DRG 140 — Angina Pectoris

ICD-9-CM Coding Guidelines

The below listed angina guidelines are not inclusive. The coder should refer to the applicable Coding Clinic guidelines for additional information. The Centers for Medicare & Medicaid Services considers Coding Clinic, published by the American Hospital Association, to be the official source for coding guidelines. Hospitals should follow the Coding Clinic guidelines to assure accuracy in ICD-9-CM coding and DRG assignment.

Definition of Principal Diagnosis

The principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Two or more diagnoses may equally meet the definition for principal diagnosis as determined by the circumstances of admission, diagnostic work-up and/or therapy provided. Be aware that there is a difference between admitting a patient to treat two conditions and two conditions being present at the time of admission. The principal diagnosis is always the reason for admission.

Documentation to Support the Principal Diagnosis

If the reason for admission is angina, determine if the etiology of angina is known and if the type of angina is specified. The underlying cause for angina is sequenced as the principal diagnosis. It may be necessary to query the physician for clarification.

Coding Guidelines

Aborted myocardial infarction

A patient presented with severe chest pain, which was documented as “resembling an acute MI.” TPA was administered and subsequently no actual myocardial injury occurred. The patient was transferred to another facility for further diagnostic testing. The principal diagnosis is an aborted myocardial infarction, 411.1, intermediate coronary syndrome. No underlying cause was identified. Code 411.81, coronary occlusion without myocardial infarction, is not assigned because no occlusion was identified. (See Coding Clinic, second quarter 2001, page 7.)

If TPA administration does not avert or abort an acute myocardial infarction, the diagnosis is acute MI and no code is assigned for angina. (See Coding Clinic, second quarter 2001, pages 8 and 9.)

Accelerated angina

Accelerated angina should be assigned code 411.1, intermediate coronary syndrome. (See Coding Clinic, first quarter 2003, pages 12 and 13.)

Acute coronary syndrome/acute ischemic syndrome

These diagnoses are assigned code 411.89, other acute and subacute forms of ischemic heart disease, other. (See Coding Clinic, third quarter 2001, page 14.)

Acute myocardial injury

Acute myocardial injury without infarction is assigned code 411.89. (See Coding Clinic, first quarter 1992, pages 9 and 10.)
Angina/coronary artery disease (CAD)
A patient was admitted with unstable angina, which was secondary to CAD of the native vessels. CAD was due in part to secondhand tobacco smoke exposure. The principal diagnosis is CAD of native vessel, 414.01, with secondary diagnoses of unstable angina, 411.1, and secondhand tobacco smoke, E869.4. (See Coding Clinic, second quarter 1996, page 10.)

Code 414.0 had fifth digits added effective 10-1-94. (See Coding Clinic, second quarter 1995, pages 17-19.)

Coding and sequencing guidelines for angina and CAD in Coding Clinic, volume 10, number 5 1993, pages 17-24, supersedes advice published in Coding Clinic, third quarter 1990, pages 6-10.

Angina is a symptom. Therefore, when the cause is known the cause is sequenced as the principal diagnosis. If the cause of angina is unknown, then angina is sequenced as the principal diagnosis. (See Coding Clinic, third quarter 2001, page 15; Coding Clinic, second quarter 1997, page 13; Coding Clinic, second quarter 1995, pages 18-19; Coding Clinic, second quarter 1994, page 15; Coding Clinic, volume 10, number 5 1993, pages 19 and 20; and Coding Clinic, fourth quarter 1993, pages 43 and 44.)

Codes 411.1/411.81
Code 411.1, intermediate coronary syndrome, is not assigned with code 411.81, coronary occlusion without myocardial infarction (MI). (See Coding Clinic, first quarter 1991, page 14.)

No code from category 411, except code 411.0, postmyocardial infarction syndrome, should be assigned when the infarction has occurred. Postmyocardial infarction syndrome does sometimes occur on the same admission in which the infarction is treated. (See Coding Clinic, second quarter 1995, page 19, and Coding Clinic, third quarter 1991, page 24.)

Coronary atherosclerosis of transplanted heart
Code 414.06, coronary atherosclerosis of coronary artery of transplanted heart, is a new code created effective October 1, 2002. (See Coding Clinic, fourth quarter 2002, pages 53 and 54.)

Postinfarction angina
A code for postinfarction angina and a code for AMI may be assigned during the same episode of care. Postinfarction angina is coded to the type of angina documented by the physician. (See Coding Clinic, second quarter 1995, page 19, and Coding Clinic, fourth quarter 1994, page 55.)

Unstable angina/AMI
If a patient is admitted with unstable angina and it is determined after study the patient had AMI, only AMI is coded. Unstable angina is considered integral to AMI. (See Coding Clinic, fourth quarter 1993, pages 39 and 40, and Coding Clinic, second quarter 1990, page 15, ODX #3.)

Unstable angina/history of MI
If a patient is admitted for unstable angina, has a history of MI three years ago and angina is treated during the admission, unstable angina, 411.1, is sequenced as the principal diagnosis and history of MI, 412, is sequenced as a secondary diagnosis. If MI occurred within eight weeks of the admission, a code from the 410.x2 series should be assigned. (See Coding Clinic, volume 10, number 5, 1993, pages 18, 19, 20 and 23.)