAD.

**TEST YOUR KNOWLEDGE**

Q10: A patient is admitted for unstable angina due to CAD of a bypass graft. Which ICD-10-CM code(s) should you assign?

**Myocardial infarctions**

In ICD-9-CM, myocardial infarctions (MI) appear in the following three code categories:

- 410.xx—Acute MI (AMI). This code includes a fourth digit to denote the location of the MI and a fifth digit to denote the episode of care. The term “acute” is defined as symptoms lasting eight weeks or less.

- 414.8—Chronic MI. This code identifies when documentation states chronic myocardial ischemia or for symptoms lasting more than eight weeks.

- 412—Personal history of MI. Assign this code when a patient experienced a previous MI but currently has no symptoms of the MI. This personal history code is unlike other codes that denote personal history in that it’s not a V code.

In ICD-10-CM, MIs appear in the following code categories:

- I21.-—This code denotes an AMI of both ST elevation MIs and non-ST elevation MIs (STEMI and NSTEMI, respectively). It also denotes the specific wall and the specific coronary artery involved in the MI. Although ICD-9-CM denotes the specific wall (i.e., the fourth digit), the specificity in ICD-10-CM regarding the coronary artery is new.

- I22.-—This code denotes subsequent MIs. In ICD-9-CM, the term “subsequent” refers to a subsequent episode of care and is included as part of the fifth digit (episode of care). In ICD-10-CM, however, there is a separate code specifically for subsequent MIs, and the term “subsequent” denotes an additional AMI within four weeks of an initial MI—rather than a specific episode of care. Code category I22.- also distinguishes between STEMI vs. NSTEMI and denotes the specific wall involved in the MI.
• I25.9—This code denotes a chronic MI. Coders should report it when patients experience symptoms for a duration of more than four weeks. Locate it in the Alphabetic Index by looking for the terms “disease,” “heart,” “ischemia,” “myocardium,” and then chronic.”

• I25.2—This code denotes an old MI. Coders should report it when a patient has a history of an MI. Locate this code in the Alphabetic Index by looking for the terms “history” and then “myocardial infarction.” Another alternative is to look in the Alphabetic Index under “Infarction, myocardium, healed or old.”

Coders should remember the following:

• Code I21 has an includes note that states acute MIs are defined as having a duration of four weeks (28 days) or less from onset. This differs from ICD-9-CM, which classifies acute MIs as symptoms lasting eight weeks or less.

• Code I22 has an includes note that states the subsequent MI occurs within four weeks (28 days) of a previous MI, regardless of site.

• Coders must report a code from the I22 category in conjunction with a code from the I21 category.

• Sequencing will depend on the circumstances of an admission. For example, a patient is admitted for an acute MI and suffers from a subsequent MI two days later while still in the hospital. In this case, sequence a code from the I21 category as principal and a code from the I22 category as secondary. Conversely, when a patient is admitted for an acute MI, is discharged, returns three days later (but still within the four weeks of the initial AMI), and is admitted with a subsequent MI, report a code from the I22 category as principal and a code from the I21 category as secondary.

**TIP:** ICD-10-CM defines an acute MI as one in which the patient’s symptoms last for less than four weeks. This is different from ICD-9-CM, which classifies an acute MI as one in which the patient’s symptoms last for less than eight weeks.
ICD-10-CM Chapter 10: Diseases of the Respiratory System (J00–J99)

Pneumonia

In ICD-9-CM, pneumonia appears in code categories 480–486. These codes denote the infectious organism (i.e., virus, bacteria) or the underlying condition that causes the pneumonia (e.g., whooping cough). A separate code category (507.x) includes aspiration pneumonia. It also denotes the causative substance (e.g., food, oils, solids) of the pneumonia. The causative substance is the substance that the patient aspirates into his or her respiratory system that causes the inflammation in the lungs.

In ICD-10-CM, pneumonia appears in code categories J12–J18. As in ICD-9-CM, there is a separate category for aspiration pneumonia in ICD-10-CM (J69.-).

Chronic obstructive pulmonary disease

In ICD-9-CM, chronic obstructive pulmonary disease (COPD) appears in code categories 491–496. This condition is commonly referring to patients with chronic bronchitis and/or emphysema. In