Heart Failure
Coding Quick Reference Guide

Risk Stratification refers to the alignment of patients with the right clinical initiatives, according to their clinical complexity. Accurately and completely documenting and communicating a patient's chronic diagnoses drives such care coordination and high-quality clinical care. Diagnosis coding and documentation should always capture the complete picture of a patient's health status at the highest level of specificity appropriate for the patient.

Clinical Information and Documentation Tips

When diagnosing and treating heart failure, it is important to determine the cause of the heart failure and the ejection fraction. Common causes are listed below.

- Left ventricular dysfunction with a reduced ejection fraction is also known as systolic heart figure
- Heart failure with preserved ejection fraction is also known as diastolic heart failure
- Cardiomyopathies can cause heart failure with normal ejection fraction
- Valvular heart disease can be the primary cause of heart failure or can be secondary to a dilated cardiomyopathy

Questions to Ask Before Choosing a Code:

✓ What type of heart failure does my patient have - systolic, diastolic or a combination of both?
✓ What is the underlying cause of the heart failure?
✓ What is the most recent ejection fraction for the patient?
✓ Does the patient's current condition reflect an acute exacerbation or stable state?
✓ Is the patient dependent on oxygen?

Reminders + Tips:

- If the heart failure is caused by another disease, for example coronary artery disease, make sure you include that code as well as the heart failure code.
- When specifying acute vs chronic vs acute on chronic, make sure the documentation reflects the symptoms/signs. For example: acute develops suddenly with severe symptoms vs chronic develops slowly with less severe symptoms.

This information is a tool for addressing common billing and coding issues, which are explained more fully in the CPT© Manual and the official, CMS-approved ICD-10 guidelines. You should not rely exclusively on this information. Providers bear full responsibility for their own billing and coding, as well as compliance with all applicable Federal and state laws and regulations.

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Best Documentation Practices

Subjective

In the subjective section of the office note, document the presence or absence of any current patient-reported symptoms of heart failure (e.g., shortness of breath, fatigue).

Objective

In the objective section, include current associated physical exam findings (e.g., jugular venous distention, heart rate abnormalities, edema, weight gain, wheezing or crackles in the lungs, etc.) and results of any related diagnostic testing.

Assessment

Specificity:

- Document heart failure to the highest level of specificity, using all applicable descriptors (hypertensive, post-operative, acute, chronic, acute-on-chronic, diastolic, systolic, etc.).
- State the cause of heart failure, if known, using terms that clearly show cause and effect (such as "associated with," "due to," "secondary to," "hypertensive," etc.).
- Include the current status of heart failure (stable, worsening, improved, in remission, compensated, decompensated, etc.).

Abbreviations: A good rule of thumb for any medical record is to limit – or avoid altogether – the use of acronyms and abbreviations. "HF" is a commonly accepted medical abbreviation for heart failure. "HF" is sometimes used to represent heart failure; however, this abbreviation has other meanings. Best documentation practice is as follows:

- The initial notation of a condition should be spelled out in full followed by the abbreviation in parentheses, e.g., "Heart Failure (HF)"
- Subsequent mention of the condition can then be made using the abbreviation.

Current vs. Historical:

- Do not use the descriptor "history of" to describe current heart failure. In diagnosis coding, the descriptor "history of" implies the condition occurred in the past and no longer exists as a current problem.
- Temporary or transient heart failure that occurred in the past and is no longer present should not be documented as if it is current.

Terms of Uncertainty:

- Do not document suspected heart failure as if it is confirmed. Rather, document the signs and symptoms in the absence of a confirmed diagnosis.
- For confirmed heart failure, do not use descriptors that imply uncertainty (such as "probable," "apparently," "likely" or "consistent with").

Plan

Document a clear and concise plan for heart failure.

- Clearly link the heart failure diagnosis to all medications being used to treat the condition. Include orders for diagnostic testing (lab work, imaging, stress tests, etc.) and other diagnostic procedures.
- Provide details of related consultation requests and referrals to other providers and specialists. Include the date of next appointment.

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Common ICD-10 Diagnosis Codes

Systolic Heart Failure	ICD-10	v24 HCC	v28 HCC
Systolic (congestive) heart failure, unspecified	I50.20	85	226
Systolic (congestive) heart failure, acute	I50.21	85	225
Systolic (congestive) heart failure, chronic	I50.22	85	226
Systolic (congestive) heart failure, acute on chronic	I50.23	85	224

Diastolic Heart Failure	ICD-10	v24 HCC	v28 HCC
Diastolic (congestive) heart failure, unspecified	I50.30	85	226
Diastolic (congestive) heart failure, acute	I50.31	85	225
Diastolic (congestive) heart failure, chronic	I50.32	85	226
Diastolic (congestive) heart failure, acute on chronic	I50.33	85	224

Combined Heart Failure	ICD-10	v24 HCC	v28 HCC
Combined systolic (congestive) and diastolic (congestive) heart failure, unspecified	I50.40	85	226
Combined systolic (congestive) and diastolic (congestive) heart failure, acute	I50.41	85	225
Combined systolic (congestive) and diastolic (congestive) heart failure, chronic	I50.42	85	226
Combined systolic (congestive) and diastolic (congestive) heart failure, acute on chronic	I50.43	85	224

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Common ICD-10 diagnosis codes

Right Heart Failure	ICD-10	v24 HCC	v28 HCC
Right heart failure, unspecified	I50.810	85	226
Right heart failure, acute	I50.811	85	225
Right heart failure, chronic	I50.812	85	226
Right heart failure, acute on chronic	I50.813	85	225
Right heart failure due to left heart failure	I50.814	85	226

Other Heart Failures	ICD-10	v24 HCC	v28 HCC
Left ventricular failure	I50.1	85	226
Biventricular failure	I50.82	85	226
High output heart failure	I50.83	85	226
End stage heart failure	I50.84	85	222
Other heart failure	I50.89	85	226
Heart failure, unspecified	I50.9	85	226

Heart Failure Complications	ICD-10	v24 HCC	v28 HCC
Hypertensive heart disease with CHF	I11.0	85	226
Hypertensive heart and chronic kidney disease with CHF and stage 1-4 CKD	I13.0	85	226
Hypertensive heart and chronic kidney disease with CHF and stage 5 CKD or ESRD	I13.2	85/136	226/326
Heart transplant status	Z94.1	186	221

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