

# Diseases of the Ear and Mastoid Process (H60-H95) and Diseases of the Circulatory System (I00-I99)

## ICD-10-CM Chapters 8 and 9 Guidelines Review

In this chapter you will find a summary of the chapter-specific coding guidelines for Chapter 9 of the ICD-10-CM codebook (Diseases of the Circulatory System) followed by case studies to build ICD-10-CM diagnosis coding skill in this area. For diseases of the ear and mastoid process (Chapter 8 of the ICD-10-CM codebook), general coding guidelines and instructional notes apply.

Many medical specialties, including primary care, ENT, otolaryngology, and cardiology, reference Chapters 8 and 9 of the ICD-10-CM codebook for coding diseases of the ear and mastoid process and diseases of the circulatory system. Keep in mind that you should always reference the ICD-10-CM Official Guidelines for Coding and Reporting in its entirety when making a code selection.

## ICD-10-CM Official Coding Guidelines for Diseases of the Circulatory System

The following summarized guidelines apply when coding hypertension and conditions causal to the condition. Hypertension is coded in ICD-10-CM as I10 whether the condition is malignant, benign, essential, or unspecified.

### HYPERTENSION WITH HEART DISEASE

The following guidelines apply to coding hypertension with heart disease:

- When a causal relationship is stated due to hypertension or implies such as hypertensive heart disease, a code from category I11 is assigned for heart conditions classified to categories I50.- or I51.4-I51.9.
- An additional code from category I50 (Heart failure) is reported for a patient with heart failure.
- The type of heart failure (if documented) should be reported with codes from category I50.
- Heart conditions with hypertension that do not have a causal relationship should be coded separately. For example, if a patient has congestive heart failure and hypertension and there is not a causal relationship, both conditions are coded individually. Sequencing is based on the circumstance.

### HYPERTENSIVE CHRONIC KIDNEY DISEASE

Hypertensive chronic kidney disease (CKD) is reported with codes from category I12 under the following conditions:

- Unlike hypertension with heart disease, ICD-10-CM coding presumes a cause-and-effect relationship between the two conditions.
- ICD-10-CM classifies CKD with hypertension as "hypertensive chronic kidney disease."
- Hypertensive CKD is assigned in category I12 when both hypertension and a condition classifiable to category N18 (CKD) is present.
- A code from category N18 should be reported as a secondary diagnosis with a code from category I12 to report the stage of the CKD whether it is stage I, II, III, IV, or end stage.
- If the documentation indicates the patient has hypertensive CKD with acute renal failure, code the acute renal failure (required) as an additional diagnosis.

### HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE

Often patients with hypertensive CKD also have hypertensive heart disease. The following guidelines are applicable when reporting a diagnosis from category I13, which is considered a combination code because it combines both hypertensive heart and kidney disease in its descriptor:

- Only report a code from category I13 (Hypertensive heart and chronic kidney disease) when both hypertensive kidney and hypertension heart diseases are documented in the medical report. Always assume the relationship as stated earlier with hypertension and CKD whether or not it is clearly stated in the documentation. If heart failure (I50) is specified, it should be reported as an additional diagnosis.
- Assign a code from category N18 (Chronic kidney disease) as a secondary diagnosis to identify the stage of the CKD.
- Do not report hypertension and CKD separately as they are considered causal even if a causal relationship is not stated in the documentation.
- For patients with both acute renal failure and CKD, an additional code for acute renal failure is required.

### HYPERTENSIVE CEREBROVASCULAR DISEASE

Codes from categories I60-I69 are reported for hypertensive cerebrovascular disease. The appropriate hypertension code is reported as a secondary diagnosis.

### HYPERTENSIVE RETINOPATHY

Subcategory H35.0 (Background retinopathy and retinal vascular changes) should be reported with a code from category I10-I15 for the hypertensive disease.

- Hypertension is reported as code I10 (Essential [primary] hypertension), which includes systemic hypertension.
- Sequencing is based on the reason for the encounter.

### HYPERTENSION, SECONDARY

Secondary hypertension is due to an underlying condition. Two codes are required: (1) one code to identify the underlying etiology and (2) one code from category I15 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

### HYPERTENSION, TRANSIENT (ELEVATED BLOOD PRESSURE)

A patient with elevated blood pressure does not necessarily mean the patient is hypertensive. There are many reasons a patient's blood pressure may become elevated. Hypertension should not be reported unless stated clearly in the documentation. Elevated blood pressure is reported with a sign and symptom code R03.0 (Elevated blood pressure reading).

### HYPERTENSION CONTROLLED VERSUS UNCONTROLLED

Hypertension controlled indicates good blood pressure control with therapy. Hypertension uncontrolled is when the current therapeutic treatment does not effectively control the patient's blood pressure. Code categories I10-I15 are assigned to both types of hypertension. There is no distinction in ICD-10-CM between controlled and uncontrolled hypertension.

### ATHEROSCLEROTIC CORONARY ARTERY DISEASE AND ANGINA

Code I25.11 (Atherosclerotic heart disease of native coronary artery with angina pectoris) and code I25.7 (Atherosclerosis of coronary artery bypass graft[s] and coronary artery of transplanted heart with angina pectoris) are combination codes that include angina pectoris. The following guidelines apply:

- A causal relationship is assumed in a patient with both atherosclerosis and angina pectoris unless the documentation indicates the angina is due to something other than atherosclerosis.
- When a patient is admitted for an acute myocardial infarction (AMI) and the patient also has coronary artery disease (CAD), the AMI is sequenced before the CAD.

### INTRAOPERATIVE AND POSTPROCEDURAL CEREBROVASCULAR ACCIDENT (CVA)

Medical record documentation should clearly specify the cause-and-effect relationship between the medical intervention and the cerebrovascular accident in order to assign a code for intraoperative or postprocedural cerebrovascular accident. Code assignment depends on the following:

- Whether the accident was an infarction or hemorrhage.
- Whether the accident occurred intraoperatively or postoperatively.

- If an AMI is documented as nontransmural or sub-endocardial, but the site is provided, it is still coded as a subendocardial AMI.

### SUBSEQUENT ACUTE MYOCARDIAL INFARCTION

The following guidelines apply when coding subsequent acute myocardial infarction:

- If a patient suffers a new AMI within four weeks of the initial AMI, two codes are required:
  - A code from category I22 (Subsequent ST elevation [STEMI] and non ST elevation [NSTEMI] myocardial infarction).
  - A code from category I22 must be used in conjunction with a code from category I21 for the current AMI.
- Sequencing depends on the circumstance of the encounter.

When the patient is admitted due to an AMI and has a subsequent AMI while still hospitalized:

- Report a code from category I21 for the first AMI as the first listed or principal diagnosis code.
- Report a code from category I22 as the secondary diagnosis.

If the patient suffers a subsequent AMI after the hospital discharge for the initial AMI, is admitted for treatment of the subsequent AMI, and is within the four-week time frame of healing from the initial AMI, the following guidelines apply:

- A code from category I22 is sequenced as the first-listed or principal diagnosis.
- A code from category I21 is reported as the secondary diagnosis.
- The guidelines for assigning the correct I22 code are the same as for the initial AMI.

Now that you have a good understanding of the chapter-specific guidelines for diseases of the circulatory system, it is time to build skill and knowledge by coding the following exercises. Be sure to reference the ICD-10-CM codebook and the ICD-10-CM Official Guidelines for Coding and Reporting, along with the instructional notes, when coding these conditions.

## Diseases of the Ear and Mastoid Process (H60-H95)

### CASE STUDY 1

Thank you for referring this patient who was seen regarding her nasal allergies. She also developed a pneumonia and was put on Prednisone, which has in fact improved her nasal function by reducing the polypoid change in the nose. She is breathing quite well through the nose, has a good sense of smell, and ears are feeling well.

**EXAMINATION:** Revealed a moderate degree of hyperemic change and congestion to the nose, consistent with a viral rhinitis. There are some very high polyps bilaterally, which are certainly not obstructive to her airway. The throat and larynx were clear. Otoscopy shows the left ear to be normal. The previously inserted tube in her right ear has now extruded, the drum has healed, and there is no fluid in this ear either.

**DIAGNOSIS:** Ongoing allergic rhinitis and polyposis problem with superimposed viral rhinitis.

**PLAN:** Once her cold settles, I have asked her to start using the Nasacort spray again on a regular basis and to see me again in June, or sooner if she notices a loss of sense of smell again.

ICD-10-CM Code(s) \_\_\_\_\_

### CASE STUDY 2

**PREOPERATIVE DIAGNOSIS:** Sensorineural hearing loss.

**POSTOPERATIVE DIAGNOSIS:** Same.

**PROCEDURE:** Left middle ear hearing device implantation.

**INDICATIONS:** Loss of hearing.

**OPERATION:** The patient was taken to the operating room and placed on the table in the supine position. General anesthesia was administered and a laryngeal mask airway was used for ventilation. The left ear was prepped in the usual sterile fashion. Ancef was given preoperatively. Facial nerve monitoring was performed throughout and the patient was infiltrated with Lidocaine and Adrenaline postauricularly. Standard incisions for implant surgery were performed.

The sigmoid sinus, middle fossa, dura, and posterior canal wall were all identified. The antrum was entered and the incus was identified. The horizontal canal was identified; the facial nerve and facial recess were identified and opened. The chordae tympani was sectioned because it was interfering with adequate visualization. Bleeding was controlled as it was encountered and a bed was created for the implant. Stay sutures of 2-0 Prolene were fixed appropriately. The implant was sent into the bed and the transducer was crimped to the incus without difficulty. The implant was irrigated and a layered closure performed. A Glasscock bubble was placed. The patient was awakened and transported to the recovery room in stable condition with the facial nerve intact. All sponge, needle, and instrument counts were correct. Estimated blood loss was 10 cc.

ICD-10-CM Code(s) \_\_\_\_\_

### CASE STUDY 3

**PREOPERATIVE DIAGNOSIS:** Recurrent serous otitis media (chronic).

**POSTOPERATIVE DIAGNOSIS:** Same.

**INDICATIONS:** This is a 10-year-old who has had multiple episodes of otitis. We did manage to clear chronic serous otitis, but it returned shortly thereafter. It was therefore felt he would benefit from bilateral myringotomy and tubes.

**PROCEDURE:** The patient was brought to the operating room and placed on the operating room table and a general anesthetic was provided by the anesthesiologist. Following that, the left ear was cleaned of cerumen and debris and an anterior inferior myringotomy incision was made and a collar button tube was slipped into position after encountering a dry middle ear. The same procedure was completed on the patient's other ear. Cortisporin otic was instilled in both ears, and cotton was placed in the os. The patient was then awakened and taken to the recovery room in good condition. Sponge and needle counts were correct.

ICD-10-CM Code(s) \_\_\_\_\_

### CASE STUDY 4

Thank you for referring this patient who was seen for an evaluation of hearing loss. Hearing allegedly is generally reduced in both ears, but he has always, throughout his entire life, had worse hearing in his left ear, presumably subsequent to childhood otorrhea that he does recall.

**EXAMINATION:** Revealed an intact right tympanic membrane. He has a relatively small posterosuperior perforation of the left drum which unfortunately overlies the stapes incus and, to a slight degree, the round window. He also has a bit of otomycosis infection involving the proximal ear canal, although no evident involvement of the middle ear.

**LABORATORY:** Audiometry shows a mild to moderately severe bilateral nerve deafness of symmetric degree with a substantial additional conductive deafness in his left ear due to the perforation. Speech levels averaged approximately 35-40 dB in the right ear and about 80 dB in the left ear.

### DIAGNOSES:

1. Mild to moderately severe bilateral sensorineural hearing loss
2. Perforated left tympanic membrane with moderate conductive deafness
3. Otomycosis, left ear canal

**PLAN:** The ear was cleaned and I have applied a Canesten ointment to the entire canal and will follow-up in a month. His option is either to use a hearing aid in the left and/or both ears to improve his hearing or to undergo tympanoplasty surgery to his left ear to close the perforation. He can then see how he feels about his hearing loss, of which the sensorineural component will remain, to see whether subsequent hearing aids are still needed. He will give me his decision on these options when he returns for a recheck of his otomycosis.

ICD-10-CM Code(s) \_\_\_\_\_

### CASE STUDY 5

The patient is a 68-year-old woman who has had approximately a four-month history of blockage, obstruction, fluid, fullness, pressure, and head noise in the right ear. She has had tubes inserted. The last tube was placed by Dr Minor in February but it did not resolve the problem. On earlier examination today, the tube was noted to have been extruded into the ear canal, and the middle ear was noted to be filled with an amber, straw-colored fluid. The right ear also was noted to be filled with an amber, straw-colored fluid.

With the patient positioned supine with no sedation, a small amount of Lidocaine was injected into the posterior superior vascular strip area. Following this, an anterior inferior quadrant radial myringotomy was performed in the good firm remnant of the tympanic membrane. Fluid was suctioned from the right middle