

MRA Documentation & Coding Best Practices

CARDIOLOGY /

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Should I code for other chronic conditions that aren't related to a cardiac diagnosis?



Yes! Document all cardiovascular diagnosis and any other chronic conditions that you address or that impact your clinical decision making. (ex. Obesity, Diabetes, Etc.)

Best Practices

1 Document the diagnosis rather than the symptom when appropriate:

Example:

Angina compared to chest pain.

2 Document to the highest degree of specificity:

Example:

Systolic or diastolic CHF compared to CHF unspecified.

They are different diagnoses and the specificity of the ICD-10 code may impact how care is reimbursed or graded. This impacts risk score and cost targets.

Example:

Arrhythmia (specified)

Specify the acuity: acute, paroxysmal, chronic, etc.

Document the location: atrial, ventricular, supraventricular, etc.

Document the rhythm name: flutter, fibrillation, type 1 atrial flutter, long QT syndrome, sick sinus syndrome, etc.

3 Never miss an opportunity to document commonly associated conditions: (unless conditions are unrelated)

Example:

- Diabetes with peripheral angiopathy
- Sleep apnea with heart failure/hypertension/atrial fibrillation
- Morbid obesity with coronary artery disease (CAD)/heart failure

4 Recognize if your patient has other conditions related to their hypertension:

Example:

- Heart disease
- Heart failure
- Chronic kidney disease

If the answer is **YES**, do not use ICD-10 I10: Essential (primary) HTN code and choose a more specific code.





Please reference the back page for a further list of ICD-10 codes.



Tell your patient's story. The only visibility insurers have to the care you provide and the conditions you manage is through **documentation** and **coding**.

Cardiology ICD-10 Reference Guide

This is not intended to be a comprehensive list of all applicable HCCs/ICD-10s.

 Essential Hypertension	Essential (primary) Hypertension I10 Essential (primary) hypertension
 Hypertension with Heart Disease (example: CHF; Myocarditis; Cardiomegaly)	Hypertensive Heart Disease I11 Hypertensive heart disease with heart failure ▲ use additional ICD-10 code below to identify (type) of heart failure I11.9 Hypertensive heart disease withOUT heart failure
 Hypertension with Chronic Kidney Disease	Hypertensive Chronic Kidney Disease I12.0 Hypertensive CKD with stage 5 CKD or end stage renal disease + use additional ICD-10 code below to identify (stage) of CKD I12.9 Hypertensive CKD with stage 1 through stage 4 CKD, or unspecified CKD + use additional ICD-10 code below to identify (stage) of CKD
 Hypertension with Heart Disease AND with Chronic Kidney Disease	Hypertensive Heart Disease with CKD I13.0 Hypertensive heart and CKD with heart failure and stage 1 through 4 CKD, or unspecified CKD ▲ use additional ICD-10 code below to identify (type) of heart failure + use additional ICD-10 code below to identify (stage) of CKD I13.10 Hypertensive heart and CKD withOUT heart failure, with stage 1 through 4 CKD, or unspecified CKD + use additional ICD-10 code below to identify (stage) of CKD I13.11 Hypertensive heart and CKD withOUT heart failure, with stage 5 CKD, or ESRD + use additional ICD-10 code below to identify (stage) of CKD I13.2 Hypertensive heart and CKD with heart failure and with stage 5 CKD or ESRD ▲ use additional ICD-10 code below to identify (type) of heart failure + use additional ICD-10 code below to identify (stage) of CKD

▲ Heart Failure	+ Chronic Kidney Disease
I50.1 Left ventricular failure, unspecified	N18.1 CKD, Stage 1
I50.2- Systolic (congestive), heart failure • Add 5th character: (1) acute, (2) chronic, (3) acute on chronic, (0) unspecified	N18.2 CKD, Stage 2 (mild)
I50.3- Diastolic (congestive) heart failure • Add 5th character: (1) acute, (2) chronic, (3) acute on chronic, (0) unspecified	N18.3 CKD, Stage 3 (moderate)
I50.4- Combined systolic (congestive) and diastolic (congestive) heart failure • Add 5th character: (1) acute, (2) chronic, (3) acute on chronic, (0) unspecified	N18.4 CKD, Stage 4 (severe)
I50.81- Right heart failure • Add 6th character: (1) acute, (2) chronic, (3) acute on chronic, (4) due to left heart failure (0) unspecified	N18.5 CKD, Stage 5
I50.82 Biventricular heart failure	N18.6 End Stage Renal Disease (ESRD)
150.83 High output heart failure	
150.84 End stage heart failure	
150.89 Other heart failure	
150.9 Heart Failure, unspecified	

Medical Risk Adjustment **M-E-A-T**

A common acronym utilized by coders to identify documentation that supports coding accuracy is M-E-A-T. You can utilize this handy tool as you complete your documentation.

Including **one or more** of the M-E-A-T details at a face-to-face visit for each condition that requires or affects patient care treatment or management will put you on the path to success in capturing risk.

M monitor
signs, symptoms, ordering or reviewing and referencing of tests/labs, disease progression or disease regression.

E evaluate
test results, medication effectiveness, physical exam findings and response to treatment.

A assess or address
by discussion, acknowledging, reviewing records, documenting status/level conditions and counseling.

T treat
with prescribing/continuation of medications, referral to specialist for treatment/consultation, surgical/other therapeutic interventions and plan for management of condition(s).

Examples:

If the treatment you are providing follows one or more elements of M-E-A-T (Monitor/Evaluate/Assess/Treat)

Monitor: Atrial Fibrillation-Patient on Coumadin followed by primary MD

Evaluate: Congestive Heart Failure+3LE edema

Assess/Address: Patient has shortness of breath, chest x-ray scheduled

Treat: Patient with hyperlipidemia-well managed on Lipitor

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Document and code for all diagnoses for each patient, every year. Keep in mind that a patient with CHF this year is considered to no longer have CHF as of January 1st of the following year or in subsequent years if it is not documented and coded **every calendar year**.