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Updating heart failure documentation

There are important differences between the 2021 universal definition of heart failure and ICD-10-CM terminology.

By Richard Pinson, MD, FACP

Heart failure is diagnosed and coded based on its diastolic/systolic nature and acuity, but the latest definition of the condition complicates that a bit.

Image by Getty Images

The 2021 Universal Definition and Classification of Heart Failure defines heart failure as a clinical syndrome with symptoms and/or signs caused by a structural and/or functional cardiac abnormality and corroborated by elevated beta natriuretic peptide levels and/or objective evidence of pulmonary or systemic congestion (edema). Heart failure is then classified based on left ventricular ejection fraction (EF).

Heart failure with reduced ejection fraction (HFrEF) is defined as heart failure with an EF less than or equal to 40%. Heart failure with preserved ejection fraction (HFpEF) is defined as heart failure with an EF equal to or greater than 50%. Heart failure with mildly reduced ejection fraction (HFmrEF) is defined as heart failure with an EF of 41% to 49%. Heart failure with improved ejection fraction (HFimpEF) is significant improvement of reduced EF, usually following aortic valve replacement (significant improvement is defined as a baseline EF <40% with a ≥10% increase resulting in a new baseline >40%). An example would be a patient with a baseline EF of 35% that increased by 12% to 47%.

ICD-10-CM uses a somewhat different classification system. Codes are based on systolic and/or diastolic dysfunction, using EF, but there are certain allowances made for the 2021 descriptions. Systolic heart failure is defined as EF less than 50%, and diastolic heart failure is an EF of 50% or greater. Therefore, both HFrEF and HFmrEF are coded as systolic heart failure and HFpEF is diastolic heart failure (EF ≥50%). HFimpEF is classified as systolic or diastolic based on the final improvement in EF achieved (for example, improvement to EF 45% = systolic, while improvement to EF 55% = diastolic).

ICD-10-CM includes codes for “combined” systolic/diastolic heart failure, which apply to patients with an EF less than 50% (systolic dysfunction) together with diastolic parameters other than EF recognizable on echocardiography, such as abnormal left ventricular relaxation, changes in compliance or stiffness, or the level of left ventricular filling pressure. The 2021 universal definition does not address combined systolic/diastolic heart failure.

Identifying the systolic versus diastolic nature of heart failure is important for clinical management and coding purposes. This distinction facilitates correct therapeutic decisions and code assignment to reflect the patient's true severity of illness and costs of care. Quality and other performance measures can also be impacted adversely by the failure to distinguish between these types. For greatest clarity, the systolic/diastolic nature of heart failure should be documented, but the 2021 terminology is often an acceptable alternative.

Establishing the acuity of heart failure is just as important as determining whether it is systolic or diastolic, but acuity will have no impact on coding if the systolic/diastolic nature is not documented. Always document clearly and consistently in the medical record if heart failure is acute or if there has been an acute exacerbation or decompensation of chronic heart failure, even if mild.

In the absence of decompensation, stable asymptomatic chronic heart failure also contributes to the determination of the patient's severity of illness and cost of hospital care even if no related treatment is required other than continuation of usual home medications. However, this is the case only if the systolic/diastolic nature of the patient's heart failure is identified.

ICD-10-CM identifies many types of heart failure (see examples in the Table), but it is most important to specify acuity and the systolic/diastolic distinction. Unspecified heart failure (e.g., “CHF” or simply “heart failure” without further

description) is assigned code I50.9, which makes no contribution to severity of illness classification.

Table. Example ICD-10-CM heart failure codes

ICD-10 description	ICD-10-CM code	DRG severity impact
Systolic heart failure	I50.20	CC
Acute systolic heart failure	I50.21	MCC
Chronic systolic and diastolic heart failure	I50.42	CC
Acute-on-chronic diastolic heart failure	I50.33	MCC
Congestive heart failure	I50.9	None
Right-heart failure	I50.810	None
Left ventricular (or heart) failure	I50.1	CC
End-stage heart failure	I50.84	None
Biventricular heart failure	I50.82	None

Derived from ICD-10-CM. CC=complication or comorbidity; DRG=diagnosis-related group; MCC=major complication or comorbidity.

Other descriptions of heart failure that are identified by ICD-10-CM codes but have no significant severity of illness classification (in other words, no complication or comorbidity [CC]) include biventricular, right, end-stage, and high-output heart failure. Whenever these terms are used, the systolic/diastolic nature and acuity should also be documented. Left ventricular (heart) failure is assigned to a code that is a CC but does not have specificity for acuity. Therefore, when left-heart failure is acute, both its acuity and the systolic/diastolic nature should be documented.

All forms of heart failure documented in the record should be coded to capture a complete picture of the patient's condition. For example, documentation of acute diastolic right-heart failure would be assigned two codes: one for right-heart failure (non-CC) and another for acute diastolic heart failure (a major CC). ◆

Dr. Pinson is a certified coding specialist, author, educator, and cofounder of Pinson and Tang, LLC, and is based in Chattanooga, Tenn. This content is adapted with permission from Pinson and Tang, LLC. The views expressed in this column are those of the author and not intended to replace authoritative sources for documentation and coding.

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