DRG 143 — Chest Pain

ICD-9-CM Coding Guidelines

The below listed guidelines for chest pain and observation for suspected cardiovascular disease 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

When reviewing the medical record, determine whether or not an underlying cause for chest pain was established. If an underlying cause for chest pain is established, sequence that condition as the principal diagnosis, chest pain is a symptom.

Coding Guidelines

Chest pain due to cocaine intoxication

This is a poisoning. Poisoning is sequenced as the principal diagnosis, 986.5, poisoning by other central nervous system depressants and anesthetics, surface (topical) and infiltration anesthetics. (See Coding Clinic, first quarter 1993, page 25.)

Chest pain probably due to a specified condition

When the final diagnosis is stated as a symptom and is assigned a code from Chapter 16, and it is also noted to probably be due to a specified condition, there are several guidelines that must be considered to determine the correct code. (See Coding Clinic, first quarter 1991, page 12.)

The definition of principal diagnosis should be considered.

If the final diagnosis is qualified as probable, suspected, likely, possible, or still to be ruled out, sequence the condition as if it existed or was established, providing that the diagnostic work-up, arrangements for further work-up or observation, and initial therapeutic approach correspond most closely with the established diagnosis. This applies only to the acute care hospital inpatient setting. (See Coding Clinic, second quarter 2002, pages 5 and 65, E, Coding Clinic, third quarter 2001, page 17, and Coding Clinic, March-April 1985, page 3.)

Codes for symptoms, signs and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established. (See Coding Clinic, second quarter 2002, page 64, A, and Coding Clinic, second quarter 1990, page 3, PDX #1.)

Conditions that are integral to the disease process should not be assigned as additional codes. (See ODX #3, Coding Clinic, second quarter 1990, page 15.)
**Intractable pain**

There is no code for intractable pain. Therefore, pain should be sequenced to the cause or site. (See *Coding Clinic*, May-June 1985, page 14.)

**Midsternal chest pain**

Midsternal chest pain is assigned code 786.51. (See *Coding Clinic*, first quarter 1998, page 10.)

**Noncardiac chest pain in emergency room**

Chest pain of gastrointestinal origin, in a patient with a history of gastroesophageal reflux, is assigned code 789.06, abdominal pain, epigastric. Assign code 530.81, gastroesophageal reflux, if the physician documented that chest pain was due to gastroesophageal reflux. (See *Coding Clinic*, first quarter 2002, page 5.)

Chest pain with presyncope, most likely gastrointestinal in origin, should be assigned code 785.59, chest pain, other, and 780.2, syncope and collapse. (See *Coding Clinic*, first quarter 2002, page 6.)

For noncardiac chest pain and anxiety, assign code 786.59, chest pain, other and 300.00, anxiety. Chest pain is not integral to the diagnosis of anxiety. (See *Coding Clinic*, first quarter 2002, page 6.)

**Observation and evaluation for suspected cardiovascular conditions**

Code V71.1 would only be assigned when a suspected cardiovascular condition is ruled out and no symptoms for the suspected condition are present. If a symptom is present, the code for the symptom is assigned and not a code from category V71. (See *Coding Clinic*, fourth quarter 1994, page 47.)

Code V71.7 is never a secondary diagnosis. (See *Coding Clinic*, fourth quarter 1996, page 59.)

Other conditions that co-exist at the time of admission may be sequenced as secondary diagnoses if they are unrelated to the suspected condition. (See *Coding Clinic*, fourth quarter 1996, page 53, and *Coding Clinic*, March-April 1987, pages 1 and 3-5.)

Category V71 is not assigned because the reason for admission is unclear in the medical record. (See *Coding Clinic*, November-December 1985, page 10.)

Parents of a child diagnosed with aortic root dilation had echocardiograms ordered. This disorder may be passed from parent to child. If results of the echocardiogram are normal, assign code V71.7, observation for suspected cardiovascular disease and assign additional diagnosis of V17.4, family history of certain chronic disabling diseases, other cardiovascular diseases. If the results confirm the presence of aortic root dilation or other related abnormality, assign the appropriate code(s) for positive findings instead of V71.7. (See *Coding Clinic*, first quarter 2004, pages 6 and 7.)


**Pain due to a malignancy**

If pain is due to a malignancy, malignancy is sequenced as the principal diagnosis. (See *Coding Clinic*, second quarter 2002, page 42, G and *Coding Clinic*, second quarter 1990, page 10, G.)
Postoperative pain
A postoperative complication code is not assigned for postoperative pain when the site of the pain is known. (See Coding Clinic, volume 10, number 5 1993, pages 8 and 15.)

Symptom due to contrasting/comparative diagnoses
When a symptom is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be sequenced as suspected conditions. (See Coding Clinic, second quarter 2002, page 65, E and Coding Clinic, second quarter 1990, page 5, PDX #7.)