Documentation and Coding Tips

Congestive Heart Failure

Proper documentation of the precise type of heart failure is important to adequately describe the severity of the patient's illness and for accurate coding. If a provider does not specify "failure" in their documentation, a code from I50.X would not be assigned. Merely stating congestive heart failure, congestive heart disease, or heart failure without further description, is only supportive of code I50.9 heart failure, unspecified. Don't miss out by leaving off specific details in your documentation.

Specify When Documenting:

- **Type:**
  - Diastolic (congestive) heart failure with preserved ejection fraction (HFpEF)
  - Systolic (congestive) heart failure with reduced ejection fraction (HFrEF)
  - Combined diastolic/systolic (congestive) heart failure
- **Severity:**
  - Acute
  - Chronic
  - Acute on chronic
- **Disease status:**
  - Stable
  - Improved
  - Worsening
  - Acute exacerbation
  - Decompensation
- **Underlying cause, if known (i.e. cardiomyopathy, hypertension)**
- **Workup/treatment plan:**
  - Testing
  - Current/new medications
  - Lifestyle changes

Documentation & Coding Examples

Non-specific documentation example:

Patient seen today for congestive heart failure. Continue diuretics and use of wedge pillow while sleeping.

Assign code: I50.9 heart failure, unspecified

Specific documentation example:

Patient with hypertensive heart disease with end-stage heart failure in acute on chronic diastolic and systolic heart failure with mild decompensation. I increased diuretics and patient is now on full-time supplemental oxygen for chronic hypoxemic respiratory failure.

Assign codes: I50.84 End-stage heart failure, I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, J96.11 Chronic respiratory failure with hypoxia, I11.0 Hypertensive heart disease with heart failure.