Heart failure
ICD-10-CM
Clinical overview

Definition

Heart failure is a condition in which the heart muscle is unable to pump enough blood through the heart to meet the body's needs for blood and oxygen.

Background

The heart has four chambers: the upper chambers (right and left atria) and the lower chambers (right and left ventricles). Oxygen-rich blood travels from the lungs to the left atrium of the heart and into the left ventricle, where it is pumped out to the rest of the body. Oxygen-poor blood returns from the body into the right atrium, then to the right ventricle where it is pumped back to the lungs to again receive oxygen. When the heart functions properly, all four chambers beat and pump blood effectively in an organized way. When heart failure develops, the heart is no longer able to pump blood effectively. In the early stages, the heart is able to compensate in these ways:

- The heart chambers enlarge, and the heart develops more muscle mass.
- The heart pumps faster, diverting blood away from less important areas of the body to the heart and brain.
- Blood vessels narrow to keep blood pressure up.

Eventually, the heart no longer can compensate, and signs and symptoms of heart failure develop.

Types

- **Left-sided heart failure:** The most common form of heart failure, it involves a decreased ability of the left ventricle to effectively pump blood out to the rest of the body. Fluid may back up in the lungs, causing shortness of breath.
- **Right-sided heart failure:** The right side no longer pumps effectively, and blood backs up in the body's veins, causing swelling in the tissues. This form is usually due to left-sided heart failure.
- **Systolic failure:** The left ventricle loses its ability to contract normally; thus, it cannot effectively pump blood out of the heart to the body.
- **Diastolic failure:** The left ventricle loses its ability to relax normally; thus, it cannot fill with blood during the resting period between beats.
- **Congestive heart failure (CHF):** A slowing of blood flow out of the heart that occurs with heart failure also can cause blood returning to the heart to slow and back up, resulting in congestion in body tissues. This leads to edema (swelling) in the lower extremities and congestion in the lungs that interferes with breathing.

Causes/risk factors

- Smoking
- Hypertension
- Diseases of heart muscle
- Past heart attack
- Coronary artery disease
- Abnormal heart valves
- Obesity
- Diabetes
- Congenital heart disease
- Lung diseases
- Heart arrhythmias
- Other medical conditions

Signs and symptoms

- Edema/swelling of feet, ankles, abdomen
- Increased heart rate or palpitations
- Shortness of breath
- Fatigue
- Confusion
- Decreased urine
- Difficulty sleeping
- Decreased exercise tolerance
- Cough, wheezing or crackles in lungs
- Weight gain
- Loss of appetite
- Indigestion
- Nausea and vomiting
- Jugular venous distention

Diagnostic tools

- Medical history and physical exam
- Lab testing, including B-type natriuretic peptide (BNP) lab test: BNP is a substance secreted by the ventricles in response to pressure changes in the heart that occur with heart failure. The blood BNP level increases when heart failure gets worse and decreases when heart failure is stable.
- Chest X-ray
- Electrocardiogram (ECG or EKG)
- Echocardiogram
- Cardiac stress testing and catheterization
- CT or MRI scans
- Nuclear heart scans

Treatment

- Regular monitoring
- Limited salt intake
- Smoking cessation
- Exercise
- Weight control and balanced nutrition
- Treatment of underlying conditions
- Medications (e.g., diuretics, beta blockers, angiotensin-converting enzyme inhibitors, digitalis glycosides, angiotensin receptor blockers)
- Pacemaker or implantable cardioverter defibrillator
- Heart pumps (left ventricular assist devices)
- Heart transplant

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Best documentation practices for physicians

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 (congestive, 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. "CHF" is a commonly accepted medical abbreviation for congestive 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., "Congestive Heart Failure (CHF)."
- Subsequent mention of the condition can then be made using the abbreviation.

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").

Current versus 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.

Treatment plan
- Document a specific and concise treatment plan for heart failure, including date of next appointment.
- If referrals are made or consultations requested, the office note should indicate to whom or where the referral or consultation is made or from whom consultation advice is requested.

Electronic health record (EHR) issues
Some EHRs insert ICD-10-CM code descriptions into the medical record to represent the final diagnosis. For example: "I5Ø.9 Heart failure, unspecified" or "I5Ø.89 Other heart failure."

With these types of vague descriptions, the diagnosis will not be complete unless the physician clearly documents the specific heart failure or the particular "other" heart failure.

ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.9.a – "Other and unspecified codes":
Codes titled "other" or "other specified" are for use when the information in the medical record provides a specific diagnosis description for which a specific code does not exist.

- Alphabetic Index entries in the coding manual with NEC (not elsewhere classified) in the line designate "other" codes in the Tabular List.
- These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.

- The "other" ICD-10-CM code with description should not be used, by itself, as a final diagnosis without clear documentation of the particular "other" condition – or in this case – the particular "other" type of heart failure.

Another scenario that causes confusion is one in which the assessment section documents a final provider-stated diagnosis *PLUS* an EHR-inserted diagnosis code with description that does not match or may even contradict the final diagnosis. Example:

Final Assessment: Systolic heart failure

I5Ø.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure

To avoid confusion and ensure accurate diagnosis code assignment, the provider-stated final diagnosis must either
 a) match the code with description; OR
 b) it must classify in ICD-10-CM to the EHR-inserted diagnosis code with description.

Note: ICD-10-CM is a statistical classification; it is not a substitute for a provider's final diagnostic statement. It is the healthcare provider's responsibility to provide legible, clear, concise and specific documentation of a final diagnosis described to the highest level of specificity, which is then translated to a code for reporting purposes. It is not appropriate for healthcare providers to simply list a code number or select a code number from a list of codes in place of a written final diagnosis.

Basics of coding

For accurate and specific diagnosis code assignment:
- Review the entire medical record to verify the heart failure condition is current.
- Note the exact heart failure description documented in the medical record; then, in accordance with ICD-10-CM official coding conventions and guidelines:
  - Search the alphabetic index for that specific description.
  - Verify the code in the tabular list, carefully following all instructional notes as appropriate.

Coding heart failure

Heart failure classifies to category I5Ø. Fourth characters specify the type of heart failure; fifth characters specify acute, chronic or acute-on-chronic; sixth characters are used to report other specific types of heart failure. (See coding manual for all instructional notes.)

I5Ø.1	Left ventricular failure, unspecified
I5Ø.2-	Systolic (congestive) heart failure
I5Ø.3-	Diastolic (congestive) heart failure
I5Ø.4-	Combined systolic (congestive) and diastolic (congestive) heart failure
I5Ø.8-	Other heart failure
I5Ø.9	Heart failure, unspecified

   Includes
   Cardiac, heart or myocardial failure NOS
   Congestive heart disease
   Congestive heart failure NOS
   Excludes 2 fluid overload unrelated to CHF (E87.7Ø)

Subcategory I5Ø.8, Other heart failure

This subcategory uniquely identifies several different specific types of heart failure. This allows for differentiating cases of pure right heart failure from left heart failure. Patients with right heart failure are treated differently than patients with left heart failure.

I5Ø.81Ø	Right heart failure, unspecified
I5Ø.811	Acute right heart failure
I5Ø.812	Chronic right heart failure
I5Ø.813	Acute on chronic right heart failure
I5Ø.814	Right heart failure due to left heart failure

   Excludes 1 right heart failure with but not due to left heart failure (I5Ø.82)

I5Ø.82	Biventricular heart failure
I5Ø.83	High output heart failure
I5Ø.84	End-stage heart failure
I5Ø.89	Other heart failure

Subcategories I5Ø.2 – I5Ø.4 include the descriptor "congestive" as a nonessential modifier (a supplementary word that may be present or absent in the diagnostic statement without affecting the code number to which it is assigned).
- Therefore, when the final diagnosis lists congestive heart failure along with either systolic or diastolic heart failure, only the code for the type of heart failure is assigned (systolic and/or diastolic).

The terms "heart failure" and "congestive heart failure" are often used interchangeably, even though congestion (pulmonary or systemic fluid buildup) is one feature of heart failure that does not occur in all patients with heart failure. Thus, clinically "heart failure" and "congestive heart failure" are not one and the same. Despite this clinical information, in ICD-10-CM, "heart failure" and "congestive heart failure" classify to the same code: I5Ø.9, Heart failure, unspecified. Code I5Ø.9 includes congestive heart failure. ICD-10-CM does not provide a separate code for CHF.

It is not appropriate to code heart failure based on the coder's own clinical interpretation of documented signs, symptoms or lab values. Rather, code assignment is strictly based on the specific description of heart failure documented by the physician.

Compensated, decompensated, exacerbation

- "Compensated" heart failure means the heart has developed compensatory mechanisms that permit near-normal heart function.
- "Decompensated" or "exacerbation" both indicate a flare-up (acute phase) of heart failure – an increase in the severity of heart failure or any of its symptoms. When heart failure is described as currently decompensated or exacerbated, it should be coded as acute-on-chronic.

Diastolic or systolic dysfunction with acute or chronic heart failure

When the medical record links either diastolic or systolic dysfunction with acute or chronic heart failure, it should be coded as "acute/chronic diastolic or systolic heart failure." If there is no documented linkage, assign code I5Ø.9, Heart failure, unspecified. (Reference: AHA Coding Clinic – Acute congestive heart failure with diastolic or systolic dysfunction, first quarter 2017, page 46)

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Tips and resources for coders

Hypertension with heart disease

ICD-10-CM presumes a cause-and-effect relationship between hypertension (HTN) and heart disease. These two conditions should be coded as related even in the absence of physician documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

HTN with heart conditions classified to I5Ø.-, or I51.4-I51.7, I51.89, I51.9 are assigned to a code from category I11, Hypertensive heart disease.

- Use additional code(s) from category I5Ø, Heart failure, to identify the type(s) of heart failure in those patients with heart failure.
- The same heart conditions (I5Ø.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately if the provider has documented they are unrelated to the hypertension. Sequence them according to the circumstances of the admission/encounter.

Hypertensive heart and chronic kidney disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement.

- If heart failure is present, assign an additional code from category I5Ø to identify the type of heart failure.
- The appropriate code from category N18, chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease.

- The *Includes* note at I13 specifies that the conditions included at I11 and I12 are included together in I13.
- If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.

Heart dysfunction

Heart dysfunction without mention of heart failure codes to I51.89, Other ill-defined heart diseases.

Coding examples

Example 1	
Final diagnosis	Decompensated congestive heart failure with diastolic dysfunction
ICD-10-CM code	I5Ø.33 Acute on chronic diastolic (congestive) heart failure

Example 2	
Final diagnosis	Acute systolic and diastolic heart failure
ICD-10-CM code	I5Ø.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure

Example 3	
Final diagnosis	Hypertensive heart disease with chronic diastolic CHF and chronic kidney disease stage 4
ICD-10-CM codes	I13.Ø Hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease I5Ø.32 Chronic diastolic (congestive) heart failure N18.4 Chronic kidney disease, stage 4 (severe)

Example 4	
Final diagnosis	Acute right ventricular failure
ICD-10-CM code	I5Ø.811 Acute right heart failure

Example 5	
Final diagnosis	Hypertensive heart failure
ICD-10-CM codes	I11.Ø Hypertensive heart disease with heart failure I5Ø.9 Heart failure, unspecified

Example 6	
Final diagnosis	Chronic systolic heart failure exacerbation
ICD-10-CM code	I5Ø.23 Acute on chronic systolic (congestive) heart failure

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