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NAMAS – Cardiology Breakout

Cathy Huyghe, CPC

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Objectives

- Discuss the importance of data quality in auditing
- Apply medical necessity guidelines to Evaluation and Management services
- Hear the 2015 Coding update for Cardiology
- Learn the basics of ICD-10-CM for Cardiology

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Data Integrity vs. Data Quality

- **Data Integrity** – The absence of unintended changes or errors in data, e.g. that data has not been corrupted in the process of being written to, and read back from, during transmission via some communication channel.
- **Data Quality** – The accuracy, completeness, and consistency of data.

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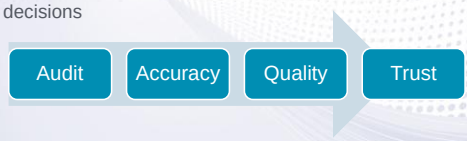
Auditing and Data Quality

- Auditing = Accuracy of data
- Accuracy = Quality data
- Quality = Trust in data
- Trust = Use the data for making clinical and administrative decisions



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MEDICAL NECESSITY

It's not just a diagnosis code!

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The Who, What, How, When and Why of Medical Necessity

- Why so much focus on medical necessity?
- Who determines what is medically necessity?
- What makes a service medically necessary?
- How is medical necessity determined?
- When is the medical necessity determination made?
- How do you AUDIT for medical necessity?

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CMS – Definition of Medical Necessity

Section 1862 (A)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expenses incurred for items or services which…are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

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Medical Necessity

- Utilization – Service exceeds allowed benefit limitations
- Diagnosis not covered for this procedure

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Medical Necessity for Procedures

- LCD's/NCD's published by CMS and the MACs
- For the most part CMS's LCD's and NCD's are pretty "black and white"
- Appeal process if you disagree
- Commercial insurance payers – Shades of Gray
  - Preauthorization
  - Check patient's coverage prior to procedure
- Cover therapeutic procedures and diagnostic tests

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Medical Necessity for E&M (50 Shades of Gray)

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of Evaluation and Management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

-CMS

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Medical Necessity – E&M

- Without a clear understanding of medical necessity and the complexity of the patient's condition as documented within the medical record, the proper level of service cannot be assigned.
- The big picture that often is missed is that medical necessity goes hand-in-hand with what should be documented as part of the encounter.
- Per CPT guidelines, the Nature of Presenting Problem is the "reason for the encounter."

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Nature of Presenting Problem

- **Minimal**: A problem that might not require the presence of the physician, but service is provided under the physician's supervision.
- **Self-limited or minor**: A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status or that has a good prognosis with management and compliance.
- **Low severity**: A problem where there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- **Moderate severity**: A problem where there is moderate risk of mortality without treatment, an uncertain prognosis or increased probability of prolonged functional impairment.
- **High severity**: A problem where there is a moderate to high risk of mortality without treatment or high probability of severe, prolonged functional impairment.

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Painting the Picture

- Considering the documentation carefully to meet the CMS recommendation that the provider is to "paint a portrait" of the patient and his or her condition(s).
- This approach drastically reduces the likelihood that an auditor, another provider, an insurance company, or any reader of the encounter (who may have little to no experience in the relevant specialty) will misinterpret the facts or question medical necessity.

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Building Your Encounter

- History
  - The patient's problem (chief complaint)
  - How long the patient has had the problem, along with the symptoms the patient is experiencing because of the problem and other contributory factors (HPI)
  - How other organ systems are being affected by the chief complaint (ROS)
  - Historical concerns that could affect the treating of the problem or points of consideration on how the current problem may affect historical concerns of the patient (PFSH)

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Building Your Encounter

- Exam
  - Relevant to the chief complaint / reason(s) for the encounter
  - Age appropriate
  - Template exams containing an array of negative findings distract from the medical necessity of the encounter

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Building Your Encounter

- Medical Decision Making
  - Analysis of the patient's condition / reason(s) for encounter
  - Reflective of severity of condition / reason(s) for encounter
  - Treatment plan

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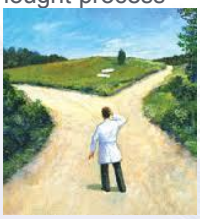
Medical Necessity Summary

- Documentation of the physician / provider's thought process



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Case Study – Cardiology Consultation

REASON FOR CONSULTATION: Abnormal echocardiogram findings and follow up. Shortness of breath, congestive heart failure, and valvular insufficiency.

- Chief Complaint documented?

- Medical Necessity established?

Moderate severity: A problem where there is moderate risk of mortality without treatment, an uncertain prognosis or increased probability of prolonged functional impairment.

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Case Study – Cardiology Consultation

HISTORY OF PRESENT ILLNESS: The patient is an 86-year-old female who presents with patient complaints of shortness of breath, which is worsening. The patient underwent an echocardiogram, which shows severe mitral regurgitation and also large pleural effusion. This consultation is for further evaluation in this regard. As per the patient, she is an 86-year-old female, has limited activity level. She has been having shortness of breath for many years. She also was told that she has a heart murmur, which was not followed through on a regular basis.

Location Timing Quality Modifying Factors
Severity Duration Context Associated Signs & Symptoms

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Case Study – Cardiology Consultation

CORONARY RISK FACTORS: History of hypertension, no history of diabetes mellitus, nonsmoker, cholesterol status unclear, no prior history of coronary artery disease, and family history noncontributory.

FAMILY HISTORY: Non-significant.

PAST SURGICAL HISTORY: No major surgery.

MEDICATIONS: Presently on Lasix, potassium supplementation, Levaquin, hydralazine 10 mg b.i.d., antibiotic treatments, and thyroid supplementation.

ALLERGIES: AMBIEN, CARDIZEM, AND IBUPROFEN.

PERSONAL HISTORY: She is a nonsmoker. Does not consume alcohol. No history of recreational drug use.

PAST MEDICAL HISTORY: Basically GI pathology with diverticulitis, colitis, hypothyroidism, arthritis, questionable hypertension, no prior history of coronary artery disease, and heart murmur.

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Case Study – Cardiology Consultation

REVIEW OF SYSTEMS

CONSTITUTIONAL: Weakness, fatigue, and tiredness.

HEENT: History of cataract, blurred vision, and hearing impairment.

CARDIOVASCULAR: Shortness of breath and heart murmur. No coronary artery disease.

RESPIRATORY: Shortness of breath. No pneumonia or valley fever.

GASTROINTESTINAL: No nausea, vomiting, hematemesis, or melena.

UROLOGICAL: No frequency or urgency.

MUSCULOSKELETAL: Arthritis and severe muscle weakness.

SKIN: Non-significant.

NEUROLOGICAL: No TIA or CVA. No seizure disorder.

ENDOCRINE / HEMATOLOGICAL: As above.

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Case Study – Cardiology Consultation

PHYSICAL EXAMINATION

VITAL SIGNS: Pulse of 84, blood pressure of 168/74, afebrile, and respiratory rate 16 per minute.

HEENT / NECK: Head is atraumatic and normocephalic. Neck veins flat. No significant carotid bruits appreciated.

LUNGS: Air entry bilaterally fair. No obvious rales or wheezes.

HEART: PMI displaced. S1, S2 with systolic murmur at the precordium, grade 2/6.

ABDOMEN: Soft and non-tender.

EXTREMITIES: Chronic skin changes. Feeble pulses distally. No clubbing or cyanosis.

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Case Study – Cardiology Consultation

- Exam
  - 95 Guidelines = 6 organ systems / EPF or Detailed?
  - 97 Guidelines = 9 bullets = EPF

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Case Study – Cardiology Consultation

DIAGNOSTIC DATA: EKG performed in office shows normal sinus rhythm. No acute ST-T changes.

LABORATORY DATA: H&H 13 and 39. BUN and creatinine within normal limits. Potassium within normal limits. BNP 9290.

DIAGNOSES:
1. Shortness of breath
2. Congestive Heart Failure
3. Valvular Insufficiency
4. History of prior heart murmur with echocardiogram findings as above. Basically revealed normal left ventricular function with left atrial enlargement, large pleural effusion, and severe mitral regurgitation and tricuspid regurgitation.

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Case Study – Cardiology Consultation

RECOMMENDATIONS:
1. From cardiac standpoint, conservative treatment. Possibility of a transesophageal echocardiogram to assess valvular insufficiency adequately well discussed extensively.
2. After extensive discussion, given her age 86, limited activity level, and no intention of undergoing any treatment in this regard from a surgical standpoint, the patient does not wish to proceed with a transesophageal echocardiogram.
3. Based on the above findings, we will treat her medically with ACE inhibitors and diuretics and see how she fares. She has a normal LV function.

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Case Study – Cardiology Consultation

- Medical Decision Making?
  - Number of diagnoses / management options
  - Data to Review
  - Risk level
- Documentation to support consultation?

Moderate severity: A problem where there is moderate risk of mortality without treatment, an uncertain prognosis or increased probability of prolonged functional impairment.

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2015 Cardiology Changes

- Very few changes
- Clarification of existing codes
- Many parenthetical changes

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2015 Cardiology Changes

- Two types of defibrillators exist:
  - Transvenous implantable defibrillator (ICD)
  - Subcutaneous implantable defibrillator (S-ICD)

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2015 Cardiology Changes

- Implantable Defibrillators:
  - Uses a combination of antitachycardia pacing, low-energy cardioversion or defibrillating shocks to treat ventricular tachycardia or ventricular fibrillation
- Subcutaneous Implantable Defibrillators:
  - Uses a single subcutaneous electrode to treat ventricular tachyarrhythmias.
  - S-ICD do no provide antitachycardia pacing or chronic pacing

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2015 Cardiology Changes

New 2015 Codes

- 33270 – Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed

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2015 Cardiology Changes

- 33270 Continued:
  - Do not report in conjunction with 33271, 93260, 93261 or 93644
  - For removal and replacement of implantable defibrillator pulse generator and subcutaneous electrode, use 33241 with 33270 and 33272
  - For insertion of subcutaneous implantable defibrillator lead(s), use 33271

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2015 Cardiology Changes

- 33271 – Insertion of subcutaneous implantable defibrillator electrode
  - Do not report in conjunction with 33240, 33262, 33270, 93260, and 93261
  - For insertion or replacement of a cardiac venous system lead, see 33224 or 33225

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2015 Cardiology Changes

- 33272 – Removal of subcutaneous implantable defibrillator electrode
  - Do not report in conjunction with 96360 or 93261
- 33273 – Repositioning of previously implanted subcutaneous implantable defibrillator electrode
  - Do not report in conjunction with 96360 or 93261

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2015 Cardiology Changes

Many code revisions converting the ICD descriptor from “pacing cardioverter-defibrillator” to “implantable defibrillator”

– (33215, 33216, 33217, 33218, 33220, 33223, 33224, 33225, 33240, 33230, 33231, 33241, 33262, 33263, 33264, 33243, 33244, 33249)

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CMS – Expanding Mod 59

- Four new modifiers
- Subset of Modifier 59
- Effective January 1, 2015
- Modifier 59 is **not** going away

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Referred to as -X{EPSU} Modifiers

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ / Structure
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

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When to Use Modifier 59

- If a diagnostic procedure precedes ***a*** surgical *or non-surgical therapeutic* procedure and is the basis on which the decision to perform the surgical *or non-surgical therapeutic* procedure is made, **the two procedures may be reported with modifier 59** appended to the column two HCPCS/CPT code under appropriate circumstances. However, if the diagnostic procedure is an inherent component of the surgical *or non-surgical therapeutic* procedure, it cannot be reported separately.

Example: A percutaneous left heart cath, then selective injections of the left ventricle and coronary arteries for diagnostic purposes followed by mechanical thrombectomy of the LAD artery with subsequent drug eluting stent placement in the LAD

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New Physician Specialty Code

- **C3 – Interventional Cardiology**
  - Effective January 1, 2015
- 06 – Cardiology
- 21 – Cardiology Electrophysiology
- 76 – Peripheral Vascular Disease
- 78 – Cardiac Surgery

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Cardiology Code Clarification

- Coronary angioplasty, atherectomy, stenting confusion
- Codes 92920 - 92944
  - Coding guideline state to code the highest intervention within each of the five major coronary arteries (left main, left anterior descending, left circumflex, right coronary, and ramus intermedius) and their branches

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Code Clarification

- E.g. Angioplasty of the right coronary, and diagonal artery along with stenting of the diagonal branch 1 and diagonal branch 2
- Coding:
  - 92920 – Coronary angioplasty single major coronary artery
  - 92928 – Coronary stent placement single major coronary artery
  - 92929 – Coronary stent placement each additional artery
  - 92921 – Coronary angioplasty each additional artery

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ICD-10 Implementation Delay

- Oct. 1, 2015 – *New Implementation Date*
- Poorly handled causing uncertainty in the industry
- Stay the Course
- Get Involved
  - Congressman
  - Senator

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Partial Code Freeze

- Last regular update to ICD-9 and ICD-10 were made on Oct. 1, 2011
- Limited updates on ICD-9-CM and ICD-10 on Oct. 1, 2012, 2013 and 2014
  - New technologies and diseases
- Limited update on ICD-10 on Oct. 1, 2015
- No update on ICD-9 on Oct. 1, 2015
- Regular, annual updates on ICD-10 starting Oct. 1, 2016*

*Assuming compliance date does not change AGAIN!

http://www.cms.gov/Medicare/Coding/ICD10/downloads/Partial_Code_Freeze.pdf

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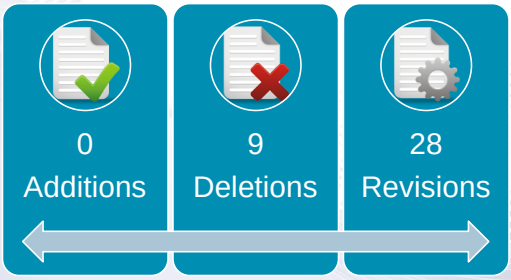
2014 Update



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2015 Update

- There were no changes to the FY 2015 ICD-10-CM Tabular or Index files over the FY 2014 ICD-10-CM

http://www.cdc.gov/nchs/icd/icd10cm.htm#icd2015

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ICD-10-CM Book and Guidelines

http://www.cdc.gov/nchs/icd/icd10cm.htm#icd2015

FY 2015 release of ICD-10-CM
Preface [PDF - 35 KB]
ICD-10-CM Guidelines [PDF - 511 KB] Modifications made on page 78.
ICD-10-CM PDF Format
ICD-10-CM XML Format
ICD-10-CM List of codes and Descriptions
General Equivalence Mapping Files [ZIP - 624 KB]

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Documentation is Key to a Successful Transition



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Documentation Awareness

- Documentation is the cornerstone for ICD-10 Transition success
- Focus on documentation elements and not the overwhelming number of new codes
- Accurate documentation is the primary responsibility physicians and other clinical providers have in the move to ICD-10
- Documentation awareness among clinical providers should start now

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"Unspecified" may lead to "Unpaid"

"Physicians may be ICD-10 compliant, but if they abuse the "other" or "unspecified" codes, payment will not occur if a more specific alternative exists."

David Winkler - Director of Technical Program Management
BCBS Michigan

Justifying medically necessary procedures and services depends on specificity of diagnoses coding!

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Organization and Classification

- Terminology was revised to reflect more current medical practice

Examples:	**ICD-9-CM**	411.1	Intermediate coronary syndrome
	ICD-10-CM	I20.0	Unstable angina
	ICD-9-CM	410	Acute myocardial infarction
	ICD-10-CM	I21	ST elevation (STEMI) and non-ST (NSTEMI) myocardial infarction
	ICD-9-CM	411.81	Acute coronary occlusion without myocardial infarction
	ICD-10-CM	I24.0	Acute coronary thrombosis not resulting in myocardial infarction

- Hypertension is no longer classified as benign, malignant or unspecified

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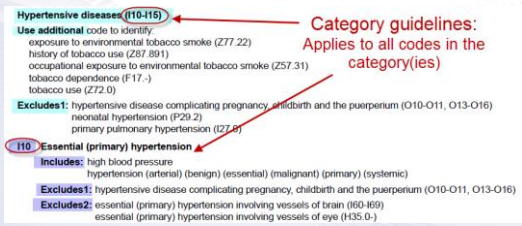
Category Guidelines



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Nicotine Dependence

ICD-9-CM = 305.1

- Tobacco Use Disorder -Current smoker

ICD-10-CM = F17-

- **Terminology change** to Nicotine dependence
- Type of nicotine (cigarette, chewing tobacco, cigar, pipe, etc.)
- Remission / Withdrawal / Uncomplicated
- Use **Z87.891** for History of nicotine dependence
- Use **Z72.0** Tobacco Use (non-dependent)
- Use **O99.33**- Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium

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Exposure to Tobacco Smoke

NEW

- **Z77.22** Contact with and exposure to environmental tobacco smoke
- **P96.81** Exposure to tobacco smoke in perinatal period
- **Z57.31** Occupational exposure to environmental tobacco smoke

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Hypertension Guidelines

- More than just I10
- HTN "with" Heart Disease requires documentation of causal relationship
  - Heart disease **due to** hypertension
  - **Hypertensive** heart disease
- HTN with CKD
  - Presumes cause-and-effect
- Read guidelines carefully

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Hypertension due to Heart Disease

9. **Chapter 9: Diseases of the Circulatory System (I00-I99)**

a. **Hypertension**

1) **Hypertension with Heart Disease**

Heart conditions classified to I50.- or I51.4-I51.9, are assigned to, a code from category I11, Hypertensive heart disease, when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.

The same heart conditions (I50.-, I51.4-I51.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.

I11 Hypertensive heart disease

Includes: any condition in I51.4-I51.9 due to hypertension

I11.0 Hypertensive heart disease with heart failure
Hypertensive heart failure
Use additional code to identify type of heart failure (I50.-)

I11.9 Hypertensive heart disease without heart failure
Hypertensive heart disease NOS

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Hypertension with Kidney Disease

2) Hypertensive Chronic Kidney Disease

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present.

Unlike hypertension with heart disease, ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.

If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

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Hypertension with Kidney Disease

I12 Hypertensive chronic kidney disease

Includes: any condition in N18 and N26 - due to hypertension
arteriosclerosis of kidney
arteriosclerotic nephritis (chronic) (interstitial)
hypertensive nephropathy
nephrosclerosis

Excludes1: hypertension due to kidney disease (I15.0, I15.1)
renovascular hypertension (I15.0)
secondary hypertension (I15.-)

Excludes2: acute kidney failure (N17.-)

I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6)

I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

Hypertensive chronic kidney disease NOS
Hypertensive renal disease NOS

Use additional code to identify the stage of chronic kidney disease (N18.1-N18.4, N18.9)

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Hypertensive Heart and CKD

3) Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.

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Atherosclerotic CAD & Angina

- Use combination code from I25.11-
- Not necessary to use an additional code for angina
- Causal relationship can be assumed in a patient with both Atherosclerotic CAD and Angina

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Acute Myocardial Infarction

- "Acute" MI codes changed from 8 weeks to 4 weeks (28 days) or less
- No longer classified by episode of care
  - I21- Initial AMI – **code used the entire 28 day period**
  - I22- Subsequent AMI – code used when a subsequent AMI occurs during the 28 day period of the Initial AMI **(not subsequent visit / encounter)**
  - I23- Complications following AMI must be used in conjunction with a code from I21- or I22-

Do not use AMI codes for encounters >28 days old

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Category I22 Subsequent MI

- Category I22 (subsequent) is never used alone
  - A code from category I22 (subsequent) must be used in conjunction with a code from category I21 (initial)
- The sequencing of the I22 and I21 codes depends on the circumstances of the encounter
  - Primary reason for encounter / admission

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Category I23 Complications Following MI

- The category I23 (complications) should be sequenced first, if it is the reason for the encounter
- If the complication of the MI occurs during the encounter for the MI, it should be sequenced after the I21 (initial) or I22 (subsequent) code

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I50 Heart Failure

- Default code for CHF – I50.9 Heart failure, unspecified
- Report heart failure by type and severity
  - Left, systolic diastolic, combined
  - Acute, chronic, acute on chronic

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Sequelae of Cerebrovascular Disease (CVD) (Category I69)

- Sequelae of conditions classifiable to I60 – I67
- May be present at onset or anytime after the onset
- Use same guidelines for dominant vs. non-dominant as Chapter 6 (next slide)
- Use I69 if patient has current CVD with deficits from old CVD
- Use Z86.73, Personal Hx of TIA if the patient does not have neurologic deficits

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Dominant vs. Non-Dominant

NEW

- Document – Dominant / Non-dominant **in addition** to Left or Right
- If dominant side is not documented use the following default guidelines:
  - For ambidextrous patients, the default should be dominant.
  - If the left side is affected, the default is non-dominant.
  - If the right side is affected, the default is dominant.

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Dominant vs. Non-Dominant

Example:

I69.03	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage
I69.031	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting right dominant side
I69.032	Monoplegia of upper limb following affecting left dominant side
I69.033	Monoplegia of upper limb following affecting right non-dominant side
I69.034	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting left non-dominant side
I69.039	Monoplegia of upper limb following nontraumatic subarachnoid hemorrhage affecting unspecified side

Need to document laterality
AND
Dovminant vs. Non-dominant

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Coding Scenario

This 58-year-old female had an acute non-ST anterior wall myocardial infarction on August 1st. On August 21th she suffered an acute inferior wall myocardial infarction. She is still being monitored for her NSTEMI three weeks earlier. She also has chronic atrial fibrillation.

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Coding Scenario – Step 1

Infarct, infarction
- adrenal (capsule) (gland) E27.49
- appendices epiploicae K55.0
- bowel K55.0
- brain (stem) —*see* Infarct, cerebral
- breast N64.89
- brewer's (kidney) N28.0
- cardiac —*see* Infarct, myocardium
- cerebellar —*see* Infarct, cerebral
- myocardium, myocardial (acute) (with stated duration of 4 weeks or less) I21.3
- - diagnosed on ECG, but presenting no symptoms I25.2
- - healed or old I25.2
- - intraoperative
- - - during cardiac surgery I97.790
- - - during other surgery I97.791
- - non-Q wave I21.4
- - non-ST elevation (NSTEMI) I21.4
- - - subsequent I22.2
- - nontransmural I21.4

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Coding Scenario – Step 1

- - subsequent (recurrent) (reinfarction) I22.9
- - - anterior (anteroapical) (anterolateral) (anteroseptal) (wall) I22.0
- - - diaphragmatic (wall) I22.1
- - - inferior (diaphragmatic) (inferolateral) (inferoposterior) (wall) I22.1
- - - lateral (apical-lateral) (basal-lateral) (high) I22.8
- - - non-ST elevation (NSTEMI) I22.2
- - - posterior (posterobasal) (posterolateral) (posteroseptal) (true) I22.8
- - - septal I22.8
- - - specified NEC I22.8
- - - ST elevation I22.9
- - - - anterior (anteroapical) (anterolateral) (anteroseptal) (wall) I22.0
- - - - inferior (diaphragmatic) (inferolateral) (inferoposterior) (wall) I22.1
- - - - specified NEC I22.8

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I21.4 Non-ST elevation (NSTEMI) myocardial infarction
Acute subendocardial myocardial infarction
Non-Q wave myocardial infarction NOS
Nontransmural myocardial infarction NOS

I22 Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
Includes: acute myocardial infarction occurring within four weeks (28 days) of a previous acute myocardial infarction, regardless of site
cardiac infarction
coronary (artery) embolism
coronary (artery) occlusion
coronary (artery) rupture
coronary (artery) thrombosis
infarction of heart, myocardium, or ventricle
recurrent myocardial infarction
reinfarction of myocardium
rupture of heart, myocardium, or ventricle
Use additional code, if applicable, to identify:
exposure to environmental tobacco smoke (Z77.22)
history of tobacco use (Z87.891)
occupational exposure to environmental tobacco smoke (Z57.31)
status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility (Z92.82)
tobacco dependence (F17.-)
tobacco use (Z72.0)

I22.0 Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
Subsequent acute transmural myocardial infarction of anterior wall
Subsequent transmural (Q wave) infarction (acute)(of) anterior (wall) NOS
Subsequent anteroapical transmural (Q wave) infarction (acute)
Subsequent anterolateral transmural (Q wave) infarction (acute)
Subsequent anteroseptal transmural (Q wave) infarction (acute)

I22.1 Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
Subsequent acute transmural myocardial infarction of inferior wall
Subsequent transmural (Q wave) infarction (acute)(of) diaphragmatic wall
Subsequent transmural (Q wave) infarction (acute)(of) inferior (wall) NOS
Subsequent inferolateral transmural (Q wave) infarction (acute)
Subsequent inferoposterior transmural (Q wave) infarction (acute)

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Coding Scenario – Step 2

Fibrillation
- atrial or auricular (established) I48.91
- - chronic I48.2
- - paroxysmal I48.0
- - permanent I48.2
- - persistent I48.1
- cardiac I49.8
- heart I49.8
- muscular M62.89
- ventricular I49.01

I48 Atrial fibrillation and flutter
- **I48.0 Paroxysmal atrial fibrillation**
- **I48.1 Persistent atrial fibrillation**
- **I48.2 Chronic atrial fibrillation**
  Permanent atrial fibrillation
- **I48.3 Typical atrial flutter**
  Type I atrial flutter
- **I48.4 Atypical atrial flutter**
  Type II atrial flutter
- **I48.9 Unspecified atrial fibrillation and atrial flutter**
  - **I48.91 Unspecified atrial fibrillation**
  - **I48.92 Unspecified atrial flutter**

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Coding Scenario

I22.1 **Infarct, Infarction, myocardium, myocardial (acute) (with stated duration of 4 weeks or less), subsequent (recurrent) (reinfarction), inferior (diaphragmatic) (inferolateral) (inferoposterior) (wall)**

I21.4 **Infarct, Infarction, myocardium, myocardial (acute) (with stated duration of 4 weeks or less), non-ST elevation (NSTEMI)**

I48.92 **Fibrillation, atrial or auricular (established), chronic**

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Coding Scenario - Rationale

Rationale: The Official Coding Guidelines specifically address the sequencing of I22 and I21 and this is stated as: "The sequencing of the I22 and I21 codes depends on the circumstances of the encounter."

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