



Documentation of Atherosclerosis of the Aorta (I70.0)

The diagnosis of atherosclerosis of the aorta (aortic calcification) is often noted incidentally on x-ray. As with all diagnoses, the submission of this diagnosis must meet ICD-10 coding guidelines. Your documentation is the only way you can support your choice of any code, and it must meet those guidelines to choose and submit a code. Coding Clinic, 1988 Q4 indicated that the term “aortic” alone did not support the selection of a diagnosis code, because it could pertain to the vessel or the aortic valve. Your documentation must make it clear which is being referred to. If your EMR short description for I70.0 indicates “aortic atherosclerosis”, some other part of your record **MUST** make it clear you are referring to the vessel. This is because coding cannot take place when there is conflicting information (such as “aortic” in the short description of I70.0).

Additionally, selection of any diagnosis must meet ICD-10 Guidelines for reporting. From Section IV Diagnostic Coding and Reporting Guidelines for Outpatient Services (which applies to all physician coding):

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80- Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

When documenting and coding arteriosclerosis/atherosclerosis of the aorta, two things are critical:

- 1). That your documentation make it clear that you are referring to the vessel (by use of the term aorta, or an anatomic landmark –e.g. abdominal aortic atherosclerosis) and
- 2) Indicating the clinical significance of the condition, by way of an indication of further follow up, treatment or indicating its impact on other conditions