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CLINICAL DOCUMENTATION

AHA CODING CLINIC CORNER

Fourth Quarter 2017, pg 15
First Quarter 2017, pg 46
Third Quarter 2016, pg 46

Congestive Heart Failure

Heart failure is the mechanical inability of the heart to pump blood efficiently, thus compromising circulation and causing systemic complications due to congestion and edema of fluids in the tissues.

ICD-10 CODES

I50.1 Left ventricular failure, unspecified
I50.2- Systolic (congestive) heart failure*
I50.3- Diastolic (congestive) heart failure*
I50.4- Combined systolic and diastolic heart failure*
I50.81- Right heart failure*
I50.82 Biventricular heart failure
I50.83 High output heart failure
I50.84 End stage heart failure
I50.89 Other heart failure
I50.9 Heart failure, unspecified

Multiple codes require a final digit to denote severity status.

0 = Unspecified
1 = Acute
2 = Chronic
3 = Acute on chronic

DOCUMENTATION ACRONYMS

DEEP Diagnosis Elements

Include elements of DEEP in documentation to clinically support congestive heart failure.

Diagnosis: Heart Failure

Evidence: HFrEF, edema in lower extremities, patient complains of SOB

Evaluation: Congestive Heart Failure with reduced ejection fraction

Plan: Start Carvedilol BID, rtc 2 weeks

Final Assessment Details

Include DSP for each addressed condition impacting treatment and patient care.

Diagnosis:

Congestive Heart Failure

- CHF Type

Status:

Severity

Secondary Conditions

- HTN
- CKD

Plan:

- CHF
  - Pharmacologic
  - Referrals
  - Medical Management
  - Lifestyle Intervention
  - Symptom Control

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BEST PRACTICES & TIPS

- **Specificity is key!** Always indicate the **type & specificit**y (chronic, acute, diastolic, systolic, right, left) with associated complications (HTN, CKD with stage) and any treatments.
- When documenting heart failure, be sure to document **any complicating factors** that are present to get a complete picture of the patients' health status.
- DSP should be applied for all CHF **as well as** for the underlying causes. Status should be apparent by using descriptive words to clarify the presence and severity of the illnesses. (Chronic, acute, symptomatic, mild, severe, newly identified, resolved, uncontrolled, etc.)
- Documentation should **always include DEEP elements** to show clinical evidence of CHF as well as any secondary conditions. Incorporate tests, imaging, signs and symptoms of each disease and document any and all associated treatments with each corresponding final diagnosis.
- **Avoid** documenting active CHF as a "history of" as this suggests a resolved status and may cause conflict within the documentation.
- **Avoid** using terms such as “probable”, “suspected”, “likely”, “questionable”, “possible”, “**history of**”, “**diastolic dysfunction” or “systolic dysfunction**” with a confirmed and active diagnosis of CHF.
- Combination codes exist in ICD-10-CM to represent the **interaction between CHF, HTN and CKD**. if these diseases are not related to each other it should be documented as such to unlink the assumed relationship.

For more resources go to:

HIOSCAR.COM/PROVIDERS/RESOURCES