OIG Targeted High Risk Condition Series

Session 2: Heart Failure, AFIB, Angina (Part 2)

Virtual Conference

Thursday, March 6, 2025

Jointly provided by Healthfirst and Northwell Health

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Session 2: Heart Failure, AFIB, Angina (Part 2)

PROGRAM OVERVIEW

The purpose of this webinar series is to outline strategies and educate Healthfirst clinical providers on ICD-10 accuracy and clinical documentation improvement based on recommendations from the Office of Inspector General (OIG). The aim is to empower the providers and coders while enhancing the quality of healthcare delivery delivery.

Program components include, but are not limited to:

- Interactive sessions covering ICD-10 coding guidelines and documentation requirements.
- Case studies and examples illustrating coding scenarios and documentation challenges.
- Modules covering key aspects of ICD-10 coding and documentation improvement.
- Sharing experiences, tips, and strategies for improving documentation accuracy.

PROGRAM OBJECTIVES

Upon completion of this activity, participants should be able to:

- **Recall** the importance of accurate ICD-10 coding and documentation in healthcare.
- **Identify** common documentation pitfalls and errors impacting coding accuracy.
- **Apply** best practices for clinical documentation improvement to support accurate coding.
- **Comply** with OIG recommendations to minimize risks of improper payments and audits.

SESSION 2 OBJECTIVES

Heart Failure, AFIB, Angina - (Part 2)

- Ensure clinicians can accurately report AFib diagnoses and treatments to capture a patient's health status and promote continuity of care. Accurate documentation and code selection for Angina will assist with diagnosis and billing.

TARGET AUDIENCE

This activity has been planned by and for both physicians and clinical documentation & coding professionals. Medical providers such as PCPS and specialists in the areas of endocrinology, vascular, pulmonology, oncology, cardiology who treat chronically ill patients affected by these disease states and who will improve patient outcomes by enhancing their knowledge of ICD-10 coding are encouraged to join.

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ACCREDITATION STATEMENT

In support of improving patient care, this activity has been planned and implemented by Northwell Health and Healthfirst. Northwell Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE) and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

CREDIT DESIGNATION STATEMENTS

Physicians: Northwell Health designates each live activity for a maximum of *1.0 AMA PRA Category 1 Credits™.* Physicians should only claim credit commensurate with the extent of their participation in the activity.

Verification of attendance: This will be provided to all professionals.

REGISTRATION

If you need additional information or to register for the event, please email Angela Sullivan, Manager of Provider Education, at asullivan@healthfirst.org or call 917-748-8455.

AGENDA

Thursday, March 6, 2025

8:55AM	Welcome and Introduction to CME Activity Bryan Patrick, MD *Medical Peer Reviewer* *Healthfirst*
Session	
9:00AM–9:45AM	OIG Targeted High Risk Conditions: Session 2: Heart Failure, AFIB, Angina (Part 2) Damarys Ayala, MJ, RHIA, CRC, CPMA, CPC, CDEO *AAPC Approved Instructor Manager, Provider Education* *Clinical and Documentation Excellence* *Healthfirst*
9:45AM	Question and Answer Session
10:00AM – Adjournment	

AAPC - Continuing Education Units (CUEs)

- This webinar is approved by **American Academy of Professional Coders (AAPC)**
- Only registered participants will be eligible for CEUs.
- To receive a CEU certificate, You must attend at least 45 minutes of the webinar.
- Participants must be connected to both the audio and visual parts of the meeting for attendance to be recorded.
- After attendance is verified, an AAPC CEU certificate will be emailed to the appropriate participants.
- Sharing or claiming a CEU certificate without attending the webinar is strictly prohibited and could be viewed as fraudulent by AAPC.

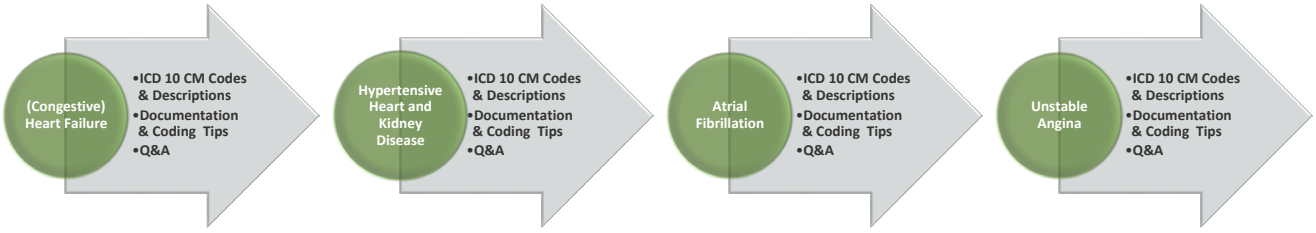
Heart Failure_ Afib

Clinical Documentation & Coding Dept.

Information Sharing

Credit: CME/CEU

Agenda



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Documenting Specifics of Heart Failure:

- **Status of Condition**
  - Stable
  - Improved
  - Worsening
  - Compensated
  - Exacerbation
- **Type of Heart Failure**
  - Systolic
  - Diastolic
  - Combined
  - Other/ Unspecified
- **Acuity of condition**
  - Acute
  - Chronic
  - Acute on chronic
- **Link associated conditions**
  - "Due to"
  - "Secondary to"
  - "Associated with"
- **Interpretation of Diagnostic Tests**
  - Catheterization
  - Cardiac stress testing
  - Echocardiogram
  - EKG
  - X-ray
  - CT/MRI scans
  - Nuclear heart scans

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Documentation Recommendation
Echocardiograms with findings should be documented

- The reason(s) for the test
- The size of the heart chambers and thickness of the heart muscle
- The function of the left and right ventricles
- A narrative of the shape, movement, and function of the heart valves
- A depiction of other structures that are important for heart function, including the large arteries and veins, the pericardium, and any abnormalities, such as blood clots
- An indication that the ordering provider reviewed the results, or the provider must indicate this in the note
- Sinus tachycardia, rate 120, non-specific ST-T changes, no acute ischemia noted, no EKG available for comparison.
- Normal sinus rhythm with rate of 72, PR and QRS intervals within normal limits, QRS complexes in lead III and T-wave abnormalities in lead I, no acute changes noted from prior EKG.
- Right bundle branch block, no ischemic changes.

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Case Study of Congestive Heart Failure

DOS: 3/21/2023

Hypertension
This is a chronic problem. The current episode started more than 1 year ago. The problem is unchanged. The problem is controlled. Pertinent negatives include no chest pain, headaches or shortness of breath. There are no associated agents to hypertension. Risk factors for coronary artery disease include diabetes mellitus, male gender and obesity. Past treatments include beta blockers, calcium channel blockers, diuretics, central alpha agonists, angiotensin blockers and alpha 1 blockers. The current treatment provides significant improvement. There are no compliance problems. Hypertensive end-organ damage includes retinopathy. There is no history of hyperaldosteronism, hypercortisolism or hyperparathyroidism.

Diabetes
He presents for his follow-up diabetic visit. He has type 2 diabetes mellitus. No MedicAlert identification noted. His disease course has been stable. Pertinent negatives for hypoglycemia include no confusion, dizziness or headaches. Pertinent negatives for diabetes include no chest pain. There are no hypoglycemic complications. Diabetic complications include retinopathy. Risk factors for coronary artery disease include diabetes mellitus, dyslipidemia, hypertension, male sex and obesity. Current diabetic treatment includes insulin injections. He is compliant with treatment all of the time. He is following a diabetic diet. When asked about meal planning, he reported none. He has not had a previous visit with a dietitian. He never participates in exercise. There is no change in his home blood glucose trend. An ACE inhibitor/angiotensin II receptor blocker is being taken. Eye exam is current.

Ronald has a past medical history of Arthritis, Asthma, Blood transfusion, BPH (benign prostatic hypertrophy), CAD (coronary artery disease) (01/2010), CAD (coronary artery disease) (06/30/2016), Cataract (11/27/2013), Chronic kidney disease, COPD (chronic obstructive pulmonary disease) (CMS/HCC), Coronary artery disease (12/2009), Coronary bypass, Coronary stent, Diabetes mellitus (CMS/HCC), Heart murmur, Hyperlipidemia, Hypertension, Myocardial infarction (CMS/HCC), Obesity, morbid (CMS/HCC), OSA on CPAP (2009), Osteoarthritis of knee, Positive PPD, and Syncope.
Ronald has a past surgical history that includes Coronary artery bypass graft; Angioplasty; Cardiac surgery; Cataract extraction w/ intraocular lens implant, bilateral; Retinal laser procedure; and Varicose vein surgery.

Review of Systems
Constitutional: Positive for activity change (decrease). Negative for fever and unexpected weight change.
HENT: Negative for rhinorrhea, sinus pressure and sinus pain.
Respiratory: Negative for cough, shortness of breath and wheezing.
Cardiovascular: Positive for leg swelling. Negative for chest pain.
Gastrointestinal: Negative for constipation, diarrhea, nausea and vomiting.
Genitourinary: Negative for enuresis, frequency and genital sores.
Musculoskeletal: Positive for arthralgias (knee) and gait problem.
Neurological: Negative for dizziness, light-headedness and headaches.
Psychiatric/Behavioral: Negative for behavioral problems and confusion.

Assessment

1.	**Breast pain**	
2.	Chronic diastolic (congestive) heart failure (CMS/HCC) Active	
3.	Chronic bronchitis, unspecified chronic bronchitis type (CMS/HCC)	
4.	Body mass index (BMI) 50.0-59.9, adult (CMS/HCC) Active	CBC w/Platelet and Differential Comprehensive Metabolic Panel Hemoglobin A1C Lipid Panel
5.	Type 2 diabetes mellitus with proliferative retinopathy without macular edema, with long-term current use of insulin, unspecified laterality (CMS/HCC)	Ambulatory referral to Ophthalmology Ambulatory referral to Podiatry Hemoglobin A1C
6.	Perineal abscess, superficial	Amoxicillin-clavulanate (AUGMENTIN) 875-125 mg per tablet
7.	Constipation, unspecified constipation type	Lactulose (CHRONULAC) 10 g/15 mL oral solution
8.	Ulcer of toe of right foot, unspecified ulcer stage (CMS/HCC)	Doxycycline Hyclate (VIBRAMYCIN) 100 MG capsule silver sulfADIAZINE (SILVADENE) 1 % cream Supply/DME Order
9.	Pain in both knees, unspecified chronicity	XR knee bilateral PA and lateral
10.	Nasal congestion	Ambulatory referral to ENT
11.	Colon cancer screening	FECAL GLOBIN,MEDICARE (11293X)

• isosorbide mononitrate (IMDUR) 60 MG 24 hr tablet	Take 1 tablet by mouth once daily.	30 tablet	5
• latanoprost (XALATAN) 0.005 % ophthalmic solution	1 drop into affected eye in the evening Strength: 0.005 %	2.5 mL	2
• losartan (COZAAR) 50 MG tablet	Take 1 tablet by mouth once daily.	90 tablet	1
• Metoprolol Succinate ER (TOPROL-XL) 50 MG 24 hr tablet	Take 1 tablet by mouth once daily.	90 tablet	1

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Case Study CHF Cont'd

Reported Diagnosis –
I50.32 - Chronic diastolic (congestive) heart failure

Dx Supported – YES

HCC Validated – YES

Comment: A/P: Chronic Diastolic CHF, on Imdur, Metoprolol Succinate ER

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Codes for Congestive Heart Failure

Systolic CHF

- **I50.20** Unspecified **systolic** (congestive) heart failure
- **I50.21 Acute systolic** (congestive) heart failure
- **I50.22 Chronic systolic** (congestive) heart failure
- **I50.23 Acute on chronic** (congestive) heart failure

Diastolic CHF

- **I50.30** Unspecified **diastolic** (congestive) heart failure
- **I50.31 Acute diastolic** (congestive) heart failure
- **I50.32 Chronic diastolic** (congestive) heart failure
- **I50.33 Acute on chronic diastolic** (congestive) heart failure

Combined CHF

- **I50.40** Unspecified **combined systolic** (congestive) and **diastolic** (congestive) heart failure
- **I50.41 Acute combined systolic** (congestive) and **diastolic** (congestive) heart failure
- **I50.42 Chronic combined systolic** (congestive) **and diastolic** (congestive) heart failure
- **I50.43 Acute on chronic combined systolic** (congestive) **and diastolic** (congestive) heart failure

Other CHF

- **I50.810** Right heart failure, unspecified
- **I50.811** Acute right heart failure
- **I50.812** Chronic right heart failure
- **I50.813** Acute on chronic right heart failure
- **I50.814** Right heart failure due to left 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

I50.1 Left ventricular failure, unspecified

I97.13 Postprocedural Heart Failure
I09.81 Rheumatic Heart Failure

I11.0 Heart failure due to Hypertension - Add additional of Heart Failure I50
I13.0, I13.2 Heart failure due to hypertension with chronic kidney disease (CKD) - Add stage of CKD (N18.1-N18.9; and Heart Failure I50

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Documentation Tips

When heart failure is described as **decompensated or exacerbated**, it should be documented as **acute-on-chronic**.

Document heart failure to the **highest level of specificity**, i.e., congestive, hypertensive, post-operative, acute, chronic, acute-on-chronic, diastolic, systolic, etc.

Ensure results of an **echocardiogram differentiating between systolic and diastolic heart failure** is documented.

ICD-10 classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement **unless provider documents clearly the conditions are unrelated (Guideline I.C.9.a).**

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Hypertension with Associated Conditions

Hypertension codes span from I10 to I15 (there is no I14)

I10 Essential Hypertension	**I11*** (HCC) Hypertensive heart disease	**I12*** (HCC) Hypertensive Chronic Kidney Disease	**I13*** (HCC) Hypertensive Heart and Chronic Kidney Disease	**I15*** Secondary Hypertension	**I97.3** Postoperative hypertension

As per American Heart Association's coding clinic for ICD-10-CM/PCS, first quarter, 2016, p10:

- *HFpEF (heart failure with preserved /normal ejection fraction)* may be coded as *diastolic heart failure (I50.3*)*
- *HFrEF (heart failure with reduced ejection fraction)* may be coded *as systolic heart failure*. (I50.2*)

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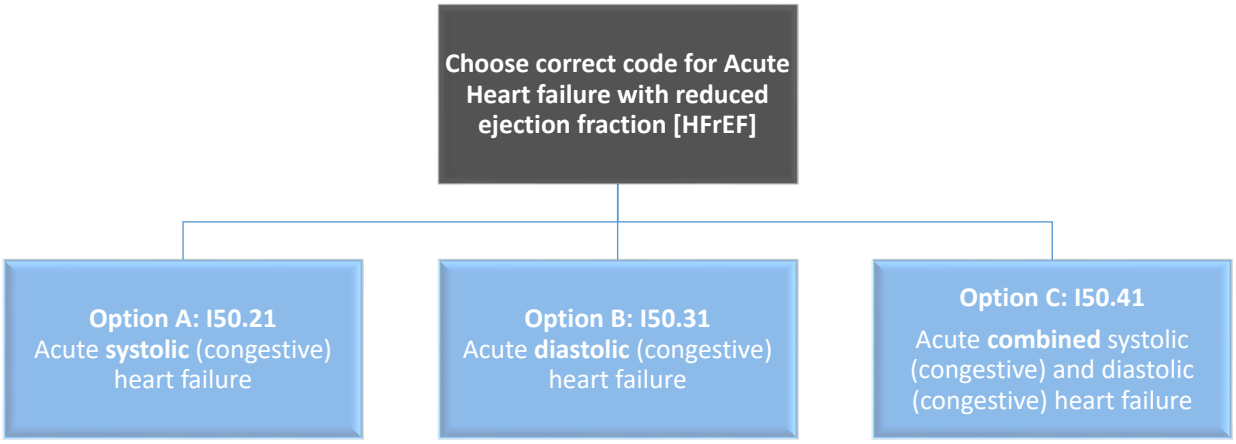
Q & A



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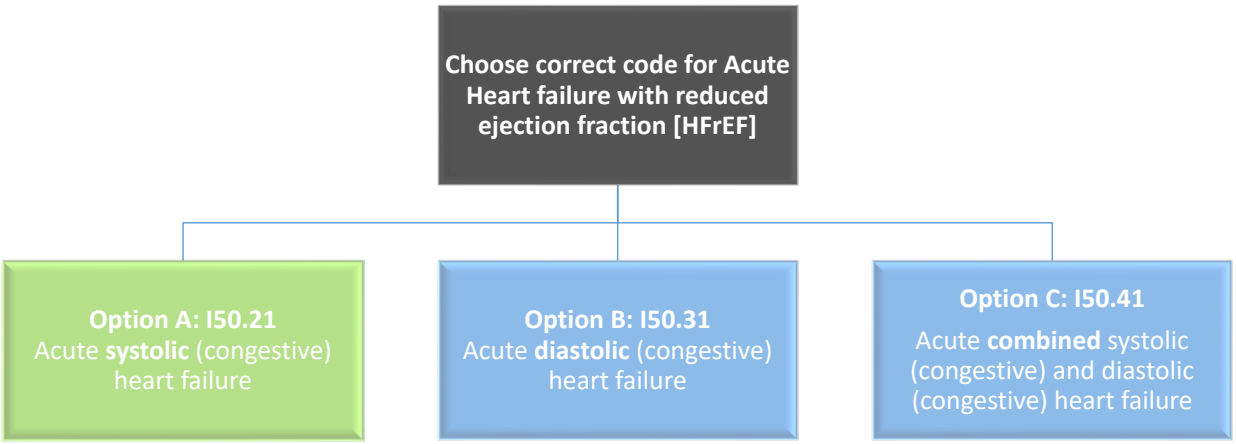

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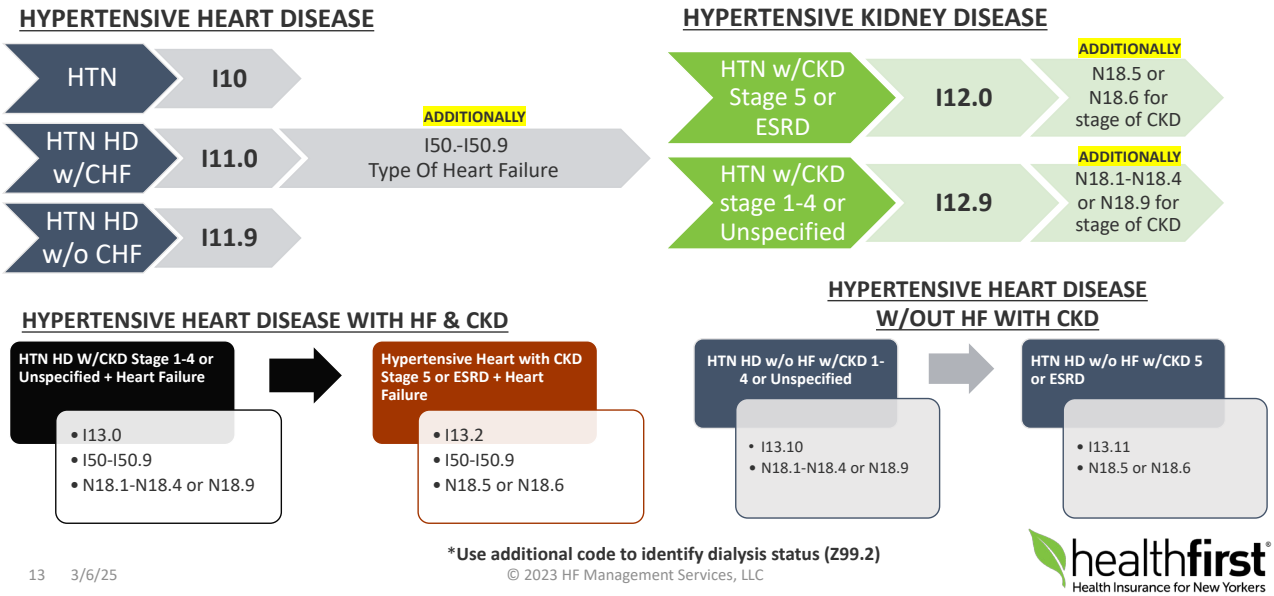
Hypertension Relationship to CKD and Heart Failure



*Use additional code to identify dialysis status (Z99.2)

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Documenting Hypertensive Heart Failure

Clinical Documentation

Heart failure with an underlying condition?

- Any causative cardiomyopathy
- Hypertension
- Hypertension with chronic kidney disease
- Relationship with chronic renal failure, volume overload, or non-cardiac pulmonary edema
- Following cardiac surgery

If Secondary to hypertensive heart disease, link should be supported by physician

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Case and Best Clinical Documentation Practices

HPI

68 yr. old male admitted to the ED with complaints of SOB and lower extremity swelling. Pt with bilateral lower extremity 2+ edema, expiratory wheezing, dyspnea at rest, use of accessory muscles

PMH

CHF, HTN, COPD on continuous home 02 at 2L, BMI 44.5

Vitals

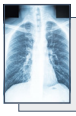
HR 98, RR 26, temp 98.2, BP 130/72, 02 Sat 84% on 02 at 2L, improved to 95% on 5 liters of O2

Labs

ABG's: pH 7.29, PO2 48, PCO2 60

Echocardiogram

EF 35%, with systolic dysfunction



Chest x-ray

Bilateral pleural effusion and pulmonary edema consistent with CHF

PE

Rhonchi and rales bilaterally, cough, + sputum, +2 edema bilaterally lower extremities

Treatment

O2 to keep Sa02 above 90%, Dietary Consult for BMI > 40, 1800 calorie Cardiac diet, Cardiology Consult, Bariatric hospital bed, Physical therapy evaluation for decreased exercise tolerance

Meds Ordered

Lasix 40 mg IVP BID changed to Lasix 20mg po bid on day 3, Lisinopril 10 mg PO daily, Solumedrol 60 mg IV q 6 hours, Albuterol aerosol q 6 hours

Cardiology Consult

Patient continues to be short of breath, Diagnosis: **Acute Exacerbation of Systolic CHF**

Discharge Summary

Patient admitted due to shortness of breath and lower extremity swelling. Given IV Lasix, found to be in exacerbation of CHF. **Final diagnosis: Acute exacerbation of systolic CHF, COPD, hypoxia and obese**

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Case and Best Clinical Documentation Practices Cont'd

Diagnoses

- Principal Diagnosis: Hypertensive heart disease with heart failure **(I11.0)**
- Secondary Diagnosis: Acute on chronic systolic CHF **(I50.23)**
- COPD unspecified **(J44.9)**
- Dependence on oxygen (Z99.81)
- Hypoxia (R09.02)
- BMI 44.5 (Z68.41, E66.9)
- Dependence on o2 (Z99.81)

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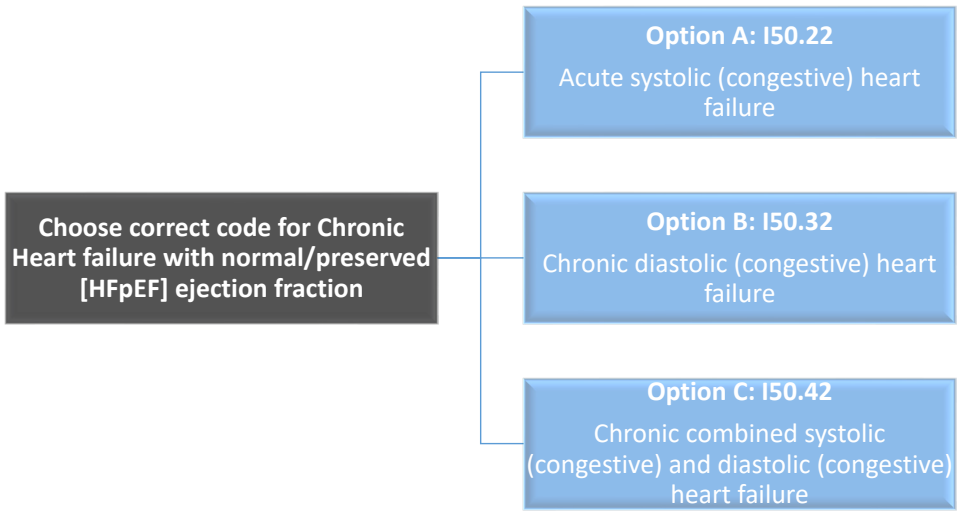
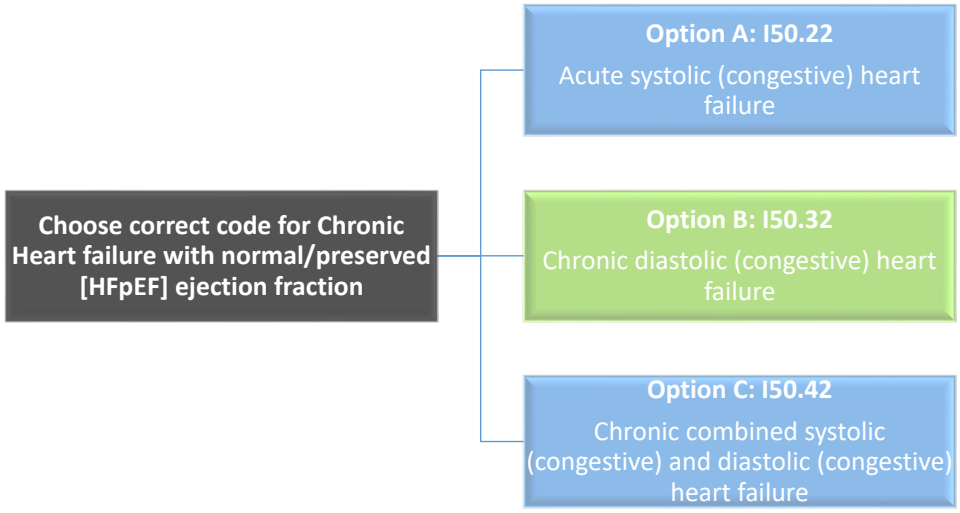


Q & A



Atrial Fibrillation

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Case Study A.fib

Assessment & Plan
Assessment:
56 y/o F with PMH HTN, HLD, depression, hypothyroidism, SLE, RA, gastric bypass/sleeve, GERD, a fib s/p ablation, asthma, presents after syncope episode today. Pt with syncope, different from previous episodes, glucose and labs wnl. Possibly orthostatic hypotension? Vasovagal? Unlikely cardiac/seizure.

Plan:
CVS/RESP/CNS: pt with hx a fib not on ac, HTN, HLD, asthma, presents after syncopal episode
-check orthos VS
-obtain records from Elmhurst
-fall precautions
-consult plastic surgery for lac repair
-ekg reviewed, nsr
-labs reviewed, LFTs wnl, lactate 0.7
-check trop and repeat ekg in am
-check u tox, a1c, lipids
-c/w symbicort bid, singulair 10mg daily
-s/w tylenol q6h prn pain
-c/w celexa 20mg daily, klonopin 2mg bid, gabapentin 800mg daily, trazodone 20mg qhs

GI/ENDO: pt with frequent episode of hypoglycemia, possibly dumping syndrome
-consult nutrition
-check FS q6h

Full code
obs
Cardiac diet
lovenox sq for dvt ppx

Plan discussed with pt and NP

Summary

- **A/P**: A.fib s/p ablation, there is no documentation that conditions is active , provider clearly documented that **Pt with Hx A.fib not on ac**. **Cardiac ablation done in 2013,**
- **PMH**: No Documentation of A.fib
- **Past surgical History**: cardiac electrophysiology study and Ablation 1/30/13, 11/15/2013
- **Assessment/Plan**: A.fib, s/p ablation 2013, not on AC. Lovenox sq for DVT ppx

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Case Study A.fib Cont'd

- Reported Diagnosis – I48.91 - Unspecified atrial fibrillation
- Dx Supported – No
- HCC Validated – No
- Coding Rational: History Vs Active
- Comment: A.fib, s/p ablation 2013, not on AC. Lovenox sq for DVT ppx
- *Recommendation: As per AHA Coding Clinic assign Z86.79 - Personal history of other diseases of the circulatory system as atrial fibrillation has been resolved. There is no documentation of medication for A.fib to prevent reoccurrence.*

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Documentation Recommendations for Atrial fibrillation (AFIB)

Persistent Atrial Fibrillation	Chronic Atrial Fibrillation	Typical Atrial Flutter	Atypical Atrial Flutter
Longstanding I48.11	Chronic I48.20	Type I I48.3	Type II I48.4
Other I48.19	Permanent I48.21		

Clinical Documentation Should Include				
Updated Status of Condition	**Specify Type of A.fib**	**Any Risk Factors**	**Link Associated Conditions with Terms**	**Include Treatment Plan**
Stable, Improved, and/or Worsening	Paroxysmal Persistent or Chronic	i.e. Smoking Obesity	"Due to," "Secondary to" or "Associated with."	• Medications to slow heart rate and to control heart rhythm • Blood-thinning medications, surgical procedures, and any diagnostic tools ordered • Details of scoring tool (CHADs2 or CHAsDS2-VASc) if used • Lifestyle changes and any referral given

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Coding Example for Atrial Fibrillation

DOS	1/30/2022
Diagnosis	I48.20 Chronic atrial fibrillation, unspecified Z79.01 - Long-term (current) use of anticoagulants
Diagnosis Supported	YES
Comments	Assign code I48.20 and Z79.01 - Long-term (current) use of anticoagulants, for long-term use of Eliquis®. Eliquis® is classified as an anticoagulant medication.
Conclusion	*This is an example of best practice clinical documentation of ICD-10 CM coding.*

Question:

A patient was admitted for placement of a Watchman™ left atrial appendage device secondary to a history of chronic paroxysmal atrial fibrillation and persistent left atrial appendage (LAA) thrombus despite anticoagulation (Warfarin) therapy. The patient is being medically managed on Eliquis®. What is the correct ICD-10-CM code assignment to capture the long-term use of Eliquis®?

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Coding Atrial fibrillation (AFIB)

Persistent Atrial Fibrillation → Chronic Atrial Fibrillation → Typical Atrial Flutter → Atypical Atrial Flutter

Coding Tips

- In an inpatient setting, **persistent atrial fibrillation** needs to be reported as a confirmed diagnosis.
- When **multiple types of atrial fibrillation** are documented in the record select the most specific type.
- Document to the **highest degree of specificity** for appropriate ICD-10 code assignment.
- Atrial fibrillation is still reported if the patient is requiring **ongoing medication** to help control the rate.
- Atrial fibrillation is very common in **postoperative patients** and should be verified as a complication before coding it.

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Documentation And Coding For Past Conditions

ICD 10-CM guidelines categorize History codes as resolved/no longer exists.

↓

When a previous condition has an impact on current care a history codes (Z77-Z99) may be required.

↓

To achieve compliance, providers should only document "History of" when the condition no longer exists and is not being treated or addressed.

Providers tend to use the term "**History of**" when referring to a patient's past and/or current conditions.

Examples of Historical or Active DX

If "history of A fib" is documented = **Personal history of** circulatory disease (Z86.79) should be coded. **Historical**

"Pt with history of Afib currently on coumadin" = This should be documented as an active condition that is actively being treated with Coumadin. **Active**

Understanding when to code for Active Condition

According to ICD-10 Guidelines, conditions that coexist at the time of the encounter that affect patient treatment or management should be coded as active conditions. **Do not code conditions that no longer exist**. Personal history codes (Z80-Z87) explains a patient's past condition. History codes may be used as secondary codes if the historical condition or family history has an impact on current treatment.

When you document this	CMS interprets the following
"H/O CHF"	CHF has resolved
"CHF compensated"	CHF is active and stable
"History of angina"	Angina has been resolved (No longer exists)
"Stable angina, Nitrostat PRN"	Angina is active
"H/O A. Fib"	A Fib has been resolved
"A. Fib controlled on Digoxin"	A Fib is active and stable
"Breast cancer s/p lumpectomy and radiation"	History of breast cancer (no longer exists)
"Breast cancer on Adjuvant Therapy"	Breast cancer is active and under treatment
"H/O CVA"	CVA has been resolved; acute CVA becomes H/O at discharge from facility
"Old MI or healed MI"	MI has been resolved; acute MI becomes H/O after 28 days

Unconfirmed Diagnosis In Outpatient Setting

The terms below will not be captured/coded as confirmed/active conditions for outpatient encounters

- Consistent/Compatible With
- Probable/May Have
- Suspected/Suggestive of
- Most Likely
- Concern for
- Rule Out
- Questionable
- Working Diagnosis
- Presumed/Presumably

Recommendation:

- Patient with
- Patient has
- Identify and clarify documentation that is conflicting, incomplete or missing, to accurately capture the patient's severity of disease.
- Patient on medication for
- For unconfirmed conditions use signs & symptoms
- Documentation must support all conditions Assessed and/or affecting patient care management during the encounter.

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Q & A

Pt with history of A fib currently on coumadin

Option A
Z86.79 - Personal history of other diseases of the circulatory system

Option B
I48.91 - Unspecified atrial fibrillation

Option C
I48.20 - Chronic atrial fibrillation, unspecified

Option D
I48.19 - Persistent atrial fibrillation, NOS

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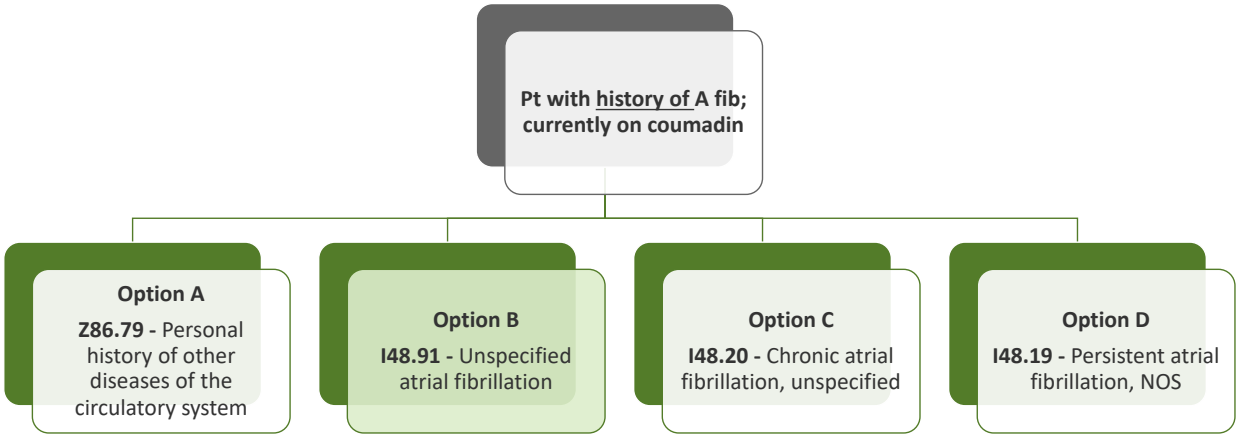
Q & A



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Unstable Angina

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Best Practice Coding Example _ Angina

Physical Exam
Constitutional:
General: He is not in acute distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes:
General: No scleral icterus.
Conjunctiva/sclera: Conjunctivae normal.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Heart sounds: Normal heart sounds.
Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: Normal breath sounds.
Abdominal:
General: Abdomen is flat. Bowel sounds are normal. There is no distension.
Tenderness: There is no abdominal tenderness.
Musculoskeletal:
Right lower leg: No edema.
Left lower leg: No edema.
Neurological:
Mental Status: He is alert and oriented to person, place, and time.

Presented follow up.

C/o constipation. States iron tablet makes it worse.

Reports that he felt dizzy and fell on his knees.

Currently 6 days x 4 hours. Request for increase in home care hours.

Review of Systems
Constitutional: Negative for chills and fever.
Respiratory: Negative for cough and shortness of breath.
Cardiovascular: Negative for chest pain and palpitations.
Gastrointestinal: Negative for abdominal pain, constipation, diarrhea, nausea and vomiting.
Neurological: Negative for dizziness and headaches.

Assement and Plan:

1. Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin (CMS/HCC)
- POCT glycosylated hemoglobin (Hb A1C): 7.
- continue current medication, diet and exercise.

2. Constipation, unspecified constipation type
- high fiber diet. Limit iron tablet to twice weekly.
- polyethylene glycol (MIRALAX) 17 g packet; Take 17 g by mouth once daily. Dispense: 30 packet; Refill: 1

3. Angina pectoris, unspecified (CMS/HCC)
- continue aspirin and statin. Prn NG for angina.

4. Diabetes mellitus due to underlying condition with other specified complication, without long-term current use of insulin (CMS/HCC)
See above

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Best Practice Coding Example _ Angina Cont'd

- **Reported Diagnosis – I20.9 - Angina pectoris, unspecified**
- **Dx Supported – YES**
- **HCC Validated – YES**
- **Coding Rational: HCC Validated**
- **Comment: A/P: Angina Pectoris, on statin, aspirin, prn NG for angina**

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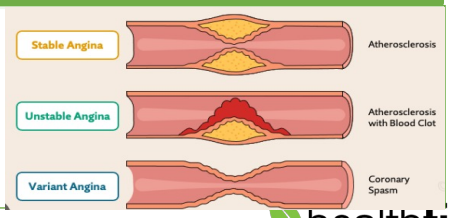
Unstable Angina

Documentation Recommendations				
Status of Condition	**Specify Vessel**	**Symptoms**	**Link Associated Conditions**	**Include Treatment Plan**
• Improved • Worsening	• Native • Autologous Vein • Bypass graft	• Occurs at rest • Becomes more frequent, severe, or prolonged than the usual pattern • Change from usual pattern • No respond to rest	**By using verbiage:** • Due to • Associated with • Secondary to i.e., Atherosclerosis, history of MI, Heart Disease, etc.	• Final diagnostic statement • **Diagnostic results with findings:** EKG, echocardiography, or stress test confirming diagnosis of unstable angina. • **Treatment options** for unstable angina, including: ○ Coronary angiography, coronary angioplasty, stent, or coronary artery bypass graft procedure, referrals ○ Medications i.e., Nitroglycerin, Heparin

Use ICD-10 codes to specify the form of angina pectoris

- **I20.0** - Unstable angina
- **I23.7** - Postinfarction angina
- **I25.110** - Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- **I25.700** - Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris
- **I25.710** - Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris
- **I25.720** - Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris
- **I25.730** - Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris
- **I25.750** - Atherosclerosis of native coronary artery of transplanted heart with unstable angina
- **I25.760** - Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina
- **I25.790** - Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris



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Coronary Microvascular Dysfunction

I20.81
Angina pectoris with **coronary microvascular dysfunction**

I21.B
Myocardial infarction with **coronary microvascular dysfunction**

I24.89
Other forms of acute ischemic heart disease

I20.89
Other forms of angina pectoris

I24.81
Acute coronary microvascular dysfunction

I25.85
Chronic coronary microvascular dysfunction

Recurrent Chest Pain → **Shortness of breath** → **Fatigue** → **If untreated, lead to Heart failure**

An acute myocardial infarction that occurs without coronary artery blockage and in the presence of coronary microvascular disease is assigned to code I21.B - Myocardial infarction with coronary microvascular dysfunction.

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Coding Example for Angina

Question:

A patient with a history of coronary artery disease (CAD) status post quadruple coronary bypass procedure, and multiple coronary interventions, including angioplasty with stent placement presents to the Emergency Department (ED) with severe chest pain. The provider documents chronic refractory angina pectoris and refers the patient to a cardiac specialist for further management. How would this encounter be coded?

Answer:

Assign codes I25.702, Atherosclerosis of coronary artery bypass graft(s), unspecified, with refractory angina pectoris, as the first-listed diagnosis. Assign also code Z98.61, Coronary angioplasty status.

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Q & A

Pt with Atherosclerotic heart disease of native coronary artery with unstable angina pectoris,

Assigned ICD-10 code : I25.110

TRUE

FALSE

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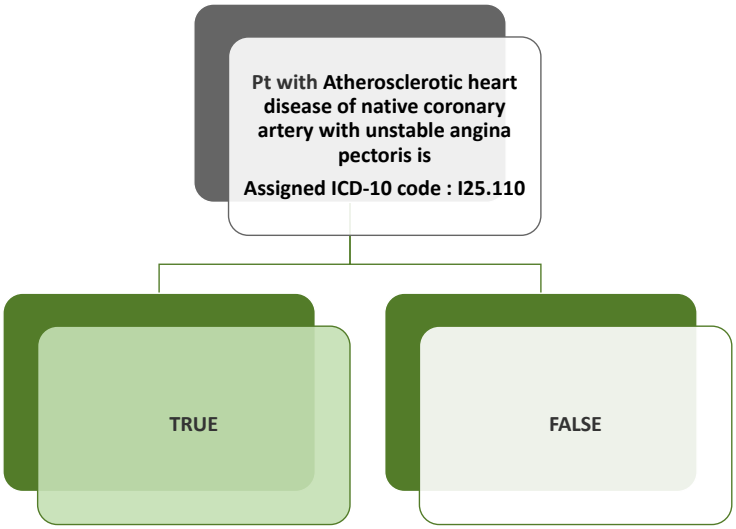
Q & A



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Coding Tips for Angina

- There is a code differentiation between stable angina and unstable angina or angina, complicated by additional comorbidities.
- Unstable angina is considered an acute condition with life-threatening consequences. It would seldom be reported in the office setting.
- American Heart Association guidelines recommend initial treatment of unstable angina in the Emergency Department/Emergency Room (ED/ER).
- Medical management of unstable angina is different from stable angina, and it should be clearly supported by documentation

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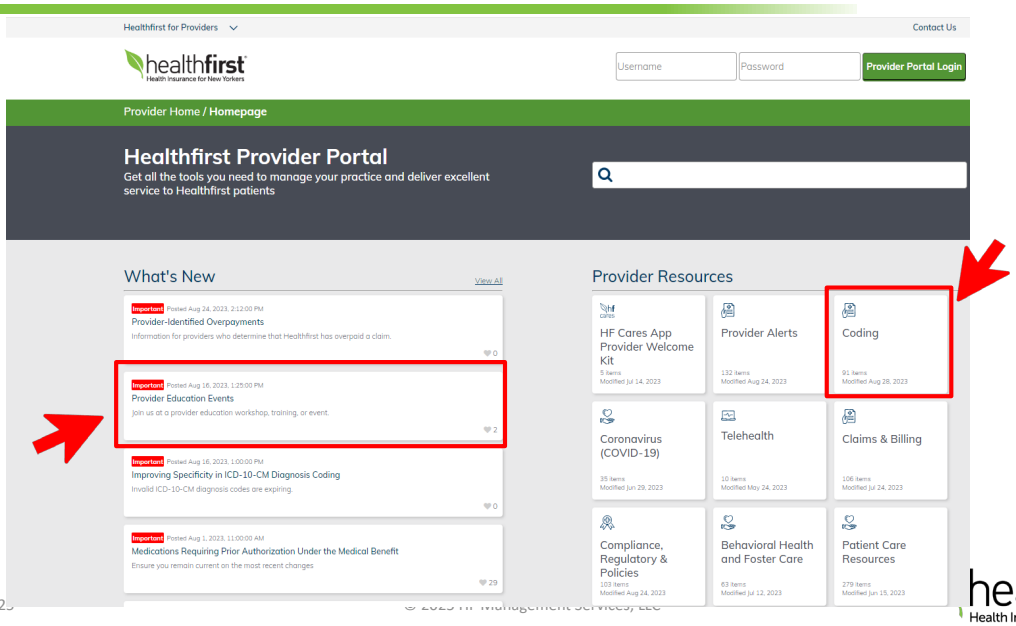
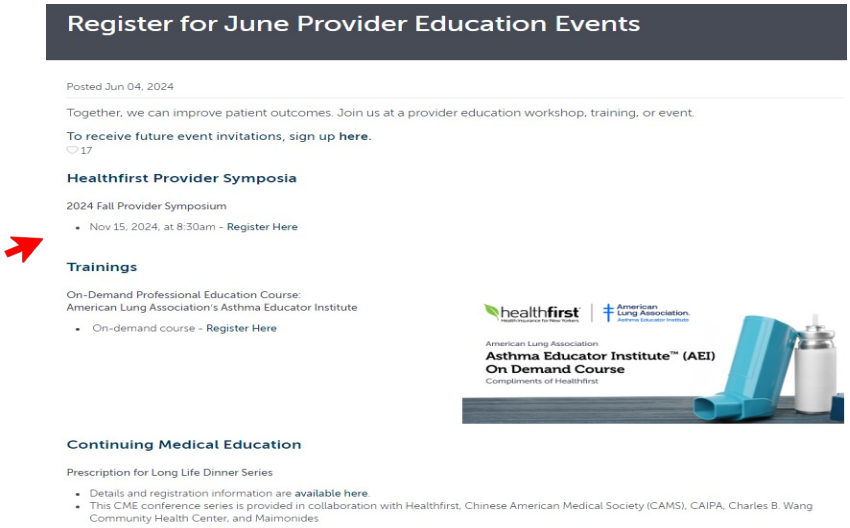
Healthfirst Job aids for Providers & Coders

https://hfproviders.org/what-s-new/provider-education-events

Healthfirst Provider Website (HFproviders.org)



Healthfirst Provider Website (HFproviders.org)



- ✓ Continuing Medical Education
- ✓ Webinars & Workshops
- ✓ Past Events & Sessions Recordings

https://hfproviders.org/what-s-new/provider-education-events

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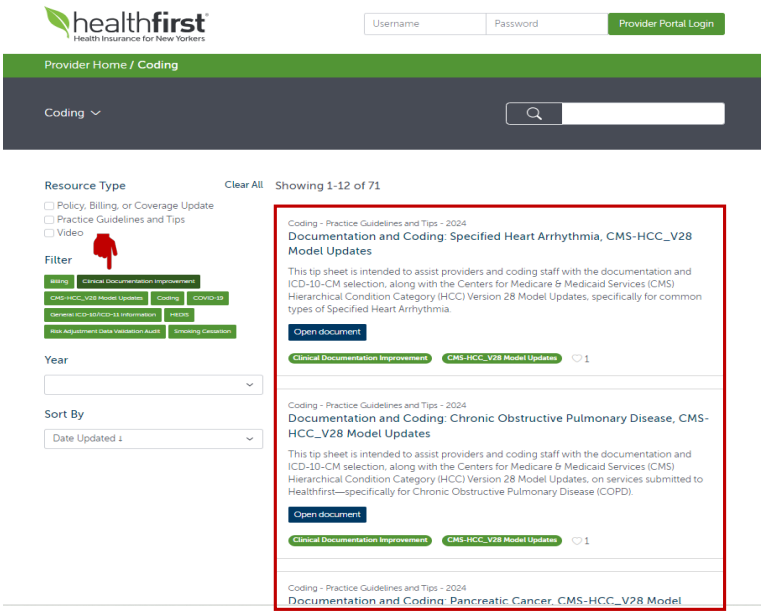

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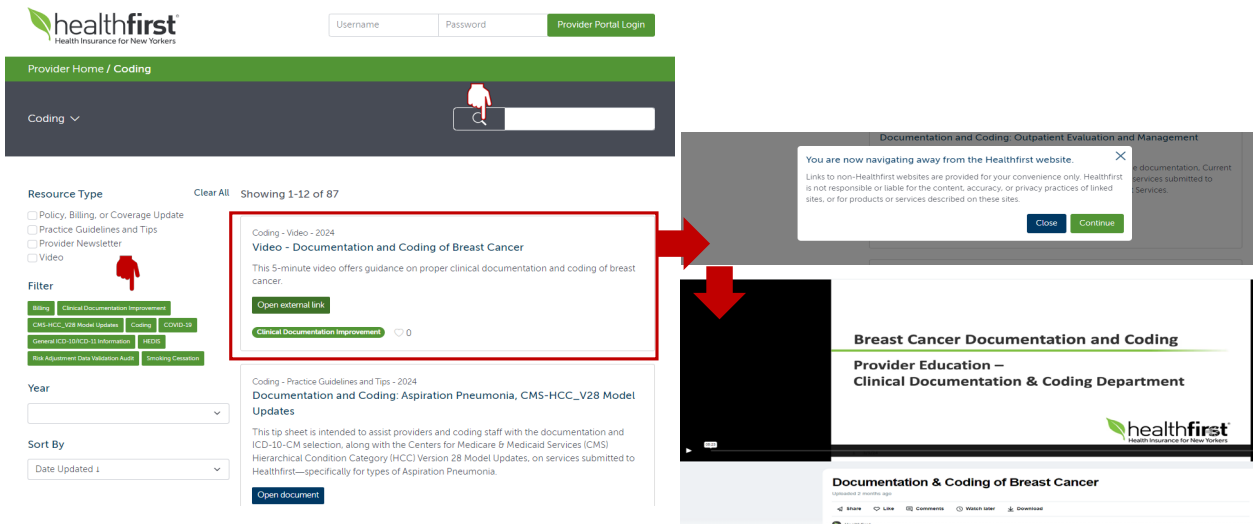

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Questions

Website of Job Aids: https://hfproviders.org/provider-resources/coding

Email any questions or concerns at: #Risk_Adjustments_and_clinical_Documentation@healthfirst.org

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References

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- https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/chronic-conditions
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- https://www.nhlbi.nih.gov/health/heart-failure
- https://www.nhlbi.nih.gov/health/angina
- https://www.nhlbi.nih.gov/health/atrial-fibrillation

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Thank you for attending
Session 2: Heart Failure, AFIB, Angina (Part 2)
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