Ischemic Heart Disease

Coding & Documentation

Angina and Coronary Artery Disease			
Condition	**Description**	**Coding**	**Documentation**
Angina Pectoris	Not all chest pain and discomfort are angina.	Category I20	Explicitly state the diagnosis and include details about the type and severity of the condition. • **Stable:** Ischemic chest pain, usually caused by exertion or excitement • **Unstable:** Pain changes in frequency, duration and intensity, or occurs while at rest • **Variant:** Coronary vasospasm that occurs most often while at rest
Coronary Artery Disease (CAD)	Chronic ischemic heart disease or coronary atherosclerosis	Category I25	**Specify the vessel:** • Native coronary artery • Coronary artery bypass graft (CABG) • Autologous/non/autologous; vein/artery of transplanted heart
When a patient has both CAD and angina, use the appropriate combination code from category I25.			

Myocardial Infarction			
Condition	**Description**	**Coding**	**Documentation**
Myocardial Infarction (MI)	Acute myocardial infarction (AMI); ST-segment elevation myocardial infarction (STEMI); non-ST myocardial infarction (NSTEMI) **Myocardial infarction types:** • **Type 1:** Spontaneous • **Type 2:** Ischemic • **Type 3:** Unknown • **Type 4a:** Due to percutaneous procedure • **Type 4b:** Due to stent thrombosis • **Type 4c:** Due to restenosis • **Type 5:** Due to CABG	Category I21	• Specified as acute type 1, or stated duration of less than four weeks (28 days) • Unspecified AMI or unspecified type: I21.9 • AMI types 3, 4a, 4b, 4c and 5 assigned to code I21.A9
Subsequent MI		Category I22	• Use I22 only when subsequent MI occurs within four weeks of initial MI and both are type 1 or unspecified. • Must be coded with code from category I21
Current Complications Following MI		Category I23	• Must code with codes from categories I21 and I22 • May be outside four weeks of initial MI • Post-infarction angina as complication must be stated to code I23.7

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Code all documented conditions present at the time of the encounter that require or affect patient care, treatment or management. Include the ICD-10 diagnosis code of the highest specificity on the claim. Use the additional codes below when applicable:

Risk/Coexisting Factors: All Categories		Contributing Factors: All Categories		Use Additional Code: Categories I21 & I22		Use Additional Code: Category I25	
Descriptor	**ICD-10**	**Descriptor**	**ICD-10**	**Descriptor**	**ICD-10**	**Descriptor**	**ICD-10**
High blood pressure	Use ICD-10 guidelines for coding and reporting.	Exposure to tobacco smoke	Z77.22	Status post administration tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility	Z92.82	Chronic total occlusion of coronary artery	I25.82
High cholesterol		History of tobacco dependence	Z87.891				
Diabetes		Tobacco use	Z72.0				
Obesity		Tobacco dependence	F17.–				

HEDIS® Measures

Blood Pressure Control			
Condition	**Requirement**	**Descriptor**	**CPT® II Code**
< 140/90 mm Hg controlled	Members ages 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mm Hg) during the measurement year	Systolic < 130	3074F
		Systolic 130–139	3075F
		Diastolic < 80	3078F
		Diastolic 80–89	3079F

Remote Blood Pressure Monitoring		
CPT® Codes		
• 93784	• 99091	• 99457
• 93788	• 99453	• 99473
• 93790	• 99454	• 99474

Quality Tips

- If blood pressure is elevated, retake it. The combination of lowest readings taken during a visit is acceptable.
- Ensure that the blood pressure cuff is the correct size for the patient's arm and is providing accurate readings.
- Do not round numbers up when using an automatic blood pressure machine.
- During telehealth or telephone visits, allow readings taken by patients with any digital device.
- During telehealth or telephone visits, exclude readings taken by a patient using a non-digital device, such as a manual blood pressure cuff and stethoscope.
- Review medication list during every visit.
- Educate patients on the importance of medication adherence.

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HEDIS® Measures

Cardiac Rehabilitation	
Members 18 years of age and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement	
Initiation	Attended two or more sessions of cardiac rehabilitation within 30 days of a qualifying event
Engagement 1	Attended 12 or more sessions of cardiac rehabilitation within 90 days of a qualifying event
Engagement 2	Attended 24 or more sessions of cardiac rehabilitation within 180 days of a qualifying event
Achievement	Attended 36 or more sessions of cardiac rehabilitation within 180 days of a qualifying event

Prescription Monitoring		
Renin angiotensin system antagonists (PDC-RASA)	Members who are 18 years of age and older and who were on a renin angiotensin system antagonist medication for at least 80% of the days from the first fill through the end of the year	
Direct Renin Inhibitor Medications and Combinations		
• aliskiren (+/- amlodipine, hydrochlorothiazide)		
Angiotensin Receptor Blocker (ARB) Medications and Combinations		
• azilsartan (+/- chlorthalidone) • candesartan (+/- hydrochlorothiazide) • eprosartan (+/- hydrochlorothiazide)	• irbesartan (+/- hydrochlorothiazide) • losartan (+/- hydrochlorothiazide) • olmesartan (+/- amlodipine, hydrochlorothiazide)	• telmisartan (+/- amlodipine, hydrochlorothiazide) • valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)
Angiotensin-Converting Enzyme (ACE) Inhibitor Medications and Combinations		
• benazepril (+/- amlodipine, hydrochlorothiazide) • captopril (+/- hydrochlorothiazide) • enalapril (+/- hydrochlorothiazide) • fosinopril (+/- hydrochlorothiazide)	• lisinopril (+/- hydrochlorothiazide) • moexipril (+/- hydrochlorothiazide) • perindopril (+/- amlodipine) • quinapril (+/- hydrochlorothiazide)	• ramipril • trandolapril (+/- verapamil)

The educational material herein complies with accepted ICD-10 guidelines and is for general supplemental purposes only. This information is not guaranteed to be complete, free of errors or the most current revision. It is the responsibility of the provider to document accurate and complete codes, clinical rationale, and medical services rendered to support appropriate ICD-10 code(s) according to official billing and coding guidelines, procedures and regulations.

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