Correctly Documenting Coronary Artery Disease

To correctly code Coronary Artery Disease (CAD) with Angina:

1. Document the **type of coronary artery:**
   - Native
   - Bypass graft
   - Non-autologous vessel
2. Document the **type of angina pectoris:**
   - unstable
   - with documented spasm
   - other specified forms of angina
   - unspecified
3. Document all **pertinent cardiovascular risk factors**, such as:
   - History of tobacco dependence or exposure
   - Myocardial Infarction or Old MI (if outside of 4 weeks from the date of infarction)
   - BMI (≥35 – document as "Morbid Obesity")
   - Arrhythmia/Dysrhythmia
   - Hypertension
   - Chronic Kidney Disease
   - Diabetes
   - PVD
   - Hypercholesterolemia
   - Family History of Cardiovascular Disease
4. Document **all current cardiovascular medications** (antiplatelet agents, antiarrhythmics, antihypertensives, thromboembolic prophylaxis, etc.) and their indications.
5. Document **pertinent lab results and screenings** (lipid panel, EKG, etc.)

The subcategories for these code are:

I25.11_ *Atherosclerotic heart disease of **native coronary artery** with angina pectoris

*Sixth Digit:
0 - unstable angina

1 - angina with documented spasm

8 - other forms of angina pectoris

9 - unspecified angina pectoris

I25.7_ *Atherosclerosis of coronary artery **bypass graft(s) and coronary artery of transplanted heart** with angina pectoris

*Sixth Digit:
Specifies type of graft and type of angina

CAD with Angina maps to an HCC88 with a weight of 0.135.

CAD with Unstable Angina maps to a higher HCC87 with a weight of 0.195

Since ICD-10 allows for a greater degree of specificity, this means that medical records must contain complete documentation for those codes to be utilized.

* Never select a code more descriptive than your documentation!

*Note – Coronary Artery Disease without angina or coded as Not Otherwise Specified (NOS) does not risk adjust.